

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345205	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Westwood Hills Nursing and Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Fletcher Street , Wilkesboro, North Carolina, 28697	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/16/25 through 11/19/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: 1DB619-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted 11/16/25 through 11/19/25. Event ID: 1DB619-H1. The following intakes were investigated: 2669670, 2618224, 2583152, 871606, 871605, and 871611. 1 out of 22 compliant allegations resulted in deficiency.	F0000		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews with resident, staff, Pharmacy Manager and the Medical Director, the facility failed to implement effective systems to safeguard a resident's controlled medication from misappropriation (30 tablets of oxycodone 15 milligrams) for 1 of 1 resident reviewed for misappropriation of property (Resident #22). The findings included: Resident #22 was admitted to the facility on 08/19/15 with diagnoses that included chronic pain syndrome. Review of Resident #22's physician orders dated	F0602	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0602 SS = D	<p>Continued from page 1 10/30/24 revealed an order for oxycodone 15 mg by mouth every six hours for pain.</p> <p>Review of Resident #22's Medication Administration Record for 08/2025 revealed he was given oxycodone 15 mg by mouth every six hours as ordered.</p> <p>Review of a pharmacy packing slip revealed Resident #22's oxycodone 15 mg /120 tablets were delivered to the facility on 08/19/25 and were counted in by Nurse #3 and Nurse #4. The packing slip indicated the count was correct.</p> <p>Review of Resident #22's quarterly Minimum Data Set assessment dated 09/05/25 indicated the Resident was cognitively intact and received routine pain medication.</p> <p>An interview was conducted with Resident #22 on 11/16/25 at 1:15 PM. The Resident explained that he was in chronic pain all the time and received routine pain medication to help control his pain. He stated that the facility provided his pain medication and he had never run out of pain medication.</p> <p>Review of an Occurrence Investigation Report Summary dated 09/12/25 revealed Resident #22 was ordered oxycodone 15 mg by mouth every six hours. The facility received the Resident's medication from the pharmacy on 08/19/25 of 4 cards of 30 tablets each card for a total of 120 tablets. The order was verified and signed in by two licensed nurses per protocol. The medication was not started until 08/21/25 due to the Resident already having some oxycodone 15 mg tablets on the cart from a previous order. On 09/11/25 the nurse notified the Director of Nursing (DON) that Resident #22 only had two tablets of oxycodone 15 mg left so the DON contacted the pharmacy and was informed that Resident #22 should have enough oxycodone tablets to get through the following week because they sent 120 tablets of oxycodone for the Resident on 08/18/25. The DON immediately reviewed the previous packaging slip and verified that 120 tablets had been verified and signed in by nursing staff on 08/19/25. The DON verified Resident #22's Medication Administration Record that the Resident had not missed any doses and verified one card in the cart labeled #4 of 4 with 2 tablets remaining in the card. The declining count sheet for the oxycodone matched with 2 tablets remaining. The DON then pulled all Resident #22's declining count sheets for the oxycodone that was received on 08/19/25 and discovered that the declining count sheet for card #3 of 4 was missing. The DON pulled the Shift Change Controlled Substance Count Check Form (a count sheet</p>	F0602		

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F0602 SS = D	<p>Continued from page 2 utilized between shifts to indicate the controlled medication cards and declining count sheets match and were correct) for the 100-hall medication cart from July to present and discovered that the sheet from dates 08/16/25 through 08/22/25 was also missing. The DON pulled the packing slip for the previous order of oxycodone for Resident #22 which was 07/17/25 to verify the number of tablets received and signed in and the count was correct. There were no concerns identified.</p> <p>Review of a Pharmacy memo to the facility dated 09/12/25 indicated that the facility was charged for 60 tablets of oxycodone 15 mgs each for Resident #22.</p> <p>Review of a Drug Enforcement Administration form dated 09/14/25 revealed the facility reported the loss or theft of 30, 15 mg oxycodone hydrochloride tablets.</p> <p>Review of the Investigation Report dated and faxed to the Health Care Personnel Registry on 09/18/25 revealed that on 09/12/25 at 9:00 AM the facility became aware of 30, 15 mg oxycodone tablets were missing for Resident #22. The Report indicated that the local police were notified of the missing narcotics on 09/12/25 at 6:30 PM and the Department of Social Services was notified on 09/12/25 as well. The Report continued to explain that the investigation could not confirm a person took the medication therefore, drug diversion could not be confirmed. Also, it was not known whether the pill pack was thrown in the trash mistaken for an empty card. The allegation was not substantiated for drug diversion.</p> <p>Review of Resident #22's Controlled Substance Count Records (declining count sheet) revealed the following: declining count sheet #1 was initiated on 08/21/25 with 30 tablets and exhausted to 0 tablets on 08/28/25. Declining count sheet #2 was initiated on 08/28/25 with 30 tablets and exhausted to 0 tablets on 09/04/25 and declining count sheet #4 was initiated on 09/05/25 with 30 tablets and exhausted to 2 tablets on 09/11/25. There was no record of declining count sheet #3.</p> <p>Review of the Shift Change Controlled Substance Count Check Form for 100 hall revealed the Shift Change Count Sheet for the dates of 08/16/25 through 08/22/25 was missing.</p> <p>An interview was conducted with the Director of Nursing (DON) on 11/17/25 at 2:15 PM. The DON explained that she was notified on the afternoon of 09/11/25 by Nurse #1 that Resident #22 only had 2 oxycodone 15 mg tablets left in the medication card and when Nurse #1 called the pharmacy to request more oxycodone to be sent, the</p>	F0602		

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F0602 SS = D	<p>Continued from page 3 pharmacy informed Nurse #1 that they had sent 120 tablets to the facility on 08/18/25 and that amount should be enough for at least another week or so. The DON continued to explain that she and Nurse #2 started an investigation into the missing oxycodone. The investigation found that the last supply of Resident #22's oxycodone was delivered to the facility on 08/18/25 and the count was verified by Nurse #3 and Nurse #4 on 08/19/25. The DON reported that the current medication card that was being used was card #4 so they located the declining count sheets for cards #1 and #2 but could not find card #3's declining count sheet. The DON continued to explain that she was able to locate the Shift Change Controlled Substance Count Check Forms for the time duration when all the declining count sheets were being utilized except for the count sheet for 08/16/25 through 08/22/25. The DON reported that she drug tested all the nurses that worked on the 100-hall medication cart during that time frame and all the drug tests were negative. The DON continued to explain that she interviewed Nurse #3 and Nurse #4 to verbally verify they conducted the correct count when the medication was delivered from the pharmacy on 08/19/25. When the DON was asked if she interviewed Nurse #4 about why he initiated medication card #4 instead of #3 on 09/05/25 the DON remarked the nurses often do not go by the sequence of order when initiating the medication cards. The DON explained that she called the pharmacy and had them send more oxycodone at the facility's expense. The DON stated Resident #22 did not miss a dose of his medication because they were able to obtain more medication before his supply was exhausted. The DON reported that after all the investigation into the missing oxycodone, she could not determine what happened to the medication. She stated that she wanted to believe that the medication card was accidentally thrown away but that would not answer how the declining count sheet and the shift change sheet went missing as well. She stated she did not want to think that someone would have taken the medication but that appeared to be the only reasonable answer. She stated she hoped the new systems they had in place would prevent diversion or misappropriation from happening again.</p> <p>An interview was conducted with Nurse #4 on 11/18/25 at 2:15 PM and 7:34 PM. The Nurse explained that Resident #22 went to the pain clinic for pain control management and prescribed the Resident's oxycodone. Nurse #1 asked him to monitor how much oxycodone Resident #22 had on hand to ensure there was enough to last until his next appointment. On 09/11/25 Nurse #4 noticed that the Resident only had 2 oxycodone left and his next appointment at the pain clinic was scheduled for</p>	F0602		

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F0602 SS = D	<p>Continued from page 4 09/22/25 so Nurse #4 notified Nurse #1 about the situation. Nurse #4 continued to explain that later the DON interviewed him about whether he and Nurse #3 verified and signed in the correct count of Resident #22's oxycodone on 08/19/25 and whether it was delivered in 4 cards of 30 tablets in each card and if he verified the count with Nurse #3. The Nurse stated that the DON questioned him about where medication card #3 was because they could not locate the declining count sheet for card #3. The DON also questioned Nurse #4 about why he initiated medication card #4. The Nurse continued to explain that he informed the DON that he and Nurse #3 verified the correct count of Resident #22's oxycodone of 120 tablets and that it was delivered in 4 medication cards. He assured her that the count was correct. He also informed the DON that he initiated medication card #4 on 09/04/25 because it was the only card left in the cart with Resident #22's oxycodone. He stated that at the time he initiated the card he did not notice that card #3 was not there, he just started the card that remained in the medication cart.</p> <p>On 11/17/25 at 3:45 PM during an interview with Nurse #1 she explained that Nurse #4 informed her on 09/11/25 that he did not think Resident #22 had enough oxycodone 15 mg tablets to get Resident #22 to his next pain clinic appointment on 09/22/25. Nurse #1 stated she called the pharmacy on 09/11/25 to send more medication, and she was informed that they had delivered enough oxycodone tablets to do the Resident for at least another week or so. She then notified the DON of what the pharmacy told her and the facility started an investigation into why Resident #22 did not have more oxycodone on hand.</p> <p>An interview was conducted with Nurse #3 on 11/18/25 at 7:39 PM who explained that she was the supervisor on 08/19/25 and remembered that she counted in Resident #22's oxycodone 120 tablets in 4 cards of 30 tablets each with Nurse #4. She stated that it was the last time she saw the medication cards because she did not work as a hall nurse.</p> <p>An interview was conducted with Nurse #2 on 11/17/25 at 4:10 PM. The Nurse explained that she collected the declining count sheets and shift change sheets about once or twice a week and filed them in her office. When she searched for the declining count sheet for Resident #22's oxycodone card #3 and the shift change sheet that pertained to that card she could not find it in her files. They were missing.</p> <p>On 11/18/25 at 6:50 PM an interview was conducted with</p>	F0602		

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F0602 SS = D	<p>Continued from page 5</p> <p>Nurse #5 who explained that he was employed on an as needed (PRN) basis and did not have a set schedule. He continued to explain that he vaguely remembered working on 09/04/25 and dispensing the last dose of Resident #22's oxycodone and that he did not remember how many cards of oxycodone were left in the medication cart. Nurse #5 stated that Nurse #4 who came on after him would have initiated the new card of oxycodone. The Nurse stated that the count on the shift change sheet was correct because if it had not been correct then they would have had to notify the supervisor and that did not happen.</p> <p>On 11/18/25 at 8:30 AM during an interview with the Medical Director, he explained that he was made aware of the missing oxycodone and the facility could not determine what happened to them. He stated the facility had initiated interventions to hopefully prevent diversion or misappropriation from happening again.</p> <p>On 11/19/25 at 9:40 AM an interview was conducted with the Pharmacy Manager who explained that on 09/10/25 the pharmacy received a prescription from the pain clinic for Resident #22's oxycodone hydrochloride 15 mg tablets and 60 tablets were delivered to the facility on 09/11/25. The Pharmacy Manager stated that the supply of Resident #22's oxycodone was previously delivered to the facility on 08/18/25 which was a total of 120 tablets of oxycodone hydrochloride 15 mg tablets that were packaged in four cards of 30 tablets in each card.</p> <p>The facility provided the following action plan with the completion date of 09/16/25.</p> <p>- How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</p> <p>On 9/12/25 an investigation by the Director of Nursing (DON) revealed 30 Oxycodone 15mg tablets were missing from the medication cart on Blue Hall for Resident #22. An investigation was initiated immediately.</p> <p>Resident #22 is a 63-year-old male with a BIMS of 15. At the time of the reported incident, the resident had an order for scheduled Oxycodone 15 mg every 6 hours. The facility received the resident's medication (Oxycodone 15 mg; 120 tablets/4 cards of 30 tabs each) from the pharmacy on 8/19/25. The pharmacy packing slip date showed the medication was prepared by the pharmacy on 8/19/25 and received in the facility on 8/19/25. On 8/19/25, at the time the facility received the medications, the order was verified, and the</p>	F0602		

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F0602 SS = D	<p>Continued from page 6 medications were signed into the facility by 2 licensed nurses as correct. The first card of 30 tablets was not started until 8/21/25 due to having some medication left in the cart from the previous order.</p> <p>On 9/11/25, the nurse notified the DON that Resident #22 had 2 tablets of Oxycodone 15mg remaining in the cart and needed a refill. The DON then contacted pharmacy and was informed that the resident should have enough medication remaining in the cart throughout the next week. The DON immediately reviewed the previous packing slip and verified 120 tabs had been delivered by the pharmacy and verified that 1 card from that delivery remained in cart labeled 4 of 4 with 2 tablets left on the card. The corresponding count sheet was verified as correct with the card. The DON reviewed all count sheets for Oxycodone 15mg that were received with this order. The DON then discovered that count sheet 3 of 3 and card 3 of 3 were missing from the cart. Upon further investigation, the DON discovered the corresponding shift change sign in sheet for 8/16/25-8/22/25 was also missing from the cart. The DON also reviewed the previous supply delivered of Oxycodone 15mg for this resident received on 7/17/25 and noted no concerns.</p> <p>On 09/11/25 the Director of Nursing and licensed nurses on the unit assisted to look for missing medication, declining count sheet, and the shift-to-shift report sheets in medication room, shred bins, and trash. All other medication carts were checked for the missing medication at this time as well. After the final search for the narcotic medication, corresponding count sheet, and shift to shift change sheets were exhausted the facility determined that the medication was indeed missing.</p> <p>The concern was reported on 9/12/25 to the Department of Health and Human Servies and the Medical Provider and the resident was notified as he is his own responsible party (RP) on 9/12/25.</p> <p>On 9/12/25, Resident #22 was assessed for pain by the licensed nurse. No concerns were identified.</p> <p>The Director of Nursing contacted the pharmacy to have the resident's Oxycodone 15mg replaced. The pharmacy replaced the medication on 9/11/25 at no cost to the resident. Facility received 60 tablets on 9/11/25 to refill the resident's current prescription.</p> <p>- Address how the facility will identify other residents having the potential to be affected by the</p>	F0602		

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F0602 SS = D	<p>Continued from page 7 same deficient practice:</p> <p>On 9/12/25 the following actions were taken to prevent concerns for other residents in the facility.</p> <p>-On 9/12/2025 the Director of Nursing (DON) completed an audit of the last 30 days of ordered narcotic medications to ensure the medications were in the medication cart, administered, or returned to pharmacy per protocol. The Director of Nursing initiated an investigation into any identified areas of concern. No concerns were identified.</p> <p>-On 9/12/2025 the DON/Quality Assurance nurse completed an audit of 100% of all residents' Controlled Substance Count sheets in comparison to the narcotic medication blister packs in the medication cart to ensure there were no discrepancies in the count of the medications. No concerns identified during this audit.</p> <p>-On 9/12/2025, the DON/QA nurse inspected the narcotic blister pill packages for any tampering of medications. No concerns for tampering identified during this audit.</p> <p>-On 9/12/2025 the licensed staff nurses-initiated assessment of all residents for pain. If pain reported the DON was to address and initiate non-pharmacological interventions, pain medication, and/or physician notification for any identified areas of concern during the audit. The audit was completed by 9/13/2025. No complaints of pain were expressed during this audit.</p> <p>-On 9/12/2025 the administrative nurses completed interviews with all alert and oriented residents regarding (1) Do you have any concerns with medication administration to include pain medication? A concern form was to be completed for any identified area of concern. No concerns identified during these interviews.</p> <p>-On 9/12/2025 the administrative nursing staff completed interviews with all licensed nurses and medication aides regarding (1) Do you have any concerns with misappropriation to include medications that have not been reported and addressed (Yes or No)? This will be completed 9/15/25. Any concerns identified were to be addressed immediately by the administrator and DON. No concerns identified during these interviews.</p> <p>-On 9/12/2025 the Payroll Clerk completed an audit of all nurses and medication aides' license verification and Health Care Personnel Registry checks which is verification of valid certification, and no abuse reported on the registry. All areas of concern were to</p>	F0602		

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F0602 SS = D	<p>Continued from page 8 be addressed during the audit. This audit was completed 9/15/25. All licenses and certifications were valid with no concerns identified during this audit.</p> <p>-On 9/12/2025 the DON/QA Nurse reviewed packing slips for the past 30 days to ensure all narcotic medications were checked in appropriately and accounted for. This audit was completed 9/15/2025. No concerns identified during this audit.</p> <p>-On 9/12/25 drug screens were initiated for all licensed nurses who worked Blue hall cart during the timeframe identified in the investigation, 8/15/25-8/23/25. The screenings with results were completed by 9/15/25. No positive screens identified during this audit.</p> <p>- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>On 9/12/25 the administrative nursing staff initiated in-service education with 100% of all licensed nurses and medication aides regarding Controlled substance diversion to include the definition, implications, process for 2 licensed nurses to verify medications and count sheets as correct as they are delivered to the facility and ensure the narcotics are placed on the appropriate cart, and the process for returning narcotic medications to the pharmacy. The process for returning narcotic medications to the pharmacy is as follows: return to pharmacy form is filled out with the narcotic medication and number of medications remaining by the licensed nurse, the form is faxed to the pharmacy and placed in the numbered bag with medications by the licensed nurse and sealed, sealed bag is placed on the medication cart in the narcotic lock box, and the driver brings the fax received with information confirming the correct narcotic medication. The medication and form are taken by the pharmacy in the sealed bag, and the shift-to-shift change form is updated by the licensed nurse to verify new count of medications and sheets in the cart. The nurses were also educated on how to appropriately count the narcotics that are on each cart to include: verifying the prescription number and well as that the narcotic count sheet matches the number on the narcotic blister card, ex: 1 of 4, 2 of 4, 3 of 4 and 4 of 4 and verify all is correct. All in-services will be completed on 9/15/25. After 9/15/25 any licensed nurse or medication aides who have not received the training will complete upon their next scheduled shift by the Staff Development Coordinator.</p>	F0602		

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F0602 SS = D	<p>Continued from page 9</p> <p>Beginning 9/13/25 the Registered (QI) Quality Assurance Nurse began picking up the completed Narcotic declining count sheets and shift to shift change sheets 2x/weekly for each cart to ensure all declining count sheets and shift to shift count sheets are correct and accounted for. The QI nurse reviews for any concerns and reports to DON as appropriate. The DON reviews and addresses any concerns identified.</p> <p>- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>Beginning 9/15/25, a 100% audit of all ordered narcotic medications will be reviewed by the Director of Nursing and the Assistant Director of Nursing weekly x4 weeks and compared to the Controlled Substance Count Sheets, medication administration record, and/or return of drug slips to ensure the narcotic medications are being administered or have been returned to the pharmacy. The Director of Nursing/Assistant Director of Nursing verifies that all narcotic medications, shift to shift change sheets, and declining count sheets are present in the cart and that no other concerns were identified using the Controlled Substance Audit tool. All areas of concern were to be addressed during the audit including any re-education of the licensed nurses and medication aides. The Director of Nursing/Assistant Director of Nursing will review and initial audits weekly for 4 weeks, then monthly for 1 month to ensure all areas of concern were addressed appropriately.</p> <p>On 9/13/25, the Director of Nursing/Assistant Director of Nursing began reviewing the order listing report daily to ensure all narcotic medications are in the medication cart/narcotic lock box and discontinued narcotic medications are taken off the medication cart/narcotic lock box. Any concerns identified are investigated by the DON immediately.</p> <p>The Administrator or Director of Nursing will present the findings of the audit tools to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will meet monthly for 2 months and review the audit tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. The QAPI meetings were held on 9/22/25 and 10/21/25.</p> <p>Date of Compliance: 9/16/25</p> <p>Validation of the corrective action plan was completed on 11/19/25.</p>	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345205	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Westwood Hills Nursing and Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Fletcher Street , Wilkesboro, North Carolina, 28697	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0602 SS = D	Continued from page 10 The corrective action plan was validated by reviewing education provided to staff, reviewing the interviews with staff and residents, and reviewing the monitoring plan put in place. Residents interviewed during the survey denied untreated pain. Controlled medication declining count sheets and shift change sheets were validated at 100% correct. Evidence that action plan was presented in monthly Quality Assurance on 09/22/25 and 10/21/25. The correction action plan completion date of 09/16/25 was validated.	F0602		
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to remove 63 expired nutritional shakes from their dry storage area which resulted in 3 of the expired nutritional shakes making it to the service line and prepared for service to residents. The findings included:	F0812		

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F0812 SS = D	<p>Continued from page 11</p> <p>An observation made of the facility's dry storage area on 11/16/25 at 9:50 AM revealed 48 mixed berry flavored nutritional supplement shakes with an expiration date of 08/01/25 and 18 vanilla flavored nutritional shakes, with an expiration date of 06/20/25, sitting in the dry storage room on the top shelf.</p> <p>A follow-up observation of the kitchen, completed on 11/18/25 at 12:21 PM revealed the 48 mixed berry nutritional supplements with an expiration date of 08/01/25 to still be on the shelf in the dry storage area. However, there were only 15 vanilla flavored nutritional supplements with an expiration date of 06/20/25 in the dry storage area.</p> <p>An observation of the tray service line on 11/18/25 at 12:25 revealed 3 vanilla flavored nutritional shakes with an expiration date of 06/20/25 to be in an ice bin on the service line, ready to be served. The surveyor intervened and removed the expired nutritional shakes from the service line to prevent them from being served to residents.</p> <p>A brief interview with the Assistant Dietary Manager on 11/18/25 at 12:27 PM revealed she believed she had checked all of the nutritional shakes earlier that week but stated she must have missed "a few" and that the expiration dates should have been checked when she pulled them from the back to place them on the service line. She also indicated that food items were checked as new food stock arrived at the facility.</p> <p>An interview with the Dietary Manager on 11/19/25 at 9:54 AM revealed the facility must have ordered too many nutritional shakes and not enough residents in the facility were drinking them. He also stated the facility's process for ensuring that expired food was removed from stock included checking the food items twice a week, usually when the new food stock comes into the facility. He reported the kitchen storage areas were small and the facility typically ordered enough food to fix the meals scheduled until the next food order arrived. He reported he expected his staff to remove expired food items as they expired and indicated there was no reason for the nutritional shakes to have been overlooked for so long. The Dietary Manager stated the responsibility ultimately belonged to himself to ensure that there were no expired food items in the kitchen.</p> <p>An interview with the Administrator on 11/19/25 at 1:24 PM revealed he did not have many residents in the facility that used nutritional shakes but there was no reason why so many expired nutritional shakes were</p>	F0812		

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F0812 SS = D	Continued from page 12 still in the dry storage area. He also indicated the no expired food items should make it to the service line.	F0812		