STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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E 000	Initial Comments The survey team entered on 9/26/22 to conduct a recertification and complaint investigation survey and exited on 9/29/22. The survey team returned to the facility on 11/15/22 to obtain additional information and exited on 11/15/22. Therefore, the exit date was changed to 11/15/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #86EF11. The 2567 was admended on 11/15/2022.	E 000		
F 000	INITIAL COMMENTS The survey team entered on 9/26/22 to conduct a recertification and complaint investigation survey and exited on 9/29/22. The survey team returned to the facility on 11/15/22 to obtain additional information and exited on 11/15/22. Therefore, the exit date was changed to 11/15/22. Event ID #86EF11. 10 of the 39 complaint allegations were substantiated resulting in deficiencies. The following intakes were investigated: NC00193554, NC00193576, NC00186872, NC00187603, NC00191694, NC00191812, NC00191390, NC00188313, NC00189262, NC00191354, NC00190298, NC00190770, NC00188103, NC00194342, NC00194327, NC00194315, NC00194301. Substandard quality of care was identified at : CFR 483.25 at Tag 689 at scope and severity (H). An extended survey was also conducted.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/17/2022

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F 000	Continued From page 1	F 000		
	The 2567 was amended on 11/15/2022.			
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to provide showers as scheduled for 1 of 2 sampled residents (Resident	F 561	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	11/17/22

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F 561	Continued From page 2 #14) reviewed for choices. Findings included: Resident #14 was originally admitted to the facility on 2/8/21 and re-admitted on 3/28/22 with diagnoses which included: osteomyelitis of the vertebra, sacral and sacrococcygeal region, paraplegia, and diabetes mellitus with diabetic neuropathy. The quarterly minimum data set dated 7/5/22 indicated Resident #14 was cognitively intact, required total assistance with bed mobility, transfers, hygiene, and bathing. The care plan dated 9/14/22 revealed Resident #14 had an activity of daily living self-care performance deficit related to paraplegia. Interventions included: required two staff assistance with all transfers and bed mobility; required total assistance with bathing; required total assistance using total mechanical lift for transfers; and offer choices in daily care. Review of the facility's Shower Schedule maintained at the nursing station on A-Wing indicated Resident #14 was to receive a shower during first shift every Monday and every Thursday. The schedule sheet included: "Assure all showers are completed as scheduled. If a resident refuses, it must be documented in (electronic health record)". Review of the Personal Care sheets from 9/1/22 through 9/26/22 indicated Resident #14 only received a shower on 9/16/22.	F 561	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F561 1.Corrective action for resident(s) affected by the alleged deficient practice: Current corrective action for resident #14 was reviewed on 11/15/2022 by the Director of Nurses (DON) and the Assistant Director of Nurses (ADON, Administrator, and Administrator). Review of the corrective action didn□t require any revisions in the current corrective action plan below. For resident #14 a corrective action was obtained on 09/27/2022 when resident received his shower. Resident #14 was interviewed on 09/30/2022, regarding his shower schedule, which was updated in the resident□s task by the Director of Nurses (DON) on 09/30/2022. 2.Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 09/30/2022 the DON, Treatment nurse, and Staff Development Coordinator	

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F 561	Continued From page 3 During an interview on 9/26/22 at 3:51 p.m. Resident #14 confirmed his shower days as Mondays and Thursdays. The resident stated that when he asked the nursing assistant about receiving his shower on Thursday, 9/22/22 and again on Monday, 9/26/22 she told him the facility did not have enough help so that he could receive a shower. He indicated he had not received a shower in a couple of weeks. An interview with nursing assistant (NA#3) on 9/28/22 at 3:10 p.m. revealed 9/27/22 was the first time she worked with Resident #14 since 8/24/22 or 8/25/2022. She stated the resident was scheduled to receive a shower on Mondays and Thursdays, in the mornings. NA#3 recalled being informed by the resident that another nursing assistant told him there weren't enough staff to give him a shower. NA#3 stated the resident also informed her Nurse #3 gave him a shower on the previous night (Tuesday, 9/27/22). She was unsure if the resident received his scheduled shower on Monday (9/26/22) because she worked on a different hall. During an interview on 9/28/22 at 3:35 p.m., Nurse #3 stated she and a nursing assistant (no name provided) gave Resident#14 a shower the previous night (9/27/22) during second shift. He was scheduled to receive showers on Mondays and Thursdays during day shift. She stated on Tuesday, 9/27/22 she asked the resident if he received his scheduled shower on Monday, 9/26/22 and was told he only received a "wash-up", and he would like to receive a shower. The resident also informed her that he did not receive a shower on Thursday (9/22/22). Nurse#3 revealed that on 9/28/22 she met with the nursing assistant who failed to provide the	F 561	(SDC) completed resident interviews on 100% of all current residents to identify if they have a preference of when they wished to take their shower. Any residents who requested a preference of when they wished to be showered had their task updated to reflect their preference. This was completed on 10/03/2022. 3.Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 10/03/2022, the Clinical Nurse Consultant educated the DON, Unit Support Nurse, and SDC on resident□s preference to choose when they wish to shower. This education included when the resident interviews for their preferences will be completed and how to update the resident record to reflect their preference. The DON, ADON, and Unit Support Nurses will complete ADL rounds which includes showers weekly to ensure showers are being completed. On 10/12/2022, the DON and the SDC began education of all full time, part time, as needed (PRN) licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) and certified nursing assistants (CNA□s), including agency staff on self-determination including resident preferences of when they wish to shower and promoting residents□ choice. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the	

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F 561	Continued From page 4 resident with his showers. She stated the nursing assistant informed her that she (nursing assistant) had requested two other nursing assistants for assistance with providing the resident with a shower on Monday (9/26/22) but was unable to name the two that she asked. The nursing assistant was unable to recall why she did not provide the resident with a shower on Thursday (9/22/22). Nurse #3 stated she informed the nursing assistant that she should have requested her (Nurse #3) assistance as she had helped nursing assistants with providing resident care many times.	F 561	Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 11/15/2022. 4.Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or Designee will monitor compliance utilizing the F561 Self Determination Quality Assurance Tool weekly x 5 weeks then monthly x 2 months or until resolved. Audits will occur on various shifts and days of the week to include weekends to assure that residents preferences are being honored. This will include auditing 5 residents on various days and shifts to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 11/16/2022	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584		11/17/22

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F 584	Continued From page 5	F 584		

The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.

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F 584	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews, the facility (1) failed to maintain the floor in good repair in 1 of 7 hallways (A wing-100 hall), maintain walls and baseboard in good repair in 2 of 6 rooms on the A wing- 100 hall (Rooms 104 and 110), maintain clean floors in 3 of 6 rooms on the A wing- 100 hall (Rooms 104, 109 and 110); (2) failed to maintain clean floors in 1 of 3 rooms on the C wing-300 hall (Room 307 bed A); (3) failed to maintain the floor in good repair in 1 of 13 rooms observed (A wing-Room 200); (4) failed to provide washcloths, towels, and fitted bed sheets to residents residing on 1 of 2 resident wings of the facility (A wing) and (5) failed to maintain a clean, safe and orderly living environment for residents residing in room numbers 402, 406, 407 and 412 of the A-wing in the facility. Findings included: 1a. During a tour of A wing-100 hall on 9/27/22 at 10:01 AM, across from Room 110, a six inch long hole was observed in the middle of the floor and crumbled cement was visible. Medication Aide #1 was interviewed on 9/27/22 at 10:03 AM. She shared the hole in the floor had been there for "at least" three weeks and said the maintenance department was aware of the hole in the floor. She added sometimes she placed a yellow caution sign over the floor tile which prevented residents, staff and visitors from walking or rolling their wheelchairs over it. In an interview with the resident who resided in Room 110 on 9/27/22 at 10:10 AM, he stated the	F 584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F584 Safe/Clean/Comfortable/Homelike Environment 1.Corrective action for affected residents. Current corrective action for residents #44, #1, #92, #114, #93, #14, #82, #5, #20, #49, #94 were reviewed on 11/15/2022 by the Director of Nurses (DON) and the Assistant Director of Nurses (ADON, Administrator, and Administrator). Review of the corrective action didn□t require any revisions in the current corrective action plan below. For resident□s A100hall, A200hall, A400hall, C300 hall a corrective action was obtained during when rooms for resident #44, #1, #92, #114, #93 were immediately cleaned by the housekeeping staff to include sweeping and mopping of floor, cleaned fall mats, replacing privacy curtains, dusting air conditioning units, removal of chipped/peeling furniture. Sufficient linens were obtained on 09/26/2022 for residents #14 and #82.	

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F 584	Continued From page 7 hole in the floor had been there "a while" and he expressed concern that someone might fall if they walked over it. On 9/29/22 at 1:56 PM, a tour of the A wing-100 hall was completed with the Maintenance Director and Assistant Maintenance Director. During the observation, the Maintenance Director measured the hole in the floor and reported it was 6.5 inches long, 2.25 inches wide and 3/8 inch deep. He described the hole in the floor as "damaged tile with cement coming up." The Assistant Maintenance Director added the hole had been in the floor for about six months, but had not been repaired since he was the only maintenance employee in the building from June 2022 until earlier in the week when the Maintenance Director had started employment at the facility. The Assistant Maintenance Director explained he had been more focused on other maintenance repairs and had not gotten to the repair of the floor in the hallway. The Assistant Administrator was interviewed on 9/29/22 at 2:57 PM. She said the hole in the hallway floor was identified on 9/23/22 and the facility had planned to cover the hole to prevent it from being a trip hazard. 1b. An observation of Room 104 on 9/26/22 at 3:27 PM revealed gouges in the wall behind the resident's bed with exposed sheetrock. During an interview with the resident in Room 104 on 9/26/22 at 3:30 PM, she shared the gouges in the wall had been there for almost a year. She said sometimes she asked staff to move her bed away from the wall so it wouldn't "scratch up the wall." Observation of Room 104 on 9/28/22 at 2:12 PM	F 584	On 10/7/2022 housekeeping staff stripped/waxed room on A200hall for resident #5. On 10/14/2022 housekeeping staff stripped/waxed affected rooms on A100 hall for resident #20, #49, and #94. On 10/17/2022 housekeeping staff stripped/waxed floors in room for resident #49. On 10/13/2022 maintenance staff repaired dry walls and baseboards in rooms for residents #49, 94, #82, #114, A400hall nursing station. On 10/13/2022 maintenance staff repaired hole in floor on A100hall. 2.Corrective Action for Potentially Affected Residents. On 10/12/2022, the Administrator and assistant administrator completed 100% audit of all rooms/hallways in the facility was completed to ensure that all rooms and halls were cleaned according to policy. Any rooms/halls identified as needing cleaning were added to deep cleaning schedule or floor cleaning schedule. On 10/12/2022, the administrator and assistant administrator completed 100% audit of all rooms in the facility to ensure that all walls, baseboards, and floors were in good repair. Any resident rooms that were affected or identified in need of repair, maintenance has been notified, and facility has plan in place for repair. On 10/12/2022, the Administrator and assistant administrator completed 100% audits of all linen closets to ensure that all linen closets were adequately stocked.	

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F 584	Continued From page 8 revealed gouges in the wall behind the resident's bed. On 9/29/22 at 2:06 PM, an observation of Room 104 was completed with the Maintenance Director and Assistant Maintenance Director. In an interview with the Maintenance Director on 9/29/22 at 2:07 PM, he stated the gouges in the wall with exposed sheetrock were because there was no guard on the bed to prevent it from bumping up against the wall. The Assistant Maintenance Director explained there was a maintenance book at each nurse's station where staff wrote down repair requests. He had not performed routine audits of resident rooms to identify areas of concern; rather, he relied on staff to notify him of issues in the maintenance repair book. The maintenance repair book, located at the A wing nurse's station was reviewed on 9/29/22 at 2:14 PM and revealed no repair requests were located inside the book. The Assistant Administrator was interviewed on 9/29/22 at 2:57 PM. She said the Assistant Maintenance Director had been the only maintenance employee in the facility since March 2022. The Maintenance Director had started at the facility earlier in the week and would address the repair of walls in resident rooms. 1c. An observation of Room 110 on 9/26/22 at 11:17 AM revealed scuff marks on the wall across from the "B" bed. The baseboard at the bottom of the "A" bed wardrobe had peeled away from the wall. During an interview with the resident in Room 110-A on 9/26/22 at 11:20 AM, he said the baseboard had been peeled away for a month	F 584	Inventory of current linen in house was completed, and was determined that facility needed to order additional linens. Linen order placed on 10/14/2022. On 10/12/2022 administrator and assistant administrator completed 100% audit of the facility for any housekeeping concerns related to include sweeping and mopping of floor, stripping/waxing floors, and floor upkeep. Findings from audit shared with environmental services director on 10/17/2022. Corrective action plan initiated for resolution to all concerns and findings from audit. On 10/12/2022 administrator and assistant administrator completed 100% audit of the facility for any maintenance concerns related to gauges/holes in walls, peeling paint or damaged furniture, and condition of condition of floors and baseboards in resident rooms. Findings from audit shared with maintenance director on 10/17/2022. Corrective action plan initiated for resolution to all concerns and findings from audit. 3.Systemic Changes All housekeeping staff will be re-educated by Administrator beginning on 10/12/2022 cleaning rooms according to policy on regular intervals to include dust mop and damp mop resident room floors, empty trash receptacles, replenish toilet tissue, paper towels, soap, hand sanitizer, and odor control. Clean furnishings used by residents and visitors. Clean spot on walls. Complete cleaning of bathrooms. Complete cleaning of overbed lights, high areas, window blinds and window sills on	

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F 584	Continued From page 9 and didn't think any staff member knew about it. On 9/29/22 at 2:06 PM, an observation of Room 110 was completed with the Maintenance Director and Assistant Maintenance Director. The Maintenance Director measured the peeled baseboard at 24 inches long, and the scuff marks on the wall measured 83 inches long. In an interview with the Maintenance Director on 9/29/22 at 2:09 PM, he stated the scuff marks were from a wheelchair that had scraped against the wall. The Assistant Maintenance Director explained there was a maintenance book at each nurse's station where staff wrote down repair requests. He had not performed routine audits of resident rooms to identify areas of concern; rather, he relied on staff to notify him of issues in the maintenance repair book. The maintenance repair book, located at the A wing nurse's station was reviewed on 9/29/22 at 2:14 PM and revealed no repair requests were located inside the book. The Assistant Administrator was interviewed on 9/29/22 at 2:57 PM. She said the Assistant Maintenance Director had been the only maintenance employee in the facility since March 2022. The Maintenance Director had started at the facility earlier in the week and would address the repair of walls in resident rooms. 1d. An observation of Room 104 on 9/26/22 at 3:27 PM revealed dark colored stains on the floor tiles throughout the room. During an interview with the resident in Room 104 on 9/26/22 at 3:28 PM, she said housekeeping staff came in daily and swept and mopped the room, but the stains remained on the floor.	F 584	regular intervals. Removing and cleaning privacy curtains on regular intervals or as needed. Sanitize beds on deep cleaning schedules. All floor tech staff will be re-educated by the housekeeping supervisor beginning on 10/12/2022 on proper floor cleaning techniques, process for stripping/waxing floors, and expectations for maintaining floors in good condition. All laundry staff will be re-educated by Administrator beginning on 10/12/2022 regarding stocking all linen in closets and carts daily and as needed, as well as, replenishing and ordering linen to ensure sufficient linen inventory at facility. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all laundry and housekeeping staff. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. All staff will be re-educated by SDC beginning on 10/12/2022 on maintenance request process, and utilization of maintenance log notebooks. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance	

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(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
F 584	Continued From page 10 Housekeeper #1 was interviewed on 9/27/22 at 3:03 PM. She explained she cleaned resident rooms daily and swept and mopped the floors. She verified there was "a lot" of dirt build up on the floors in residents' rooms and halls which had been an issue throughout the entire facility since at least April 2022, when she started her employment. She thought the facility needed more floor technicians and added one went on medical leave three weeks ago. Housekeeper #1 added the floors needed to be stripped and waxed. Observation of Room 104 on 9/28/22 at 2:12 PM revealed dark colored stains on the floor tiles throughout the room. On 9/29/22 at 2:30 PM, an observation of Room 104 was completed with the Housekeeping Supervisor. During an interview on 9/29/22 at 2:31 PM, the Housekeeping Supervisor said he thought the stains on the floor were from aging floor tiles or glue. He explained the floor in Room 104 had recently been stripped and waxed which helped with removing the glue stains but typically within a few weeks the stains re-appeared. He confirmed there were two floor technicians who worked at the facility, but one was out on medical leave. The Assistant Administrator was interviewed on 9/29/22 at 2:57 PM. She said the housekeeping department stripped and waxed two resident rooms per day. She added the building was older and the flooring had thinned out and thought the cement under the floor had pushed up through and caused the stains on the floor.	F 584	process to verify that the change has been sustained. The facility specific in-service will be provided to all staff. Quality Assurance The Administrator or designee will monitor compliance utilizing the Quality Assurance Tool Clean/ Safe Homelike Environment weekly x 4 weeks then monthly x 3 months. The tool will monitor (5) rooms and bathrooms for cleanliness of rooms, bathrooms, floors, walls, odors, gauges or scuff marks on walls, chipped or damaged walls or baseboards. This tool will also monitor linen closets and linen inventory. Reports will be presented to the weekly Quality Assurance (QA) committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the housekeeping, linen issues, or maintenance. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Rehab Manager, Health Information Manager, Environmental Services Manager, and the Dietary Manager Date of Compliance 11.16.2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 584	Continued From page 11	F 584		

1e. An observation of Room 109 on 9/26/22 at 11:40 AM revealed dark colored stains on the floor tiles throughout the room.

Housekeeper #1 was interviewed on 9/27/22 at 3:03 PM. She explained she cleaned resident rooms daily and swept and mopped the floors. She verified there was "a lot" of dirt build up on the floors in residents' rooms and halls which had been an issue throughout the entire facility since at least April 2022, when she started her employment. She thought the facility needed more floor technicians and added one went on medical leave three weeks ago. Housekeeper #1 added the floors needed to be stripped and waxed.

Observation of Room 109 on 9/28/22 at 2:10 PM revealed dark colored stains on the floor tiles throughout the room.

On 9/29/22 at 2:32 PM, an observation of Room 109 was completed with the Housekeeping Supervisor. During an interview on 9/29/22 at 2:33 PM, the Housekeeping Supervisor said he thought the stains on the floor were from aging floor tiles or glue. He confirmed there were two floor technicians who worked at the facility, but one was out on medical leave.

The Assistant Administrator was interviewed on 9/29/22 at 2:57 PM. She said the housekeeping department stripped and waxed two resident rooms per day. She added the building was older and the flooring had thinned out and thought the cement under the floor had pushed up through and caused the stains on the floor.

1f. An observation of Room 110 on 9/26/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(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
F 584	Continued From page 12	F 584		

11:17 AM revealed dark colored stains on the floor tiles throughout the room. During an interview with the resident in Room 110 on 9/26/22 at 11:18 AM, he said housekeeping staff came in every other day and swept and mopped the room, but didn't always mop the entire floor.

Housekeeper #1 was interviewed on 9/27/22 at 3:03 PM. She explained she cleaned resident rooms daily and swept and mopped the floors. She verified there was "a lot" of dirt build up on the floors in residents' rooms and halls which had been an issue throughout the entire facility since at least April 2022, when she started her employment. She thought the facility needed more floor technicians and added one went on medical leave three weeks ago. Housekeeper #1 added the floors needed to be stripped and waxed.

On 9/29/22 at 2:35 PM, an observation of Room 110 was completed with the Housekeeping Supervisor. During an interview on 9/29/22 at 2:36 PM, the Housekeeping Supervisor said he thought the stains on the floor were from aging floor tiles or glue. He explained the floor in Room 110 had recently been stripped and waxed which helped with removing the glue stains but typically within a few weeks the stains re-appeared. He confirmed there were two floor technicians who worked at the facility, but one was out on medical leave.

The Assistant Administrator was interviewed on 9/29/22 at 2:57 PM. She said the housekeeping department stripped and waxed two resident rooms per day. She added the building was older and the flooring had thinned out and thought the cement under the floor had pushed up through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(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
F 584	Continued From page 13	F 584		

and caused the stains on the floor.

2. During a tour of C wing-300 hall on 9/26/22 at 10:00 AM, a dark orange colored stain approximately 24 inches long and 12 inches wide was observed under the bed of Resident #44.

On 9/26/22 at 10:05 AM during an interview with the Resident #2's visitor, the visitor revealed the catheter bag for the Resident #44 had leaked on the floor one week prior and had not been cleaned up properly. There was a faint odor of urine in the room.

An observation on 09/27/22 at 10:00 AM revealed the floor under the bed still a dark orange stain.

On 09/27/22 at 11:24 AM the dark orange stain was still visible under Resident #44's bed.

In an interview on 9/28/22 at 9:35 AM a nurse aide (NA) stated she did not know what the stain was under Resident #44's bed. She further stated she had not noticed the stain.

On 9/28/22 at 9:55 AM an interview was conducted with the Housekeeping Supervisor. He stated the stain had not been reported to him. He further stated that there should not be a stain under bed 307A. He explained the resident room floors were swept and mopped daily. He further explained if the stain could not be mopped up, he would schedule for the floor to be stripped and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
F 584	Continued From page 14	F 584		

waxed.

An observation of room 307A on 9/29/22 at 10:00 AM revealed the stain under had been removed. Resident #44 stated the housekeeping staff had mopped under the bed on 9/28/22.

On 9/29/22 at 3:00 PM an interview was conducted with the assistant administrator. She stated she expected the floors to be cleaned routinely and as needed. She further stated the facility had floor projects in place to strip two rooms a week until all floors are done.

3. An observation of Room 200 on 9/26/22 at 10:45 AM revealed dark colored stains on the floor tiles throughout the entire room. There were also several broken tiles underneath the resident's bed.

During an interview with the resident in Room 200 on 9/26/22 at 10:50 AM, she said housekeeping staff came in every day and swept and mopped the room, but the dark stains remained. She stated that sometimes they were able to get some the dark areas up but not much. She also stated that she really didn't want her family to come and visit in the room because the floor looked so bad. The resident also stated that the broken tiles didn't bother her because they were under the bed so she never rolled over them with her wheelchair.

Housekeeper #1 was interviewed on 9/27/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From page 15	F 584		

3:03 PM. She explained she cleaned resident rooms daily and swept and mopped the floors. She verified there was "a lot" of dirt build up on the floors in residents' rooms and halls which had been an issue throughout the entire facility since at least April 2022, when she started her employment. She thought the facility needed more floor technicians and added one went on medical leave three weeks ago. Housekeeper #1 added the floors needed to be stripped and waxed.

On 9/28/22 at 3:35 PM, an observation of Room 200 was completed with the Housekeeping Supervisor. During an interview on 9/28/22 at 3:38 PM, the Housekeeping Supervisor said he thought the stains on the floor were from aging floor tiles or glue. He stated the floor in Room 200 was due to be stripped and waxed next week when the resident would be out of the building. He stated that will usually help but sometimes the stains would re-appear within a few weeks. He also stated that there were two floor technicians who worked at the facility, but one was out on medical leave

The Assistant Administrator was interviewed on 9/29/22 at 2:57 PM. She said the housekeeping department stripped and waxed two resident rooms per day. She added the building was older and the flooring had thinned out and thought the cement under the floor had pushed up through and caused the stains on the floor.
4a. During an interview on 9/26/22 at 10:45 a.m., Resident #14 who was cognitively intact indicated there were no washcloths and towels available for the nursing assistant to use when providing his care. He stated the nursing assistant (unable to recall name) used a pillowcase to wash him. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(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
F 584	Continued From page 16	F 584		

resident indicated this occurred a few days prior to this interview. He also stated there were no fitted sheets available for his bed. An observation revealed a flat/top sheet was used as the bottom sheet of the resident's bed.

4b. An interview was conducted on 9/26/22 at 11:15 a.m. with Resident #82 who was cognitively intact. He stated he usually bathed himself but had been unable to bathe due to a lack of washcloths and towels. He revealed the facility had not provided washcloths and towels for at least 2-3 weeks. He also revealed there were no fitted bottom bed sheets available. Observation of the raised head of the resident's bed revealed a flat bed sheet that had loosened from the mattress.

On 9/27/22 at 10:23 a.m. an observation of the linen cart on the A-200 hall revealed several hospital gowns, 1-blanket, several flat bedsheets. There were no washcloths and towels stored in the cart.

On 9/27/22 at 10:48 a.m. the linen cart on the A-400 hall contained several top sheets, several bed pads, 1-blanket, and 7-towels. There were no washcloths in the cart.

The observation on 9/27/22 at 3:42 p.m. of the linen closet on the A-100 hall revealed multiple hospital gowns, multiple flat bed sheets, 1-fitted sheet; 1-pillow; 1-tub of assorted socks, and 2-tan blankets. There were no towels or washcloths in the closet.

On 9/27/22 at 4:26 p.m. the linen cart on the A-400 hall consisted of a pack of wipes, 1-bottle of perineal/body cleanser, 2-boxes of latex gloves

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
F 584	Continued From page 17	F 584		

on the top shelf, the second shelf was empty. The bottom shelf with multiple bags of adult diapers, 1-pack of wipes and a washbasin containing various items. There were no towels, washcloths or bed linen on the cart.

During an interview on 9/28/22 at 3:26 p.m., NA#3 stated in the past 2-weeks there were not enough washcloths, towels and fitted sheets. She recalled when the laundry staff put the clean linen on the hall carts and in the linen closet, there were only 6-washcloths available for residents on three of the halls in the A-wing of the facility.

An interview with the Environmental Director on 9/29/22 at 1:32 p.m. revealed he was first notified by Laundry Staff when there was a shortage of towels and washcloths in the facility. He stated the facility had a shortage of washcloths, towels, and fitted bedsheets for approximately two weeks. He also stated dirty fitted sheets were coming into the laundry department ripped at the seams. An order was placed for more linen one and a half weeks ago. Until the delivery of the new linen, the Laundry Staff was required to check the dirty linen closets every thirty minutes instead of every one hour and thereby wash linen more frequently due to the shortage.

During an interview on 9/29/22 at 2:05 p.m., the Laundry Staff stated there had been a shortage on washcloths, towels, and fitted sheets since the prior month. He stated he put in an order request in August 2022 but had not received any of the items as of the time of this interview. He revealed the nursing assistants would horde clean linen in residents' rooms, put soiled linen in the same bag as trash, and/or throw away washcloths that have fecal material. The Laundry Staff also revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 584	Continued From page 18	F 584		

that the day before this interview 1-large bag of washcloths, 1-large bag of towels, 1-large bag of fitted sheets, and 2-cases of bedpads were delivered from the facility's sister facility.

5. During an observation of room 402 on A-wing of the facility on 9/26/22 at 10:26 a.m. and on 9/29/22 at 12:34 p.m., the surfaces of 2-overbed tables were peeling, exposing rough edges.

On 9/26/22 at 11:15 a.m. there were dirty, dried yellow and brown stains on floor, near the headboard of the bed and in the bathroom in room 406a on A-wing. Also, there was torn drywall on the wall in the bathroom.

A follow-up observation of room 406a on 9/27/22 at 9:33 a.m. and 9/29/22 at 1:10 p.m. revealed the floor surrounding the bed remained dirty with the brown, yellow stains.

On 9/27/22 at 10:33 a.m., 9/28/22 at 2:15 p.m. and 9/29/22 at 12:44 p.m., there was a dirty fall mat stained with white/gray residue and multiple brown particles on the floor next to the bed in room 407b on A-wing. The frontal vents of the air conditioning/heating unit in the room were covered in thick, dark gray lint. Also, the drywall on the lower wall, near the head of the bed of 407a was scratched/torn.

During an interview on 9/27/22 at 3:03 p.m., Housekeeper #1 indicated there was a lot of dirty build-up on floors in the residents' rooms and hallways and the floors were in this condition since April 2022. She stated the floors need to be stripped and waxed. The housekeeper stated there were not enough floor and housekeeping

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(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
F 584	Continued From page 19 staff. She revealed there were no housekeepers on duty at the facility after 3:00 p.m. During an interview on 9/28/22 at 9:55 a.m., the Environmental Director revealed housekeeping department was responsible for deep cleaning one room on each hall per day and as needed. Also, when a resident was discharged from the facility housekeeping would deep clean the vacated room. He stated there should not be stains on the floors in the facility. On 9/28/22 at 2:17 p.m. and on 9/29/22 at 12:54 p.m. during an observation of room 412, the privacy curtain pulled between the residents' beds was stained with several large brown/tan blotches visible from the open doorway of the room. On 9/29/22 at 12:59 p.m., there was a large hole in the lower wall at the workstation located on the 400 hall of A-Wing in the facility. An interview on 9/29/22 at 1:16 p.m. with the Assistant Maintenance Director revealed he was aware of the hole in the wall at the workstation on the 400 hall of the A-Wing. He indicated he had been the only maintenance worker at the facility for one and a half years until two days prior to this interview. As a result, work orders were prioritized based on urgency with residents' requests as first priority. He stated he was unaware of the peeling overbed tables and would replace them, immediately.	F 584		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		11/17/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(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
F 641	Continued From page 20 resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately complete Minimum Data Set (MDS) assessments to reflect a gradual dose reduction of an antipsychotic medication for 1 of 5 residents (Resident #7) reviewed for unnecessary medications and the behaviors for 1 of 1 resident (Resident #116) reviewed for behaviors. The findings included: 1. Resident #7 was admitted from the hospital on 1/24/22. The resident's cumulative diagnoses included Parkinson ' s disease and recurrent major depressive disorder. The resident ' s medical record indicated physician ' s orders were received on 3/16/22 for 25 milligrams (mg) of quetiapine (an antipsychotic medication) to be given as one-half tablet by mouth one time a day (scheduled in the morning) and 25 mg quetiapine given as one tablet by mouth every night at bedtime. A review of the resident ' s Minimum Data Set (MDS) assessments included an MDS for a significant change in status dated 4/12/22. This assessment reported the resident received an antipsychotic medication on 7 out of 7 days during the look back period. Resident ' s #7 medical record indicated a physician ' s order was received on 5/13/22 to discontinue the ½ tablet of quetiapine administered in the morning. He continued to receive 25 mg quetiapine given as one tablet by	F 641	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F641 ACCURACY OF ASSESSMENTS Corrective Action: Current corrective action was reviewed for all residents listed below #7, and #116 on 11/15/2022 by the Director of Nurses (DON) and the Assistant Director of Nurses (ADON), Administrator, and Assistant Administrator. Review of the corrective action didn□t require any revisions in the current corrective action plan below. Resident # 7: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) 09/28/2022 was modified. Resident # 116: Resident Minimum Data Set (MDS) assessment (Admission Assessment,) with Assessment /Reference Date (ARD) 09/28/2022 was modified. Identification of other residents who may	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641	Continued From page 21 mouth every night at bedtime. Resident #7 ' s most recent MDS was a quarterly assessment dated 6/28/22. A review of this MDS assessment revealed the resident continued to receive an antipsychotic medication on 7 out of 7 days during the look back period. However, the MDS indicated a gradual dose reduction (GDR) had neither been attempted nor documented as contraindicated by her physician since the date of the last MDS assessment. An interview was conducted on 9/29/22 at 12:38 PM with MDS Nurse #1. During the interview, MDS Nurse #1 reviewed Resident #7 ' s medication history and his quarterly MDS assessment dated 6/28/22. When asked about the GDR for quetiapine, MDS Nurse #1 stated, "I probably just didn't catch that." Upon further inquiry, the nurse reported the MDS should have indicated a GDR had been attempted for the resident ' s antipsychotic medication on 5/13/22. An interview was conducted on 9/29/22 at 3:08 PM with the facility's Assistant Director of Nursing (ADON). During the interview, concerns regarding the accuracy of MDS assessments were discussed. When asked, the ADON reported her expectation would be that "the information on the MDS is accurate according to what has happened with the patient." 2. Resident # 116 was admitted to the facility on 9/2/2022 and had diagnoses of post-traumatic stress disorder, psychosis, and major depressive disorder.	F 641	be involved with this practice: All current residents who have antipsychotic medication and all current residents with behavior or rejection of care during the Mini Data Set (MDS) 7 day look back for assessment reference date(s) have the potential to be affected by the alleged practice. On 10/14/2022 through 10/18/2022 an audit was completed by Mini Data Set (MDS) Nurse Consultant to review all Minimum Data Set (MDS) assessments in the last 3 months to ensure that all current residents who have antipsychotic medication have Section NO450B (Antipsychotic Medication Review: Has a gradual Dose Reduction [GDR] been attempted?) . Out of a total number of 7 # assessments, 1 # of assessments were modified to reflect accurate data for section NO450B due to inaccuracy. On 10/14/2022 through 10/18/2022 an audit was completed by Mini Data Set (MDS) Nurse Consultant to review all Minimum Data Set (MDS) assessments in the last 3 months to ensure that all current residents who have behaviors or rejection of care have section E0200(Behavioral Symptoms-Presence & Frequency) and Section E0800 (Rejection of Care-Presence & Frequency). Out of a total number of 38 # assessments, 32 # of assessments were modified to reflect accurate data for section E0200(Behavioral Symptoms-Presence & Frequency) and Section E0800 (Rejection of Care-Presence & Frequency) This was completed on 10/18/2022. Systemic Changes:	

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	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

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F 641	Continued From page 22 The admission minimum data set (MDS) assessment dated 9/9/2022 revealed Resident #116 had cognitive impairment. No behaviors, or rejection of care were noted on the MDS. A review of the care plan dated 9/5/2022, last revised on 9/13/2022 read in part Resident #116 was resistive to care related to adjustment to nursing home, refusal of skin assessments, refusal to eat and activities of daily living (ADL) care, refusal of COVID testing, refusal of medications. Interventions included: allow Resident to make decisions about treatment regimen, to provide sense of control, educate Resident of the possible outcome(s) of not complying with treatment of care and give clear explanation of all care activities prior to and as they occur during each contact. A review of the nursing progress notes revealed on 9/3/2022, 9/5/2022, 9/6/2022, 9/7/2022, 9/8/2022, and 9/9/2022 Resident #116 refused medications and/or care. On 9/29/2022 at 9:42 AM an interview with Social Worker (SW) # 1 was conducted. She indicated she was responsible for noting behaviors on the MDS. She indicated she did not see the documentation of Resident #116 refusing care, and it had been an oversight. The SW indicated the refusal of medications/care should have been included. An interview was conducted on 9/29/2022 at 3:08 PM with the facility's Assistant Director of Nursing (ADON). During the interview, the ADON reported her expectation would be that "the information on the MDS is accurate according to	F 641	On 10/14/2022 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator and MDS Support nurse and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the Director of Nursing. The education focused on: The facility must ensure that each assessment accurately reflects the resident□s status. Section NO450B (Antipsychotic Medication Review: Has a gradual Dose Reduction [GDR] been attempted?) Review the resident□s medication administration records to determine if the resident received an antipsychotic medication since admission/entry or reentry or the prior OBRA assessment, whichever is more recent. If the resident received an antipsychotic medication, review the medical record to determine if a gradual dose reduction has been attempted. If a gradual dose reduction was not attempted, review the medical record to determine if there is physician documentation that the GDR is clinically contraindicated. Any medication that has a pharmacological classification or therapeutic category of antipsychotic medication must be recorded in this section, regardless of why the medication is being used. In N0450B and N0450C, include GDR attempts conducted since the resident was admitted to the facility, if the resident was receiving an antipsychotic medication at the time of admission, OR since the resident was started on the antipsychotic medication, if the medication was started after the	

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F 641	Continued From page 23 what has happened with the patient." During an interview with the Administrator on 9/29/2022 she indicated it was her expectation that the MDS was completed accurately.	F 641	resident was admitted. Do not include gradual dose reductions that occurred prior to admission to the facility (e.g., GDRs attempted during the resident□s acute care stay prior to admission to the facility). If the resident was admitted to the facility with a documented GDR attempt in progress and the resident received the last dose(s) of the antipsychotic medication of the GDR in the facility, then the GDR would be coded in N0450B and N0450C. If the resident received a dose or doses of an antipsychotic medication that was not part of a documented GDR attempt, such as if the resident received a dose or doses of the medication PRN or one or two doses were ordered for the resident for a specific day or procedure, these are not coded as a GDR attempt in N0450B and N0450C. Discontinuation of an antipsychotic medication, even without a GDR process, should be coded in N0450B and N0450C as a GDR, as the medication was discontinued. When an antipsychotic medication is discontinued without a gradual dose reduction, the date of the GDR in N0450C is the first day the resident did not receive the discontinued antipsychotic medication. Do not count as a GDR an antipsychotic medication reduction performed for the purpose of switching the resident from one antipsychotic medication to another. The start date of the last attempted GDR should be entered in N0450C, Date of last attempted GDR. The GDR start date is the first day the resident received the reduced dose of the antipsychotic	

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F 641	Continued From page 24	F 641		

medication. In cases in which a resident is or was receiving multiple antipsychotic medications on a routine basis and one medication was reduced or discontinued, record the date of the reduction attempt or discontinuation in N0450C. If multiple dose reductions have been attempted since admission OR since initiation of the antipsychotic medication, record the date of the most recent reduction attempt in N0450C. For section E0200(Behavioral Symptoms-Presence & Frequency) Review the medical record for the 7-day look-back period. Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period, including family or friends who visit frequently or have frequent contact with the resident. Observe the resident in a variety of situations during the 7-day look-back period. Code 0, behavior not exhibited: if the behavioral symptoms were not present in the last 7 days. Use this code if the symptom has never been exhibited or if it previously has been exhibited but has been absent in the last 7 days. Code 1, behavior of this type occurred 1-3 days: if the behavior was exhibited 1-3 days of the last 7 days, regardless of the number or severity of episodes that occur on any one of those days. Code 2, behavior of this type occurred 4-6 days, but less than daily: if the behavior was exhibited 4-6 of the last 7 days, regardless of the number or severity of episodes that occur on any of those days. Code 3, behavior of this type occurred daily: if the behavior was

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F 641	Continued From page 25	F 641	exhibited daily, regardless of the number or severity of episodes that occur on any of those days. Code based on whether the symptoms occurred and not based on an interpretation of the behavior□s meaning, cause or the assessor□s judgment that the behavior can be explained or should be tolerated. Code as present, even if staff have become used to the behavior or view it as typical or tolerable. Behaviors in these categories should be coded as present or not present, whether or not they might represent a rejection of care. For Section E0800 (Rejection of Care-Presence & Frequency) Review the medical record. Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period. Review the record and consult staff to determine whether the rejected care is needed to achieve the resident□s preferences and goals for health and well-being. Review the medical record to find out whether the care rejection behavior was previously addressed and documented in discussions or in care planning with the resident, family, or significant other and determined to be an informed choice consistent with the resident□s values, preferences, or goals; or whether that the behavior represents an objection to the way care is provided, but acceptable alternative care and/or approaches to care have been identified and employed. If the resident exhibits behavior that appears to communicate a rejection of care (and that rejection behavior has not been previously	

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F 641	Continued From page 26	F 641	determined to be consistent with the resident□s values or goals), ask him or her directly whether the behavior is meant to decline or refuse care. If the resident indicates that the intention is to decline or refuse, then ask him or her about the reasons for rejecting care and about his or her goals for health care and well-being. If the resident is unable or unwilling to respond to questions about his or her rejection of care or goals for health care and well-being, then interview the family or significant other to ascertain the resident□s health care preferences and goals. Code 0, behavior not exhibited: if rejection of care consistent with goals was not exhibited in the last 7 days. Code 1, behavior of this type occurred 1-3 days: if the resident rejected care consistent with goals 1-3 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Code 2, behavior of this type occurred 4-6 days, but less than daily: if the resident rejected care consistent with goals 4-6 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Code 3, behavior of this type occurred daily: if the resident rejected care consistent with goals daily in the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. This in service was completed by 11/15/2022. Any Registered Nurse (RN) and or Licensed Practical Nurse (LPN) Support Minimum Data Set (MDS) Coordinators	

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F 641	Continued From page 27	F 641	and any other Interdisciplinary team member that participates in the MDS assessment process who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Administrator will review 5 resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments Admission, Annual or Quarterly Assessment to ensure that Section NO450B (Antipsychotic Medication Review: Has a gradual Dose Reduction [GDR] been attempted?) and section E0200(Behavioral Symptoms-Presence & Frequency) and Section E0800 (Rejection of Care-Presence & Frequency) are coded accurately. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the	

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F 641	Continued From page 28	F 641	Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 11/16/2022	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		11/17/22

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F 657	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and nurse practitioner interviews, the facility failed to revise a care plan for 2 of 2 residents (Resident #2 and Resident #335) reviewed for falls. Findings included: 1. Resident #2 was admitted on 5/8/18 with a diagnosis of cerebral infarction. A Quarterly Minimum Data Set (MDS) dated 10/18/21 indicated Resident #2 was totally dependent on staff for bed mobility and required 2 staff members for assistance. A progress noted dated 12/12/21 at 12:10 PM revealed the Resident fell off the bed while a nurse aid (NA) provided incontinence care. The most recent care plan dated 6/23/22 revealed Resident #2 was at increased risk for falls related to limited mobility. The two interventions noted were that the Resident ' s risk for falls would be minimized through current interventions x 90 days and anticipate and meet the Resident ' s needs as much as possible. An interview on 9/29/22 at 2:45 PM with MDS Nurse #1 revealed the facility administrative staff reviewed falls during the daily resident review meeting. She explained interventions appropriate for falls were updated in the care plan during the meeting. She stated she did not update the care plan for Resident #2 after his fall on 12/12/21. She further stated she did not have a reason for not updating his care plan.	F 657	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F657 Care Plan Timing and Revision Corrective Action: Current corrective action was reviewed for all residents listed below #335, and #2 on 11/15/2022 by the Director of Nurses (DON) and the Assistant Director of Nurses (ADON), Administrator, and Assistant Administrator. Review of the corrective action didn□t require any revisions in the current corrective action plan below Resident #2: Care plan for fall revised and updated on ¿¿9/27/2022 by MDS nurse. Resident #335: Care plan for fall revised and updated on ¿¿9/27/2022 by MDS nurse. Identification of other residents who may be involved with this practice: All current residents with an actual fall; have the potential to be affected by the alleged practice. On 10/1/2022 an audit was completed by the Director of Nursing team to ensure that a care plan was	

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F 657	Continued From page 30 In an interview with MDS Nurse #2 on 9/29/22 at 2:45 PM she revealed it was her responsibility to update Resident #2 ' s care plan after his fall. She stated she did not know why she did not update his care plan. She further stated the MDS staff needed to focus better on updating care plans after falls. She explained she needed to update Resident #2 ' s care plan with appropriate interventions. In an interview with the Assistant Administrator on 9/30/22 at 3:00 PM she stated that she expected the resident ' s care plan to be reviewed and revised with appropriate interventions following a fall. 2. Resident #335 was admitted to the facility on 2/4/2021 with diagnoses epilepsy (seizure disorder), and persistent vegetative state. A progress note dated 4/30/2022 at 10:33 PM stated that Resident #335 was observed laying on the floor next to his bed. No injury occurred. A Quarterly Minimum Data Set (MDS) dated 5/1/22 indicated Resident #335 was totally dependent on staff for bed mobility and required 2 staff members for assistance. The most recent care plan dated 5/20/22 revealed Resident #335 was at increased risk for falls related to limited mobility. The interventions noted were that the Resident's risk for falls would be minimized through current interventions x 90 days, anticipate and meet the Resident's needs as much as possible, and monitor frequently. This was unchanged from his last care plan review dated 2/22/22.	F 657	implemented for current residents with an actual fall. This was completed on 10/1/2022. Systemic Changes: On 10/14/2022 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by Director of Nursing. The education focused on: The facility must develop, implement, review and revise a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident□s medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident□s highest practicable physical, mental, and psychosocial wellbeing; and any services that would otherwise be required but are not provided due to the resident□s exercise of rights , including the right to refuse treatment ; and any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations, and after consultation with the resident and the resident□s representative□s on the residents goals for admission and desired outcomes, the resident□s preference and potential for future	

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F 657	Continued From page 31 An interview on 9/29/22 at 2:45 PM with MDS Nurse #1 revealed the facility administrative staff reviewed falls during the daily resident review meeting. She explained interventions appropriate for falls were updated in the care plan during the morning meetings. She stated she was unsure why Resident #335's care plan was not updated to include his recent fall with new interventions. In an interview with Assistant Director of Nursing on 9/29/22 at 2:45 PM she stated that they discuss incidents in their morning meetings. She stated the Director of Nursing did comment on the incident report to add bolsters to Resident #335's bed after he was found on the floor. She stated she did not know why he care plan was never updated following the incident. In an interview with the Assistant Administrator on 9/30/22 at 3:00 PM she stated that she expected the resident's care plan to be reviewed and revised with appropriate interventions following a fall.	F 657	discharge, and discharge plans. A comprehensive person centered care plan must developed, implemented, reviewed and revised upon admission, readmission and with any change in condition. This in service was completed by 11/15/2022. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will observe 5 resident□s with actual falls to ensure that care plan is reviewed /revised. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS	

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F 657	Continued From page 32	F 657	Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 11/16/2022	
F 689 SS=H	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and nurse practitioner interviews, the facility failed to provide care in a safe manner and/or implement fall safety interventions developed and care planned by its interdisciplinary team (IDT) for 4 of 5 residents (Residents #2, #335, #7 and #132) reviewed for falls. Resident #2 sustained a fall from his bed that resulted in a fracture of the left femur neck requiring open reduction and internal fixation (surgical intervention). Resident #335 sustained a fall from his bed that resulted in a non-displaced fracture to his right femur that was conservatively managed (no surgical intervention). The plan of correction implemented after Resident #2 had fallen failed to keep resident #335 safe from falls and injury. The findings included: Example 1	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F689 The facility failed to prevent repeated falls by not providing effective interventions after each fall. 1.Corrective action for resident(s) affected by the alleged deficient practice: Current corrective action was reviewed for	11/17/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 689	Continued From page 33 Resident #2 was admitted on 5/8/18 with a diagnosis of quadriplegia, and cerebral infarction. A review of a care plan dated 10/12/21 revealed Resident #2 was a fall risk. The one intervention noted was to anticipate and meet the Resident's needs as much as possible. There were no interventions to specify the number of staff required to provide bed mobility assistance. A Quarterly Minimum Data Set (MDS) dated 10/18/21 indicated Resident #2 was totally dependent on staff for bed mobility and required two staff members for assistance. A review of the Kardex from 12/12/2021 revealed Resident #2 was total dependence for bed mobility and required two staff members for assistance. A note written by Nurse #2 dated 12/12/2021 stated that Nurse Aide #2 (NA #2) had rolled Resident #2 over on right side to change him and that the Resident used his left arm to pull himself over. The nurse also stated NA #2 tried to pull him back but was unsuccessful in keeping him from rolling off the bed. A statement written by NA #2 dated 12/12/21 stated she had Resident #2 turned on his side while bathing him and that he used his left arm to pull himself over and he rolled off the bed. NA #2 then stated she called for help and Nurse #2 came and assessed the Resident and assisted with putting him back in bed. A review of the hospital radiology report dated 12/12/21 revealed a nondisplaced fracture	F 689	all residents listed below #335, #7, and #132 on 11/15/2022 by the Director of Nurses (DON) and the Assistant Director of Nurses (ADON). Review of the corrective action didn□t require any revisions in the current corrective action plan below. A corrective action was completed for resident #2 on 07/15/2022, when all staff were educated on utilizing the Kardex, demonstrated or verbalized how to use the Kardex, and the orientation process was updated to include Kardex education. A corrective action was completed for resident #335 on 07/15/2022, when all staff were educated on utilizing the Kardex, demonstrated or verbalized how to use the Kardex, and the orientation process was updated to include Kardex education. A corrective action was completed for resident #7, on 09/27/2022, when the air mattress was removed from the bed and the bed was placed in low position. A corrective action was completed for resident #132 on 09/28/2022, when falls mats were placed on both sides of the bed and the bed was placed in low position. 2.Corrective action for residents with the potential to be affected by the alleged deficient practice. On 11/15/2022, the DON and ADON	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 689	Continued From page 34 involving the greater trochanter with possible extension to the anterior cortex of the femoral neck. A hospital discharge record dated 1/3/22 revealed Resident #2 had an acute closed fracture of the neck of the left femur and underwent open reduction and internal fixation of his fracture on 12/13. In an interview on 9/27/22 at 4:17 PM with NA #3, she stated Resident #2 was not able to hold on to the side of the bed to assist with care. She explained Resident #2 was totally dependent on staff for all his personal care and hygiene. She explained that he required the total assistance of two people with bed mobility, turning and repositioning. She revealed the information on how much assistance a resident needed could be found in the Kardex. During a phone interview with Nurse #2 on 9/27/22 at 5:22 PM, she stated she was passing medications when she and the Respiratory Therapist heard a loud boom. When they entered the room, they saw Resident #2 lying on the floor. She stated she and NA #2 got the lift and put the Resident back in bed. Nurse #2 said NA #2 told her that when she rolled the Resident over, he reached over and pulled himself too far and fell out of the bed. Nurse #2 explained Resident #2 required two people to provide his care. She further explained information regarding a resident's care needs could be found on the Kardex. Multiple attempts to reach NA #2 were unsuccessful.	F 689	completed an audit on all current residents with falls from 9/29/2022 □ 11/15/2022. This audit consisted of review to identify that all appropriate interventions were in place, on the care plan, and carried out with no further concerns noted. This audit didn□t identify any areas that required corrective action. All care plans and interventions had been previously updated. On 10/01/2022 - 10/02/2022 the DON and Minimum Data Set Nurse audited all current residents with falls in the past 90 days to ensure that all appropriate interventions identified were in place, on the care plan, and carried out with no further concerns noted. All care plans and interventions had been previously updated. 3.Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 11/15/2022, the Nurse Consultant reviewed education with the DON, ADON, Administrator, and Assistant Administrator on the falls and falls process including falls investigation, review of falls, and timely entry of falls interventions to the care plan including tools to assist with falls investigation. On 10/03/2022, the Nurse Consultant educated the Director of Nursing on the following topics: "Root cause analysis and timely entry of fall interventions to the care plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 35 In an interview with the Assistant Director of Nursing (ADON) on 9/28/22 at 10:03 AM she stated they expected the NAs to provide care according to the Kardex. She further stated Resident #2 was a two-person physical assist with bed mobility. The ADON explained that NAs are trained upon hire to use the Kardex and staff are checked off on skills competencies yearly. The facility also offered skills fairs throughout the year to reinforce skills. The ADON provided the Plan of Correction (POC) for review. The POC included education of all full time, part time, as needed and agency nurses on providing bed mobility according to the Kardex, and ensuring staff knew how to review the Kardex. The Director of Nursing (DON) would ensure that any of the above identified staff who did not complete the in-service training by 12/20/2021 would not be allowed to work until the training was completed. The in-service was incorporated into the new employee facility orientation for the above identified staff. The DON or designee would monitor this issue using the Bed Mobility Quality Assurance Tool for monitoring compliance with bed mobility assistance. The monitoring included reviewing staff providing bed mobility according to Kardex and ensuring the staff knew how to review the Kardex. The Tool would be completed weekly times six weeks or until resolved by the Quality Assurance (QA) Committee. Reports would be presented weekly to the QA committee by the Administrator or DON to ensure corrective action was initiated as appropriate. Compliance would be monitored, and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA meeting was attended by the Administrator, DON, MDS Coordinator, Therapy, Health Information Management, and the Dietary Manager.	F 689	"Review of falls at Daily Stand Up meeting (Monday thru Friday) by the interdisciplinary team with addition of appropriate interventions to the care plan. On 10/06/2022 to 10/19/2022, the DON educated the interdisciplinary team (DON, Staff Development Coordinator (SDC), Minimum Data Set Nurses (MDS), Dietary Manager, Therapy manager, Activity Director, Social Work, Infection Control, Admissions Coordinator, Maintenance Director, Nurse unit managers, Housekeeping Supervisor, Medical Records Coordinator, Business Office Manager, Administrator, Assistant Administrator) on the following topics: "Root cause analysis and timely entry of fall interventions to the care plan. "Review of falls at Daily Stand Up meeting (Monday thru Friday) by the interdisciplinary team with addition of appropriate interventions to the care plan. Beginning on 09/27/2022 the ADON and SDC educated all Licensed Nurses, Registered Nurses (RN□s) and Licensed Practical Nurses (LPN□s) and Certified Nurses Assistants (CNA) Full Time, Part Time, and as needed including agency on implementation of fall interventions and accessing the resident Kardex/Care plan. On 11/15/2022, the QA Committee met to discuss F689 to ensure that the current plan of correction to address F689 was sufficient to address the alleged deficient practice. The QA Meeting was attended	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 689	Continued From page 36 In an interview with the Assistant Administrator on 9/29/22 at 3:00 PM she stated that she expected the nursing staff to follow the Resident's care plan regarding the number of staff required to provide assistance with bed mobility. 2. Resident #335 was admitted to the facility on 2/4/2021 with diagnoses quadriplegia, epilepsy (seizure disorder), and persistent vegetative state. A Quarterly Minimum Data Set (MDS) dated 5/1/22 indicated Resident #335 was totally dependent on staff for bed mobility and required 2 staff members for assistance. The plan of care for Resident #335 included the focus area of falls related to quadriplegia and epilepsy. This focus area was initiated on 2/4/21 and last revised on 2/2/22. Interventions included frequent monitoring. A note dated 7/12/22 by Nurse #1 stated that the Nurse Aide #1 (agency aide) was changing Resident #335 and when she turned him, he slipped out of her hand and rolled to the floor. A review of Resident #335's hospital record dated 7/12/22 showed an x-ray of the right hip that was positive for an acute displaced basicervical femoral fracture with valgus alignment (a fracture through the base of the femur bone with good alignment). The report also stated that the fracture would be managed conservatively and no surgical intervention was needed at that time. A statement written by Nurse Aide #1 (NA#1) dated 7/12/22 stated that she turned Resident #335 on his left side to provide incontinent care	F 689	by the Administrator, Assistant Administrator, Director of Nurses, Assistant Director of Nurses, MDS Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Activity Director, Social Work, Infection Control, Admissions Coordinator, Maintenance Director, Nurse unit managers, Housekeeping Supervisor, Business Office Manager. There were no changes as a result of this meeting and monitoring will be completed address the alleged deficient practice. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 11/15/2022. 4.Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F689 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. This monitoring will include review of 5 resident falls to ensure the interventions were in place and current on the care plan. The Director of Nursing will monitor to ensure fall	

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	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 689	Continued From page 37	F 689		

and he slipped from her hand and fell to the floor off the left side of the bed landing with his weight on his right hip and back. NA #1 then stated that she immediately went to get the Assistant Director of Nursing (ADON) and then assisted him back into the bed using a lift. NA#1 stated that she was not aware he was a 2 person assist, she was not aware how to look on the care guide for resident information, she did not receive an electronic chart sign on, and she did not sign an orientation packet.

During an interview with Nurse #1 on 9/27/22 at 10:52 AM, she stated she was aware that Resident #335 had always been a two person assist and that is stated on his care guide for staff to see. Nurse #1 stated was on lunch break when the incident occurred. She stated she was told that the resident fell by Nurse Aide #1 and the ADON when she returned to the floor. Nurse #1 stated there were no obvious injuries but Resident #335 was unable to let the staff know when he was in pain due to his diagnosis. She stated that Resident #335 was assessed by the ADON and she assisted in preparing him for transport to the hospital for assessment.

Multiple attempts to contact Nurse Aide #1 were unsuccessful.

During an interview with the ADON on 9/27/22 at 2:43 PM, she stated NA#1 alerted her that Resident #335 fell off the bed. She stated that she assessed him, completed vital signs, and then helped assist him into bed using the lift. She stated NA#1 told her she was not aware Resident #335 was a two person assist, she did not have an electronic sign on, and she didn't sign the orientation packet. The ADON stated the care

interventions implemented are carried out timely and have been entered into the resident care plan. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Assistant Administrator, Director of Nurses, Assistant Director of Nurses, MDS Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Activity Director, Social Work, Infection Control, Admissions Coordinator, Maintenance Director, Nurse unit managers, Housekeeping Supervisor, Business Office Manager.
Date of Compliance: 11/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 38	F 689		

guides were all electronic and the aides needed a sign on to assess them. She also stated the aide did receive training but was unsure if she actually signed the orientation packet and it was never located. She stated the facility was in the process of completing a plan of correction to address this issue including in-servicing for all staff, organizing on-boarding material for new directs hires and all contract staff, and conducting weekly audits. She also stated, as a part of the plan of correction, they plan on assuring that all staff is able to access the care guides for each resident. She stated they are currently in the auditing phase and they are discussing the need for ongoing audits in their morning meetings and within the interdisciplinary team during quality assurance meetings.

3. Resident #7 was admitted to the facility on 1/24/22 from a hospital. His cumulative diagnoses included dementia and Parkinson ' s disease.

Review of a Fall Incident Report dated 5/31/22 at 3:45 PM revealed Resident #7 had an unwitnessed fall and was found lying on the floor on the right side of his bed. The resident stated that he was reaching for his call bell that had fallen to the floor. He reported he went too far to retrieve the call bell and fell out of bed. No injuries were reported. An additional note made on the Fall Incident Report was dated 6/1/22. This notation indicated Resident #7 had an air mattress at the time of the fall which increased his risk for falls. The note read, "Mattress will be replaced with regular mattress to decrease risk of fall."

The resident ' s most recent Minimum Data Set

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 689	Continued From page 39	F 689		

(MDS) was a quarterly assessment dated 6/28/22. The MDS reported Resident #7 was assessed by staff as having severely impaired cognitive skills for daily decision making. Resident #7 required supervision with transfers and eating, limited assistance for walking in his room and locomotion on the unit, and extensive assistance for the remainder of his Activities of Daily Living (ADLs). The resident ' s MDS assessment revealed he had one fall without injury since his prior assessment.

Resident #7's care plan included the following areas of focus:
--I have had an actual fall with risk for further (Date Initiated 6/1/22). The planned interventions included, in part: "Change mattress" (Date Initiated: 6/1/22).
--I have a communication problem related to hearing deficit (Date Initiated 4/14/22). The planned interventions included, in part: "Ensure/provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked, avoid isolation" (Date Initiated 4/14/22).

An observation was conducted on 9/26/22 at 3:36 PM of Resident #7 as he was lying on an air mattress on his bed. His bed was not in the low position at the time of the observation.

On 9/27/22 at 9:50 AM, Resident #7 was observed to be lying on an air mattress on the bed. His bed was not placed in the low position.

An observation was conducted on 9/27/22 at 3:55 PM as Resident #7 was lying in bed. Nurse #5 was in his room at the time of the observation. Upon leaving the room, the nurse confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(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
F 689	Continued From page 40	F 689		

Resident #7 was lying on an air mattress which was powered "on." The bed was not in the low position at the time of the observation.

An interview was conducted on 9/27/22 at 4:15 PM with Nurse Aide (NA) #4. NA #4 was assigned to care for Resident #7 on 2nd shift. During the interview, the NA was asked how she would find out what kind of care and assistance a resident required. The NA stated she typically received report from the off-going NA. Additionally, NA #4 stated she had log-in access for an electronic tablet which provided information on resident care. Upon request, the NA demonstrated how she could obtain access to a resident ' s Care Guide. The Care Guide detailed the resident ' s care needs.

On 9/27/22 at 4:25 PM, a printed copy of Resident #7's Care Guide was provided for review. The Care Guide included a section on "Safety" which included the following interventions, in part:
--Change mattress;
--Ensure /provide a safe environment: Call light in reach, adequate low glare light, bed in lowest position and wheels locked. Avoid isolation.

An observation conducted on 9/28/22 at 9:04 AM revealed Resident #7 was lying on a standard mattress placed on his bed (not an air mattress). The bed was not in the lowest position. On 9/28/22 at 12:00 PM, another observation revealed the resident ' s bed had a standard mattress and his bed had been placed in the low position.

An interview was conducted on 9/28/22 at 2:42 PM with the MDS Nurse #1. During the interview,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 689	Continued From page 41	F 689		

the MDS Nurse discussed the facility ' s process for reviewing a resident after he/she had experienced a fall. The nurse stated falls were discussed during the daily stand up (clinical) meetings on Monday through Friday each week. At that time, potential interventions to promote the resident ' s safety were discussed. If a new intervention was implemented, the MDS nurse was responsible to put the changes/revisions into the resident ' s care plan. If the new interventions were not yet decided upon and needed to be discussed later, the Director of Nursing (DON) would typically make the revisions to the care plan.

On 9/28/22 at 2:55 PM, an interview was conducted with the facility's Assistant Director of Nursing (ADON). During the interview, the observations made on 9/26/22 and 9/27/22 were discussed. It was noted Resident #7' s care plan interventions had not been implemented as planned at the time of these observations. The ADON stated new care plan interventions were communicated to the direct care nursing staff when they were put into the care plan. She explained that when the interventions were care planned, they were typically put into the computer so they would be carried over into the Care Guide (available via the electronic tablet for NAs). Both nurses and NAs had electronic access to this resource. When asked, the ADON stated she would expect nursing staff to be following a resident ' s care plan.

4. Resident #132 was admitted to the facility on 11/11/19 from a hospital. Her cumulative diagnoses included Alzheimer's disease and functional quadriplegia (complete inability to move due to severe disability or frailty caused by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(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
F 689	Continued From page 42	F 689		

another medical condition).

Review of a Fall Incident Report dated 7/2/22 at 6:00 AM revealed Resident #132 had an unwitnessed fall and was found lying on top of a floor mat with her bed in a "safe" position. The resident was unable to provide a description of what had happened. No injuries were reported at the time of the incident. An additional note made on the Fall Incident Report was dated 7/4/22 and indicated the resident's current safety interventions included a low bed and mats placed on the floor. It also included a notation which read, "Will place a beveled mattress on bed to define perimeter."

Resident #132 's most recent Minimum Data Set (MDS) was a quarterly assessment dated 9/9/22. This MDS reported the resident was assessed by staff as having severely impaired cognitive skills for daily decision making. Resident #132 was totally dependent on staff for all of her Activities of Daily Living (ADLs).

The resident 's care plan included the following areas of focus: I have had an actual fall with risk for further falls. Poor communication and comprehension, functional quadriplegia (Date Initiated 6/12/21; Revision on 9/21/22).
The planned interventions included, in part:
--Concave mattress placed on resident's bed (Date Initiated 7/6/22);
--Low bed (Date Initiated: 6/12/21; Revision on 7/6/22);
--Mats to floor (Date Initiated 7/19/21).

An observation was conducted on 9/26/22 at 9:56 AM as the resident was lying in her bed on a concave mattress. Her bed was not in the low

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 689	Continued From page 43	F 689		

position. No fall mats were placed on either side of the bed.

On 9/26/22 at 3:35 PM, another observation was conducted as the resident was lying in bed asleep on a concave mattress. Her bed was not in the low position. No fall mats were placed on either side of the bed.

Additional observations were conducted on 9/27/22 at 9:48 AM and on 9/27/22 at 4:00 PM of the resident lying on a concave mattress while in bed. The resident 's bed was not in the low position and there were no fall mats placed on the floor during these observations.

An interview was conducted on 9/27/22 at 4:15 PM with Nurse Aide (NA) #4. NA #4 was assigned to care for Resident #132 on 2nd shift. When asked about Resident #132, the NA reported the resident could fidget at times resulting in slight movements and the removal of clothing. During the interview, the NA was asked how she would find out what kind of care and assistance a resident required. The NA stated she typically received report from the off-going NA. Additionally, NA #4 stated she had log-in access for an electronic tablet which provided information on resident care. Upon request, the NA demonstrated how she could obtain access to a resident ' s Care Guide. The Care Guide detailed the resident ' s care needs.

On 9/27/22 at 4:25 PM, a printed copy of Resident #132 ' s Care Guide was provided for review. The Care Guide included a section on "Safety" which included the following interventions, in part:
--Concave (beveled) mattress placed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 44	F 689		

resident's bed;
--Mats to floor.

An observation conducted on 9/28/22 at 9:04 AM revealed Resident #132 was lying on a concave mattress on her bed with a fall mat placed on each side of her bed. The bed was not in the lowest position. On 9/28/22 at 11:19 AM, another observation revealed the resident was lying in bed with a concave mattress, a fall mat on each side of her bed, and her bed placed in the low position.

An interview was conducted on 9/28/22 at 2:42 PM with the MDS Nurse #1. During the interview, the MDS Nurse discussed the facility ' s process for reviewing a resident after he/she had experienced a fall. The nurse stated falls were discussed during the daily stand up (clinical) meetings on Monday through Friday each week. At that time, potential interventions to promote the resident ' s safety were discussed. If a new intervention was implemented, the MDS nurse was responsible to put the changes/revisions into the resident ' s care plan. If the new interventions were not yet decided upon and needed to be discussed later, the Director of Nursing (DON) would typically make the revisions to the care plan.

On 9/28/22 at 2:55 PM, an interview was conducted with the facility ' s Assistant Director of Nursing (ADON). During the interview, the observations made on 9/26/22 and 9/27/22 were discussed. It was noted Resident #132 ' s care plan interventions had not been implemented as planned at the time of these observations. The ADON stated new care plan interventions were communicated to the direct care nursing staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 45 when they were put into the care plan. She explained that when the interventions were care planned, they were typically put into the computer so they would be carried over into the Care Guide (available via the electronic tablet for NAs). Both nurses and NAs had electronic access to this resource. When asked, the ADON stated she would expect nursing staff to be following a resident ' s care plan.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		11/17/22

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F 690	Continued From page 46 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection or injury for 1 of 5 residents (Resident #27) reviewed with indwelling urinary catheters. The findings included: Resident #27 was admitted to the facility on 8/1/18 with re-entry from a hospital on 8/29/22. His cumulative diagnoses included acute urinary retention, benign prostatic hyperplasia (an enlarged prostate gland), and a history of urinary tract infections (UTI). A review of Resident #27 ' s most recent Minimum Data Set (MDS) was an annual assessment dated 7/15/22. This MDS indicated the resident had intact cognitive skills for daily decision making. The resident was reported to be occasionally incontinent of bladder. Resident #27 was seen by a urologist on 9/9/22 due to urinary retention. The urologist ' s recommendations included placement of a urinary catheter if he was unable to void. A urine culture was ordered by urology and an antibiotic initiated on 9/13/22. The resident ' s medical	F 690	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 690 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 9/26/2022 the staff nurse properly secured the foley catheter bag off the floor for resident # 27. There were no adverse effects observed as a result of the deficient practice. The physician was notified of the above information. On 10/3/22 the catheter was discontinued for resident # 27. Current corrective action for resident #27	

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F 690	Continued From page 47 record indicated an indwelling catheter was placed on 9/14/22. An initial observation was made on 9/26/22 at 10:00 AM as Resident #27 was lying in bed. A urinary catheter bag was observed to be hanging from the bed frame with approximately 4 inches of the bag lying on the floor. On 9/26/22 at 12:59 PM, Resident #27 was observed to be lying in bed. His urinary catheter bag was hanging from the bed frame with approximately one-half of the bag lying on the floor at the time of the observation. An observation made on 9/26/22 at 1:42 PM revealed approximately one-half of Resident #27 ' s urinary catheter bag continued to be lying on the floor as the resident laid in his bed. An interview was conducted 9/26/22 at 1:55 PM with Nurse #4. Nurse #4 was the 1st shift nurse assigned to care for Resident #27. During the interview, the nurse was asked what her thoughts were about the placement of Resident #27's urinary catheter bag. Nurse #4 was observed as she entered the resident ' s room and repositioned the catheter bag so it was no longer touching the floor. After she exited the room, the nurse reported the urinary catheter bag should not have been on the floor. An interview was conducted on 9/29/22 at 12:04 PM with the facility ' s Assistant Director of Nursing (ADON). During the interview, the observations of Resident #27 ' s urinary catheter bag touching the floor were discussed. When asked, the ADON reported she would expect a catheter bag to be positioned "off the floor."	F 690	was reviewed on 11/15/2022 by the Director of Nurses (DON) and the Assistant Director of Nurses (ADON, Administrator, and Administrator). Review of the corrective action didn□t require any revisions in the current corrective action plan below 2.How the facility will identify other residents having the potential to be affected by the same deficient practice: On 09/30/2022 the Assistant Director of Nurses (ADON) and Unit Managers audited all residents with indwelling catheters to ensure the bags were secured to the bed frame and not touching the floor. Results of the audit indicated that none of the indwelling catheter bags were touching the floor and they were all secured properly to the bed frame. 3.Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: Education: On 10/13/2022, the Staff Development Coordinator (SDC) Nurse initiated education for all Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and nurse assistants; full time, part time, PRN staff, and agency staff on catheter education how to secure catheter bag off the floor. This education includes:	

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F 690	Continued From page 48	F 690		

" Securement device is in place
" Infection control is maintained
" Catheter bags should never touch the floor

This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 11/15/2022, any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed.

As a result of the alleged citation the Director of Nursing or designee will complete monthly rounds to ensure catheter bags are secure in a manner that they are not on the floor.

4.Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements:

The Director of Nursing or designee will monitor compliance utilizing the F690 Quality Assurance Tool weekly x 5weeks then monthly x 2 months. The DON or designee will monitor for compliance the proper way to secure an indwelling catheter bag to ensure it is not touching the floor. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing

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F 690	Continued From page 49	F 690	program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Compliance Date: 11/16/2022	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		11/17/22

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F 761	Continued From page 50	F 761		

by:
Based on observations, staff interviews and record reviews, the facility failed to discard expired medications stored in 1 of 4 medication carts observed (A100 Hall Medication Cart).

The findings included:

1. An observation was conducted on 9/28/22 at 12:10 PM of the A100 Hall Medication (Med) Cart in the presence of Med Aide #1 and Nurse #3.

The observation revealed one - 10 milliliter (ml) opened vial of Humalog insulin dispensed from the pharmacy for Resident #94 was stored on the med cart. A yellow auxiliary sticker placed on the clear plastic box containing this vial of insulin read: "Store using directions provided. Throw away any medicine that remains 28 days after first use." A hand-written notation on the box containing the insulin indicated the vial had been opened on 8/27/22 (32 days before the date of the observation). Upon inquiry, Nurse #3 reported the vial of insulin was expired and needed to be discarded.

A review of Resident #94 ' s medication orders revealed he had a current order for Humalog insulin.

According to Lexi-Comp (a comprehensive electronic medication database), once punctured (in use), vials of Humalog insulin may be stored under refrigeration or at room temperature; use within 28 days.

An interview was conducted on 9/28/22 at 2:55 PM with the facility's Assistant Director of Nursing (ADON) to discuss the findings of the medication

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.
To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

F761
1. Corrective action for resident(s) affected by the alleged deficient practice:
Current corrective action for resident #94 and #99 was reviewed on 11/15/2022 by the Director of Nurses (DON) and the Assistant Director of Nurses (ADON, Administrator, and Administrator). Review of the corrective action didn□t require any revisions in the current corrective action plan below
Resident #94, the Humalog was removed and discarded from the cart on 09/28/2022 by Nurse #3.

Resident #99, the lantus was removed and discarded on 09/28/2022 by Nurse #3.

Resident #94, the lantus was removed and discarded on 09/28/2022 by Nurse #3.

2. Corrective action for residents with the potential to be affected by the alleged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 761	Continued From page 51 storage observations. During the interview, the ADON stated she would expect "that we follow the guidelines on the dates expired." 2. An observation was conducted on 9/28/22 at 12:10 PM of the A100 Hall Medication (Med) Cart in the presence of Med Aide #1 and Nurse #3. The observation revealed one - 10 milliliter (ml) opened vial of Lantus insulin dispensed from the pharmacy for Resident #99 was stored on the med cart. A yellow auxiliary sticker placed on the clear plastic box containing this vial of insulin read: "Store using directions provided. Throw away any medicine that remains 28 days after first use." A hand-written notation on the box containing the insulin indicated the vial had been opened on 8/27/22 (32 days before the observation). Upon inquiry, Nurse #3 reported the vial of insulin was expired and needed to be discarded. A review of Resident #99 ' s medication orders revealed she had a current order for Lantus insulin. According to Lexi-Comp (a comprehensive electronic medication database), once punctured (in use), vials of Lantus insulin may be stored under refrigeration or at room temperature; use within 28 days. An interview was conducted on 9/28/22 at 2:55 PM with the facility's Assistant Director of Nursing (ADON) to discuss the findings of the medication storage observations. During the interview, the ADON stated she would expect "that we follow the guidelines on the dates expired."	F 761	deficient practice. All residents in the facility who take medications have the potential to be affected. Beginning on 09/30/2022, Staff Development Coordinator (SDC), Assistant Director of Nurses (ADON), and the Unit Support Nurses audited all medication carts, treatment carts, and medication rooms two times weekly to identify any expired or undated medications. Corrections were made immediately where indicated. This was completed on 10/19/2022. No resident was found to be affected by the deficient practice. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 10/12/2022, the DON and SDC began educating all full time, part time, and PRN Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPN), and Medication Aides including agency staff on the following topics: " Checking medications for expiration date prior to administering the medication. " Labeling medications when opened with date open as indicated. " Pharmacy recommended storage for selected items. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also	

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	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 761	Continued From page 52 3. An observation was conducted on 9/28/22 at 12:10 PM of the A100 Hall Medication (Med) Cart in the presence of Med Aide #1 and Nurse #3. The observation revealed one - 10 milliliter (ml) opened vial of Lantus insulin dispensed from the pharmacy for Resident #94 was stored on the med cart. A yellow auxiliary sticker placed on the clear plastic box containing this vial of insulin read: "Store using directions provided. Throw away any medicine that remains 28 days after first use." A hand-written notation on the box containing the insulin indicated the vial had been opened on 8/28/22 (31 days before the date of the observation). Upon inquiry, Nurse #3 reported the vial of insulin was expired and needed to be discarded. A review of Resident #94 ' s medication orders revealed he had a current order for Lantus insulin. According to Lexi-Comp (a comprehensive electronic medication database), once punctured (in use), vials of Lantus insulin may be stored under refrigeration or at room temperature; use within 28 days. An interview was conducted on 9/28/22 at 2:55 PM with the facility's Assistant Director of Nursing (ADON) to discuss the findings of the medication storage observations. During the interview, the ADON stated she would expect "that we follow the guidelines on the dates expired."	F 761	provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 11/15/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F761 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. The DON or designee will monitor for compliance with labeling medications with a date when opened and ensuring the medication and treatment carts and the medication room is free of expired medications for. This monitoring will consist of monitoring each cart once weekly. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 53	F 761	Date of Compliance: 11/16/2022	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey completed on 6/14/21. This was for 3 deficiencies that were cited in the areas of Safe/Clean/Comfortable/Homelike Environment (F584), Accuracy of Assessments (F641), and Bowel/Bladder Incontinence, Catheters (F690) on 6/14/21 and recited on the current recertification and complaint survey of 9/29/22. The QAA committee additionally failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification and complaint survey conducted on 5/10/19. This was evident for 3 deficiencies in the area of Safe/Clean/Comfortable/Homelike Environment (F584), Accuracy of Assessments (F641), and Label/Store Drugs and Biologicals (F761) originally cited on the recertification and complaint survey on 5/10/19 and recited on the current recertification and complaint survey of 9/29/22. The QAA committee additionally failed to maintain	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 Corrective action for resident(s) affected by the alleged deficient practice: Current corrective action for Quality Assessment and Assurance program was reviewed on 11/15/2022 by the Director of Nurses (DON) and the Assistant Director of Nurses (ADON, Administrator, and Administrator). Review of the corrective action didn□t require any revisions in the current corrective action plan below	11/17/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

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(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
F 867	Continued From page 54 implemented procedures and monitor interventions the committee put in place following the complaint survey of 1/20/22. This was evident for 1 deficiency in the area of Free of Hazards/Supervision/Devices/Accidents (F689) that was originally cited during a complaint investigation on 1/20/22 and recited on the current recertification and complaint survey of 9/29/22 which resulted in two residents who sustained hip fractures and one required surgical repair. The continued failure of the facility during three federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The finding included: This citation is cross referred to: F584: During the recertification of 09/29/22 the facility (1) failed to maintain the floor in good repair in 1 of 7 hallways (A wing-100 hall), maintain walls and baseboard in good repair in 2 of 6 rooms on the A wing- 100 hall (Rooms 104 and 110), maintain clean floors in 3 of 6 rooms on the A wing- 100 hall (Rooms 104, 109 and 110); (2) failed to maintain clean floors in 1 of 3 rooms on the C wing-300 hall (Room 307 bed A); (3) failed to maintain the floor in good repair in 1 of 13 rooms observed (A wing-Room 200); (4) failed to provide washcloths, towels, and fitted bed sheets to residents residing on 1 of 2 resident wings of the facility (A wing) and (5) failed to maintain a clean, safe and orderly living environment for residents residing in room numbers 402, 406, 407 and 412 of the A-wing in the facility. During the recertification investigation on 6/14/21, the facility failed to unpack a resident ' s	F 867	On 10.12.2022, the Administrator educated the Quality Assurance Committee on how to sustain an overall effective Quality Assessment and Assurance (QAA) program including Safe/Clean/Comfortable/Homelike Environment (F584), Accuracy of Assessments (F641), and Bowel/Bladder Incontinence, UTI, Catheters (F690). These deficiencies were cited again on the current recertification survey completed on 9.29.2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: Corrective action has been taken for the identified concerns in the areas of: Safe/Clean/Comfortable/Homelike Environment (F584.) Corrective action has been taken for the identified concerns in the areas of: Accuracy of Assessments (F641). Corrective action has been taken for the identified concerns in the areas of: Bowel/Bladder Incontinence, UTI, Catheters (F690). The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 10.12.2022 to review the deficiencies from the September 26 □ September 29, 2022 annual recertification survey and reviewed the citations. On 10/18/2022, the RDO in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies related to the areas of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/15/2022

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F 867	Continued From page 55 belongings stored in cardboard boxes for 1 of 32 residents sampled. During the recertification investigation on 5/10/19, the facility failed to maintain the walls in 4 resident rooms (Room C212A, C211B, C207B, and A303) and failed to maintain a tray table and nightstand in good repair in 1 resident room (Room C207B). F641: During the recertification on 09/29/22 the facility failed to accurately complete Minimum Data Set (MDS) assessments to reflect a gradual dose reduction of an antipsychotic medication for 1 of 5 residents (Resident #7) reviewed for unnecessary medications and the behaviors for 1 of 1 resident (Resident #116) reviewed for behaviors. During the recertification investigation on 6/14/21, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of catheters, medications, and hospice. During the recertification investigation on 5/10/19, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect dialysis, the Preadmission Screening and Resident Review (PASRR) Level status, and services provided by the facility's restorative nursing program. F689: During the recertification on 09/29/22, the facility failed to provide care in a safe manner and/or implement fall safety interventions developed and care planned by its interdisciplinary team (IDT) for 4 of 5 residents (Residents #2, #335, #7 and #132) reviewed for falls. Resident #2 sustained a fall from his bed that resulted in a fracture of the left femur neck	F 867	Safe/Clean/Comfortable/Homelike Environment (F584), Accuracy of Assessments (F641), and Bowel/Bladder Incontinence, UTI, Catheters (F690). 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 10.12.2022 the administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies in the areas of Safe/Clean/Comfortable/Homelike Environment (F584), Accuracy of Assessments (F641), and Bowel/Bladder Incontinence, UTI, Catheters (F690). This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 11/15/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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F 867	Continued From page 56 requiring open reduction and internal fixation (surgical intervention). Resident #335 sustained a fall from his bed that resulted in a non-displaced fracture to his right femur that was conservatively managed (no surgical intervention). During a complaint investigation on 1/20/22, the facility failed to ensure 1 of 2 residents requiring extensive assistance with bed mobility and bathing was provided care safely to prevent injury. F690: During the recertification on 09/29/22, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection or injury for 1 of 5 residents (Resident #27) reviewed with indwelling urinary catheters. During the recertification investigation on 6/14/21, the facility failed to change a urinary catheter as ordered for a resident. F761: During the recertification on 09/29/22, the facility failed to discard expired medications stored in 1 of 4 medication carts observed (A100 Hall Medication Cart). During a complaint investigation on 11/5/20, the facility failed to keep medications secured in a locked medication cart for 2 of 2 medication carts observed. During the recertification investigation on 5/10/19, the facility: 1) Failed to remove expired medications from 4 of 5 medication carts (Unit C-200 Hall, Unit C-100 Hall, Unit C-400, and Unit A-400 Hall med carts) observed; 2) Failed to store medications as specified by the manufacturer in 1 of 5 medication carts (Unit	F 867	and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the missing laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 11/16/2022	

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F 867	Continued From page 57	F 867		

A-400 Hall med cart) observed; and, 3) Failed to label medications with the minimum required information (including the resident ' s name) in 2 of 5 medication carts (Unit C-200 Hall and Unit C-100 Hall med carts) observed.

The Assistant Administrator (AA) was interviewed on 9/29/22 at 2:40 pm. The AA stated the QA members were made up of Administrator, the Assistant Administrator (AA), the Director of Nursing, Dietary Manager, Business office manager, Maintenance Director, Social Worker, Activities Director, and Housekeeping Director. The Nurse Supervisor and the Medical Director were always invited to attend. The AA stated that the QA committee usually meets quarterly but they have met monthly this year due to new staff. She stated that both her and the Administrator were new to the building, and this was their first recertification and she (the AA) had only been working in her position for a few months. She stated she did know there was a lot of turnover, and the facility was having to utilize a lot agency staff these last few months. She stated she was aware there were issues to address but was unaware to what extent. She stated they facility has a whole will meet to discuss these issues and how to achieve compliance.

The facility administrator was unavailable for interview.