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 05/10/2019

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
E 000	Initial Comments An unannounced Recertification survey was conducted 5/7/19 through 5/10/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # LVWS11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey completed 5/7/19-5/10/19. Event ID# LVWS11.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. 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	F 584		6/7/19

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

Electronically Signed | 05/29/2019

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 05/10/2019

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 1 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. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, 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 night stand in good repair in 1 resident room (Room C207B). The findings included: 1a. An observation on 5/7/19 at 11:34 AM of room C212A revealed the area behind the headboard to have dark streaks approximately 12" in length. There were also chipped paint on the wall exposing sheetrock across the room between the bathroom and closet. Follow up observations on 5/8/19 at 9:15 AM and 5/9/19 at 11:38 AM revealed no change in the condition of the walls. 1b. An observation on 5/7/19 at 10:20 AM of room C211B revealed chipped paint exposing sheetrock running horizontally between the closet and bathroom. Follow up observations on 5/8/19 at 8:50 AM and 5/9/19 at 1:30 PM revealed no change in the	F 584	Oak Forest Health and Rehabilitation requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is 6/7/2019. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law. The facility failed to maintain walls free from holes and streaks in C212A, C211B, C207B, and A303. The facility also had a night stand and bedside table with chipped laminate in C207B. The areas cited in the deficiency were repaired by 5/29/2019. The bedside table 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 05/10/2019

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 2 condition of the walls. 1c. An observation on 5/7/19 at 10:28 AM of room C207B revealed thick black marks approximately 12" long behind the headboard of the bed. A follow up observation on 5/8/19 at 8:43 AM revealed no change in the condition of the walls. 1d. An observation on 5/10/19 at 9:33 AM revealed a softball sized hole through the sheetrock located behind the bed toward the floor. The sheetrock was crumbling at the base of the hole on the floor. 2. An observation on 5/7/19 at 10:28 AM of room C207B revealed peeling laminate on the corner of the left side of the nightstand and chipped molding observed to an area on the bedside table. A follow up observation on 5/8/19 at 8:43 AM revealed no change in the condition of the nightstand and bedside table. An interview on 5/10/19 at 9:15 AM with NA #1 revealed when she sees something broken in a resident ' s room, there is a maintenance log book located at the nurse ' s station to write it in. She stated she had not noticed the areas on the bedside table and nightstand. An interview on 5/10/19 at 3:24 PM with the Maintenance Director revealed he had been working at the facility for 9 months. He stated his daily routine is to check the facility and make sure the sprinkler system is working and that there are no emergency needs to take care of. He stated he then goes out on the floor and makes rounds, checks the maintenance request book and takes care of those needs as he is able to. Throughout	F 584	nightstand were replaced on 5/28/2019. A 100% audit of all resident rooms were completed by 5/23/2019. Any areas of concern were placed in the work order book for the Maintenance team to address timely. The Maintenance Director and Maintenance Assistant were educated on 5/28/2019 about the importance of Maintenance services to maintain a sanitary, orderly, and comfortable interior. All facility staff will be educated by 6/5/2019 on the importance of writing work orders in the maintenance books daily for Maintenance to address any safety concerns. The facility will utilize a Maintenance Audit tool for resident rooms and facility common areas to ensure areas are free of holes in walls and walls are painted as needed. This tool will be used twice a week for 4 weeks, weekly x 1 month, and monthly x 1 year. Any areas of concern will be brought to the attention of the Maintenance department on work orders. The Director of Maintenance will present the results of the audit tool to the Monthly QAPI Committee monthly for 1 year. The Director of Maintenance, Maintenance Assistant, and several department managers will implement the above corrective actions.	

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 05/10/2019

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 3 the day, he takes care of routine maintenance needs like changing lightbulbs and minimal plumbing. He stated he is currently the only maintenance employee in the facility. A tour of the C200 hall and A303 was conducted with the Maintenance Director on 5/10/19 at 3:30 PM. He was shown the areas observed and stated they were able to patch holes and repaint areas behind the beds. He stated department heads audited about 6 rooms each daily and logged them on the Room Audit sheet and they were turned in daily. He stated the audits included repairs needed. A review of the audit tool used revealed no audits for the rooms listed above. An interview on 5/10/19 at 4:18 PM with the Administrator revealed the administrative staff conduct daily audits and the facility is still conducting audits from the recertification survey last year. She stated the facility tried to complete room repairs promptly and her expectation was that resident rooms are clean, there are no holes in the walls and the walls are painted when needed.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument.	F 636		6/7/19

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 05/10/2019

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 636	Continued From page 4 A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i)	F 636		

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 05/10/2019

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 636	Continued From page 5 through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to comprehensively assess a resident in the area of mood on the Minimum Data Set (MDS) assessment for 1 of 5 residents (Resident # 69) reviewed for unnecessary medications. The findings included: Resident #69 was admitted to the facility on 3/27/19 with diagnoses that included, in part, Alzheimer's disease, anxiety disorder and depression. A review of the comprehensive MDS assessment dated 4/3/19 revealed Resident #69's communication ability was rarely understood and rarely understands. She had impaired memory and severely impaired daily decision making skills. Further review of the MDS assessment revealed section D0500 (Staff Assessment of Resident Mood) was coded as not assessed. Section D of the MDS assessment was completed by Social Worker (SW) #1. On 5/10/19 at 9:51 AM an interview was	F 636	The facility failed to comprehensively assess a resident in the area of mood on the Minimum Data Set. The resident's assessment was corrected by the Social Worker on 5/28/2019. The facility's Senior Reimbursement Specialist will audit 100% of all current residents' MDS assessment for accuracy regarding Section D in regards to Mood by 6/7/2019. Any assessments not accurate will be corrected by the Social Workers. The Social Workers that complete the MDS assessments were educated on 5/28/2019 on the importance of interviewing staff, reviewing the medical record, and observing the resident for completion of Section D of the MDS. MDS Section D Audit Tools will be used weekly x 1 month and monthly x 1 year. Any areas of concern will be addressed with the Social Worker for correction and education. The MDS nurses will present the results to the Monthly QAPI Committee Monthly for 1 year. 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 05/10/2019

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 636	Continued From page 6 completed with SW #1 and MDS Nurse #1. SW #1 said she typically completed the mood section of the MDS assessment. She stated since Resident #69 was coded as rarely understood and rarely understands she proceeded to the staff assessment for mood when she completed the mood section. SW #1 reported that she interviewed staff but checked the mood section as not assessed because the staff members "couldn't really answer the mood questions." MDS Nurse #1 stated she thought some of the items in the mood section that addressed appetite, restlessness, agitation and sleeping patterns could have been assessed through observation and record review and therefore should have been coded as yes or no instead of checked as not assessed. A review of nurses' notes dated 3/27/19 and 3/28/19 revealed documented mood indicators and behaviors of combativeness, yelling, cursing and agitation. On 5/10/19 at 3:48 PM an interview was completed with the Administrator. She stated when staff completed the MDS assessment she expected them to interview other staff, make observations and review the medical record to assess a resident who was unable to participate in an interview due to cognitive or communication deficits.	F 636	Senior Reimbursement Specialist and MDS Nurses will implement the above correction actions.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		6/7/19

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 05/10/2019

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 7 by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment: 1) To reflect the provision of dialysis for 1 of 1 resident (Resident #62) reviewed for dialysis; 2) To indicate the Preadmission Screening and Resident Review (PASRR) Level II status for 1 of 1 resident (Resident # 121) reviewed for PASRR determination; and, 3) To report services provided by the facility ' s Restorative Nursing Program (RNP) for 1 of 5 residents (Resident # 97) reviewed for position/mobility. The findings included: 1) Resident #62 was admitted to the facility on 3/21/19 from a hospital. His cumulative diagnoses included end stage renal disease and dependence on renal dialysis. A review of the Physician ' s History and Physical from admission (dated 3/28/19) was completed. The History and Physical included a notation which read, " ...Pt (patient) has been tolerating his dialysis since admission to this facility ..." A review of Resident #62 ' s admission Minimum Data Set (MDS) assessment dated 4/1/19 was completed. Section I (Active Diagnoses) of the MDS indicated the resident had renal insufficiency, renal failure, or end stage renal disease (ESRD). Additional diagnoses listed in this section included ESRD and dependence on dialysis. However, Section O of the MDS assessment did not indicate the resident received dialysis while a resident in the facility. A review of the resident ' s care plan included the	F 641	The facility failed to accurately code the Minimum Data Set assessment on a dialysis resident, a resident with a PASRR Level II status, and code that a resident was on a Restorative Nursing Program. The MDS nurse corrected the MDS assessments on these three residents immediately. The Senior Reimbursement Specialist will complete a 100% audit of all MDS assessments of residents on dialysis, having a PASRR Level II status, and residents currently on a Restorative Nursing Program by 6/7/2019. Any MDS assessments not coded accurately will be corrected. The MDS nurses were educated on the importance of accurate coding on the MDS for these areas on 5/29/2019. Starting 5/27/2019, the MDS Nurses will be provided a list of dialysis residents weekly by the Transportation Scheduler. The Level II PASRR resident status will be updated on the company shared drive for every Level II PASRR admission. Starting 5/27/2019, the MDS nurses will be provided a list of all residents currently on a Restorative Nursing Program at least weekly by Nursing Administration. MDS Audit Tools will be used weekly x 1 month and monthly x 1 year. The MDS Nurses will present the results of the Monthly QAPI Committee for 1 year. The Senior Reimbursement Specialist and MDS Nurses will implement the above corrective actions.	

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 05/10/2019

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 8	F 641		

following problem initiated on 4/11/19: "Risks, Impairments or Complications: Has renal failure and has dialysis and has potential for infection at dialysis port and other complications."

An interview was conducted on 5/9/19 at 4:37 PM with the facility ' s MDS Nurse. Upon request, the nurse reviewed Section O of Resident #62 ' s admission MDS. The MDS Nurse confirmed Section O was not coded to indicate the resident received dialysis. The nurse reported if the resident had been care planned for dialysis, the MDS should have indicated he was receiving dialysis.

An interview was conducted on 5/10/19 at 4:05 PM with the facility ' s Administrator in the presence of the Corporate Consultant. During the interview, concerns regarding the failure to accurately code MDS assessments were discussed. Upon inquiry, the Administrator stated her expectation was to make sure the MDS coding was accurate for dialysis.

2) Resident #121 was admitted to the facility on 2/1/19 with a cumulative diagnoses which included schizophrenia.

A review of Resident #121 ' s state Medicaid FL2 form (entitled ' Level of Care Screening Tool ') dated 2/1/19 was reviewed. This form revealed the resident ' s Preadmission Screening and Resident Review (PASRR) number ended with the letter "B," which was indicative of a PASRR Level II determination. Determination of a PASRR Level II resident is made by an in-depth evaluation. Results of the evaluation would be used for formulating a determination of need, an appropriate care setting, and a set 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 05/10/2019

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 9	F 641		

recommendations for services to help develop an individual's plan of care.

A review of Resident #121 ' s admission Minimum Data Set (MDS) assessment (dated 2/8/19) was completed. Section A of the MDS revealed the resident was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability.

An interview was conducted on 5/9/19 at 4:42 PM with MDS Nurse #1. At that time, inquiry was made with regards to Resident #121 ' s PASRR Level II determination.

Upon request, an interview was conducted on 5/9/19 at 5:01 PM with Social Worker (SW) #2 in the presence of MDS Nurse #1. During the interview, SW #2 reported Resident #121 came from the hospital with a PASRR number which ended with the letter "B" and a diagnosis of schizophrenia. Upon further inquiry, the SW reported this resident would be a PASRR Level II resident.

A follow-up interview was conducted on 5/9/19 at 5:10 PM with MDS Nurse #1 in the presence of MDS Nurse #2. The nurses reported they needed to ask other disciplines when completing the PASRR section of the MDS in order to obtain the information needed. On 5/9/19 at 5:42 PM, MDS Nurse #1 provided a corrected copy of Section A for the admission MDS, which indicated Resident #121 was determined to be a PASRR Level II resident. The correction also reported the PASRR Level II condition was a serious mental illness.

An interview was conducted on 5/10/19 at 4:05

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 05/10/2019

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 10	F 641		

PM with the facility ' s Administrator in the presence of the Corporate Consultant. During the interview, concerns regarding the failure to accurately code MDS assessments were discussed. Upon inquiry, the Administrator stated her expectation was to make sure the MDS coding was accurate for PASRR.

3) Resident #97 was admitted to the facility on 4/13/15 from a hospital. Her cumulative diagnoses included multiple sclerosis.

A review of Resident #97 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 4/9/19 was completed. Section O (titled ' Special Treatments and Programs ') of the MDS assessment did not indicate the resident received services from the facility ' s Restorative Nursing Program for at least 15 minutes a day in the last 7 calendar days.

A review of Resident #97 ' s Point of Care History from 4/3/19 - 4/9/19 indicated PROM was provided by Restorative Nursing for 15 minutes on 4/3/19 and on 4/4/19. It also documented the provision of splint or brace assistance by Restorative Nursing for 15 minutes on 4/3/19 and 4/4/19.

Further review of the resident ' s Interdisciplinary Progress Notes included another notation written by the ADON on 4/9/19. This note read as follows: "Restorative Nursing Program reviewed. Currently receives PROM (passive range of motion) and splinting. Aides work on shoulder, elbow, hands, and wrist flex and extension. Aides gently stretch to tolerance. L (left) hand roll splint applied 2-6 hours. R (right) resting hand splint (palm guard) for 2-6 hours. No skin issues

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 05/10/2019

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 11 noted. Cont (Continue) current program at this time." An interview was conducted on 5/9/19 at 1:41 PM with the ADON. The ADON was identified as the staff member who was responsible to coordinate the facility ' s Restorative Nursing Program. During the interview, the ADON confirmed the resident was placed on the Restorative Nursing Program on 3/12/19 and continued to receive these services to date. An interview was conducted on 5/10/19 at 2:50 PM with MDS Nurse #2. During the interview, the MDS nurse reviewed Section O of Resident #97's MDS assessment dated 4/9/19. Upon inquiry, the nurse reported the 7-day look back period for this assessment was 4/3/19-4/9/19 (inclusive). MDS Nurse #2 confirmed the MDS assessment did not indicate the resident received Restorative Nursing services. However, upon review of Resident #97 ' s Point of Care History report for Restorative Nursing (4/3/19 - 4/9/19), the nurse stated the MDS should have been coded to reflect the resident received 2 days of PROM and 2 days of brace/splint services by Restorative Nursing. An interview was conducted on 5/10/19 at 4:05 PM with the facility ' s Administrator in the presence of the Corporate Consultant. During the interview, concerns regarding the failure to accurately code MDS assessments were discussed. Upon inquiry, the Administrator stated her expectation was to make sure the MDS coding was accurate in regards to the services provided by the facility ' s Restorative Nursing Program.	F 641		
F 761	Label/Store Drugs and Biologicals	F 761		6/7/19

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 05/10/2019

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 761 SS=E	Continued From page 12 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 by: Based on observations, record review and staff interviews, 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 A-400 Hall med cart) observed; and, 3) Failed to label medications with the minimum required information (including the resident ' s name) in 2	F 761	The facility failed to remove expired medications, store medications as specified by the manufacturer, and failed to label medications with the minimum requirement of a resident's name in the facility's medication carts. The medications found in this deficiency were discarded immediately. The facility conducted a 100% audit of all	

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 05/10/2019

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 761	Continued From page 13 of 5 medication carts (Unit C-200 Hall and Unit C-100 Hall med carts) observed. The findings included: 1a) Accompanied by Nurse #3, an observation was made on 5/8/19 at 11:10 AM of the Unit C-200 Hall medication cart. The observation revealed an opened, single-dose vial of 20 milligrams (mg)/2 milliliters (ml) furosemide (a diuretic) solution for injection was stored on the med cart. Approximately 0.5 ml were observed to remain in the vial. The vial of furosemide was not labeled with the minimum required information, including a resident ' s name. Nurse #3 was observed as she discarded the medication. An interview was conducted on 5/9/19 at 3:03 PM with the facility ' s Director of Nursing (DON) in the presence of the Assistant Director of Nursing (ADON) and Corporate Consultant. During the interview, the observations of the medication storage on med carts were discussed. When asked, the DON stated she would expect the nurses and med aides to follow the facility and pharmacy ' s storage policies and procedures for the handling of medications in the facility. 1b) Accompanied by Nurse #2, an observation was made on 5/8/19 at 10:55 AM of the Unit C-100 Hall medication cart. The observation revealed an opened, single-dose 10 milliliter (ml) vial of 0.9% sodium chloride solution was stored on the med cart. The vial of sodium chloride was not labeled with the minimum required information, including a resident ' s name. Nurse #2 was observed as she discarded the medication.	F 761	medication carts on 5/22/2019. Any areas of concern were fixed during the audit. 100% of all nurses and medication aides will be educated by Nursing Administration team on the importance of labeling in accordance with the regulation as well as proper storage of drugs and biologicals by 5/31/2019. Storage bins will also be placed in each medication cart in order for eye drops to be stored upright by 5/31/2019. A Medication storage audit tool will be completed by Nursing Administration team which includes all medication rooms and medication carts twice a week x 4 weeks, weekly x 3 months, and monthly x 1 year. The Director of Nursing will present the results of the audit tool to the Monthly QAPI committee monthly for 1 year. The Nursing Administration team which includes the Unit Managers, Assistant Director of Nursing, and Director of Nursing will implement the above actions.	

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 05/10/2019

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 761	Continued From page 14	F 761		

An interview was conducted on 5/9/19 at 3:03 PM with the facility ' s Director of Nursing (DON) in the presence of the Assistant Director of Nursing (ADON) and Corporate Consultant. During the interview, the observations of the medication storage on med carts were discussed. When asked, the DON stated she would expect the nurses and med aides to follow the facility and pharmacy ' s storage policies and procedures for the handling of medications in the facility.

1c) Accompanied by Nurse #4, an observation was made on 5/8/19 at 11:23 AM of the Unit C-400 Hall medication cart. The observation revealed an opened bottle of 10 milligrams (mg) cetirizine tablets (an over-the-counter antihistamine) labeled for Resident #168 had an expiration date of March 2019. Nurse #4 reported the resident ' s family had brought the medication into the facility for administration to the resident. The nurse confirmed the manufacturer ' s expiration date indicated the medication was expired.

A review of Resident #168 ' s medical record revealed she was admitted to the facility on 4/26/19. A review of the resident's current physician's orders included 10 mg cetirizine to be given as one tablet by mouth once daily (initiated 4/26/19).

An interview was conducted on 5/9/19 at 3:03 PM with the facility ' s Director of Nursing (DON) in the presence of the Assistant Director of Nursing (ADON) and Corporate Consultant. During the interview, the observations of the medication storage on med carts were discussed. When asked, the DON stated she would expect 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 05/10/2019

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 761	Continued From page 15	F 761		

nurses and med aides to follow the facility and pharmacy ' s storage policies/procedures for the handling of medications in the facility.

1d) Accompanied by Nurse #1, an observation was made on 5/8/19 at 10:25 AM of the Unit A-400 Hall medication cart. The observation revealed an unopened vial of Humalog insulin dispensed by the pharmacy on 4/7/19 and labeled for use by Resident #8 was stored on the medication cart. A pharmacy auxiliary label placed on the box containing the insulin vial read, "Refrigerate until open." The vial of insulin was not dated as to when it had been placed on the medication cart. The vial was not cold. Upon inquiry, Nurse #1 confirmed the vial was not cold and stated that she did not put the insulin vial on the med cart on this date. When asked how she would know when the insulin was put on the med cart, the nurse stated, "Don't know." Nurse #1 reported, "I'm going to get rid of it...that bothers me."

According to the product manufacturer, unopened vials of Humalog insulin may be stored under refrigeration until the manufacturer ' s expiration date or at room temperature for 28 days.

A review of Resident #8 ' s Physician Orders revealed a previous order for sliding scale Humalog insulin had been discontinued on 4/12/19.

An interview was conducted on 5/9/19 at 3:03 PM with the facility ' s Director of Nursing (DON) in the presence of the Assistant Director of Nursing (ADON) and Corporate Consultant. During the interview, the observations of the medication storage on med carts were discussed. When

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 05/10/2019

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 761	Continued From page 16	F 761		

asked, the DON stated she would expect the nurses and med aides to follow the facility and pharmacy ' s storage policies and procedures for the handling of medications in the facility.

2) Accompanied by Nurse #1, an observation was made on 5/8/19 at 10:25 AM of the Unit A-400 Hall medication cart. The observation revealed an opened bottle of 1% prednisolone ophthalmic suspension (a steroid eye drop medication) labeled for Resident #31 was stored lying down on its side in a drawer of the medication cart. The manufacturer ' s storage instructions printed on the label of the eye drops read in all capital letters, "Store Upright." Upon inquiry, the nurse reported she did not know the eye drops needed to be stored in an upright position.

A review of Resident #31's physician's orders included a current order for 1% prednisolone ophthalmic suspension eye drops to be instilled as one drop in the left eye twice daily.

An interview was conducted on 5/9/19 at 3:03 PM with the facility ' s Director of Nursing (DON) in the presence of the Assistant Director of Nursing (ADON) and Corporate Consultant. During the interview, the observations of the medication storage on med carts were discussed. When asked, the DON stated she would expect the nurses and med aides to follow the facility and pharmacy ' s storage policies and procedures for the handling of medications in the facility.

3a) Accompanied by Nurse #3, an observation was made on 5/8/19 at 11:10 AM of the Unit C-200 Hall medication cart. The observation revealed an opened bottle of 0.4 milligrams (mg) of nitroglycerin (a medication used to treat

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 05/10/2019

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 761	Continued From page 17	F 761		

angina) sublingual (under the tongue) tablets was stored on the med cart. The bottle of nitroglycerin tablets was not labeled with the minimum required information, including a resident ' s name. When asked, Nurse #3 reported she did not know who the medication belonged to. She stated the medication needed to be discarded.

An interview was conducted on 5/9/19 at 3:03 PM with the facility ' s Director of Nursing (DON) in the presence of the Assistant Director of Nursing (ADON) and Corporate Consultant. During the interview, the observations of the medication storage on med carts were discussed. When asked, the DON stated she would expect the nurses and med aides to follow the facility and pharmacy ' s storage policies and procedures for the handling of medications in the facility.

3b) Accompanied by Nurse #2, an observation was made on 5/8/19 at 10:55 AM of the Unit C-100 Hall medication cart. The observation revealed 2 loose vials of 0.5 milligrams (mg) / 3 mg ipratropium/albuterol solution for inhalation were found stored in the top drawer of the med cart. The vials were not labeled with the minimum required information, including a resident ' s name.

An interview was conducted on 5/9/19 at 3:03 PM with the facility ' s Director of Nursing (DON) in the presence of the Assistant Director of Nursing (ADON) and Corporate Consultant. During the interview, the observations of the medication storage on med carts were discussed. When asked, the DON stated she would expect the nurses and med aides to follow the facility and pharmacy ' s storage policies and procedures for the handling of medications in the facility.

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 05/10/2019

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 761	Continued From page 18 3c) Accompanied by Nurse #2, an observation was made on 5/8/19 at 10:55 AM of the Unit C-100 Hall medication cart. The observation revealed a tablet of 40 milligrams (mg) atorvastatin (a medication used to treat high cholesterol and lipids in the blood) was stored in a single-dose bubble pack in the top drawer of the med cart. The tablet was not labeled with the minimum required information, including a resident ' s name. When asked, Nurse #3 reported she did not know who the medication belonged to. An interview was conducted on 5/9/19 at 3:03 PM with the facility ' s Director of Nursing (DON) in the presence of the Assistant Director of Nursing (ADON) and Corporate Consultant. During the interview, the observations of the medication storage on med carts were discussed. When asked, the DON stated she would expect the nurses and med aides to follow the facility and pharmacy ' s storage policies and procedures for the handling of medications in the facility.	F 761		