STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345443	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	**5680 WINDY HILL DRIVE , WINSTON SALEM, North Carolina, 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
E0000	Initial Comments An onsite recertification and complaint investigation survey was conducted from 5/18/25 through 5/22/25. Additional information was obtained offsite on 6/5/25. Additional complaint intakes were investigated on 6/11/25 through 6/12/25. Therefore, the exit date was changed to 6/12/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #S6A811.	E0000		
F0000	INITIAL COMMENTS An onsite recertification and complaint investigation survey was conducted from 5/18/25 through 5/22/25. Additional information was obtained offsite on 6/5/25. Additional complaint intakes were investigated on 6/11/25 through 6/12/25. Therefore, the exit date was changed to 6/12/25. Event ID# S6A811. The following intakes were investigated: NC00231103, NC00231081, NC00231007, NC00230352, NC00229481, NC00229135, NC00227980, NC00226006, NC00224770, NC00222415, NC00220402, NC00220226, NC00219171, NC00217086, NC00217014, NC00216789, NC00216641, NC00215663, NC00215605, and NC00215179. 20 of the 60 complaint allegations resulted in deficiency.	F0000		
F0561 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	F0561	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 allegations of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 561 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: A thorough review was conducted by the Director of Nursing (DON) on 06/12/2025 in direct relation to	06/27/2025

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F0561 SS = D	Continued from page 1 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 observations, record review, and staff interviews, the facility failed to allow residents who had been assessed as a safe independent smoker the choice to smoke unsupervised for 2 of 3 residents reviewed for choices (Resident #114 and Resident #117). The findings included: Review of "Policy Title: Smoking Agreement" signed and dated 12/23/24 by Resident #114 stated "independent smoker may smoke in designated areas when they would like to smoke. They must also adhere to the rules as outlined". 1. Resident #114 was admitted to the facility on 09/24/24 with diagnoses which included tobacco use. Review of Resident #114's quarterly Minimum Data Set (MDS) dated 03/13/25 revealed his cognition was intact. Review of Resident #114's care plan revised on 04/04/25 revealed Resident #114 was at risk for injuries related to the preference of smoking. The goal was Resident #114's smoking related injuries would be minimized.	F0561	Continued from page 1 Resident #114 and Resident #117 identified during the survey process. The review showed that the facility failed to allow residents who had been assessed as safe independent smokers the choice to smoke unsupervised. The smoking policy and times were immediately reviewed and updated to ensure that independent smokers could smoke unsupervised in designated areas at any time of their choosing. The DON and Administrator held a meeting with the affected residents to inform them of the changes and ensure their preferences were respected. On 6/26/25 the resident smoking area was opened for 24 hours a day, and independent smokers are able to smoke unsupervised and at any time of their choosing. 2. Corrective action for residents with the potential to be affected by the deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 06/12/2025, the DON initiated an audit of 100% of current residents who smoke to ensure their smoking assessments and care plans are up to date. The purpose of this audit is to ensure that all residents who smoke have the choice to smoke unsupervised if they have been assessed as safe independent smokers. On 6/26/25 the resident smoking area was opened for 24 hours a day, and independent smokers are able to smoke unsupervised and at any time of their choosing. Signage was placed at smoking area to indicate area was open 24 hours per day. 3. Measures/Systemic changes to prevent reoccurrence of deficient practice: On 6/13/2025 education was initiated with all Licensed Nurses (RNs/LPNs) including agency staff by the DON on Resident choices, Self-determination, and resident Smoking while in the facility. The smoking policy will be reviewed and discussed during the clinical meeting for review by the Interdisciplinary Team (IDT). As of 06/15/2025, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. The DON and/or designee will conduct quarterly smoking assessments for all residents who smoke to ensure compliance. 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: Beginning the week of 6/27/2025 the DON and/or designee will conduct monitoring by interviewing 5 unsupervised	

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F0561 SS = D	Continued from page 2 Review of Resident #114's quarterly smoking assessment dated 03/24/25 revealed Resident #114 was able to hold the cigarette safely without a device, extinguish cigarette safely, and ambulate independently. Resident #114 was assessed as able to smoke safely independently. An observation conducted on 05/20/25 at 12:30 PM revealed the designated smoking area door posted a sign that stated smoking was allowed from 8:00 AM- 8:00 PM daily. Observation and interview conducted with Resident #114 on 05/20/25 at 2:00 PM revealed Resident #114 was outside in the designated smoking area smoking independently. Resident #114 stated he was upset that times had been put in place and independent smokers were unable to smoke after 8:00 PM. Resident #114 stated he preferred to smoke independently in the evenings after 8:00 PM. An interview conducted with Nurse Aide (NA) #5 on 05/21/25 at 12:10 PM revealed she worked both 1st and 2nd shift. NA #5 stated multiple residents that smoked had complained that they were not able to smoke after 8:00 PM. NA #5 indicated Resident #114 had complained to her. NA #5 indicated she had spoken to multiple nursing staff before and told them that residents were upset. An interview conducted with the Director of Nursing (DON) and Administrator on 05/21/25 at 3:40 PM revealed Resident #117 was an independent smoker. The DON and Administrator stated they had not had any complaints from residents having to smoke at assigned times. It was indicated the assign times were implemented several months back and was a decision made by department heads. 2. Resident #117 was originally admitted to the facility on 10/23/24 with diagnoses which included tobacco use. Review of Resident #117's annual MDS dated 03/05/25 revealed his cognition was intact and was coded for tobacco use.	F0561	Continued from page 2 resident smokers per week to ensure that they have had access to smoke per their choice. Monitoring will be completed by the DON and/or designee weekly for 4 weeks and monthly for 3 months. Reports will be presented to the monthly Quality Assurance (QA) committee by the DON or designee to ensure corrective action is initiated as appropriate. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Compliance Date: 06/27/2025	

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F0561 SS = D	Continued from page 3 Review of Resident #117's care plan revised on 03/18/25 revealed Resident #117 was at risk for injuries related to the preference of smoking. The goal was Resident #117's smoking related injuries would be minimized. Review of Resident #117's quarterly smoking assessment dated 03/24/25 revealed Resident #117 was able to hold the cigarette safely without a device, extinguish cigarette safely, and ambulate independently. Resident #117 was assessed as able to smoke safely independently. Observation conducted on 05/20/25 at 12:30 PM revealed on the door going out to the designated smoking area revealed smoking was allowed from 8:00 AM- 8:00 PM daily. Observation and interview conducted with Resident #117 on 05/20/25 at 2:00 PM revealed Resident #117 was outside in the designated smoking area smoking independently. Resident #117 stated he was upset that times had been put in place and independent smokers were unable to smoke after 8:00 PM. Resident #117 stated he used to be able to go out anytime to smoke and liked to smoke before 8:00 AM and after 8:00 PM. An interview conducted with Nurse Aide (NA) #5 on 05/21/25 at 12:10 PM revealed she worked both 1st and 2nd shift. NA #5 stated multiple residents that smoked had complained that they were not able to smoke after 8:00 PM. NA #5 indicated Resident #117 had complained to her. NA #5 indicated she had spoken to multiple nursing staff before and told them that residents were upset. An interview conducted with the Director of Nursing (DON) and Administrator on 05/21/25 at 3:40 PM revealed Resident #117 was an independent smoker. The DON and Administrator stated they had not had any complaints from residents having to smoke at assigned times. It was indicated the assign times were implemented several months back and was a decision made by department heads.	F0561		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12	F0602	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	06/13/2025

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F0602 SS = D	Continued from page 4 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and staff, Pharmacy Consultant and Medical Director interviews, the facility failed to protect the resident's right to be free from misappropriation of narcotic medications (Oxycodone) for 2 of 3 residents reviewed for misappropriation of property (Resident #2 and Resident #3). The findings included: a. Resident #2 was admitted to the facility on 1/11/25 with diagnoses that included chronic pain. The admission Minimum Data Set (MDS) assessment dated 5/28/25 indicated she was moderately cognitively impaired and received opioid medications. Physician's orders for Resident #2 revealed an order dated 5/28/25 for Oxycodone 5 milligrams (mg) every 8 hours by mouth as needed (PRN) for pain. Resident #2's Medication Administration Record (MAR) for May 2025 revealed that from 7:00 PM on 5/28/25 to 7:00 AM on 5/29/25, Resident #2 did not report pain and did not receive PRN Oxycodone. b. Resident #3 was admitted to the facility on 11/30/23 with diagnoses that included chronic pain. The admission MDS assessment dated 5/8/25 indicated she was moderately cognitively impaired and received opioid medications. Physician's order for Resident #3 revealed an order dated 5/8/25 for Oxycodone 5 mg every 8 hours via feeding tube for pain.	F0602	Continued from page 4 have been or will be corrected by the dates indicated. F 602 How corrective action will be accomplished for residents found to have been affected by the deficient practice: A chart review was initiated by the Director of Nursing (DON) on 06/12/2025 in direct relation to Resident #2 and Resident #3 identified during the survey process. In addition, resident number 2 and 3 were accessed for pain and the provider was notified. No new orders for either resident. The review showed that the facility failed to protect the residents' right to be free from misappropriation of narcotic medications (Oxycodone). The narcotic medication administration process was immediately revised, and all narcotic medications were audited. The DON conducted interviews with all nursing staff and implemented stricter controls on narcotic medication storage and administration. The facility ordered and paid for both resident s medications. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 05/29/2025, the DON initiated an initial audit of 100% of current residents' narcotic medication administration records. The same audit will be completed by the DON and/or designee for all new admissions. The purpose of this initial audit is to ensure compliance with CMS guidelines and to identify any deficiencies that need to be addressed. The audit revealed there were no discrepancies on 8 of 9 medication carts. Additionally, 47 out of 155 residents were accessed for pain and had body audits completed. The other 108 of 155 residents were interviewed to see if they had any pain or any trouble with receiving pain medications, and the results revealed no one had pain or trouble accessing pain medication. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not occur: Immediate education on CMS guidelines and facility policies was initiated on 5/29/2025 with all Licensed Nurses (RN's/LPN's) including agency by the DON. The	

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F0602 SS = D	Continued from page 5 Resident #3's MAR for May 2025 revealed that Nurse #5 administered 5 mg of Oxycodone tablet on 5/29/25 at 6:00 AM. The controlled drug form revealed Nurse #5 signed out Oxycodone 5 mg for Resident #3 on 5/29/25 at 6:00 AM. The Initial Allegation Report submitted to the State by the Administrator on 5/29/25 at 11:10 AM revealed an allegation of misappropriation of property was made on 5/29/25 when narcotic discrepancies were found on two residents (Resident #2 and Resident #3) narcotic records involving Nurse #5. The Investigation Report completed by the Administrator on 6/5/25 revealed that on 5/29/25 at 10:30 AM during the audit of narcotic process the Director of Nursing (DON) found that two cards of narcotics and the second page of Narcotic Count Sheet were missing from the C-100 hall medication administration cart: Oxycodone 5 mg tablets (30 tablets for Resident #2 and 54 tablets for Resident #3, 84 total). The DON initiated an investigation, suspended Nurse #5 who was assigned for C-100 hall medication administration cart from 7:00 PM on 5/28/25 to 7:00 AM on 5/29/25, and notified the Medical Director, Law Enforcement, the State, Adult Protective Service (APS), Drug Enforcement Administration (DEA), the Administrator, and Pharmacy. The DON conducted an interview with Nurse #5 who indicated that she counted narcotics during the shift change report with another nurse at the beginning and the end of her shift, and did not realize that two cards of narcotics were missing. The administration interviewed all the RN's, LPN's and Medication Aides, who had work on that specific medication cart, and there were no concerns related to Resident #2's and Resident #3's Oxycodone, and no suspicious behavior or narcotic discrepancies reported. All the staff members who worked on C-100 medication administration cart were sent for urine drug screens with negative results. Law Enforcement did not have charges related to the allegation and did not investigate further. On 6/11/25 at 10:30 AM during an interview, the DON indicated that the discrepancy with the narcotic count for the C-100 medication administration cart was discovered the morning of 5/29/25. She reported that during the narcotic process audit, the DON noted that	F0602	Continued from page 5 following measures were implemented to prevent reoccurrence of the alleged deficient practice: " Stricter controls on narcotic medication storage and administration were implemented- All narcotics will be stored in a safe in the DON s office and will be under lock and key at all times. " Staff were re-educated on the importance of keeping narcotic medication keys secure and conducting narcotic counts at the change of shifts. This education will be integrated into new hire orientation. " Abuse- Misappropriation of property is defined as the deliberate misplacement, exploitation or wrongful temporary or permanent use of a resident s belonging s or money without the resident s consent. 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 and/or designee will continue to monitor the narcotic medication administration records for all residents to ensure compliance. Monitoring will be completed weekly for 2 weeks and monthly for 3 months. This will begin on 6/6/2025, using the QA tool Narcotic Count and Monitoring. Reports will be presented to the monthly QA committee by the DON or designee to ensure corrective action is initiated as appropriate. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Compliance Date: 06/13/2025	

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F0602 SS = D	Continued from page 6 on C-100 hall, two narcotic cards (30 tablets for Resident #2 and 54 tablets for Resident #3, 84 total) and the second page of the Narcotic Count Sheets were missing from the medication administration cart. The investigation started immediately and Nurse #5, the last nurse, assigned for this cart, was suspended. All medication carts were audited, and no additional missing narcotics were found. Nursing staff conducted pain assessments for all residents, including Residents #2 and #3, and no issues with pain on that shift were reported. Urine drug screen tests were conducted for all the staff who worked on C-100 hall medication administration cart with negative results. The DON interviewed Nurse #6 and Nurse #5, the outgoing and one oncoming nurses for 5/28/25 second shift, who reported no narcotic discrepancy. The DON notified the Medical Director, Law Enforcement, State, APS, DEA, the Administrator, and Pharmacy. The DON reviewed the facility cameras in the C-100 hall area, including the medication administration cart area. On 5/29/25, multiple employees were observed walking past the medication cart, but nobody had touched the medication cart, and no other suspicious behavior was noted. The pharmacy requested to bill the missing medications to the facility. The DON stated that two nurses were responsible for completion of the narcotic count at the change of shifts: one outgoing and one oncoming nurse. She further stated any discrepancy found must be reported immediately and an investigation would be started. On 6/11/25 at 2:45 PM during a phone interview, Nurse #7 indicated that she worked on 5/29/25 from 7:00 AM to 7:00 PM and received the change of shift report from Nurse #5 at 7:30 AM. Nurse #5 did not report a narcotic discrepancy. Nurse #7 indicated Both nurses counted the narcotics on C-100 hall medication administration cart, signed the narcotic book and did not see a problem. A couple of hours later, the DON notified her about two missing narcotic cards from the same medication administration cart. Nurse #7 did not know how the narcotics were lost. On 6/11/25 at 10:40 AM during a phone interview Nurse #5 indicated that from 7:00 PM on 5/28/25 to 7:00 AM on 5/29/25 she was assigned to C-100 hall medication administration cart. Nurse #5 stated that on 5/28/25 at 7:00 PM, she received the shift change report from Nurse #6 and the narcotic count was correct. On 5/29/25 at 7:30 AM, she gave the shift change report to Nurse #7 (agency) and did not find the discrepancy. After an hour and a half, the DON notified Nurse #5 that during	F0602		

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F0602 SS = D	Continued from page 7 the narcotic process audit, it was discovered that two Oxycodone tablets cards were missing from C-100 hall medication administration cart. Nurse #5 reported that during her shift, Resident #3 received her scheduled Oxycodone 5 mg at 6:00 AM, and Resident #2 did not require as needed pain medication. Nurse #5 confirmed that she did not leave the narcotic keys unattended and did not know how the narcotic loss occurred. Law Enforcement did not contact her in regards to missing narcotics. On 6/12/25 at 8:50 AM during a phone interview, Nurse #6 indicated that on 5/28/25 from 7:00 AM to 7:00 PM, she was assigned to C-100 hall medication administration cart. At the end of her shift, she reconciled the narcotics with the upcoming nurse, Nurse #5, and the count was correct. There was no problem with narcotics during her shift. She became aware of missing narcotics from the C-100 hall medication administration cart the next day (5/29/25). On 6/11/25 at 3:30 PM during a phone interview, the Pharmacist indicated that the pharmacy was notified of the missing narcotic cards by the DON, and helped the facility report the diversion to the DEA. She stated that the Pharmacy Consultant regularly performed monthly random narcotic audits of the medication carts, medication rooms, and did not report issues or concerns before or after this incident. On 6/12/25 at 10:00 AM during a phone interview, the Medical Director indicated that he was notified about the missing narcotics. He asked the staff to assess the residents for the pain. The staff reported that on 5/29/25, Resident #2 did not need her PRN narcotic, and Resident #3 received Oxycodone according to the order. On 6/12/25 at 10:30 AM during a phone interview, the Administrator indicated that her expectation was for the nursing staff to keep the narcotic drawer and medication cart locked at all times when not in use, medication cart keys on nurses at all times, for nursing staff to count narcotics on the cart each shift, and both ongoing and oncoming staff sign off the narcotic count was completed and was correct. The Administrator stated that the allegation of misappropriation of resident property was not substantiated because the investigation was unable to identify how the medications were missing.	F0602		
F0656 SS = D	Develop/Implement Comprehensive Care Plan	F0656	F656 Develop/Implement Comprehensive Care Plan	06/27/2025

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F0656 SS = D	Continued from page 8 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.	F0656	Continued from page 8 Corrective actions for residents affected by alledged deficient practice: "Resident #30 Careplan was added by the facility Minimum Data Set (MDS) Coordinators on 5/21/2025 to reflect accuracy in the smoking status and risk factors for the resident. "Resident #159 Careplan was added by the facility Minimum Data Set(MDS) Coordinator on 5/20/2025 to reflect accuracy in the smoking status and risk factors for the resident. 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. A 100 % audit of the most recent care plans in the past 14 days of all current residents will be completed in order to identify if any residents that are smokers that were missed during the care planning process. This audit will be completed by the facility MDS nurses no later than 6/26/2025. Any care plan identified as not having accurate smoking status will be corrected completed immediately by the facility Minimum Data Set (MDS) Coordinator or designee. Any necessary Minimum data set corrections will be completed no later than 6/26/2025. Systemic Changes By 6/26/2025, education will be completed with all facility Minimum Data Set (MDS) nurses by facility that includes the importance of thoroughly reviewing each residents medical record in order to ensure that residents are care planned correctly. Special emphasis will be placed on care planning smoking preference. This information has been integrated into the standard orientation training for new Minimum Data Set(MDS) Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345443	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2025

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

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F0656 SS = D	Continued from page 9 This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation and staff interviews, the facility failed to develop and implement care plan interventions for 2 of 5 residents reviewed for smoking (Resident #30 and Resident #159). The findings included: 1. Resident #30 was admitted to the facility on 01/30/25 with diagnoses which included hypertension and nicotine dependence. Review of Resident #30's most current smoking assessment was dated 04/29/25. Review of Resident #30's quarterly Minimum Data Set (MDS) dated 05/05/25 revealed Resident #30 was cognitively intact and required limited assistance with activities of daily living (ADL). Review of Resident #30's care plan revealed no goals or interventions regarding Resident #30's smoking. Observation and interview conducted with Resident #30 on 05/20/25 at 2:00 PM revealed Resident #30 smoking independently. Resident #30 indicated he had been smoking since admission. An interview conducted with MDS Coordinator #1 on 05/21/25 at 3:20 PM revealed she was not aware Resident #30 had not been care planned for smoking. MDS Coordinator #1 stated through record review and communication with nursing staff Resident #30 should have been care planned for smoking. An interview conducted with the Director of Nursing (DON) and Administrator on 05/21/25 at 3:20 PM revealed Resident #30 smoked independently but they were not aware the resident had not been cared planned for smoking. The interview further revealed all residents that smoked were expected to be care planned for goals and interventions.	F0656	Continued from page 9 Beginning the week of 6/27/25 the Administrator or designee will begin auditing 5 random recently completed care plans for accuracy in residents smoking status. This audit will be done weekly x 4 weeks, and monthly for 3 months using the audit tool titled Accurate Care plan Audit Monitoring Tool. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set (MDS) Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction: Administrator and/or Director of Nursing. Date of Compliance: 6/27/2025	

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F0656 SS = D	Continued from page 10 2. Resident #159 was admitted to the facility on 03/30/25 with diagnoses which included hypertension and nicotine dependence. Review of Resident #159's admission Minimum Data Set (MDS) dated 03/30/25 revealed the resident was cognitively intact and required extensive assistance for ADL. Review of Resident #159's care plan revealed no goals or interventions regarding smoking. Review of Resident #159's most current smoking assessment was dated 04/29/25. Observation and interview conducted with Resident #159 on 05/20/25 at 2:10 PM revealed Resident #159 smoking independently. Resident #159 indicated he started smoking two weeks after he was admitted. An interview conducted with MDS Coordinator #2 on 05/21/25 at 3:25 PM revealed she was not aware Resident #159 had not been care planned for smoking. MDS Coordinator #1 stated through record review and communication with nursing staff Resident #30 should have been care planned for smoking. An interview conducted with the Director of Nursing (DON) and Administrator on 05/21/25 at 3:20 PM revealed Resident #159 smoked independently but they were not aware the resident had not been cared planned for smoking. The interview further revealed all residents that smoked were expected to be care planned for goals and interventions.	F0656		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to shave facial	F0677	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 677 Corrective action for resident(s) affected by the alleged deficient practice: A chart review was initiated by the Director of Nursing	06/27/2025

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F0677 SS = D	Continued from page 11 hair for 1 of 3 dependent residents reviewed for assistance with activities of daily living (ADL) (Resident #56). The findings included: Resident #56 was admitted to the facility on 01/24/24 with diagnoses which included stroke, muscle weakness, hypertension, osteoporosis, and dysphagia. Review of Resident #56's care plan, revised 10/18/24, revealed the resident had an ADL self-care performance deficit due to left side hemiplegia (weakness on one side of the body), sequelae of poliomyelitis (Post-Polio Syndrome), muscle weakness, and a need for assistance with personal care. The goal was Resident #56 would receive staff assistance with all aspects of daily care to ensure that all needs are met. Interventions listed for Resident #56 included total assistance with bathing and required staff assistance with grooming and personal hygiene. Review of Resident #56's quarterly Minimum Data Set (MDS) dated 03/19/25 revealed the resident was cognitively intact and required extensive assistance with bathing and personal hygiene. An observation and interview conducted with Resident #56 on 05/18/25 at 11:55 AM revealed the resident was laying in bed watching television. Resident #56 had several hairs located on her chin, at an estimated length of one inch. Resident #56 stated she did not like having chin hair and she preferred for her chin and face to be kept trimmed. Resident #56 indicated she often had to ask staff to shave her chin for her. An interview conducted with Nurse Aide (NA) # 5 on 05/21/25 at 12:10 PM revealed she had cared for Resident #56 consistently and was assigned to Resident #56 on this date. NA #5 indicated Resident #56 rarely refused care and preferred to have a clean shaved face. NA #5 stated she was unsure why Resident #56's face had not been shaved but it needed to be. An interview conducted with Nurse #3 on 05/21/25 at 12:30 PM revealed she was the nurse assigned to Resident #56 and was not aware the resident had facial	F0677	Continued from page 11 (DON) on 06/12/2025 in direct relation to Resident #56 identified during the survey process. The review showed that the facility failed to shave facial hair for Resident #56. The grooming and personal hygiene care plan for Resident #56 was immediately updated and Resident # 56 was shaved. Corrective action for residents with the potential to be affected by the alleged deficient practice: All current residents have the potential to be affected by the alleged deficient practice. On 06/26/2025, the DON initiated an initial audit of 100% of current residents' faces for shaving. The audit revealed 2 of 152 residents that needed to be shaved. This was completed by the Assistant DON on 6/26/25. All careplans were reviewed on 6/26/25 by the DON, Assistant Director of Nursing, unit coordinators to ensure preferences not to shave were present. 108 of 152 residents careplans were accurate. There was no deficient practice therefore no corrective action was initiated. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Activities of Daily Living (ADL) education was initiated by the Staff Development Clinician on 06/26/2025 with all Licensed Nurses (RN's/LPN's)and certified nurse aids including agency by the DON. The following measures were implemented to prevent reoccurrence of the deficient practice: " Grooming and personal hygiene care plans were updated if indicated " Staff were re-educated on the importance of aiding with grooming and personal hygiene including shaving. This education will be ongoing and included in the new hire orientation process. . 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, Assistant Director of Nursing (ADON), or licensed practical nurse (LPN) unit	

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F0677 SS = D	Continued from page 12 hair. Nurse #3 did not recall Resident #56 being resistive to personal care and expected residents to be clean shaved if preferred. A follow up interview with Nurse #3 on 05/21/25 at 2:30 PM revealed she had observed Resident #56 and indicated the resident had long chin hairs that needed to be shaved. Nurse #3 stated she shaved Resident #56 without any issue. An interview conducted with the Administrator and Director of Nursing (DON) on 05/21/25 at 3:40 PM revealed they were unsure why Resident #56 had not been clean shaven and they expected residents to remain clean and shaved as preferred.	F0677	Continued from page 12 coordinators will continue to monitor 5 random residents weekly for 4 weeks, monthly for 3 months, to ensure that they are receiving ADL care related to shaving per their preference. This monitoring will be completed using the QA Tool ADL audit for shaving, beginning the week of 6/27/25. Monitoring will be completed weekly for 4 weeks and monthly for 3 months. Reports will be presented to the monthly QA committee by the DON or designee to ensure corrective action is initiated as appropriate. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process Compliance Date: 06/27/2025	
F0687 SS = D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to arrange or coordinate podiatry care for 1 of 3 dependent residents reviewed for assistance with activities of daily living (ADL) (Resident #134). The findings included: Resident #134 was admitted to the facility on 12/20/24 with diagnoses which included stroke and hypertension. Review of Resident #134's care plan, revised 01/08/25,	F0687	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. Corrective action for resident(s) affected by the deficient practice: A chart review was initiated by the Director of Nursing (DON) on 05/21/2025 in direct relation to Resident #134 identified during the survey process. The review showed that the facility failed to arrange or coordinate podiatry care for Resident #134. The provider was notified on 5/20/25 and a referral was received, and an appointment with a podiatrist was scheduled. The unit manager cut and trimmed the resident # 134 s toenails on 5/21/25 until she could see podiatry. Resident # 134 was seen by outside podiatry on 6/23/2025. . Corrective action for residents with the potential to be affected by the deficient practice: All current residents have the potential to be affected by the deficient practice. On 5/21/2025, the DON initiated an initial audit of 100% of all current residents' feet to see if they needed podiatry services. The purpose of this initial audit is to ensure they did not have ingrown toenails, long toenails, are able to put shoes and socks on, and feet do not in pain as a result. The audit revealed 4 of 163	06/24/2025

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F0687 SS = D	Continued from page 13 revealed the resident had an activities of daily living self-care performance deficit due to Cerebrovascular Accident (CVA) (stroke). The goal was for Resident #134 to improve the current level of functioning, including improvement in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. Review of Resident #134's quarterly Minimum Data Set (MDS) assessment dated 03/13/25 revealed the resident was cognitively intact and required extensive assistance with personal hygiene. The MDS further revealed the resident was coded for not being ambulatory. An interview and observation with Resident #134 on 05/21/25 at 11:30 AM revealed the resident's great toenails on both feet to be extending beyond the end of her toes, and were thick, and yellow in color. Resident #134 stated she had an ingrown toenail and was unable to wear shoes or socks because it was hurting and uncomfortable and had been that way for several days. Resident #134 stated a Nurse Aide had trimmed a couple toenails on her smaller toes a couple days prior but had not been seen by podiatry and would like to have a podiatry visit. An interview conducted with Nurse #5 on 05/21/25 at 3:30 PM revealed she was not aware Resident #134's was supposed to be seen by podiatry last week but was not seen. Nurse #5 further revealed she was unsure why she had not been seen by podiatry but observed Resident #134's toenails and stated they needed to be done. An interview was conducted with the Director of Nursing (DON) and Resident #134 in conjunction with an observation of Resident #134 on 05/21/25 at 2:00 PM. Resident #134 stated she could not wear enclosed shoes due to her toes hurting and the length of her great toenails. The DON revealed the podiatrist the facility used created a list of which residents were to be seen for their visit. The DON indicated Resident #134 had an ingrown toenail and needed to be seen by the podiatrist. The DON further stated she was going to contact the Podiatrist and make sure Resident #134 was seen as soon as possible but she went ahead and put her on the list for the next scheduled podiatry visit on 6/26/25. An interview conducted with the Administrator and DON	F0687	Continued from page 13 residents had long toenails and requested podiatry services. Corrective action included: provider notification, responsible party notification, order for treatment. Corrective action: the podiatrist saw those four identified residents on 6/26/2025 in the facility. Measures/Systemic changes to prevent reoccurrence of deficient practice: Immediate education was initiated on 06/12/2025 with all Licensed Nurses (RN's/LPN's) including agency by the staff development clinician (SDC). The education included toenail care/podiatry (how to report why it s important to refer to social worker for podiatry services), the steps necessary to ensure that resident referral for podiatry services is followed up in a timely manner. Any staff who have not received the education will not be allowed to work until educated. Licensed nurses (RNs and LPNs) and nurse aids educated to refer residents to social worker for long, ingrown, or painful toenails. A podiatry appointment scheduling system was implemented by the DON with the Social Workers. This will be ongoing education and integrated in new hire orientation. . 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 and/or designee will monitor 5 residents weekly for four weeks and then monthly for 3 months beginning 6/20/2025 using the QA Podiatry tool to ensure compliance. Reports will be presented to the monthly QA committee by the DON or designee to ensure corrective action is initiated as appropriate. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The QA meeting is attended by the Administrator, DON, Assistant DON, SDC, MDS Coordinator, Therapy Director, Activities Director, Social Worker, and Environmental Services Director. Compliance Date: 06/24/2025	

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F0687 SS = D	Continued from page 14 on 05/21/25 at 3:40 PM revealed Resident #134 had not been assessed by podiatry since admission. The DON stated Resident #134 was on the list to be seen during the previous podiatry visit in May 2025 but was unsure why she had not been seen. The interview further revealed they expected for residents' toenails to remain trimmed and if there were issues, podiatry would be consulted.	F0687		
F0689 SS = G	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: 2. Resident #117 was admitted to the facility on 10/23/24 with diagnoses which included tobacco use. Review of Resident #117's annual Minimum Data Set (MDS) dated 03/05/25 revealed the resident was alert and oriented and was coded for tobacco use. Review of Resident #117's care plan revised on 03/18/25 revealed Resident #117 was at risk for injuries related to the preference of smoking. The goal was Resident #117's smoking related injuries would be minimized through current interventions. Review of Resident 117's smoking assessments revealed a smoking assessment was completed on 03/24/24 and the next assessment was not completed until 08/27/24. Smoking assessments were completed quarterly after 08/27/24. The smoking assessments from 03/24/24 and 08/27/24 concluded Resident #117 was an unsupervised smoker because he was able to demonstrate and understand the smoking policy, times, and place to smoke.	F0689	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 689 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 4/13/25 the nurse aide #3 provided bed mobility without using two persons per the resident's care plan, as a result Resident #71 fell out of bed. The resident was assessed for injuries by the nurse on duty. There was a large hematoma to the left side of her head. Vital signs were obtained as follows: temperature 98.4, blood pressure 98/66, pulse 60, respirations 20, and oxygen saturation 96% on room air. There was no bleeding and skin was intact. Resident appeared at baseline as she was non- verbal. On call provider was notified and an order was received to send to the hospital for evaluation on 4/13/25. The responsible party was notified. Upon arrival to the emergency department the resident was diagnosed with a left distal clavicle fracture, a left second rib fracture, and a golf ball size hematoma to the left side of the head. The staff member was suspended immediately pending investigation. She was terminated at the end of the investigation. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 4/13/25, the Director of Nursing (DON) identified residents that were potentially impacted by this practice by completing 100% audits on all current residents to ensure they had no injuries or concerns related to bed mobility. This was completed on 4/13/25.	06/27/2025

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F0689 SS = G	Continued from page 15 An observation and interview conducted with Resident #117 on 05/20/25 at 2:00 PM revealed Resident #117 was outside in the designated smoking area smoking independently. Resident #117 stated he had always been an independent smoker in the facility. During the observation, Resident #117 was observed to safely ash his cigarette into an appropriate receptacle, and he was observed to not have any burns on his clothing, or his skin. An interview conducted with the Director of Nursing (DON) on 05/21/25 at 3:40 PM revealed she had expected quarterly smoking assessments to be completed. It was indicated nurses were notified by the medical record system what assessments were pending and needed to be completed during their shift, including smoking assessments, and they were expected to complete the assessments during their shift. The DON further revealed she was not aware Resident #117 had gone beyond the quarterly time frame without having had a smoking assessment conducted. Based on observation, record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to provide care in a safe manner when Resident #71 was rolled out of her bed during incontinent care hitting the floor. Resident #71 was sent to the Emergency Department (ED) and diagnosed with a fracture of her left distal (away from the center) clavicle, a closed fracture of the second rib on the left side, and a large left-sided scalp hematoma. The facility also failed to conduct smoking assessments when Resident #117 was not assessed for smoking. The deficient practice occurred for 2 of 4 sampled residents reviewed for supervision to prevent accidents (Resident #71 and Resident #117). Findings included: 1. Resident #71 was admitted to the facility on 4/2/22 with diagnoses which included dementia, adult failure to thrive, contractures of left and right extremities, right hip osteoarthritis, dysphagia, and a history of pulmonary embolism. The revised care plan dated 1/17/25 revealed Resident #71 had an activities of daily living (ADL) self-care performance deficit related to limited mobility and dementia. Interventions included: extensive, two-person	F0689	Continued from page 15 The results included: 72 of 157 residents received bed mobility according to the care plan and had no signs or injuries or concerns related to bed mobility. On 4/13/25 there was no corrective action implemented due to no deficient practice identified as result of the audit. On 4/13/25, current residents that were able to be interviewed were asked if they had concerns with bed mobility or injuries related to bed mobility and if staff had repositioned them according to their plan of care. This was completed by the Director of Nursing and Assistant Director of Nursing. Results included: 72 of 72 residents denied any concerns related to bed mobility. Additionally, body audits were completed on current residents that were not interviewed. These residents were assessed to identify if there were any injuries related to bed mobility. Results included: 85 of 85 residents showed no injuries related to bed mobility. On 4/13/25 there was no corrective action implemented due to no deficient practice as result of the audit. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. During an interview conducted by the Director of Nursing on 4/13/2025 with Nurse Aide (NA) #3, the NA acknowledged she was aware of the Kardex and resident #7 s need for two people for bed mobility. Nurse Aide #3 acknowledged there were other staff available to assist but she failed to ask the staff for assistance and failed to follow policy. Nurse Aide #3 stated that she did not take the time to find help. Nurse Aide #3 was immediately re-educated on 4/13/2025, suspended pending investigation, and terminated on 4/13/2025 following facility investigation for failure to follow policy related to resident Kardex and bed mobility. On 4/13/25, the Staff Development Clinician in-serviced all registered nurses (RNs), licensed practical nurses (LPNs), and nurse aide staff (including agency) on the bed mobility policy. This training included when providing care you must follow the instructions on the care plan. Example: If a resident requires two people for bed mobility there must be two persons. This information will be found on the care plan/Kardex. The Director of Nursing will ensure that any of the above identified staff who do not complete the in-service training by 4/17/25 will not be allowed to work until the training is completed. All RNs, LPNs, and nurse aides including agency will be educated on this policy.	

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

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F0689 SS = G	Continued from page 16 staff assistance to re-position and turn in bed; and two-person assistance using a mechanical lift for transfers. Resident #71's physician orders revealed on 2/27/25 the Resident was ordered 5 milligrams of Eliquis (blood thinner medication) via a gastrostomy tube two times a day due to her history of pulmonary embolism/deep vein thrombosis (DVT). The annual Minimum Data Set assessment dated 3/5/25 indicated Resident #71was severely cognitively impaired, dependent on staff for bed mobility and transfer, had impairment of bilateral upper and lower extremities, had an indwelling catheter, was always incontinent of bowel, had a feeding tube, and had no falls since her last annual assessment. Review of a progress note by Nurse #3 dated 4/13/25 documented that at 6:15 a.m. nursing assistant (NA#3) reported she was performing personal care on Resident #71 and when she turned the Resident on her side to place a brief on her, the Resident rolled off the opposite side of bed. NA#3 reported that the Resident's bed was waist level to her during this time. Resident #71 had a golf ball sized hematoma to the left side of her head. The on-call health provider was notified and ordered the Resident to be sent out for further evaluation. Resident #71's normal mental baseline remained the same. The Resident left facility via ambulance via stretcher at 7:15 a.m. NA#3 was educated on the importance of requesting assistance with residents that required the assistance of two people to help prevent falls or potential injuries while performing personal care and transferring residents. A telephone interview was conducted on 5/20/25 at 5:30 p.m. with Nurse #3 who revealed she last worked at facility approximately 3.5 weeks ago. She revealed she worked at the facility on 4/13/25 during the 11:00 p.m. to 7:00 a.m. shift. Nurse #3 stated that at approximately 6:35 a.m. NA #3 informed her Resident #71 was on the floor in her room. The Nurse reported that she entered Resident #71's room and observed Resident #71 lying on her back, on the floor on the right side of the bed awake and moaning. Nurse #3 stated NA #3 informed her that as she was on the left side of the bed changing the Resident's brief, the NA #3 rolled the Resident away from her to apply the brief but Resident #71 rolled off the bed onto the floor. Nurse #3 stated	F0689	Continued from page 16 This system will be implemented on 4/18/25, moving forward. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. The DON or designee will monitor 5 aides and or nurses weekly for 2 weeks and monthly for 3 months for proper bed mobility according to the Kardex using the Bed Mobility Monitoring Tool monitoring will take place on all shifts. This monitoring will consist of observing the nurse aides and/or nurses utilizing the Kardex to ensure they were using the required number of people for bed mobility. Reports will be presented to the weekly QA committee for three months by the Administrator or Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the on-going auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. Date of compliance: 6/13/25 VALIDATION of POC completed on 5/22/25: The facility's corrective action plan was validated on 5/22/25 through record review of in-services given to nursing staff, observations of bed mobility during care, and review of the monitoring of full body skin audits completed by staff management. Validation was also evidenced by interviews with nurse aides and nurses on the use of Kardex and bed mobility policy. The facility's education was reviewed and included documentation of completion by all nursing staff. The facility's audits and monitoring tools were also reviewed. Nurses and nursing assistants were interviewed and reported that they had received in-service training on following residents Care Plans/Kardex for number of staff required when providing care, bed mobility, and transfers. Training included "Bed Mobility & Transfers Safety" Education Packet with staff signed attestation forms. Observations of two residents receiving incontinent care with two nursing assistants providing bed mobility during the care for each resident including the transfer of one of the two residents from the bed to the wheelchair as indicated by the residents Kardex. The completion date of 4/18/25 for the corrective	

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F0689 SS = G	Continued from page 17 she conducted a physical assessment of Resident #71 and noted a golf ball sized "knot" on the left side of her head, above her left ear but no bleeding. Nurse #3 stated she informed NA #3 that she should have requested her assistance with the Resident's care because the Resident required two staff for assistance with bed mobility and transfers due to the resident was very contracted and stiff. Nurse #3 stated she reminded NA #3 and pointed to a small note on yellow paper on the wall above the resident's head of bed which read "two person assist." The Nurse reported NA #3 responded she did not notice the note. Nurse #3 stated that at approximately 6:45 a.m., with the use of the mechanical lift, she and NA#3 returned Resident #71 to her bed where her vital signs were taken and were within normal limits. Nurse #3 stated she notified the on-call physician of the incident who ordered the resident sent to the emergency room due to the large hematoma to her head. She revealed 911 was called and emergency medical services (EMS) arrived at approximately 7:15 a.m. Nurse #3 stated that throughout the incident, Resident #71 did not lose consciousness, had no bleeding, and was no longer moaning. Nurse #3 revealed she reported the resident's fall to the on-coming Charge Nurse (Nurse #4). On 5/20/25 at 8:47 a.m., an interview was conducted with Nurse #4 who stated she worked as the first shift Charge Nurse on 4/13/25. She recalled that upon her arrival to begin her shift (timecard indicated Nurse#4 reported to work at 6:51 a.m. on 4/13/25), Nurse #3 informed her Resident #71 had a fall and had an injury "to the side of her head." Nurse #4 stated this prompted her to conduct an observation of the resident. Nurse #4 stated she observed the Resident was awake in bed, nonverbal (which was normal) at her baseline, with a large hematoma (palm size) to the left side of her head. Nurse #4 stated she immediately told Nurse #3 to phone the physician "STAT" (immediately). The physician gave orders to send the Resident to the emergency room, immediately. Nurse #4 revealed she was unsure if Resident #71 received blood thinning medication because she was not her assigned nurse; but there was no blood, and the hematoma was not purple and the Resident was not flinching in pain. Nurse #4 revealed she interviewed Nurse #3 and NA #3 on the amount of time since the resident was returned to her bed and both estimated no longer than thirty minutes. Nurse #4 stated she interviewed the NA #3 who reported that when she was providing incontinence care to Resident #71 she (NA) rolled the resident onto her side, and the Resident rolled off the other side of the bed. NA #3 admitted she did not have assistance and was aware	F0689	Continued from page 17 action plan was validated. 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 689 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The deficient practice was identified on 5/21/25 when the Director of Nursing was made aware that resident # 117 did not receive a quarterly smoking assessment between 3/24/24 and 8/27/24. The smoking assessment for resident # 117 was updated by the floor nurse on 5/22/25. The resident remains a safe and independent smoker. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 6/26/25, the Director of Nurses (DON) identified residents that had the potential to be affected by this practice by completing a 100% audit of all current residents identified for smoking to ensure they had quarterly smoking assessments completed timely. This completed on 6/26/25. The audit revealed: 0 of 30 identified smokers had missed smoking assessments. There was no corrective action due to no deficient practice. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: Education: On 6/26/25 the Staff Development Clinician began educating all licensed nurses (RN s and Licensed Practical Nurses, full time, part time, PRN staff, and agency staff on smoking assessments. This education includes:	

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F0689 SS = G	Continued from page 18 Resident #71 was a two person assist with bed mobility and transfers but she had no help. When Nurse #4 asked if NA #3 asked assistance from her nurse, NA #3 response was no. Nurse #4 stated she immediately notified the Director of Nursing who instructed her to have the Schedular notify NA#3 (who had left at end of the shift) that she was suspended pending investigation. Nurse #4 stated NA #3 had not returned to the facility since the incident on 4/13/25. The review of the facility's "Initial Falls Review" form dated 4/13/25 documented Resident #71 rolled or fell out of the bed which was in the low position. NA#3 went in to perform personal care for Resident #71 and during the interaction NA#3 rolled the resident over to place brief on when the resident rolled off the opposite side of the bed resulting in a hematoma to left side of her head. The Resident remained alert, pupils were equally round and reactive to light, equal hand grasp, and moved all extremities. The Nurse Practitioner was notified and ordered to send the resident out to the emergency room. NA #3 was unable to be reached for an interview. The Hospital Discharge Summary dated 4/18/25 revealed Resident #71 presented to the hospital's emergency room on 4/13/25 after a fall from the bed when being turned by staff at the nursing home. Reportedly staff was caring for the resident when they went to roll her back over they rolled her off the bed and the resident landed on her left side. As a result of the x-rays and computed tomography (CT scan), Resident #71 was diagnosed with a fracture of her left distal clavicle, a closed fracture of the second rib of the left side, and a large left-sided scalp hematoma. Also, a Complete Blood Count (CBC) test showed Resident #71 had a slightly elevated white count and a slightly elevated procalcitonin (a protein produced in response to bacterial infections). A urinalysis showed minimal infection. Resident #71 was diagnosed with possible sepsis along with her new fractures. The resident developed a low-grade temperature of 100.6 degrees Fahrenheit while in the emergency room. The Resident was hospitalized to allow for the administration of intravenous antibiotics before being discharged back to the facility. On 5/18/25 at 1:03 p.m., Resident #71 was observed in bed awake, nonverbal and covered with bed linen.	F0689	Continued from page 18 " On admission, quarterly, and as changes occur residents identified as smokers will have smoking assessments per policy. The DON or designee will be responsible for ensuring this information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 6/26/25. 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, Assistant Director of Nursing, or Licensed Practical Nurse Coordinators will monitor compliance utilizing the QA tool: Quarterly Smoking UDA beginning 6/27/2025 weekly x 4weeks then monthly x 3 months. Reports will be presented to the monthly 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 monthly Quality Assurance Meeting. The monthly 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:6/27/25	

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F0689 SS = G	Continued from page 19 An interview with the Administrator on 5/19/25 at 2:17 p.m. revealed NA #3 was terminated from the facility on 4/13/25 due to her failure to follow policy related to bed mobility. She also revealed Nurse #3 (an Agency nurse), last worked at the facility on 4/21/25. On 5/21/25 at 11:47 a.m., the Nurse Practitioner (NP) was interviewed and revealed she was not the on-call provider on 4/13/25 but based on the triage timing documented by the on-call provider, the time frame of the call was appropriate as well as the nurse's assessment. The NP indicated the nurse should always assess a resident before contacting the provider to be able to provide answers quickly to questions about a resident's injuries and/or health status. On 5/22/25 at 11:18 a.m. the Director of Nursing was interviewed and stated during admission, a resident's mobility and transfer ability would be assessed by nursing and therapy and the determination made if a resident required 1 or 2 staff assistance with bed mobility and the use of a mechanical lift for transfers. This determination would be documented in the Kardex (a resident's care plan used by staff when providing care) which all nursing assistants had been educated.	F0689		
F0690 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	F0690	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 Corrective action for resident(s) affected by the alleged deficient practice: A chart review was initiated by the Director of Nursing (DON) on 06/12/2025 in direct relation to Resident #14 identified during the survey process. The review showed that the facility failed to keep a urinary catheter bag from touching the floor. Resident # 14 s catheter was removed from the floor and secured to the bed frame with a basin underneath. Corrective action for residents with the potential to	06/13/2025

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F0690 SS = D	Continued from page 20 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. §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 record review, observations, and staff interviews, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 1 of 5 residents reviewed with urinary catheters (Resident #14). The findings included: Resident #14 was admitted to the facility on 10/20/23 with diagnoses which included unspecified hydronephrosis (swelling of one or both kidneys due to a buildup of urine), presence of urogenital implants, and neuromuscular dysfunction of the bladder. A quarterly Minimum Data Set (MDS) assessment dated 4/3/25 revealed Resident #14 was moderately cognitively impaired. The assessment indicated Resident # 14 was dependent upon staff for all his activities of daily living (ADL). Resident #14 was coded for an indwelling urinary catheter. Resident #14's care plan revised 3/7/25 indicated Resident #14 had a goal of being free from a urinary tract infection due to the presence of an indwelling suprapubic catheter. Interventions included keeping the urinary collection bag below the level of the urinary bladder. An initial observation was conducted on 5/18/25 at 10:39 AM of Resident #14 as he was lying in his bed.	F0690	Continued from page 20 be affected by the alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 06/12/2025, the DON initiated an initial audit of 100% of current residents' urinary catheters to ensure they were not touching the floor. The audit revealed 31 of 31 residents with catheters were secured to the bed and not touching the floor. There was no corrective action due to no deficient practice. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Immediate education related to the importance of keep urinary catheter bags off of the floor was initiated on 06/12/2025 with all Licensed Nurses (RN's/LPN's) including agency by the DON. This education included: " Indwelling catheter care- catheter tubing or bag should not be touching the floor at any time. " When in bed catheter bag must be affixed securely off the floor. This education will be integrated into new hire and ongoing for all nurses and nurse aids including agency. 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, Assistant Director Of Nursing, or licensed practical nurses unit coordinators will monitor 5 random residents with urinary catheters beginning the week of 6/20 using the QA tool: Urinary Catheters to ensure compliance. Monitoring will be completed weekly for 4 weeks and monthly for 3 months. Reports will be presented to the monthly QA committee by the DON or designee to ensure corrective action is initiated as appropriate. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process Compliance Date: 06/13/2025	

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F0690 SS = D	Continued from page 21 The bed was noted to be in a low position. A urinary catheter drainage bag was observed to be hanging off the bedframe on the resident's right side of the bed with a solid, blue-colored privacy flap covering the bag facing the window. The entire bottom of the urinary catheter drainage bag was resting on the floor. Additional observations were conducted on 5/19/25 at 11:25 AM and on 5/20/25 at 4:00 PM. Resident #14's bed was noted to be in the low position, and a urinary catheter drainage bag was observed to be hanging off the bedframe on the resident's right side of the bed. The entire bottom of the urinary catheter drainage bag was resting on the floor during both observations. During an interview with Nurse Aide (NA) #1 on 5/20/25 at 4:19, she stated urinary catheter bags were not supposed to be touching the floor to prevent risk of infection. NA #1 stated she had noticed Resident #14's urinary catheter bag had been on the floor several times during her shift, and she had picked it up and repositioned the urinary catheter drainage bag so that it was not resting on the floor. An interview was conducted with the Director of Nursing (DON) on 5/21/25 at 11:51 AM. She stated she had educated all staff to keep urinary catheter bags off the floor, and there was a hook on the bag to hang it on the resident's bed. The Unit Manager was interviewed on 5/21/25 at 4:50 PM. She stated the resident's urinary drainage bag should not touch the floor. She further stated she had placed a basin underneath Resident #14's urinary catheter bag that day to prevent it from touching the floor since the resident preferred to keep his bed low.	F0690		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F0755	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. Corrective action for resident(s) affected by the deficient practice: A medication review was initiated by the Director of Nursing (DON) on 06/12/2025 in direct relation to	06/13/2025

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F0755 SS = D	Continued from page 22 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff and Pharmacist interviews, the facility failed to have an effective system and safeguards in place to prevent drug diversion when they did not ensure narcotic medications for discharged residents were secured for 2 of 3 residents (Resident #1 and Resident #271) reviewed for medication management. As a result, a total of 75 doses of Oxycodone (a narcotic medication) 5 milligrams (mg) were unaccounted for. Findings included: a. Resident #122 was admitted to the facility on 12/12/2024 and was readmitted on 2/6/2025. His diagnoses included diabetes and diabetic neuropathy. A quarterly Minimum Data Set assessment dated 2/12/2025 indicated Resident #122 was cognitively intact and received opioid medications. Resident #122 had a Physician's Order dated 2/6/2025	F0755	Continued from page 22 Resident #122 and Resident #271 identified during the survey process. The review showed that the facility failed to store unused narcotics in a separately locked, permanently affixed compartment. There was no corrective action for Resident # 122 he discharged to the hospital on 4/8/25 or Resident # 271 he expired in the facility on 3/21/25. Corrective action for residents with the potential to be affected by the deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 06/12/2025, the DON initiated an initial audit of 100% of discharge residents' narcotic medication storage practices for the past 7 days to ensure discharged narcotics were stored under two locks and only one person had access to these medications. The audit revealed that four discharge residents had medications not stored under two lock and key. These medications were placed in a locked safe in the Director of Nursing office until they were sent back to pharmacy, and the lock on her office door was also replaced. Measures/Systemic changes to prevent reoccurrence of deficient practice: On 06/12/2025 education initiated related to narcotic processes with all Licensed Nurses (RN's/LPN's) and medication aids, including agency by the DON. This education includes promptly notifying DON of discounted or discharged controlled substances so that they are removed from the cart and stored in a double locking key in DON office until returned to pharmacy. 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: Beginning 6/20/2025 DON or ADON will monitor 5 discharge residents per week related to the narcotic medication storage practices for all discharged residents or discontinued narcotics to ensure compliance. Monitoring will be completed weekly for 4 weeks and monthly for 3 months. Reports will be presented to the monthly Quality Assurance committee by the DON or designee to ensure corrective action is initiated as appropriate. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345443	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2025

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

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F0755 SS = D	Continued from page 23 for Oxycodone (narcotic/opioid pain medication) 5 mg every 4 hours as needed for pain. The Medication Administration Record for March 2025 for Resident #122 indicated he received Oxycodone 5 mg as needed for pain on 3/8/2025, 3/16/2025, and 3/19/2025. On 3/25/2025 a discharge with an anticipated return Minimum Data Set assessment indicated Resident #122 was discharged to the hospital. During an interview with the Director of Nursing (DON) on 5/22/2025 at 11:06 am she stated the pharmacy had notified the facility on 5/1/2025 when the pharmacy tote (a tote bag used to store medications to be returned to the pharmacy) was returned to the pharmacy there was a Narcotic Count Form for Oxycodone 5 mg with 45 doses ordered for Resident #122 and the medication correlating to the form was missing from the tote. The DON stated Resident #122 was discharged to the hospital on 3/25/2025 and his medication should have been sent back to the pharmacy when he was discharged. The DON stated they immediately began an investigation. She stated Nurse #1 and Nurse #2 were interviewed and suspended pending an investigation; Nurse #1 and Nurse #2 both received narcotic drug tests; and the facility changed the process for returning unused narcotic medications to the pharmacy. Nurse #2 was interviewed by phone on 5/22/2205 at 12:40 pm and she stated she counted 45 doses of Oxycodone 5 mg that was ordered for Resident #122 with Nurse #1 after the resident was discharged and placed the medication in the pharmacy tote and placed two numbered zip lock seals on the tote. Nurse #2 stated she left the tote in the Unit Managers office to be picked up by pharmacy. Nurse #2 stated when she worked as the night shift supervisor, she kept the Unit Manager's office door locked. Nurse #2 stated there were several staff (the Unit Managers and Administrative Staff) that had keys to the Unit Manager's office, but she was not aware of anyone leaving the Unit Manager's office unlocked. Nurse #1 was interviewed by phone on 5/22/2025 at 11:37 am and stated she did not remember the date Nurse #2, the night shift supervisor, had asked her to reconcile narcotic medications with her that needed to be sent back to the pharmacy. Nurse #1 stated she did count the	F0755	Continued from page 23 process Compliance Date: 6/13/2025	

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F0755 SS = D	Continued from page 24 medications for Resident #122 with Nurse #2, and they put the medications in the pharmacy tote and placed the numbered zip lock tag on the tote. She stated she did not know when the pharmacy tote was returned to the pharmacy and did not know how long the pharmacy tote was left in the Unit Manager's office before it was sent back to the pharmacy. Nurse #1 stated on 5/1/2025 she was suspended pending an investigation, she was drug tested, she received education regarding returning narcotic medication to the pharmacy, and the facility changed the process for sending unused narcotics back to the pharmacy. The Pharmacist was interviewed by phone on 5/23/2025 at 2:59 pm and stated she received the facility's pharmacy tote on 5/1/2025 and found a Narcotic Count Form for Oxycodone 5 mg, 45 doses, in the returned pharmacy tote. The Pharmacist stated the tote was sealed with two zip tie seals that were numbered, and the Medication Return Form in the tote had the corresponding numbers from the two zip ties. The Pharmacist stated she notified the facility that the narcotic medication was not in the tote when she received it at the pharmacy. The Pharmacist stated the Oxycodone 5 mg should have been secured under two locks to prevent diversion of the medication. During an interview with the DON on 5/22/2025 at 11:06 am she stated that Resident #122 had not been charged for the medication and the medication was provided by the hospital when Resident #122 was admitted to the facility, so they had not considered the missing medication a misappropriation of Resident #122's property. b. Resident #271 was admitted to the facility on 2/21/2025 with diagnoses that included and lung cancer. An admission Minimum Data Set assessment dated 2/27/2025 indicated Resident #271 was cognitively intact and received opioid medications. A Physician's Order dated 3/12/2025 indicated Oxycodone 5 mg for Resident #271 three times a day for pain. The Medication Administration Record for Resident #271 for March 2025 indicated he received Oxycodone 5 mg by mouth three times a day for pain from 3/12/2025 to	F0755		

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F0755 SS = D	Continued from page 25 3/21/2025. The medical record indicated Resident #271 died in the facility on 3/21/2025. The Director of Nursing was interviewed on 5/22/2025 at 11:06 am and she stated during an investigation into missing narcotic medication for Resident #122 they discovered that a medication card of Oxycodone 5 mg that was ordered for Resident #271 was also missing. The Director of Nursing stated the Narcotic Count form for Resident #271's Oxycodone 5 mg with 30 doses was found in an unlocked desk drawer in the Unit Manager's office and the medication correlating to the form was missing. Nurse #2 stated she was the Night Shift Supervisor, and she was responsible for ensuring the narcotic medications were reconciled and sent back to the pharmacy when a resident was discharged. Nurse #2 stated after Resident #271's death, she placed the resident's medication in an unlocked desk drawer in the Unit Manager's office and the door to the office was locked but there were other staff members that had keys to the office. Nurse #2 stated all nurse management and supervisors had access to the office. Nurse #2 stated she kept the door to the office locked when she worked but she did not know if it was left open when she was not working. Nurse #2 stated she did not know that she should keep narcotic medications double locked until they were sent to the pharmacy. During an interview with the Pharmacist by phone on 5/23/2025 at 2:59 pm she stated when the facility investigated the 45 missing doses of Oxycodone 5 mg for Resident #122, they notified her there was another card of 30 doses of Oxycodone missing for Resident #271. The Director of Nursing was interviewed on 5/22/2025 at 11:06 am and she stated that the investigation into the missing Oxycodone for Resident #271 revealed Nurse #2, the night shift supervisor, had placed the medication in the drawer in the Unit Manager's office and had planned to return it to the pharmacy. She stated Nurse #2 stated she was not aware the medication should not be left in the desk drawer which was not locked. The Director of Nursing stated the facility changed the process for sending narcotic medications back to the pharmacy to prevent any further diversion of narcotic	F0755		

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F0755 SS = D	Continued from page 26 medications. The Director of Nursing stated Resident #271 was not charged for the 30 doses of Oxycodone 5 mg since the medication was provided by the hospital when Resident #271 was admitted to the facility and the facility did not investigate it as misappropriated for that reason. The Administrator was interviewed by phone on 5/22/2025 at 2:25 pm and stated the facility should have ensured Resident #271 and Resident #122's narcotic medication was secured with two locks to prevent diversion of narcotic medications.	F0755		
F0761 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 by: Based on record review, observations, and interviews with staff and the Pharmacist, the facility failed to store unused narcotics prescribed to Resident #122 and #271 in a separately locked, permanently affixed compartment. The narcotics for Resident #122 were stored in a pharmacy tote with a numbered zip lock tag	F0761	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 761 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The deficient practice was identified on 5/1/2025 by the pharmacy when 45 of resident s # 122 s oxycodone 5milligrams and 30 of resident # 271 s oxycodone 5 milligrams did not return to the pharmacy. Resident #122 was discharged to the hospital on 3/25/25 therefore no corrective action. Resident # 271 expired in the facility on 3/21/2025, therefore no corrective action required. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 5/29/2025, the Director of Nurses (DON) identified residents that had the potential to be affected by this practice by completing a 100% audit of all narcotics for the past 7 days to ensure they were under double lock and key and no one had access. This completed on 5/29/2025. The audit revealed: 4 of 4 cards of discontinued narcotics were not under double lock and key. Corrective action: the director of nursing put all discontinued narcotics in a safe in the DON office under double lock and key.	06/13/2025

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F0761 SS = D	Continued from page 27 and the doses for Rsdt #271 were placed in an unlocked desk drawer in the Unit managers office by the Nurse #2, the night shift supervisor. The Unit Manager's office was not always locked and several staff had keys to the office. On 5/1/2025, the Pharmacy identified that 45 doses of oxycodone, 5 milligrams, were missing for Resident #122 when they received the narcotic count sheet without the narcotic medication in the medication tote that was delivered to the pharmacy. The facility initiated an investigation and discovered 30 doses of oxycodone, 5 milligrams, missing for Resident #271. This deficient practice affected two of two discharged residents reviewed for drug storage (Resident #122 and #271). Findings included: The facility's Controlled Medication Storage Policy stated all narcotic medications are stored under double lock in a locked cabinet or safe designated for that purpose. 1. Resident #122 was admitted to the facility on 12/12/2024 and had a recent readmission on 4/2/2025. Resident #122 had a Physician's Order dated 2/6/2025 for Oxycodone 5 mg every 4 hours as needed for pain. On 3/25/2025 a discharge with an anticipated return Minimum Data Set assessment indicated Resident #122 was discharged to the hospital. Nurse #1 was interviewed by phone on 5/22/2025 at 11:37 am and stated she did not remember the date Nurse #2, the night shift supervisor, had asked her to reconcile narcotic medications with her that needed to be sent back to the pharmacy. She stated she did count the medications for Resident #122 with Nurse #2, and they put the medications in the pharmacy tote (a plastic bin that medications are place in to transport to and from the pharmacy) and placed the numbered zip lock tag on the tote. She stated she did not know when the pharmacy tote was returned to the pharmacy and did not know how long the pharmacy tote was left in the Unit Manager's office before it was sent back to the pharmacy. Nurse #2 was interviewed by phone on 5/22/2025 at 12:40	F0761	Continued from page 27 Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: Education: On 5/29/25 the Staff Development Clinician began educating all licensed nurses (RN s and Licensed Practical Nurses, med aids, full time, part time, PRN staff, and agency staff on Drug Storage and Biologicals. This education includes: " How to recognize potential diversion " The narcotic supply is to be kept under two locks at all times. " What to do with narcotics that have been discontinued or discharged. The DON or designee will be responsible for ensuring this information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 6/12/2025. 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 QA tool: Discontinued Narcotic Processes beginning 6/13/2025 weekly x 4weeks then monthly x 3 months. The DON or designee will monitor for compliance the proper way to store discontinued narcotics until sent back to pharmacy. Reports will be presented to the monthly 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 monthly Quality Assurance Meeting. The monthly 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	

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F0761 SS = D	Continued from page 28 pm and she stated she counted 45 doses of Oxycodone 5 mg that was ordered for Resident #122 with Nurse #1 and placed the medication in the pharmacy tote with the numbered zip lock tag on the tote which Nurse #2 stored in the unit managers office. She stated she did not remember the date they put the medication in the pharmacy tote and did not know the date the pharmacy tote was sent to the pharmacy. Nurse #2 stated when she worked as the night shift supervisor, she kept the door to the Unit Manager's office locked at all times, but she knew there were several staff that had keys to the Unit Manager's office, but she was not aware of anyone leaving the Unit Manager's office unlocked. The Pharmacist was interviewed by phone on 5/23/2025 at 2:59 pm and she stated when the facility's pharmacy tote was received in the pharmacy on 5/1/2025 the zip lock seals were in place and the Narcotic Return Form for Oxycodone 5 mg (45 doses) was not in the pharmacy tote. The Pharmacist stated she notified the facility's Director of Nursing (DON). During an interview with the DON on 5/22/2025 at 11:06 am she stated the pharmacy had notified the facility on 5/1/2025 when the pharmacy tote was returned to the facility there was a Narcotic Count Form for Oxycodone 5 mg with 45 doses ordered for Resident #122 and the medication was missing from the tote. The DON stated at that time the narcotics that were being sent back to the pharmacy were being stored in the Unit Manager's office and the door was not always locked, several people had keys to the office, and the medications were kept in an unlocked desk drawer. The DON stated they were not able to determine when the misappropriation occurred, but they had changed the process for sending narcotics back to the pharmacy. The DON stated the facility had installed a safe in the DON office, which was observed during the interview, and the process for storing and returning narcotic medications had changed. The DON stated the Assistant Director of Nursing (ADON) counted all narcotics that should be returned to the pharmacy (either when a resident was no longer taking them or the resident was discharged) and placed them in the safe and they were kept in the safe until the pharmacy courier picked them up to return them to the pharmacy. The DON stated she and the ADON put the seals on the pharmacy tote after they counted the medications again and sent them with the courier to the pharmacy. 2. Resident #271 was admitted to the facility on 2/21/2025.	F0761	Continued from page 28 Manager. Compliance Date:6/13/2025	

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F0761 SS = D	Continued from page 29 A Physician's Order dated 3/12/2025 indicated Resident #271 should have Oxycodone 5 mg three times a day for pain. Nurse #2 was interviewed by phone on 5/22/2025 at 12:40 pm and stated she was the Night Shift Supervisor, and she was responsible for ensuring the narcotic medications were reconciled and sent back to the pharmacy when a resident was discharged. Nurse #2 stated she put Resident #271's medication in an unlocked desk drawer in the Unit Manager's office and the door to the office was locked but there were other staff members that had keys to the office. Nurse #2 stated all nurse management and supervisors had access to the office. Nurse #2 stated she kept the door to the office locked when she worked but she did not know if it was left open when she was not working. The Director of Nursing was interviewed on 5/22/2025 at 11:06 am and she stated during an investigation into the missing narcotic medication for Resident #122 they discovered that a medication card of Oxycodone 5 mg that was ordered for Resident #271 was also missing. The Director of Nursing stated the Narcotic Count form for Resident #271's Oxycodone 5 mg with 30 doses was found in an unlocked desk drawer in the Unit Manager's office and the medication was missing. The Director of Nursing stated Nurse #2, the night shift supervisor, had placed the medication in the drawer and had planned to return it to the pharmacy. The DON stated Nurse #2 stated she was not aware the medication should not be left in the desk drawer which was not locked. The Administrator was interviewed by phone on 5/22/2025 at 2:25 pm and stated the facility should have ensured Resident #271 and Resident #122's narcotic medication was secured with two locks to prevent diversion of narcotics. The facility submitted a plan of correction for past noncompliance but it was not acceptable to the state agency.	F0761		