STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	05/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	6680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews the facility failed to allow a resident to fulfill a choice by not giving coffee when requested for 1 of 2 residents (Resident #322). The findings included: Resident #322 was admitted to the facility on 4/8/13 with diagnoses of rehabilitation and chronic obstructive pulmonary disease. The resident's care plan dated 4/11/13 indicated altered nutrition related to diet due to his diagnoses and varied intake. The goals were measureable and interventions included honoring resident's food preferences. The care plan also indicated the resident was legally blind. Goals were measureable and interventions included set up meal tray and encourage use of call bell. A social work note dated 4/18/13 indicated the resident was alert and oriented, could communicate needs effectively, and had a pleasant mood.	F 242	Oak Forest Health and Rehab requests to have this Plan of Correction serve as written allegation of compliance. Our alleged date of compliance is 6/6/13. Preparation and or execution of the plan of correction does not constitute admission or agreement with either the existence of, or scope and severity of any cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law. F 242 Resident #322 was interviewed regarding his choice regarding am coffee and other areas of self-determination at the time of survey. He was re-interviewed on 5/31/2013. System has been implemented for resident to have coffee in early am upon rising. In-house oriented residents will be interviewed regarding issues of choice and self-determination by 6/6/2013. Any issue identified will be incorporated into the plan of care and communicated to staff via the resident care guide. Activities and Social Services Department will complete the interviews. A resident satisfaction survey will be utilized.	6/6/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Jolly | TITLE: RN, UNHA | (X6) DATE: 6/4/13

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

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F 242	Continued From page 1 A social work note dated 4/25/13 indicated the resident required moderate assistance with activities of daily living. The admission Minimum Data Set (MDS) dated 4/25/13 indicated the resident was cognitively intact, independent with eating, needing set-up help only, had no swallowing disorders, and the resident participated in the assessment. On 5/7/13 at 10:20 am the resident indicated he had asked two nurse aides around 7:00 am to bring him a cup of coffee, neither brought him coffee, and both told him to wait until his breakfast came. Resident #322 stated, "I drank coffee all my life as soon as I get up and I knew breakfast wouldn't be here until about 8." On 5/7/13 at 10:40 am observed a nourishment room located approximately 10 feet away from the resident's room. The door was open and there was a coffee pot with coffee in it. On 5/9/13 at 8:15 am Resident #322 stated he asked for coffee on 5/8/13 around 7 am and was told he would have to wait until mealtime. He indicated that with his poor vision he could "not see well at all", but remembered people by the sound of their voice. He did not know the name of the aide. Resident #322 also indicated the hot liquid helped with his congestion in the morning and stated, "coffee in the morning may not be important to some people but it is important to me." On 5/9/13 at 8:30 am Nursing Aide (NA) #1 stated if a resident wanted coffee at 7:00 am she could get it from the kitchen.	F 242	System will be implemented in facility by 6/6/2013 for each unit to have coffee available in nourishment room 24/7. Coffee is also available in facility dietary department during dietary department hours. Facility staff will be re-trained in all departments regarding the resident's right of choice and self-determination. Re-training will be completed by administrative staff by 6/6/2013. A resident satisfaction survey was developed and will be included in the facilities Quality Improvement process. The resident satisfaction survey will address choices, self-determination, and other such resident right/customer service information. 10 randomly selected oriented residents will be interviewed weekly X4 weeks and monthly thereafter on-going. Any issues identified will be reported to the appropriate department manager for immediate follow-up.	

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F 242	Continued From page 2 On 5/9/13 at 8:31 am the Administrator was interviewed and indicated the kitchen opens at 5:30 am and staff can get coffee for residents. She stated, "If a resident wants coffee before 5:30 am, staff can get it from the nourishment room. There is always coffee available." On 5/9/13 at 9:26 am NA #2 stated, "[Resident #322] is always asking me to fill his water cup. He has had two cups of coffee this morning. He asked me for coffee yesterday morning. He usually asks for coffee around 7 in the morning." When asked if the resident is asked to wait until mealtime for coffee she stated, "I will say 'you know your tray is coming out soon' and he says 'I want it now.'"	F 242	The administrator will review all satisfaction survey results a minimum of monthly and direct/initiate action plans as trends and issues are identified. A summary of these findings, trends, and interventions to correct will be reported to the Quality Assurance Committee at least quarterly for review and recommendations.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to maintain sanitary conditions in the kitchen by ensuring opened and resealed food items were dated and labeled and discard food items past the expiration	F 371	F 371 Food items improperly labeled and stored were discarded of at the time of survey. Dishes found to be improperly washed were pulled from service and washed at the time of survey. All dietary staff will be re-trained regarding sanitation guidelines and their professional responsibilities by 6/6/2013. Dietary manager is conducting this re-training.	6/6/13

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OAK FOREST HEALTH AND REHABILITATION	6080 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 371	Continued From page 3 date in 1 of 1 dry storage area; 2) the facility failed to ensure food items in 1 of 1 walk-in refrigerator and freezer were labeled and dated when taken out of original container and 3) the facility failed to ensure the dishes and steam table pots and pans on the dry storage racks were dry and free from dried food debris on 2 of 2 drying racks. The findings included: 1. During an observation of the kitchen dry storage area on 5/6/13 at 10:25AM, the following: dried products were observed unlabeled: 1 1/1 bag of opened unsealed and unlabeled oatmeal cookies, 1 sub roll half opened in seran wrapped unlabelled or dated, 1 opened package of pancake mix in seran wrap unlabeled or dated and 1 opened half used gravy mix. Further inspection revealed 1 open, undated, unlabeled bag of stove-top stuffing on a shelf, 2 bags of expired whole wheat bread dated 5/2/13 and 5/3/13, 1 bag of stuffing mix dated 1/13/13 and shredded cheese dated 3/13/13 on the shelf. During an interview with dietary manager (DM) on 5/6/12 at 10:25AM, he identified the products and indicated that he was unaware the products should be labeled once they have been removed from the package and put into the container. He added that the expired foods/bread should have been discarded when new products arrived and the bread delivery person was responsible for checking and discarding any expired products. 2. During an observationon 5/6/13 at 10:25AM, of walk-in refrigerator was the following items; 1 bag of opened chicken fritters, 1 bag of opened	F 371	A QI Audit tool will be implemented to monitor sanitation issues. The Dietary Manager, Assistant Dietary Manager, Administrator and/or Assistant Administrator will complete sanitation rounds with findings documented on the QI audit tool a minimum of 3 X per week X 4 weeks and weekly thereafter, ongoing. Issues of non-compliance will be corrected immediately at the time of audit. All findings will be forwarded to Dietary Manager for follow-up/intervention. A summary of trends and/or issues of non-compliance will be discussed by Dietary Manager, Assistant Administrator, and Administrator weekly X 4 and monthly thereafter, on-going. Further re-training or disciplinary action will be implemented as appropriate. The administrator and/or assistant administrator will review all QI Sanitation Audit results a minimum of monthly. A summary of these findings, trends, and interventions to correct will be reported to the Quality Assurance Committee at least quarterly for review and recommendations.	

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F 371	Continued From page 4 buffalo wings unlabeled/undated. In the walk in freezer the following items were opened with freezer burn 2 bags of onion rings, 1 ball of cilantro undated and unlabelled, 1 bag of freezer burned dumplings unlabelled/undated, 1 bag of chicken breast unlabelled/undated, 1 bag of open freezer burned veal patties unlabelled/undated, 2 bags of opened undated/unlabeled potatoes ' fries, 1 half roll of beef unlabelled/undated and half opened pepperoni. On the floor of the freezer several food products and trash was found under the last shelves where the meats were stored. During an interview with dietary manager (DM) on 5/6/12 at 10:25AM, he identified the products and indicated that he was unaware the products should be labeled once they have been removed from the package and put into the container. DM indicated that the cook staff was responsible for labeling and dating all items that were open with the date item was open. The DM acknowledged that several of the items that were found should have a label and date. The DM indicated a new system for proper storage of food items would be implemented. 3. During a follow-up observation on 5/9/13 10:58AM, the following items were checked on the clean/dry storage area rack, 2 clear containers of serving utensils, ladles and scoops were found in dirty container that had dry food particles. One of two dry storage racks had two wet silver serving pans with food debris on the drying rack. The second dry storage rack had 13 silver loaf pans that were wet with dirty dried food particles, 9 silver serving pans on dry rack with dried food particles.	F 371		

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F 371	Continued From page 6 DM indicated that cook was responsible for checking the dishes to ensure that they were clean and debris free before they are stacked on the dry shelf. DM also indicated that he was responsible for monitoring and checking after the cook staff to ensure the procedures and policies were followed During an interview on 5/9/13 at 11:41AM, the cook indicated that she was responsible for labeling/dating open foods used for breakfast and lunch. She was also responsible for washing items used for cooking of meal.	F 371		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/31/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/29/2013

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system. Facility is using special locking system. The deficiencies determined during the survey are as follows:	K 000	Oak Forest Health and Rehab requests to have this Plan of Correction serve as written allegation of compliance. Our alleged date of compliance is 7/8/13. Preparation and or execution of the plan of correction does not constitute admission or agreement with either the existence of, or scope and severity of any cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K 018 Doors to Engineer office, C102, and linen door between rooms 104 & 108 on C wing repaired on 6/6/13. The Director of Facility Services inspected all doors protecting corridor openings to ensure closing and latching on 6/10/13. The Director of Facility Services will inspect all doors on a weekly basis X4 weeks throughout the building and monthly thereafter using a QA Safety Audit. Issues will be corrected at the time of Audit. A QA Safety Audit will be used to inspect all doors on a weekly basics X4 weeks, monthly for 3 months, and then quarterly by the Director of Facility Services. The QA Safety Audit results will be discussed in the facility's QA Meeting and bi-weekly in the Manager's Safety Committee for 3 months.	7/8/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tonya Gilley — TITLE: LNHA — (X6) DATE: 6/10/13

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview approximately 8:30 am onward, the following items were noncompliant, specific findings include: door to Engineer office and C 102 not closing and latching for smoke tight seal. Also linen door between rooms 104 & 106.	K 018	K 038 1) Access exit doors on 200, 300, and 400 hall on C Wing released during fire alarm test after repair was made by outside contact vendor on 5/29/2013. All other doors released properly when in test mode on 5/29/13. The Director of Facility Services inspected all exit access doors during a fire alarm test to ensure release of all doors on 6/6/13. The Director of Facility Services will inspect access exit doors on a weekly basis for X4 weeks alternating on all shifts. Then doors will be checked for compliance during monthly practice fire drills alternating on all three shifts thereafter. Access exit doors will be checked during monthly fire drills alternating on all shifts. The results will be discussed during the facility's QA meeting and during the bi-weekly Manager Safety Committee meeting for 3 months. 2) Activity door dead bolt was removed on 6/3/13. The Director of Facility Services inspected all doors in the facility on 6/10/13 to ensure there aren't any deadbolts permitting two motion of hands to open door. There will be no dead bolts added to any doors in the facility. In-service was given to Floor Tech and Maintenance employees on 6/10/13.	7/8/13
K 038 SS=E	42 CFR 483.7(a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: 1. exit access doors on 200, 300 and 400 hall did not release on activation of fire alarm test. 2. Activity door requires two motion of hand to open door(dead bolt installed on door). 3. staff did not have knowledge of were emergency release switch was located at for mag. locking system.	K 038		
K 056 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is	K 056		

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K 056	Continued From page 2 installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: tamper switches located in riser room did not send signal to fire alarm control panel when tested. Accelerator switch was in trouble at time of survey. Ice machines on A and C wings are within 18 inches of sprinkler head. 42 CFR 483.70(a)	K 056	The Director of Facility Services will ensure there are no dead bolts used in the facility by using a QA Safety Audit weekly X4 weeks and monthly thereafter. Results from Audit will be brought to the facility's QA committee and bi-weekly Manager Safety Committee for 3 months. 3) Staff member was informed during survey the process of releasing the emergency release switch in case of an emergency. The Director of Facility Services will provide a mandatory in-service with all staff on the location of the over-ride switches in case of any emergency scenario from 6/13/13 through 6/17/13. Random staff will be asked 3X weekly X4 weeks after in-services on their knowledge of over-ride switches and other emergency protocol. The Director of Facility Services will continue to orientate all new employees on emergency procedures including the location of the over-ride switches. The facility will include this in the Emergency Disaster Planning in-services provided yearly for all employees. The in-service information and results with random employee audits will be discussed in the facility's QA meeting and the Manager Safety Committee held bi-weekly for 3 months.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	K 056 1) Accelerator switch repaired on 6/6/13. Taper switches located in riser room tested to ensure signals to main fire alarm control	7/8/13

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K 062	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: facility could not provide proper documentation that : 1. 3 year full flow test 2. 5 year obstruction investigation has been preformed on sprinkler system. 42 CFR 483.70(a)	K 062	panel on this date as well. All taper switches tested for compliance by The Director of Facility Services on 6/6/13. The Director of Facility Services will test taper switches weekly X4 weeks. During monthly fire drill tests, Director will also include testing taper switches to check signal at fire panel. Taper checks will be conducted weekly X4 weeks, during monthly fire drills, and quarterly thereafter during routine inspections by K&S Sprinkler Systems. Results will be discussed at facility's QA meeting.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: GFCI outlets right of sink in beauty shop did not trip on test. 42 CFR 483.70(a)	K 147	2) Sprinkler heads above ice machines on A and C Wing capped on 6/11/13. Wall protruding downward was removed 6/11/13 to ensure adequate sprinkler coverage from other sprinkler head in hallway. The Director of Facility Services inspected all equipment and items 18 inches away from sprinkler heads in the facility on 6/11/13. Red tape placed in storage areas to ensure the practice of 18 inches is followed for items stored. The Director of Facility Services will ensure all areas are meeting these requirements by using a QA Safety Audit weekly X4 Weeks. Weekly rounds by Manager Safety Committee will continue thereafter. Any areas not meeting compliance will be corrected at time of the inspection.	

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			The QA Safety Audit results will be brought to the Manager Safety Committee Meeting bi-weekly for three months and to the facility's QA Meeting. K 062 3 Year Full Flood Test and 5 Year Obstruction Investigation test will be performed on 6/26/13 by K&S Sprinkler Company. The Director of Facility Services will maintain proper documentation for all mandatory tests required. Every 3 years and 5 years from this date, the Full Flood Test and 5 Year Obstruction Investigation Test will be performed and documented. Mandatory tests will be kept logged and brought to QA committee to review. K 147 GFCI outlets to the right of sink in beauty shop repaired on 6/3/13. All outlets were checked to ensure proper electrical wiring by The Director of Facility Services on 6/12/13. The Director of Facility Services will test all facility outlets weekly X4 weeks and then quarterly thereafter. Any outlets not to code will be fixed upon inspection.	7/8/13 7/8/13

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	345443	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/29/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Results from inspection will be discussed at facility's QA meeting and at the Manager Safety Committee for 3 months.	