PRINTED: 03/11/2019 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
		345443	B. WING		02/08/2019
	ROVIDER OR SUPPLIER EST HEALTH AND REHA	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS	3	F 00	00	
F 624 SS=J	on 12/3/18 until 12/6/NC00144001. The sallegation of safe and intake at tag F660 at Per the Quality Improcessive and reviews and reviews and reviews and orderly discharge the facility on 2/8/19. The survey team idea Past-noncompliance groupings: CFR 483.15 at tag F6(J) CFR 483.21 at tag F6(J) Immediate Jeopardy removed on 1/4/19. A Partial extended stag Preparation for Safe/CFR(s): 483.15(c)(7) §483.15(c)(7) Oriental discharge. A facility must provide preparation and orients afe and orderly transitation.	in the following regulatory 624 at a scope and severity 660 at a scope and severity began on 10/4/18 and was arvey was conducted. Orderly Transfer/Dschrg ation for transfer or e and document sufficient intation to residents to ensure sfer or discharge from the on must be provided in a	F 6:	24	2/22/19
	understand. This REQUIREMEN	Γ is not met as evidenced		TITLE	(VE) DATE

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

Electronically Signed 03/04/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345443	B. WING _			C 02/08/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	02/06/2019	
OAK FOR	EST HEALTH AND REHA	ADII ITATION		5680 WINDY HILL DRIVE			
OAK FOR	EST HEALTH AND REHA	ABILITATION	WINSTON SALEM, NC 27105		105		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 624	facility staff, home he and family member the safe discharge plannid discharge goals, need 1 of 4 residents review #1). The facility failed to after being discharfacility failed to assess condition to identify published by discharge home. The Resident #1 was adm 8/28/18 after a recent hemiarthroplasty (repioint) due to a fall at hemoral fracture. The diagnoses included do hypertension, atrial fill infarction. Review of a 48-hour in Resident #1 dated 8/2 resident would have a home/assisted living included to initiate dis resident/representative community resources resident/representative the facility. Review of the 14-day dated 9/11/18 coded impaired cognition. The person for dressi personal hygiene and the safe was transfer, and required one person for dressi personal hygiene and the safe discovered the safe facility.	iews, interviews with the alth agency staff, van driver he facility failed to provide a ling process that included ds and caregiver support for wed for discharge (Resident to ensure a safe place to go ged from the facility. The is Resident #1's medical ossible barriers for a safe e findings included: nitted to the facility on thospital course for a left hip placement of half of the hip home that resulted in a left resident's cumulative iabetes, heart failure, brillation and cerebral interim care plan for 28/18 revealed a goal that a smooth transition to facility. Approaches scharge planning, provided we with information regarding and educate we on services provided in Minimum Data Set (MDS) Resident #1 with severely the MDS indicated Resident assistance of 2 people for a extensive assistance of ing, eating, toilet use,	F 6	Past noncompliance correction required.	no plan of		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	02/00/2019
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F 624	and bladder. The resas steady only when assistance and her massistance and her expected discharge for the planning. A review of the treatmagner of the pressure sore to the pressure sore to the pressure sore has further wound assessment in the wound assessment in length by 1.5 cm in with 100% slough tis assessment of the princision site prior to a Review of the Octobricluded: "Amlodipine 5 mile every day (qd) for hy massistance and her provided in the prior to a servery day (qd) for hy massistance and her massistance and	ident's balance was coded stabilized with staff nobility device was a at #1 was also coded as to the community. In the community or the ensive care plan dated de a care plan for discharge ment progress note dated sident #1 had a newly entified unstageable left buttock. An unstageable left buttock. An unstageable left buttock are loss in the interest of the engore of the engote	F 6	24	
	" Citalopram 40 m	ng po qd for depression. at 1 mg po qd a steroid to treat twice a day. An			

Facility ID: 933496

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345443	B. WING		02/08/2019		
	ROVIDER OR SUPPLIER	HABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105		1 02/00/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
F 624	three times a day be control. " Lantus U-100 in for diabetic control. " Lipitor 40 mg p " Metformin 1,00 cholesterol. " Potassium Chlomilliequivalent once replacement. " Vitamin C 500 chealing. " MVI with miner. " Vitamin D3 5,00 supplement. " Zinc sulfate 220 " Donepezil 10 menhancement. " Cleanse sacral saline apply nickel to (enzymatic debridin calcium alginate (aba a dry dressing daily) A review of discharge for Resident #1 reversided to treatment sore, draining incision prescribed medicati sticks for blood gluc Record review reversidischarged home on van service without An interview on 2/6/17 Treatment Nurse (Tothe family about how or the surgical incision or the surgical incision or the surgical incision or the surgical incision of the surgical i	insulin per a sliding scale efore meals for diabetic ansulin per sliding scale at 8 pm of possible of the problem of the problem of the resident's pressure on site, information at the problem of the resident #1 was a 10 /4/18 via a transportation	F 624				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILD	NG		Ι,	C
		345443	B. WING				08/2019
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
041/ 505	FOT HEALTH AND DE	IA DIL ITATION		56	80 WINDY HILL DRIVE		
OAK FOR	EST HEALTH AND REI	HABILITATION		w	INSTON SALEM, NC 27105		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 624	Planner (DP) who is non-coverage for R 9/28/18. She stated informed her they of the Resident was to on 9/28/18. Further had at home a hand wheelchair. The DF one came to pick R The DP stated on 1 call from Resident # transportation to Referred them to a pshe called the van stransportation apportation apportation apportation approved Resident An interview on 2/6 indicated she admit medications crusher required total care a instructions becaus home health service stated she discharg was told to complet stated she never sa prescriptions to sen added home health home the next day, was the only day stresident and she reher. She stated no resident there was she would review a	at 1:21 PM with the Discharge tated the Medicare esident #1 was in effect on the Responsible Party (RP) ould not afford private pay so be discharged to her home rinterview revealed the family dicap van, hospital bed and stated no one called and no esident #1 up on 9/28/18. 0/1/18 she received a phone #1's RP who requested esident's home and she orivate van service. She stated service and made the intment for Resident #1. The	F	624			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED		
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		345443	B. WING			1	/08/2019	
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				5	680 WINDY HILL DRIVE			
OAK FOR	EST HEALTH AND REH	ABILITATION		v	VINSTON SALEM, NC 27105			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD		COMPLETION DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROF	EFERENCED TO THE APPROPRIATE DEFICIENCY)		
					DEI IOIENOT)			
E 004		_						
F 624	Continued From pag		F	624				
	·	ent orders for Resident #1's						
	·	tated this was not the normal						
	process for dischargi	~						
		phone on 2/6/19 at 7:14 PM						
	that they pick up the	P revealed DP requested						
		licated that during that call						
		e facility that they had no						
		of Resident #1. She stated						
		/ called again and the next						
	-	ent #1 was dropped off at						
	_	dent #1's RP indicated they						
		except insulin for the resident						
		wledge that the resident had						
	a pressure sore on h	er buttocks. Resident #1's						
	RP stated the facility	just dumped Resident #1 off						
	-	ons on how to take care of						
		esident was placed in						
	_	e. Continued interview						
		only one sheet of paper. The						
		cate the family did not have						
		administer and had told the						
	_	not take care of her at home and move Resident #1. The						
	· ·	led the pharmacy to get the						
		indicated she "Tried talking						
		and told us we had no						
	choice but to bring he							
		9 at 2:30 pm with Nursing						
		tated resident required total						
		of daily living, fed herself						
	finger foods but staff							
		nent of urine and stool and						
		le to transfer her to the toilet.						
		urn her at least every 2-3						
	· ·	er with pillows on her right						
	side due to leaning.							
	An interview on 2/6/1	9 at 3:30 pm with Home						

Health Nurse #1 and Home Health Nurse #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345443	B. WING _			C 2/08/2019	
	ROVIDER OR SUPPLIER	EHABILITATION		STREET ADDRESS, CITY, STATE, ZIP 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	•	2/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 624	conducted the initic conducted via the on arrival on 10/5/home. Resident #* sheets were soake episode of bowels Resident #1 exprehungry and had not member then browwalked into and ouset up date for a fowere there any mestated she called the delivered and show office. Additionor strips to test the HHA Nurse #2 individual was transferred to An interview on 2/5 Transportation (Tomember was presented in the van drait of the wastated no facility significant to bed so facility's wheelchail Interview on 2/8/15 Therapist(Pt) reversident was maximidid not have good previous stroke an inquiry was made therapist indicated does not conduct thome health physical conduct in the conduct	A Nurse #2 (nurse who all evaluation on 10/5/18) was phone. HHA Nurse #2 stated 18 at 1:06 pm to Resident #1's 1's brief, clothing and bed ed with urine and incontinent. HHA Nurse #2 stated ssed to her that she was of eaten all day. A family ght Resident#1 a pop tart and ut of the room. There was no ollow-up with the physician nor edications. HHA Nurse #2 the pharmacy for medication to get up an appointment to the nally, there was no glucometer eresident's blood glucose level. It is at 12:23 PM with the 20 van driver indicated a family ent when he arrived at the iver stated he brought Resident ingings and a "discharge int #1's home. TC van driver taff accompanied the resident in member transferred the that he could return the	F	624			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		ATE SURVEY OMPLETED
		345443	B. WING _			C 02/08/2019
	ROVIDER OR SUPPLIER EST HEALTH AND REF	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	<u>'</u>	32.00.2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 624	Continued From pag		F 6	24		
	from staff. Interview on 2/6/19 Administrator reveal accompanied reside expectation that starnot specific) for disc. The facility impleme action: "Resident # 1 was a and Rehabilitation of diagnoses of hypert Diabetes Mellitus wired of Left Artificial Hip of Left Artificial H	ent home and was his If follow the regulations (was sharging residents home. Inted the following corrective Idmitted to Oak Forest Health In August 28, 2018 with In August 28, 2018 with In Ensive heart disease, Type 2 In Hyperglycemia, Presence Joint and Cerebral Infarction. In Integrity. A 48-hour In Integrity. A				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345443	B. WING				С	
NAME OF D	20/4050 00 01 1001 150	343443	B. WING _	_	OTDEET ADDRESS SITV STATE 7/D SODE	02	/08/2019	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
OAK FOR	EST HEALTH AND RE	HABILITATION			5680 WINDY HILL DRIVE			
				١ ١	WINSTON SALEM, NC 27105			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 624	Continued From pa	age 8	F	624				
	· ·	ers in the home prior to						
	discharge.	era in the nome phor to						
		es were discontinued on						
		18 and ST services were						
		eptember 27, 2018. At this time						
		ed her maximum potential and						
		mber 25, 2018 was received						
	•	Director to discharge resident						
		on September 28, 2018. On						
		18 the discharge planner						
	issued a Notice of	Non-Coverage and discussed						
	with Resident's Re	presentative via phone call at						
	1:59 pm. Resident	's Representative was notified						
	of last covered day	of skilled services to be on						
	September 27, 201	Resident's Representative						
		anding and confirmed the plan						
		rn home on September 28,						
		Representative did not arrive to						
		per 28, 2018 to pick up						
		nned. At approximately 7pm,						
		on duty notified the facility						
		the family had not picked						
	•	dministrator instructed that						
		off on discharge and revisit						
		October 1, 2018. On October						
		Social Worker attempted to						
		Representative and was unable						
		al Worker then contacted						
		nber and left messages to cond family member called						
		k on October 4, 2018 and						
		ty to transport Resident #1						
		sportation was notified and						
	•	t resident and bill family for						
		Resident was picked up at						
		4, 2018 and taken home and						
		ent Representative. Resident's						
		ons including information						
		Home Health agency was given						
			1		T. Control of the Con		1 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345443	B. WING				08/2019	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2013	
				١,	5680 WINDY HILL DRIVE			
OAK FOR	EST HEALTH AND REH	ABILITATION		١ ،	WINSTON SALEM, NC 27105			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
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F 624	Continued From pag	e 9	F	624				
		ntative at time of transport.						
		provide and document						
		and orientation to resident						
	representative to ens							
	discharge from the fa							
	representative did no	ot have knowledge of the						
	resident's wound and	treatment for the wound or						
		cal incision site had small						
		The nurse failed to provide						
		tion list and medication						
	1 .	nily representative. Family						
	_	ntation was not completed.						
	1	the facility failed to train a						
	condition including; v	of Resident #1's medical						
	_	cision drainage, medication						
	_	edication prescriptions, type						
		ed, level of supervision and						
	1	ded prior to Resident #1's						
	1	e discharge planning of						
	_	ide a referral for Home						
	Health services to inc	clude PT, OT evaluation and						
	treatment and nursin	g for treatment of sacral						
	wound.							
	Corrective action acc	complished for those						
		ave been affected by the						
	deficient practice.							
	1	charged from the facility on						
		the time of this compliance,						
		ng in another skilled nursing						
	facility. Address how correct	ive action will be						
		se residents having the						
	1	ed by the same deficient						
	Starting December 1	3 2018 the facility						
	completed a 100% a							
	· ·	e last two weeks prior to the						
		lan of correction regarding						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	COMPL	
		345443	B. WING			C 02/08/2019
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, 2 5680 WINDY HILL DRIVE WINSTON SALEM, NC 2710	ZIP CODE	210012013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 624	and no negative find was completed on 1 the facility implement preparation, and traincluding education medical treatment in By failing to provide review of Resident # medication listing, at this is considered net the discharge plann Resident #1's discharge plann Resident #1's discharge plann Resident #1's discharge planning, was not limited to; not development, preparation and discharge planning in Nursing, Assistant Dadministrator gave at including but not limited to social worker and not and completed by Jain-service included Area 100% audit was comprehensive care 12/19/18 and completed by Director of Nursing. Director of Nursing of matched the dischar Measures will be pursystematic changes the deficient practice.	adit included sixteen residents ings were found. This audit 2/14/18 and was to ensure sted an effective orientation, esition to post-discharge care of medications and residents' eeds. a family representative with a fail's wound treatment, and medication prescriptions, eglect according to regulation. Her and nurse involved with arge was educated on by the Administrator and and the in-servicing included, but obtification of changes, ration, and implementation of the plan for discharge, as well dimplementation of the process. The Director of prirector of Nursing, assistant an in-service to all staff, itself to the discharge planner, arses starting January 2, 2019 anuary 4, 2019. The abuse and Neglect education between the facility to ensure each arge care plan. This audit ischarge Planner and Discharge Planner and ensured the current care plan arge plan for each resident. It into place or what will be made to ensure that	F	624		

OE: TE: T	OT OIL WILDIO, WE G	WEDIO/ ND OLIVIOLO				CIVID IVO	7. 0000 000 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345443	B. WING				08/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	, ,	00.2010
				5	680 WINDY HILL DRIVE		
OAK FOR	EST HEALTH AND REHA	ABILITATION		١v	WINSTON SALEM, NC 27105		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 624	Continued From page	a 11	F	624			
	· -	care plan is initiated on	'	02-			
		nitting nurse and completed					
	_	ger, Assistant Director of					
		of Nursing. All nurses were					
		ctor of Nursing on December					
	-	equirement of the facility to					
	develop and impleme	ent a care plan for each					
		discharge plan. The interim					
		e discharge plan of whether					
		ty or desire to discharge					
		ty. The discharge plan of					
		ial discharges for the next					
		viewed by the Discharge					
	planner weekly and d	neeting by the administrator,					
		herapy manager, assistant					
	_	or of Nursing, Social Worker					
	and the MDS coordin	•					
	Medicare/Medicaid m						
		through the next seven days					
	are discussed and ca	are plans are updated at this					
	time. The potential d	ischarges discussed are					
	evaluated the interdis	sciplinary team including but					
	not limited to; home h						
	1	edical equipment needs, any					
		the community, education					
	_	gement, treatments, food					
		are needs of activities of daily					
		pervision needed. During the neetings, the interdisciplinary					
		gression of each resident					
		rge date based upon safety					
		The Director of Nursing or					
		Nursing brings information					
		a change in condition					
		ion gathered from Unit					
		e Nurses. These residents					
		ime for any significant					
		ect an upcoming discharge.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII	- The Solid British Control of the Solid Brit		c		
		345443	B. WING	B. WING		02/08/2019		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2019	
					680 WINDY HILL DRIVE			
OAK FOR	EST HEALTH AND REI	HABILITATION			VINSTON SALEM, NC 27105			
0(0)15	CUMMADV	STATEMENT OF DEFICIENCIES			· 		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 624	Continued From page	ge 12	F	524				
	-	dition including discharge						
	, ,	nunicated to the resident or						
		tive and provider by the						
		nurse and/or Unit Manager.						
	_	y team consists of at least the						
		Social Worker, Dietician,						
		nd Nursing MDS Coordinator.						
		sing communicates any						
		residents to the Unit						
	1 .	er to initiate training/teaching						
	to resident or reside							
	applicable. This inc							
	blood sugar checks	, insulin administration, wound						
	care, tube feedings,	, oxygen therapy, and						
	medication manage	ement. The providers are also						
	included in the disc	ussions of potential						
	discharges and add	lress safety and medical						
	needs. The Social	Worker and/or Discharge						
	Planner are respons	sible for communicating with						
		nily representative on						
		cluding community resources						
		ges. The Dietician is						
		cation on dietary needs						
		nosis. The Therapy Director						
	l . • .	e oversight of the treating						
		resident meets goals for safe						
		barriers to discharge are						
		ne team for follow up. If a						
		able based on discharge						
		Director will be responsible						
		ne Therapy Director will also						
		er training where applicable						
		tion. The Nursing MDS s each resident for clinical						
		and also ensuring the						
		oriate follow up based on						
		lischarge. Resident and						
		res are then notified by the						
		of future discharge date and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345443	B. WING		C 02/08/2019	
	ROVIDER OR SUPPLIER EST HEALTH AND REH	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	, 02.00.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 624	discharge planner uplan as needed. The nursing staff will instructions given to representative upon be reviewed prior to Nursing as noted wiprovider will comple visiting resident to ir resident and ensure to discharge. On October 30, 201 President of Operation therapy company exported by the provider will comple visiting resident to ir resident and ensure to discharge. On October 30, 201 President of Operation therapy company exported by the president of the president's safety or a discharge from the frand/or therapy manadetermining the need discharged resident member that will go home visit is deemed safety, it is complete home. Beginning January 2 Administrator, Director of Nursing pataff, including the discharging nurse, rof residents. This was 2019. Beginning December discharge planning admission. The discondinector will speak was director will speak was a speak was a series of the planning admission. The discondinector will speak was a series of the planning admission. The discondinector will speak was a series of the planning was a seri	arge follow up needs. The podates the discharge care I document the discharge the resident and/or resident discharge. This process will discharge by the Director of the the discharge audit. The te a discharge summary after reclude discharge plan for medical needs are met prior 8, the Regional Vice ons for the contracted flucated all facility Rehab one regarding the importance needed to determine a additional safety needs post acility. The discharge planner ager is responsible for d of a home visit for all is and assigning the staff out to the home. When a dinecessary for resident and prior to the discharge 2, 2019, the Assistant tor of Nursing, and Assistant provided in-servicing for all ischarge planner and regarding abuse and neglect as completed by January 4, ar 14, 2018, a resident's will begin at the time of tharge planner, and/or therapy in the resident and/or 172 hours of admission to	F 624			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345443	B WING	B. WING		C		
NAME OF P	ROVIDER OR SUPPLIER	343443		-	STREET ADDRESS, CITY, STATE, ZIP CODE	02/	/08/2019	
NAME OF FI	NOVIDER OR SUFFLIER							
OAK FOR	EST HEALTH AND RE	HABILITATION			5680 WINDY HILL DRIVE			
				1	WINSTON SALEM, NC 27105			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 624	Continued From pa	age 14	F	624				
	determined will inc	lude discharge disposition,						
		such as stairs or other						
		w up physician needs,						
		ices, home health preferences,						
		nese needs will continue to be						
		t the social worker, discharge						
	_	rector, and nurse management						
		and leading up to discharge						
		with change in condition.						
		presentatives will be notified of						
		ake place by the Discharge						
		nitial discharge plans or if a						
		ed to assess safety.						
		rsing educated all nurses,						
		nent nurse, dietary manager,						
	_	activity director, and social						
		ber 17, 2018 and completed						
	by December 28, 2	2018. This in-service included;						
	-	ve training to ensure						
	understanding of d	ischarge instructions,						
	notification of chan	ge in condition, including but						
		y acquired wounds or change						
	in condition of a re-	sident's skin, development and						
	implementation of	a care plan, and discharge						
	planning process.	The nurses and social workers						
	were educated to d	document all discharge						
	planning including	training given prior to						
	discharge. Any nur	sing staff and/or social worker						
	that did not receive	this in-servicing on December						
	17, 2018 were not	allowed to work until						
		empleted. This in-service was						
	100% complete on	December 28, 2018.						
	In-servicing for Abu	use and Neglect policies will be						
		v staff orientation and also in						
	annual training of e	existing staff. This in-servicing						
		the Administrator, Assistant						
	Administrator, Dire	ctor of Nursing and/or Staff						
		dinator; including but not						
	limited to education	n/training regarding unsafe						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345443	B. WING	B. WING		C 02/08/2019	
	NAME OF PROVIDER OR SUPPLIER OAK FOREST HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CO. 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	•	12/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 624	make sure that solu Beginning December Nursing began com audit tool. This tool documentation post limited to; resident's education of treatmed disposition of resided discharge. This tool a minimum of three of monthly for one y tools will be present the Director of Nursoutcome resolutions On December 14, 2 Administrator begar tool. This tool involvered prior to dischiplanner documented involvement of care team in conducting allows the facility to for post discharge a documented in their was completed we months and then anyear. The assistan newly discharged resident in the resident in	monitor its performance to tions are sustained. er 18, 2018, the Director of pletion of a daily discharge is used to ensure proper discharge including, but not comorbidities, mental status, ents, destination, and nt's personal properties upon will be completed weekly for months and then a minimum ear. Results of these audit ed to the QAPI committee by ing for any changes or s. 018, the Assistant a discharge planning audit wes reviewing the medical arge to ensure the discharge discharge needs and givers and interdisciplinary a safe discharge plan. It ensure all agencies required re ordered timely and are resident's record. This tool of x 4 weeks and will continue eakly for a minimum of three minimum of monthly for one that administrator calls each resident and/or representative	F 62				
	and implemented to listings, transportation home health initiation treatment education	rges were properly prepared include; review of medication on method was appropriate, on occurred, wounds if applicable was provided, ation needed related to eeds was provided.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345443	B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER	010110		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	08/2019
OAK FOR	EST HEALTH AND REHA	BILITATION		5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 624	Reassurance is made the time and ensures call back number if no audit tools will be precommittee by the Assistance of committee of	e of no concerns or issues at resident or caregiver has a seded. Results of these sented to the QAPI istant Administrator for any resolutions. The assistant hitor that each resident has a mission and ensure that the revised as needed. "14/19 in was verified via staff reviews on 2/8/19 and as a wing: verification of large planner, social worker All staff interviewed sing staff, administrative stated new processes for reglect Staff training and of audits. Review of sident discharge of a ind-up meeting, assessment, dmission, discharge release form and discharge at staff reviewed resident erify needed equipment, ssessment, documentation	F	524		
F 660 SS=J	CFR(s): 483.21(c)(1)(§483.21(c)(1) Dischar The facility must deve effective discharge pl on the resident's disc of residents to be acti	i)-(ix)	F	560		2/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		345443	B. WING	B. WING		C 02/08/2019		
	ROVIDER OR SUPPLIER EST HEALTH AND REHA	BILITATION		5	STREET ADDRESS, CITY, STATE, ZIP CODE 6680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	1 021	00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 660	process must be consights set forth at 483 (i) Ensure that the disresident are identified development of a discresident. (ii) Include regular reidentify changes that discharge plan. The cupdated, as needed, (iii) Involve the interdiby §483.21(b)(2)(ii), ii developing the discharge plan and the resident's or person(s) capacity an required care, as part discharge needs. (v) Involve the resider representative in the discharge plan and in resident representative (vi) Address the resid treatment preferences (vii) Document that a about their interest in regarding returning to (A) If the resident indit to the community, the referrals to local contrappropriate entities must up comprehensive care pappropriate, in response	rading to preventable cility's discharge planning sistent with the discharge .15(b) as applicable and-charge needs of each and result in the charge plan for each evaluation of residents to require modification of the lischarge plan must be to reflect these changes. sciplinary team, as defined in the ongoing process of arge plan. er/support person availability caregiver's/support and capability to perform the identification of the form the resident and we of the final plan. ent's goals of care and sc. resident has been asked receiving information the community. cates an interest in returning a facility must document any fact agencies or other had for this purpose.	F	660				

1 1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED C 02/08/2019	
		345443	B. WING				
	ROVIDER OR SUPPLIER EST HEALTH AND REH	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP COI 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105		02/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 660	to not be feasible, the made the determination of the post-acute care sassessment data on resource use the resident's representative on the resident's representative on the resident's representative on the resident's goals of preferences. (ix) Document, componithe resident's representation must be discharge plan to fact to avoid unnecessar discharge or transfer This REQUIREMEN by: Based on record rediver, home health sinterview the facility #1's care needs (meliving, and pressure of caregiver support that the resident had required. The facility comprehensive care	e community is determined e facility must document who tion and why. The are transferred to another charged to a HHA, IRF, or ats and their resident electing a post-acute care ta that includes, but is not plecting a post-acute care ta that includes, but is not plecting a post-acute care ta that includes, but is not plecting a post-acute care ta that includes, but is not plecting a post-acute care ta that includes, but is not plecting a post-acute care ta that includes, but is not plecting a post-acute care ta that includes, but is not plecting and a plecting a post-acute care that standardized patient at an explication of the facility must ensure that standardized patient and applicable to plecting and include in the clinical and include in the clinical and include in the clinical and includes the plan. The results of the discussed with the resident or ative. All relevant resident incorporated into the cilitate its implementation and y delays in the resident's facility in the resident's facility staff failed to address Resident dications, activities of daily sore management), the type and the logistics of assuring in the equipment and support	F 66	Past noncompliance: no pla correction required.	an of		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED C	
		345443	B. WING		l	08/2019	
	ROVIDER OR SUPPLIER	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	1 02/	02/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 660	family members' vo to care for Resident in 1 of 4 residents r planning (Resident The findings include Resident #1 was ac 8/28/18 after a rece hemiarthroplasty (rejoint) due to a fall affemoral fracture. The diagnoses included hypertension and conceive of a 48-hou Resident #1 dated resident would have home/assisted living included to initiate community resource.	g to address and acknowledge iced concerns of being unable at #1 at home. This was evident eviewed for discharge #1). In the discharge in the properties of the hip eplacement of half of the hip is home that resulted in a left hip eplacement in the resident's cumulative diabetes, heart failure, erebral infarction. In interim care plan for 8/28/18 revealed a goal that he a smooth transition to g facility. Approaches discharge planning, provided tive with information regarding	F 66				
	dated 9/11/18 code impaired cognition. #1 required extensi bed mobility, total a transfer, and require one person for drespersonal hygiene a indicated Resident and bladder. The reas steady only whe assistance and her wheelchair. Resided discharge to the con A review of the cometation.	ay Minimum Data Set (MDS) d the resident with severely The MDS indicated Resident we assistance of 2 people for essistance of 2 people for ed extensive assistance of sing, eating, toilet use, and bathing. The MDS #1 was incontinent of bowel esident's balance was coded an stabilized with staff mobility device was a ent #1 was coded as expected ammunity. uprehensive care plan dated ude a care plan for discharge					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345443	B. WING		C 02/08/2040	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	02/08/2019	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION	
F 660	9/17/18 revealed R acquired inhouse ic sore to the left butto sore has full thickned base of sore is covin the wound bed. assessment report revealed this an inhouttock measured by 1.5 cm in width, 100% slough tissue assessment of the discharge. Review of a Discharge. Review of a Discharge (SW) had informed that Resident #1 la was 9/28/18. The Sonn-coverage letter and appeal president. Review of 9/28/18 revealed Robe discharged hom Home health had bowas determined to to arrange for a foll care physician. A review of discharfor Resident #1 reverlated to treatmen ulcer or information medications. Review of a depart DP dated 10/3/18 at (family) and left me speak with family a	atment progress note dated esident #1 had a newly dentified unstageable pressure lock. An unstageable pressure less tissue loss in which the lered by slough and/or eschar Review of the wound dated 9/17/18 and 9/24/18 nouse pressure sore to the left 1.2 centimeters (cm) in length no measurable depth with less. There was no further pressure sore prior to large Planner (DP) note dated at #1 stated the Social Worker the responsible party (RP) st day of Medicare coverage	F 66			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 ti Boile			С		
		345443	B. WING				08/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	06/2019	
	10115211 011 001 1 21211				6680 WINDY HILL DRIVE			
OAK FOR	EST HEALTH AND REH	ABILITATION			WINSTON SALEM, NC 27105			
					·		I	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 660	Continued From page	e 21 orting patient home soon, so	F	660				
		ny personal cell #/am."						
	_	progress notes dated						
		revealed resident took						
	medications crushed	and placed in pudding.						
	An interview on 2/6/1	9 at 11:56 am with the						
	Treatment Nurse (TN	I) stated "I do not know the						
		referring to the pressure						
	,	discharged and did not						
	· ·	oout how to care for the						
		site also had drainage.						
		ealed the home health						
	Interview on 2/6/19 a	n the dressing changes.						
	Administrator reveale							
		nt home and it was his						
	-	follow the regulations (was						
		narging residents home.						
		t 1:21 PM with the DP who						
	stated the Medicare	non-coverage for Resident						
	#1 was in effect on 9	/28/18. The RP stated to her						
	that they could not af	ford private pay so Resident						
		d to her home on 9/28/18.						
		ealed the family had at home						
		oital bed and wheelchair. DP						
		and no one came to pick				ĺ		
		28/18. On 10/1/18 she						
		nember on 10/4/18 who						
		tion and she refer them to a "I then called them (referring						
	-	transport the resident on						
		she was unaware of the				ĺ		
		of the discharge. Home						
		as the agency that approved						
	Resident #1's admiss							
	An interview on 2/6/1	9 at 2:20 PM with Nurse #10						
	indicated she adminis	stered the resident's						
	medications crushed	and mixed with pudding,						
	required total care ar	nd was fragile. Nurse #10						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	FIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345443	B. WING			C 2/08/2019	
NAME OF PROVIDER OR SUPPLIER OAK FOREST HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP (5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	•	2/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 660	resident went home Nurse #10 indicated discharge paper wo She stated she disc and was told to comidentify who gave he stated she never sa prescriptions to send added home health home the next day. #10 indicated 10/4/1 worked with this resknow much about he she discharged a remember present and medications and ap #10 added she didn for Resident #1's prowas not the normal resident. An interview via the with a family member the facility that they no means to take castated on 10/4/18 the next thing we knew by a van. This family no medications except they had no knowled pressure sore on he stated the facility just without any instruction. She added the another nursing hom revealed "I received family member contidid not have all the	ge 22 structions because the with home health services." I she had completed the rk on 10/4/18 for Resident #1. harged the resident to no one uplete the paper work (did not per instructions). Nurse #10 we a medication list or do home with the resident. She was scheduled to be in the Further interview with Nurse 18 was the only day she had ident and she really didn't per. She stated normally when sident there was a family do she would review all of the pointments with them. Nurse 14 see any treatment orders persure sore. She stated this process for discharging a phone on 2/6/19 at 7:14 PM per indicated she had informed (referring to the family) had per indicated she had informed (referring to the family) had per insulin for the resident and doge that the resident thad a per buttock. The family member st dumped Resident #1 off ons on how to take care of resident was placed in the Continued interview only one sheet of paper. The inued to indicate the family medications to administer and that they could not take care of the family medications to administer and that they could not take care of the family medications to administer and that they could not take care of the family medications to administer and that they could not take care.	F	660			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345443	B. WING		C 02/08/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	02/00/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 660	of her at home due to Resident #1. Furthe home care nurse cal medications and she	e 23 o inability to lift and move r interview revealed the led the pharmacy to get the "Tried talking to (DP) who we had no choice but to	F 66	60	
	bring her home." An interview on 2/6/1 Assistant (NA) #11 s care for all activities finger foods but staff Resident was inconti would require 2 peop She needed staff to the	9 at 2:30 pm with Nursing tated resident required total of daily living, fed herself			
	An interview on 2/6/1 Health Agency (HHA #2 (nurse who conduct 10/5/18) was conduct Nurse #2 stated on a to the resident's hom clothing and bed she She also experience bowels. HHA Nurse	9 at 3:30 pm with Home) Nurse #1 and HHA Nurse icted the initial evaluation on ited via the phone. HHA irrival on 10/5/18 at 1:06 pm ie, Resident #1's brief, ets were soaked with urine. d an incontinent episode of #2 stated Resident #1 t she was hungry and had			
	not eaten all day. A Resident#1 a pop tai the room. There was follow-up with the ph medications. HHA Nipharmacy for medicatup an appointment to there was no glucom resident's blood gluc indicated by 10/24/18 transferred to anothe An interview on 2/7/1 Transportation comp	family member then brought and walked into and out of sono set up date for a sysician nor were there any curse #2 stated she called the ation to be delivered and set to the MD office. Additionally, eter or strips to test the cose level. HHA Nurse #2 B Resident #1 was			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345443	B. WING		C 02/08/2019	
	ROVIDER OR SUPPLIER	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	OE/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 660	present when he ar driver stated he bro belongings and a "driver stated no fac resident and a fami resident to bed so t facility's wheelchair Interview on 2/8/19 Therapist (PT) reveresident was maxim did not have good to previous stroke and inquiry was made a therapist indicated to does not conduct he home health physic indicated the reside and needed maxim from staff. The facility implement action: "Resident # 1 was a and Rehabilitation of diagnoses of hyper Diabetes Mellitus word Left Artificial Hip Upon admission to identified with Impainterim care plan was 2018 including disc smooth transition to physician order for Therapy evaluation 28, 2018, and Physiteatment on August therapy services the much encouragement September 17, 201	rived at the home. The van ught the Resident's personal discharge packet". TC van illity staff accompanied the ly member transferred the hat he could return the	F 660			

STATEMENT OF DEFICIE AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		345443	B. WING				C
NAME OF PROVIDER (OR SLIPPLIER	343443	3		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	08/2019
NAME OF TROVIDER	OK SOLT EIEK				5680 WINDY HILL DRIVE		
OAK FOREST HEA	LTH AND REH	ABILITATION			WINSTON SALEM, NC 27105		
				<u>'</u>	<u> </u>		T
	EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
buttock approp and no Medica the phy treatments of the properties	riate docume tified resident I Director. New sician on Sepent of the president of the president and nursing The facility the early barriers ge. OT services aber 25, 2018 inued on September 25, 2018 inued on September 21, 2018 a Notice of Nesident's Reponse to the president's Reponse to the president to return Resident's Reponse to the president to return Resident to return Resident to return Resident's Reponse to the president to the president to return Resident's Reponse to the president to t	ent Nurse completed the intation for the pressure ulcer is attending physician and ew orders were received from otember 18, 2018 for the issure ulcer. The treatment the Resident Representative if the discharge planning of id a referral for Home Health in PT, OT evaluation and ing for treatment of sacral failed to do a home visit and is in the home prior to is were discontinued on and ST services were interested the maximum potential and in the maximum potential and in the discharge resident in September 28, 2018. On it the discharge planner in Coverage and discussed resentative via phone call at Representative was notified in skilled services to be on it. Resident's Representative inding and confirmed the plan home on September 28, presentative did not arrive to in 28, 2018 to pick up it indicated in the plan home on September 28, presentative did not arrive to in 28, 2018 to pick up it indicated in the plan home on September 28, presentative did not arrive to in 28, 2018 to pick up it in the plan home on September 28, presentative did not arrive to in 28, 2018 to pick up it in the plan home on September 28, presentative did not arrive to in 28, 2018 to pick up it in the plan home on September 28, presentative did not arrive to in 28, 2018 to pick up it in the plan home on September 28, presentative did not arrive to in 28, 2018 to pick up it in the plan home on September 28, presentative did not arrive to in 28, 2018 to pick up it in the plan home on September 28, presentative did not arrive to in 28, 2018 to pick up it in the plan home on September 28, presentative did not arrive to in 28, 2018 to pick up it in the plan home on September 28, presentative did not arrive to in 28, 2018 to pick up it in the plan home on September 28, presentative did not arrive to in 28, 2018 to pick up it in the presentative did not arrive to in 28, 2018 to pick up it in the presentative did not arrive to in the plan home on September 28, presentative did not arrive to in the presentative did not arrive to in the presentative d	F	660			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE COMF	SURVEY
		345443	B. WING _			C /08/2019
	ROVIDER OR SUPPLIER	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	•	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 660	second family men return call. The sec Social Worker back requested for facilit home. Transportat transport resident at transport. Resident October 4, 2018 at Resident Represer instructions includit Health agency was Representative at The facility failed to sufficient preparative representative to edischarge from the representative did resident's wound at that the left hip sur amount of drainage and review a medic prescriptions with facility representative condition including treatment/surgical listing review, and of diet resident med ADL assistance ned discharge home. The Resident #1 did incomplete the treatment and nurse wound. Corrective action at transportation and corrective action at the services to treatment and nurse wound.	al Worker then contacted aber and left messages to cond family member called k on October 4, 2018 and ty to transport Resident #1 ion was notified and agreed to and bill family for cost of t was picked up at facility on and taken home and received by antative. Resident's discharge ang information regarding Home as given to Resident time of transport. To provide and document on and orientation to resident ansure safe and orderly facility. The family not have knowledge of the and treatment for the wound or gical incision site had small the. The nurse failed to provide cation list and medication family representative. Family facility failed to train a face of Resident #1's medical	F	660		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	` ´COMI	E SURVEY PLETED
		345443	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	02	/08/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 660	October 4, 2018. At Resident #1 is residi facility. Address how correct accomplished for the potential to be affect practice. Starting December 1 completed a 100% a discharged within the start of the original p Resident #1. This au and no negative find was completed on 13	charged from the facility on the time of this compliance, ng in another skilled nursing live action will be use residents having the ed by the same deficient	F 60	60		
	including education of medical treatment not by failing to provide review of Resident # medication listing, arthis is considered net The discharge plann Resident #1's discharge planned by the Director of Nursing. Was not limited to; not development, prepart a comprehensive cates a preparation and discharge planning provides a proposition of the provides and provides	a family representative with a 1's wound treatment, and medication prescriptions, glect according to regulation. For and nurse involved with arge was educated on you the Administrator and the in-servicing included, but obtification of changes, ration, and implementation of the plan for discharge, as well a implementation of the process. The Director of irrector of Nursing, assistant in in-service to all staff, ted to the discharge planner, irrses starting January 2, 2019 inuary 4, 2019. The labuse and Neglect education.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345443	B. WING			l	08/2019
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		30/2010
				56	680 WINDY HILL DRIVE		
OAK FOR	EST HEALTH AND REF	IABILITATION		W	/INSTON SALEM, NC 27105		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 660	Continued From page comprehensive care 12/19/18 and completed by Englished E	ge 28 e plan tool starting on eted on 12/20/18 of all current in the facility to ensure each large care plan. This audit discharge Planner and Discharge Planner and Discharge Planner and ensured the current care plan large plan for each resident. It into place or what will be made to ensure that le will not occur. It discharge plan process is in care plan is initiated on laritting nurse and completed lager, Assistant Director of lor of Nursing. All nurses were lector of Nursing on December requirement of the facility to literate a care plan for each literate discharge plan of whether litity or desire to discharge lity. The discharge plan of littlal discharges for the next leviewed by the Discharge discussed in the literate a care plan gor literate a care litera		660			
	not limited to; home physician, durable n services needed fro	isciplinary team including but health, primary care nedical equipment needs, any m the community, education agement, treatments, food					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILD	ING .		l ,	c
		345443	B. WING				08/2019
NAME OF P	ROVIDER OR SUPPLIER	-			STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
0.11/ 505					5680 WINDY HILL DRIVE		
OAK FOR	EST HEALTH AND REH	IABILITATION		١ ا	WINSTON SALEM, NC 27105		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 660	Continued From pag	ne 29	F	660			
		care needs of activities of daily		-			
		pervision needed. During the					
	_	meetings, the interdisciplinary					
		ogression of each resident					
		arge date based upon safety					
		The Director of Nursing or					
		f Nursing brings information					
	I .	th a change in condition					
		ation gathered from Unit					
	_	ge Nurses. These residents					
	_	time for any significant					
		ffect an upcoming discharge.					
		ition including discharge					
	, ,	nunicated to the resident or					
		tive and provider by the					
	,	nurse and/or Unit Manager.					
	_	team consists of at least the					
		Social Worker, Dietician,					
		nd Nursing MDS Coordinator.					
	The Director of Nurs	sing communicates any					
	potential discharge	residents to the Unit					
	Coordinator/Manage	er to initiate training/teaching					
	to resident or reside	nt representative when					
	applicable. This inc	ludes but is not limited to;					
		insulin administration, wound					
	care, tube feedings,	oxygen therapy, and					
	medication manage	ment. The providers are also					
	included in the discu	ussions of potential					
		ress safety and medical					
		Worker and/or Discharge					
		sible for communicating with					
	I .	nily representative on					
		luding community resources					
		ges. The Dietician is					
	1	cation on dietary needs					
		nosis. The Therapy Director					
	1	e oversight of the treating					
		resident meets goals for safe					
	discharge and any b	parriers to discharge are					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345443	B. WING _			C 02/08/2019	
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, Z 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105		02100/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 660	home visit is applicate needs, the Therapy E for coordination. The coordinate caregiver and ensure completic Coordinator reviews needs at the facility a resident has approprimedical needs for disfamily representative Discharge Planner of will assist with discharge planner up plan as needed. The nursing staff will instructions given to representative upon the reviewed prior to the Nursing as noted with provider will complete visiting resident to incresident and ensure it to discharge. On October 30, 2018 President of Operation therapy company education of home visits when it resident's safety or an adischarge from the far and/or therapy mana determining the need discharged residents member that will go chome visit is deemed.	team for follow up. If a ble based on discharge Director will be responsible and Therapy Director will also training where applicable on. The Nursing MDS each resident for clinical and also ensuring the atte follow up based on acharge. Resident and as are then notified by the future discharge date and arge follow up needs. The dates the discharge care document the discharge care document the discharge he resident and/or resident discharge. This process will discharge by the Director of a the discharge audit. The ea discharge summary after clude discharge plan for medical needs are met prior when the contracted discharge and the importance and ditional safety needs post cility. The discharge planner ger is responsible for of a home visit for all and assigning the staff out to the home. When a necessary for resident disprior to the discharge	F6	360			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		STRUCTION	\ '	SURVEY PLETED
		345443	B. WING _			1	C / 08/2019
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 02/	100/2019
		-		5680 V	VINDY HILL DRIVE		
OAK FOR	EST HEALTH AND RE	HABILITATION		WINS	TON SALEM, NC 27105		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 660	Continued From pa	age 31	F 6	860			
	Administrator, Dire Director of Nursing staff, including the discharging nurse, of residents. This section 2019. Beginning December discharge planning admission. The discharge planning admission. The discharge planning admission. The discharge planning admission. The discharge determine discharge determined will increased of the home impediments, follow pharmacy preferent and care needs. The discussed amongs planner, therapy distribution the stay at least weekly and Resident and/or reany changes that the Planner from the inhome visit is needed. The Director of Nurincluding the treatmerapy manager, aworkers on Decembre 28, 2 family representation understanding of distribution of channot limited to, newlin condition of a reimplementation of a planning process.	ctor of Nursing, and Assistant provided in-servicing for all discharge planner and regarding abuse and neglect was completed by January 4, wer 14, 2018, a resident's will begin at the time of charge planner, and/or therapy with the resident and/or in 72 hours of admission to ge needs. The needs lude discharge disposition, such as stairs or other wup physician needs, nees needs will continue to be the social worker, discharge rector, and nurse management wand leading up to discharge with change in condition. In presentatives will be notified of the place by the Discharge with change in condition. In presentatives will be notified of the place by the Discharge with change in condition. In presentatives will be notified of the place by the Discharge with change in condition. In presentatives will be notified of the place by the Discharge with change in condition, included; we training to ensure ischarge instructions, ge in condition, including but y acquired wounds or change sident's skin, development and a care plan, and discharge The nurses and social workers document all discharge					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		NSTRUCTION	(X3) DATE	SURVEY PLETED
		345443	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	343443	B. WING_	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	02/	/08/2019
TO UNIC OF T	NOVIBER OR OUT FEEL				WINDY HILL DRIVE		
OAK FOR	EST HEALTH AND REHA	ABILITATION			STON SALEM, NC 27105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 660			F 6	60			
		ng staff and/or social worker nis in-servicing on December					
	17, 2018 were not all	•					
	· ·	pleted. This in-service was					
	100% complete on D						
	-	e and Neglect policies will be					
	included in the new s	taff orientation and also in					
		sting staff. This in-servicing					
		e Administrator, Assistant					
		or of Nursing and/or Staff					
		nator; including but not					
	discharges.	raining regarding unsafe					
		nonitor its performance to					
	make sure that soluti	•					
		18, 2018, the Director of					
		letion of a daily discharge					
		used to ensure proper					
	documentation post of	discharge including, but not					
		comorbidities, mental status,					
	education of treatmen						
	· ·	t's personal properties upon					
		vill be completed weekly for					
		nonths and then a minimum					
		ar. Results of these audit d to the QAPI committee by					
	the Director of Nursin						
	outcome resolutions.	ig for arry chariges or					
	On December 14, 20	18. the Assistant					
		a discharge planning audit					
		es reviewing the medical					
	record prior to discha	rge to ensure the discharge					
	· ·	discharge needs and					
		ivers and interdisciplinary					
		safe discharge plan. It					
		ensure all agencies required					
		e ordered timely and are					
		sident's record. This tool					
	was completed daily	x 4 weeks and will continue					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		E SURVEY MPLETED
		345443	B. WING		0	C 2/08/2019
	ROVIDER OR SUPPLIER EST HEALTH AND REH	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	1 -	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 660	months and then any year. The assistant newly discharged re to ensure all dischar and implemented to listings, transportation home health initiation treatment education and any other education and the time and ensured call back number if reaudit tools will be procommittee by the Aschanges or outcome administrator will modischarge plan on any plan is reviewed and The Director of Nursof Nursing will bring along with the medic stand up meeting. The reviewed by the DOI new admissions are Interim Care plan indischarge plan, is confor a discharge in the reviewed and revise the Medicare/Medication Completion date: 1/4 The credible allegation interviews and recore evidenced by the fol re-education for discand licensed nurses	ekly for a minimum of three minimum of monthly for one administrator calls each sident and/or representative ges were properly prepared include; review of medication on method was appropriate, in occurred, wounds if applicable was provided, ation needed related to eeds was provided. He of no concerns or issues at its resident or caregiver has a needed. Results of these esented to the QAPI sistant Administrator for any resolutions. The assistant onitor that each resident has a dmission and ensure that the larevised as needed. In an admission and ensure that the larevised as needed. In a list of all new admissions cal record of each to the daily the residents' records will be N/ADON to ensure that all reviewed to ensure the cluding but not limited to the ompleted. All projected plans a next 7 days, will be do by the IDT team weekly in aid meeting."	F 6	60		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345443	B. WING _		C 02/08/2019
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	1 02/06/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 660	and abuse/neglect is resident discharge of stand-up meeting, as at admission, dischargelease form and disstaff reviewed residenceded equipment, assessment, documerranged at the time verification the facilition 1/4/19. Quality of Care	new processes for discharge Review of documentation for f a resident including ssessment, discharge began rge summary, medication charge instructions, validated ent discharges daily to verify	F 6		3/8/19
SS=D	applies to all treatment facility residents. Base assessment of a residents received accordance with propractice, the comprescare plan, and the residents recorded and the resident facilities. Based on record resconsultant pharmaci of the manufacturer's to follow the manufactur	undamental principle that ent and care provided to sed on the comprehensive ident, the facility must ensure e treatment and care in fessional standards of hensive person-centered esidents' choices. T is not met as evidenced view, interview with the st, staff interview and review is literature, the facility failed cturer's instructions to applied transdermal patch of a new one. This was dents reviewed with a transdermal patch.		Oak Forest Health and Rehabilita requests to have this Plan of Correserve as our written allegation of compliance. Our alleged date of compliance is 3/8/19. Preparation execution of this plan of correction not constitute admission to nor agwith either the existence of, or sco severity of any cited deficiencies, conclusions set forth in the statem deficiencies. This plan of correction prepared and executed to ensure	and/or a does reement upe and or lent of

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY IPLETED
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		345443	B. WING _			02	2/08/2019
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				50	680 WINDY HILL DRIVE		
OAK FOR	EST HEALTH AND RE	EHABILITATION		V	VINSTON SALEM, NC 27105		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	age 35	F	684			
	_ ·	ously applied Neupro	, ,		continuing compliance with Federal an	Ч	
		placed on the skin must be			State regulatory law.	u	
	· ·	e application of a new one.			Ctate regulatory law.		
	Temoved belove th	e application of a new one.			The facility nurse failed to follow the		
	Resident #6 was a	dmitted from a recent hospital			manufacture's literature instructions to		
		on 1/7/19 with cumulative			remove a Neupro patch applied on		
		ncluded Parkinson's disease.			1/22/19 prior to application of a new pa	atch	
					on 1/23/19. The nurse was educated of	on	
		ealed on 1/21/19 a physician			1/25/19 by the Director of Nursing in		
		milligrams (mg) transdermal			regards to the Neupro patch not being		
		urs for two (2) weeks then			removed. The affected resident was n		
	_	very 24 hours which was			residing in the facility at the time of the		
		ologist recommendation.			plan of correction.		
		treat Parkinson's disease by			The facility conducted a 1000/ audit of	all.	
	decreasing tremor	s and sunness.			The facility conducted a 100% audit of residents with patches on 2/7/19 during		
	Review of the F-M	edication Administration			the survey. Another 100% audit of all	J	
		Neupro 2 mg patch was			current residents will be completed by		
		dent's skin on 1/22/19 and			3/4/19. 100% of all nurses and		
	1/23/19.	2011.0 01111 011 1/22 10 0110			medication aides will be educated on		
					proper placement and removal of topic	al	
	Record review rev	ealed a written grievance dated			patches by 3/8/19. Nurses and		
		two (2) Neupro patches dated			medication aides will also be educated	on	
	1/22/19 and 1/23/1	9 found on			practices to reduce medication errors to	Эy	
					3/8/19. The Unit Manager and Unit		
		ew of the investigation dated			Coordinator will continue to complete		
		lurse #14 failed to remove the			second checks to ensure physician ord		
		dated 1/22/19 before applying			are properly keyed in the computer. The		
	a new patch on 1/2	23/19.			Unit Manager, Unit Coordinator, nurse	3,	
	Interview an 0/7/40	ot 2:47 DM with Nives 444			and medication aides will notify the		
		e at 3:17 PM with Nurse #14			Director of Nursing immediately of any medication errors.		
		aced the new patch on without one. "I meant to go back and			medication ends.		
		us one, it was an oversight."			Medication Patch Audits will be used to	1	
	Torriove the previou	ao ono, it was an oversigni.			ensure proper placement and removal		
	Interview on 2/7/19	9 at 4:57 PM with the			following manufacturer's instructions d		
		ministrator revealed the 1st patch (dated			x 4 weeks, weekly for 3 months and	,	
		ive been removed. The			monthly x 1 year. The Director of Nurs	sing	
	· · · · · · · · · · · · · · · · · · ·	(DON) joined the conversation			will present the results of the audit tool	-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		345443				C 02/08/2019	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 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	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETI DATE		
F 684	via the phone who ince to take off the previous. "We educated her on and remove the old period parts." Interview on 2/8/19 at the consultant pharms manufacturer's instruction.	dicated Nurse #14 just forgot is patch. The DON stated, how to administer the patch atch prior to applying the acist who stated that the ctions stated to remove the ethe application of a new	F 68	the Monthly QAPI committee med 1 year. The Director of Nursing, Unit Ma Unit Coordinator, and RN Staff Development Manager will imple above corrective actions.	nager,		