STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/04/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 11/2/2021 thru 11/04/2021. The facility was found in compliance with 42 CFR & 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# JDP911.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 11/02/21 to conduct and unannounced COVID-19 Focused Infection Control Survey and complaint investigation and exited on 11/02/21. Event ID#JDP911 14 of 15 allegations were unsubstantiated. 1 of 15 allegations was substantiated without a deficiency.	F 000		

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

Electronically Signed | 01/24/2022

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.