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 07/26/2023

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 Infection Control Survey was conducted from 7/25/2023 through 7/26/2023. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 6FY611	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted from 7/25/2023 through 7/26/2023. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# 6FY611. The following intakes were investigated NC00204674, NC204714 and NC00205078. 2 of the 6 complaint allegations resulted in deficiency.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		8/9/23

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

Electronically Signed | 08/09/2023

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 07/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to honor a resident's (Resident #1) bathing preference for 1 of 3 residents reviewed for choices. The findings included: Resident #1 was admitted to the facility on 12/7/2019. A review of Resident #1's care plan dated, 6/28/2023, identified a focus area that the Resident had an activities of daily living self-care performance deficit. The interventions included: 1. The Resident required assistance with bathing. 2. Resident #1 required total assistance of two staff members for transfers with a mechanical lift. 3. Allow the Resident to make decisions about the treatment regime, to provide a sense of control.	F 561	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 561 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #1 a corrective action was obtained on 7/26/2023 when resident was offered her shower and she accepted. Resident #1 was interviewed regarding her shower schedule preferences, which	

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 07/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 2 A review of the quarterly Minimum Data Set (MDS) dated 7/10/2023 revealed Resident #1 was cognitively intact, required extensive assistance of one staff member for personal hygiene and bathing. She had range of motion impairment on both sides of the upper and lower extremities. The Resident had no rejection of care during the lookback period. A review of the electronic medical record for Resident #1 revealed she was schedule for showers twice a week on Thursday and Sunday. The staff were provided a question, "Shower completed." The answers included 1) yes, 2) no, 3) Resident not available, 4) Resident refused, 5) Not applicable. The shower documentation for the following dates revealed: 1. 6/29/2023 No shower completed. 2. 7/9/2023 Resident refused. 3. 7/13/2023 No shower completed. 4. 7/23/2023 Resident refused. An interview was conducted with Resident #1 on 7/25/2023 at 3:24 p.m. and she revealed in the past month she had received a shower 3 of the 8 scheduled showers. She added she had not refused to take a shower and preferred a shower to a bed bath because it felt like a spa day. She stated she was told by the agency Nursing Assistant (agency NA) #1 that the NA was unable to conduct a shower on 7/23/2023 because getting her into a mechanical lift was difficult and there was not enough staff. She stated this had been occurring for several months and she had not reported this to anyone in a long time because when she reported it in the past it had not made a difference.	F 561	was updated in the residents' task by the Director of Nurses (DON) on 07/27/2023. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 07/27/2023 the DON and unit coordinators completed resident interviews on 100% of all current residents to identify if they have a preference of if they wished to take showers or have bed baths. Any residents who requested a preference of when they wished to be showered had their task updated to reflect their preference. This was completed on 7/27/2023. All new admissions and readmissions will be allowed to voice their choice for showers and or bed baths. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 07/27/2023, the SDC began education of all full time, part time, as needed (PRN) licensed nurses, Registered Nurses (RN)s, Licensed Practical Nurses (LPN), med-aids, and certified nursing assistants (CNA's), including agency staff on self-determination including resident preferences of when they wish to shower and promoting residents' choice. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also	

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 07/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 3 An observation of Resident #1 was conducted on 7/25/2023 at 3:26 p.m. and she had on a hospital gown (Resident's choice), groomed hair, nails trimmed and free of debris. An interview was conducted with the Agency NA #1 on 7/25/2023 at 1:32 p.m. and she revealed on the date of 7/23/2023 she had completed all the assigned bed baths for her assignment but had not provided showers to the residents that had scheduled showers on that date. She revealed it was difficult to locate a second NA if a resident required two staff assistance with a mechanical lift. She indicated the facility had scheduled shower days for some residents on Sundays and she found it difficult to complete showers on a Sunday. She indicated Resident #1 was on her assignment on 7/23/2023 and required two staff for assistance with a mechanical lift for transfers. She added Resident #1 preferred a shower and was offered a bed bath instead on 7/23/2023. She stated she had not requested a Nurse to assist or to locate assistance to transfer Resident #1. An interview was conducted with the Director of Nursing on 7/25/2023 at 3:52 p.m. and she revealed it was her expectation that an NA reach out to the hall nurse if she required a second staff member to be available and was unable to locate a staff member. She added that all residents should receive the scheduled shower on the shower days.	F 561	provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 7/29/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or Designee will monitor compliance utilizing the F561 Self Determination Quality Assurance Tool weekly x 5 weeks then monthly x 2 months or until resolved. Audits will occur on various shifts and days of the week to include weekends to assure that residents preferences are being honored. This will include auditing 5 residents on various days and shifts to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 07/29/2023.	