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 02/15/2024

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

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/12/24 through 2/15/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # W65J11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/12/24 through 2/15/24. Event ID# W65J11. The following intakes were investigated NC00209036, NC00212099, and NC00212657. 2 of the 6 complaint allegations resulted in deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		3/8/24

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

Electronically Signed | 03/09/2024

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F 656	Continued From page 1 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interview the facility failed to provide the resident the opportunity to participate in the care planning process for 2 of 2 residents (Resident #31 and #8). Findings included: 1. Resident #31 was admitted to the facility on 1/13/2015 with diagnoses of quadriplegia and chronic pain.	F 656	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	

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F 656	Continued From page 2 An annual Minimum Data Set (MDS) assessment completed 12/27/2023 indicated Resident #31 was cognitively intact and participated in his assessment. Resident #31 was interviewed on 2/12/2024 at 12:09 pm and he stated he had not been invited to a care plan meeting during his stay at the facility. During an interview with Social Worker #1 on 2/14/2024 at 2:27 pm he stated Resident #1 had not been invited to a care plan meeting. He stated he meets with each resident every quarter for an assessment and if the resident indicates they have an issue he would notify the other disciplines as needed and they meet with him individually. Social Worker #2 further stated the facility does not provide care plan meetings with the interdisciplinary team members unless there is a concern brought up by the resident or the resident's family member. Social Worker #1 further indicated there was no invitation sent out to the residents or family members from the facility and the facility does not document who attends care plan meetings when the resident or family member requests a care plan meeting. The Administrator was interviewed on 2/14/2024 at 2:50 pm and she stated typically there is an admission care plan meeting, quarterly care plan meeting, and care plan meetings when a resident or family member has concerns. The Administrator stated she was not aware the care plan meetings were not being done until Social Worker #1 told her after he was interviewed. The Administrator stated she was given a calendar of the scheduled Care Plan meetings and was not aware the invitations were not being sent to the	F 656	corrected by the dates indicated. F656 Develop/Implement Comprehensive Care Plan 1. Corrective action for residents affected by the alleged deficient practice. On 3/5/2024 care plan meetings were offered and scheduled for resident #31 and resident #8. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 3/5/2024 audit was completed to determine residents with comprehensive care plans due. All current residents have the potential to be affected by the alleged practice. Each resident/family/Power of Attorney or legal representative will receive notification of quarterly care plan meetings either by mail, phone or other preferred method of communication. 3. Systemic Changes: On 3/5/2024 education was provided to the facility Minimum Data Set (MDS) Coordinator, Social Workers and other Interdisciplinary team members that participate in development and revision of care plans. The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, mental and psychosocial needs	

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F 656	Continued From page 3 residents and family members and the Care Plan meetings were not completed. 2. Resident #8 was admitted to the facility on 12/10/19. The quarterly Minimum Data Set (MDS) assessment dated 1/8/24 revealed Resident #8 was cognitively intact and participated in his assessment. The care plan was last reviewed on 1/9/24. During an interview with Resident #8 on 2/12/24 at 9:42 AM and he indicated he had not been invited to care plan meetings but would like to be included in the development of his care plan and participate in the process. During an interview with Social Worker #1 on 02/14/24 at 03:05 PM he indicated that Resident #8 had not been invited to a care plan meeting. He further revealed that he meets with each resident every quarter for an assessment and if the resident has an issue or concern then he will schedule a care plan. He further explained that Resident #8 did not have any concerns, so he did not offer a care plan meeting to Resident #8 or his resident representative. The Administrator was interviewed on 2/14/2024 at 2:50 pm and she stated typically there was an admission care plan meeting, quarterly care plan meeting, and care plan meetings when a resident or family member has concerns. The Administrator stated she was not aware the care plan meetings were not being done until Social	F 656	that are identified in the comprehensive assessment. A comprehensive person-centered care plan will include meeting with resident, family, power of attorney or legal representative for review at least quarterly. 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 the Director of Nursing and/or designee will review 5 residents to evaluate resident, family, power of attorney or legal representative have been invited and attended quarterly care plan meetings. This will be done on weekly basis for 5 weeks then monthly for 2 months using the audit tool titled Development of Comprehensive Care Plan Audit. The results of this audit will be reviewed at the weekly QA/ Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound	

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F 656	Continued From page 4 Worker #1 told her after he was interviewed. The Administrator stated she was given a calendar of the scheduled Care Plan meetings and was not aware invitations were not being sent to the residents and family members and the Care Plan meetings were not completed.	F 656	Nurse. Date of Compliance: 3/8/2024	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff, and resident interviews the facility failed shave facial hair for a female resident that was dependent on staff for activity of daily living (ADL) care needs in 1 of 5 residents (Resident #70) reviewed for ADL care. The findings included: Resident #70 was admitted to the facility on 12/18/20 with diagnoses that included vascular dementia. A review of the quarterly Minimum Data Set (MDS) 1/29/24 revealed Resident #70 had moderate cognitive impairment, was able to communicate her needs, had no behaviors or rejection of care, and required extensive assistance of one staff member for personal hygiene and bathing. A review of the care plan for Resident #70, dated 1/29/24, had a focused area for activities of daily	F 677	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. F677 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #70 was provided ADL shaving of facial hair on 2/14/2024 and the DON/designee has made daily observations to ensure that this resident	3/8/24

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F 677	Continued From page 5 living (ADL) with interventions that included to assist resident with all aspects of daily care to ensure that all needs were met and to anticipate needs. A second focused area was for refusing staff to provide showers and medications with interventions that included to report all refusals of care to the nurse, document refusals, and if care was refused to return at later time and attempt again. A review of progress notes from 1/12/24-2/12/24 revealed no documentation of refusing facial hair removal by staff. An observation of Resident #70 was made on 2/12/24 at 9:50 AM. Resident #70 was observed sitting outside of her room in a wheelchair, dressed in street clothes and had gray and white facial hair covering her chin about ¼ inch long. A second observation and a resident interview was conducted on 2/14/24 at 12:47 PM. Resident #70 was observed to still have the ¼ inch long facial hair covering her chin. Resident #70 revealed that she preferred to get the facial hair shaved but that staff had not shaved it for her. An interview was conducted with Nursing Assistant (NA) #1 on 2/14/24 at 2:15 PM. NA #1 was the assigned NA for Resident #70 on 2/12/24-2/14/24. She revealed that Resident #70 relied on nursing staff to assist with all ADL's which included shaving of facial hair. On 2/14/24 at 2:19 PM an interview was conducted with the A Wing Nurse Manager #1. She revealed that the nursing assistant assigned	F 677	has received ADL care related to shaving of facial hair. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility have the potential to be affected. On 2/16/2024, the Director of Nurses and Assistant Dir of Nurses conducted an audit of all residents to determine if ADL/grooming were being provided and no negative findings were identified. On 2/15/2024, the Director of Nurses, and staff Development Coordinator initiated the following education to all licensed nurses and certified nursing assistants, full time, part time, agency, and PRN staff to be completed by 3/8/2024: " ADL Care " Grooming " Dignity and respect 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 2/15/2024, the Director of Nurses and the STAFF Development Nurse initiated education ADL care, grooming of facial hair, and dignity and respect. Education will be completed by all licensed nurses and nursing assistants, full-time,	

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F 677	Continued From page 6 to Resident #70 (NA #1) was responsible for assisting her with all personal hygiene needs. A follow up interview on 2/15/24 at 3:06 PM with the A Wing Nurse Manager #1 revealed that NA #1 did offer facial hair removal to Resident #70 on 2/15/24 and she accepted the care without refusal. On 2/15/24 at 9:20 AM an interview was conducted with the Administrator. She revealed that staff were required to assist residents who were dependent on staff for ADL's.	F 677	part-time, agency staff, and PRN staff by 3/8/2024. Any employee who has not received this education will not be allowed to work until the training has been completed. This includes licensed nurses and nursing assistants full time, part time, agency staff, and PRN staff. The in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning on 3/12/2024 Director of Nurses or designee will complete weekly audits to ensure that ADL/grooming of facial hair is being completed. The audits described above will be completed using the QA Monitoring Tool for ADL□s. These audits will include a sample of 5 residents weekly x 5 weeks, and monthly x 2 months. Results will be reported to the weekly Quality Assurance Committee by the Director of Nurses or designee to ensure corrective action is initiated as appropriate. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Assistant Dir of Nursing, Staff Development Coordinator, MDS Coordinator, Therapy Director, Activities Dir, Social Worker, and Environmental Services Dir. Date of Compliance: 3/8/2024	
F 732 SS=C	Posted Nurse Staffing Information	F 732		3/8/24

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F 732	Continued From page 7 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732		

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F 732	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to post accurate daily nurse staffing information for 3 of 7 days reviewed. Findings included: An observation and interview with the Staffing Coordinator was conducted on 2/15/2024 at 1:39 pm and she stated she corrects the Posted Nurse Staffing forms from the previous day each morning when she arrives to work and when she arrives to work each Monday, she corrects the Posted Nurse Staffing forms for the previous weekend. She stated she was not aware of a staff member being assigned to correct the schedules each shift when the staff call out or there are changes to the schedule. The Staffing Coordinator reviewed a sample of 7 consecutive days, 1/1/2024 to 1/7/2024, of Posted Nurse Staffing forms and indicated the following: The 1/1/2024 Posted Nurse Staffing was reviewed with the Staffing Coordinator and the Posted Nurse Staffing form indicated the facility had 6 licensed nurses, but the Staffing Coordinator stated it should indicate the facility had 7 licensed nurses on the 7:00 am to 3:00 pm shift. The Staffing Coordinator also stated there were 7 licensed nurses on the first half of the 3:00 pm to 11:00 pm shift but the posted nurse staffing form indicated there were 6 licensed nurses. When the 1/2/2024 Posted Nurse Staffing form was reviewed with the Staffing Coordinator she stated the shift totals for licensed nurses was incorrect and should have been recorded as 6 instead of 5 on both the 7:00 am to 3:00 pm	F 732	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. F732 1. Corrective action for resident(s) affected by the alleged deficient practice: On 2/15/2024 the staffing sheet was updated to reflect accurate nurse staffing posting. No residents were identified as affected. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 3/5/2024 the staffing sheets were audited by the Administrator and Staffing Coordinator from 2/16/2024 through 3/4/2024 to ensure that daily nurse staffing postings reflected the correct daily census on each posting. The daily census was reviewed in PCC and compared to the staffing sheet. Corrections were made at the time of the audit by the Administrator. Completion date 3/5/2024.	

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F 732	Continued From page 9 shifts and the first half on the 3:00 pm to 11:00 pm shift. The Posted Nurse Staffing form was reviewed with the Staffing Coordinator for 1/7/2024 and she stated the Registered Nurse shift total incorrect for the 7:00 am to 3:00 pm shift and the first half of the 3:00 pm to 11:00 pm shift. She stated the form indicated there was a registered nurse on the 7:00 am to 3:00 pm shift and the first half of the 3:00 pm to 11:00 pm shift on 1/7/2024, but a Registered Nurse was not working during those shifts. The Administrator was interviewed on 2/15/2024 at 1:44 pm and she stated there is a supervisor assigned to each shift and they are responsible for the correction of the Post Nurse Staffing forms when there are call-outs by staff or any changes to the schedule. The Administrator stated the Payroll-Based Journal (PBJ) Staffing Data Report is not affected by the Posted Nurse Staffing because the facility's electronic software records the staff's hours worked each shift from the facility's time clock. She stated the Posted Nurse Staffing should be posted correctly by the supervisors.	F 732	3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/5/2024, the nurse consultant began educating the administrator, Director of Nurses and Nursing Scheduler on the requirement of the facility to document on the Daily Nurse Staffing Posting the current resident census each day. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any identified staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 3/8/2024. 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 administrator or designee will monitor compliance utilizing the F732 Quality Assurance Tool weekly for daily nursing staff postings that include the current resident census each day x 2 weeks then monthly x 3 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality	

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F 732	Continued From page 10	F 732	Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/8/2024	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure meal trays used to serve residents' meals were in good condition for 1 of 1 tray line observation. This practice had the potential for cross contamination of food from chipped and cracked meal trays.	F 812	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	3/8/24

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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 812	Continued From page 11 Findings included: During a visit to the kitchen on 2/14/24 at 12:45 p.m., 33 meal trays with chipped, rough edges were observed stacked on the meal tray line, ready for use, during the plating of meals prepared for the residents. The Dietary Manager was present for the observation and did not offer an explanation or comment why the chipped/rough edged meal trays were stacked on the trayline, ready for use by the residents receiving plated meals in their rooms. On 2/15/24 at 11:16 a.m. the Administrator acknowledged some of the meal trays were chipped with rough edges. She revealed that prior to this survey the facility ordered more meal trays.	F 812	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. F812 1. For dietary services, a corrective action was obtained on 2/14/2024. During visit of the kitchen on 2/14/2024, 33 meal trays had chipped, rough edges were observed stacked on the meal tray line ready for use, during the plating of meals prepared for the residents. On 2/14/2024 Dietary Manager and Senior Nutrition Service Coordinator discarded all items cited. 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 3/5/2024, the dietary services manager completed a 100% audit of all meal trays used to serve resident meals, to ensure that they were in good condition. Any items found to be chipped or with rough edges, were discarded. 3. Systemic changes In-service education was provided to all full time, part time, and as needed dietary	

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F 812	Continued From page 12	F 812	staff on 3/5/2024 by dietary services manager. Topics included: - All food items should be served in/on service ware in good condition. - Any service ware noted to be in poor condition should be removed from serviced and replaced - Inspections on each shift to review all service ware is in good condition. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director or assignee will monitor condition of service ware weekly x 5 weeks then monthly x 2 months using the Dietary QA Audit. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and 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, Health Information Manager, and the Dietary Manager Date of compliance: 3/8/2024	
F 814 SS=F	Dispose Garbage and Refuse Properly	F 814		3/8/24

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F 814	Continued From page 13 CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure the area surrounding 1 of 1 trash compactor remained free from garbage, refuse, and standing water. Findings included: During the initial tour of the facility on 2/12/24 at 10:00 a.m. a large trash compactor was observed outside, behind the facility. The area surrounding the trash compactor was littered with used plastic gloves, plastic cup lids, plastic straws, cardboard boxes, broken plastic pieces and pieces of plaster/tile. There were also 2 plastic trash barrels without lids, filled with trash less than three feet from the trash compactor. The follow-up observation on 2/14/24 at 1:10 p.m., revealed the area surrounding the trash compactor contained trash and debris scattered on the ground, including soiled plastic gloves, plastic cup lids, straws, face masks, and a broom lying in a pile of broken plaster. Also, behind the trash compactor, there was one uncovered trash barrel filled with trash and standing water. During an interview on 2/14/24 at 1:15 p.m., the Dietary Manager (DM) acknowledged the trash and debris surrounding the trash compactor needed cleaning. She revealed she was unsure which department was responsible for maintaining the trash compactor and its	F 814	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. F812 1. For dietary services, a corrective action was obtained on 2/14/2024. During visit of the kitchen on 2/14/2024, 33 meal trays had chipped, rough edges were observed stacked on the meal tray line ready for use, during the plating of meals prepared for the residents. On 2/14/2024 Dietary Manager and Senior Nutrition Service Coordinator discarded all items cited. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be	

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F 814	Continued From page 14 surrounding area. On 2/14/24 at 1:20 p.m., the Housekeeping Supervisor revealed the housekeeping floor technicians were responsible for maintaining the garbage disposal area, ensuring any trash/debris was removed from the ground. After observing the debris and trash surrounding the trash compactor, the Housekeeping Supervisor stated that the area would be cleaned immediately.	F 814	affected by the alleged deficient practice. On 3/5/2024, the dietary services manager completed a 100% audit of all meal trays used to serve resident meals, to ensure that they were in good condition. Any items found to be chipped or with rough edges, were discarded. 3. Systemic changes In-service education was provided to all full time, part time, and as needed dietary staff on 3/5/2024 by dietary services manager. Topics included: - All food items should be served in/on service ware in good condition. - Any service ware noted to be in poor condition should be removed from serviced and replaced - Inspections on each shift to review all service ware is in good condition. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director or assignee will monitor condition of service ware weekly x 5 weeks then monthly x 2 months using the Dietary QA Audit. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action	

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F 814	Continued From page 15	F 814	initiated as appropriate. Compliance will be monitored and 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, Health Information Manager, and the Dietary Manager Date of compliance: 3/8/2024	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.	F 867		3/5/24

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§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its

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performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

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F 867	Continued From page 18 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey completed on 6/14/21. This was for 2 deficiencies that were cited in the area of Food Procurement, Store/Prepare/Serve-Sanitary (F812) and Infection Prevention & Control (F880) that were cited on the recertification survey on 6/14/21 and then recited on the current recertification and complaint survey of 2/15/24. The continued failure of the facility during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This citation is cross referred to: F812: During the recertification survey on 2/15/24, the facility failed to ensure meal trays used to serve residents' meals were in good condition for 1 of 1 tray line observation. This practice had the potential for cross contamination of food from chipped and cracked meal trays. During the recertification survey on 6/14/21, the facility failed to sanitize dishware for meal service	F 867	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. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: On 3/5/2024, the Administrator educated the Quality Assurance Committee on how to sustain an overall effective Quality Assessment and Assurance (QAA) program, the purpose of the QA program, monitoring outcomes and identifying and maintaining desired results. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: Corrective action has been taken for the identified concerns in the areas of	

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F 867	Continued From page 19 by failing to ensure the wash and final rinse cycles of the dishwashing machine operated at accurate temperatures. Also, the facility failed to maintain sanitary conditions in the kitchen by not ensuring opened food items in the refrigeration/freezing units and dry storage areas were resealed, labeled, and dated; and by failing to ensure the food preparation areas, food storage areas, and food service equipment were maintained clean and free from debris. The facility also failed to ensure the food items stored in the snack/nourishment refrigerators in 2 of 2 residents' nourishment rooms were clean, and food items not provided by the facility were dated and labeled. These practices had the potential to affect food served to residents. F880: During the recertification survey on 2/15/24, the facility failed to follow the Centers for Disease Control and Prevention's (CDC) transmission-based precautions for 1 of 2 residents (Resident #93) reviewed for contact precautions. A nursing staff member, Nurse #2, entered Resident #93's room, who was on contact precautions, without the required Personal Protective Equipment (PPE) including gloves and a gown, she was observed to check the resident's blood pressure, touch the resident's clothing, touch the resident's bed linens, repositioned the resident's ventilator tubing, touched the side rails, and then proceeded to provide care to Resident #93's roommate (Resident # 58) without washing her hands or using hand sanitizer. Upon completion of providing care to Resident #93's roommate (Resident #58), Nurse #2 then exited the residents' room without washing her hands or using hand sanitizer.	F 867	deficiencies cited during the February 15th survey in which facility failed to maintain an effective QAPI program. The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 3/5/2024 to review the deficiencies from the February 12th-February 15th recertification and complaint survey and reviewed the citations. The QAPI citations included F812, and F880. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 3/5/2024 the administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Assistant Dir of Nursing, Staff Development Nurse, Minimum Data Set Coordinator, Therapy Manager, Activities Dir, Social Worker and the Environmental Service Dir on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies in the areas of F812 and F880. This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. 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	

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F 867	Continued From page 20 During the recertification survey on 6/14/21, the facility failed to ensure staff performed hand hygiene prior to entering a resident's room and after providing personal assistance to another resident during meal tray delivery in 2 of 2 observations of one staff member. During an interview on 2/15/24 at 3:15 PM with the facility's administrator. She stated that the QA members were made up of Administrator, the Director of Nursing, Dietary Manager, Business office manager, Maintenance Director, Social Worker, Activities Director, and Housekeeping Director. The Nurse Practitioner and the Medical Director were always invited to attend. She stated that she and the director of nursing were aware of the concerns regarding this survey and the repeat of several citations. She stated that all of the issues will be looked into, and a thorough plan of correction will be drawn up and implemented to ensure these citations would not be repeated again in the future.	F 867	work until training has been completed by 3/5/2024. 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. Starting on March 12, 2024 Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the accident process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Assistant Dir of Nursing, MDS Coordinator, Therapy Manager, Staff Development Coordinator. Activities Dir, Social Worker, and Environmental Services Dir. Date of Compliance: 3/5/2024	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		3/8/24

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F 880	Continued From page 21	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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F 880	Continued From page 22 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to follow their policy regarding transmission-based precautions for 1 of 2 residents (Resident #93) reviewed for contact precautions. A nursing staff member, Nurse #2, entered Resident #93's room, who was on contact precautions, without the required Personal Protective Equipment (PPE) including gloves and a gown, she was observed to check the resident's blood pressure, touch the resident's clothing, touch the resident's bed linens, repositioned the resident's ventilator tubing, touched the side rails, and then proceeded to provide care to Resident #93's roommate (Resident # 58) without washing her hands or	F 880	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 880	

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OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 880	Continued From page 23 using hand sanitizer. Upon completion of providing care to Resident #93's roommate (Resident #58), Nurse #2 then exited the residents' room without washing her hands or using hand sanitizer. Findings included: The facility's Infection Prevention and Control Standards Policy last reviewed 12/2023 indicated the facility's employees must adhere to all policy and procedures related to infection prevention, including standard and transmission-based precautions. The facility's Infection Prevention and Control Standards Policy further indicated contact precautions would be put into place if the route of transmission is not completely interrupted using standard precautions alone. The facility's Hand Hygiene Policy last reviewed 12/2023 indicated the facility's employees must practice hand hygiene when entering and leaving a resident's room and when providing resident care. A Physician's Order dated 2/9/2024. Resident #93 was on Contact Precautions for Extended Spectrum Beta-Lactamase (ESBL) a bacterium in her urine that was resistant to antibiotics. During an observation of Resident #93 on 2/12/2024 at 12:54 pm a contact precaution sign was noted on her door (which stated staff should wear a gown and gloves when entering the room and removed before exiting the room). Personal protective equipment (PPE), including gowns and gloves, were in a bin hanging from her door. Nurse #2 was observed to enter the room which was under contact precautions without donning a	F 880	The facility failed to implement their PPE policy for residents on contact precautions when staff did not don gloves and gown when entering the room of a resident on contact precautions. 1. How corrective action will be accomplished for those residents found to have been by the deficient practice: On 2/12/2024 corrective action was completed and the Director of Nursing educated the staff person on facility policy related to following the contact precaution sign directions and appropriate PPE utilization at all times when in resident rooms who are on contact precautions. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 2/12/2024 the Director of Nurses audited all resident rooms with precautions for staff compliance with wearing of the appropriate PPE. Results: No other breaches in practice observed. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: On 2/12/2024 the DON, and staff development coordinator-initiated education for all registered nurses, licensed practical nurses, certified nursing assistants, housekeeping staff including agency staff on: facility policy and	

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	345443	A. BUILDING _____ B. WING _____	C 02/15/2024

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F 880	Continued From page 24 gown nor donning gloves. The nurse proceeded to check Resident #93's blood pressure, touch the resident's clothing, touch the resident's bed linens, repositioned the resident's ventilator tubing, touched the side rails. Without washing her hands nor using hand sanitizer in between residents, Nurse #2 touched Resident #58's side rails, clothing, and bed linens, and repositioned her ventilator tubing. Nurse #2 then left the room without washing her hands or using hand sanitizer. Nurse #2 was interviewed on 2/12/2024 at 1:00 pm and stated she did not put on a gown or gloves on because Resident #93 had a catheter. She stated she thought she sanitized her hands after caring for Resident #93, but she realized now she did not. She stated she knew she should wash her hands or use hand sanitizer between residents when she was providing care. On 2/12/2024 at 1:17 pm Nurse #2 returned and stated Resident #93 no longer had a catheter and was on contact precautions because she had a bacterium in her urine that is resistant to antibiotics. She stated she should have put a gown and gloves on before entering Resident #93's room and removed the gown and gloves and washed her hands before providing care to Resident #58. Nurse #3 who was assigned to Resident #93 was interviewed on 2/14/2024 at 12:39 pm and she stated Resident #93 had been on contact precautions and an antibiotic since 2/9/2023. She stated the staff should wear gloves and a gown before going into the room and providing care to Resident #93. She stated they should also remove the gown and gloves and wash their	F 880	following precautions to include adhering to appropriate PPE utilization (PPE donning and doffing) in all special droplet contact precaution identified resident rooms at all times. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. On 2/12/2024 the ICP and implemented IC rounds to include appropriate PPE utilization for residents on all precautions. 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 observe 5 staff/agency per week for appropriate PPE utilization for those residents on contact precautions. Monitoring to be done weekly x 5 and monthly x 2 or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing 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 Quality Assurance Meeting is attended by the Administrator, Director of Nursing/Infection Control Preventionist,	

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F 880	Continued From page 25 hands before caring for Resident #93's roommate. On 2/14/2024 at 12:26 pm Unit Manager #1 was interviewed, and she stated Resident #93 was ventilator dependent and was put on contact precautions on 2/9/2023 when they received the culture and sensitivity for her urinalysis which showed Resident #93 had bacterium in her urine that was resistant to antibiotics. Unit Manager #1 stated staff should put on a gown and gloves before entering the room to provide care for Resident #93 and should remove the gown and gloves and wash their hands before providing care for her roommate. The Administrator was interviewed on 2/16/2024 at 2:57 pm and she stated Nurse #2 should have followed the guidelines Disease Control and Prevention's (CDC) guidelines for personal protective equipment should be used and for handwashing when providing care for Resident #93 who was on contact precautions.	F 880	Minimum Data Set Coordinator, Therapy, Health Information Manager and Dietary Manager. Compliance date 3/8/2024.	