**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/Clinic Identification Number:** 345443  
**Multiple Construction:**  
**Date Survey Completed:** C 06/21/2011

**Name of Provider or Supplier:** Oak Forest Health and Rehabilitation  
**Street Address, City, State, Zip Code:**  
5580 Windy Hill Drive  
Winston Salem, NC 27105

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID Prefix Tag</th>
<th>Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
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No deficiencies were cited as a result of the complaint investigation conducted on 06/21/11. Event ID OQLV11.

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**Laboratory Director's or Provider/Supplier Representative's Signature**

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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 patient. (See instructions.) Except for nursing homes, the findings stated above are discloseable 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 discloseable 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.