## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345443  

**Date Survey Completed:** 03/08/2022

### Name of Provider or Supplier

**Oak Forest Health and Rehabilitation**

**Street Address, City, State, Zip Code:** 5680 Windy Hill Drive, Winston Salem, NC 27105

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>Tag</th>
<th>Initial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td></td>
<td>A Complaint investigation survey was conducted from 03/07/22 through 03/08/22. Event ID# QZNJ11. The following intakes were investigated: NCOO185416, NCOO186172, and NCOO186274. 9 of the 9 complaint allegations were not substantiated.</td>
</tr>
</tbody>
</table>

### Provider's Plan of Correction

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.

**Laboratory Director's or Provider/Supplier Representative's Signature:** Electronically Signed  

**Date:** 03/24/2022

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