PRINTED: 12/03/2024 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI				С
		345443	B. WING _			11/	08/2024
NAME OF PR	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OAK EODI	EST HEALTH AND REHA	ARII ITATION		5	680 WINDY HILL DRIVE		
UAK FURI	EST HEALTH AND REHA	ABILITATION		٧	VINSTON SALEM, NC 27105		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
TAG	NEGOLATON ON	ESCIDENTIFY TING INFORMATION)	IAG		DEFICIENCY)	\IL	
F 000	INITIAL COMMENTS		F (000			
	Δ complaint investiga	ation survey was conducted			Past noncompliance: no plan of		
	from 11/5/24 through				correction required.		
	•	ing intake was investigated:			correction required.		
	NC00223689. One (1						
	allegations resulted ir	,					
	NC00223689 resulted	d in immediate jeopardy.					
	Past noncompliance	was identified at:					
	CFR 483.45 at tag F7	760 at a scope and severity J					
	3	, , ,					
	The tag F760 constitu	uted substandard quality of					
	care.						
	Noncompliance hega	n on 10/18/24. The facility					
		liance effective 10/23/24. A					
	partial extended surve						
F 658	•	eet Professional Standards	F	658			
SS=D	CFR(s): 483.21(b)(3)	(i)					
	§483.21(b)(3) Compre	ehensive Care Plans					
		d or arranged by the facility,					
		mprehensive care plan,					
	must-	•					
	(i) Meet professional	standards of quality.					
	This REQUIREMENT	is not met as evidenced					
	by:						
		iews, and interviews with			Past noncompliance: no plan of		
		ner (NP) and the Medical			correction required.		
		ailed to protect a resident					
		nedication errors for 1 of 3 r medication administration					
	(Resident #1).	i modication administration					
	(
	Findings included:						
	Resident #1 was adm	nitted to the facility on					
		to the lability off					
LABORATORY	DIDECTOR'S OF PROVINCE	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITI E		(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

11/26/2024

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.

Electronically Signed

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345443	B. WING _			C 11/08/2024
	ROVIDER OR SUPPLIER	HABILITATION		STREET ADDRESS, CITY, STATE, 2 5680 WINDY HILL DRIVE WINSTON SALEM, NC 2710		11700/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE EIENCY)	(X5) COMPLETION DATE
F 658		ge 1 oses including bipolar anxiety disorder, heart failure	F€	658		
	assessment dated s was moderately cog	erly Minimum Data Set (MDS) 0/2/24 revealed Resident #1 gnitively impaired.				
	Record (MAR) for C 10/18/24 at 9:58 AM prescribed medicati mg (milligrams), zol tablet, Anoro Ellipta asthma/COPD) 1 pi magnesium oxide 4 proscar 5 mg, vitam	uff, ferrous sulfate 325mg, 00 mg, multivitamin 1 tablet,				
	October 2024 revea metformin (anti-diak aspirin (nonsteroida medication) 81 million	gram (mg), Levocarnitine ent) 500 mg, Baclofen, 5 mg				
	dated 10/18/24 at 1 went to the common was seated. She ad name of [Resident # yes. Nurse #1 gave [Resident #1] include 81 mg, levocarnitine Nurse #1 realized the error, obtained the vero.	t, created by Nurse #1 and 2:40 PM, revealed Nurse #1 area, where [Resident #1] Idressed [Resident #1] by the #2], and [Resident #1] replied [Resident 2's] medications to ling metformin 500 mg, aspiring 500 mg, and baclofen 5 mg. The medication administration wital signs, which were within ee #1 called the Unit Manager,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345443	B. WING	_			00/2024
NAME OF P	ROVIDER OR SUPPLIER	040440	3	s	TREET ADDRESS, CITY, STATE, ZIP CODE	11/0	08/2024
	EST HEALTH AND REHA	ABILITATION		5	680 WINDY HILL DRIVE VINSTON SALEM, NC 27105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	During a phone interval Nurse #1 indicated slade 10/18/24 was her secondary between 9:00 AM and Resident #1 his present and at approximately medications for Resident #2's name as which she felt the resent Resident #1. Nurse #1 medications to returned to her medications to immediately called the assessed Resident #1 distress and his vital limits. Nurse #1 notified (NP #1) and Residen order to check the resent hours, monitor for hyppressure), bradycard provider of any abnorn the medication admir during the shift change. The nurses' note date indicated Nurse #1 readministration error for Practitioner (NP) #1 and Residen (NP) #1 and	view on 11/5/24 at 10:10 AM the was an agency nurse and cond time in the facility. In administration on 10/18/24 Id 10:00 AM she gave cribed morning medications. In the morning medication pass I1:00 AM she prepared dent #2. Nurse #1 went to deaddressed Resident #1 by and the resident replied yes, ponse indicated he was refugave Resident 2's ent #1. When Nurse #1 reation administration cart to red she accidently gave the resident was not in signs were within normal red the Nurse Practitioner to the Nurse Practitioner to the Nurse Practitioner to the Nurse with the signs every four potension (low blood its (low heart rate), and notify mal results. She reported histration error to Nurse #2 ge report. The resident #1 to Nurse and NP #1 provided new signs every four hours for	F	658			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345443	B. WING _			C 11/08/2024
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 271		11700/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIAT ICIENCY)	
F 658	#5 (Unit Manager) refrom Nurse #1 on 10 accidentally administ medications to Resid together with Nurse # distress, seated in be The resident's vital silimits: BP 112/52, purespirations 17 breat notified the Nurse Pr. NP ordered to check four hours and report On 11/5/24 at 1:50 P conducted with Nurse #1 indicated on 10/18 medication administrathe time of the report with no distress and vital signs every four monitoring for hypote #1 did not expect a langative effect, or chato the resident having medications. NP #1 sesident #1 the next On 11/6/24 at 11:20 vinterview, the Medications administration plan for identification plan for identification plan for identification plan for identifications administration plan for identification plan for identification plan for identifications administration plan for identification plan for identifications administration plan for identification plan for identifications administration plan for identification plan for identifica	AM and interview with Nurse vealed she received report /18/24 at 12:30 PM about ering Resident #2's lent #1. Upon assessment #1, the resident was not in ed, and stated he was fine. Igns were within normal ise 63 beats per minute, and he per minute. Nurse #1 actitioner (NP) and family. resident's vital signs every at the abnormalities. M a phone interview was a Practitioner (NP) #1. NP 8/24 she was informed of the ation error by Nurse #1. At a Resident #1 was stable, NP #1 ordered to check his hours with continued ension and bradycardia. NP ong-term systemic (overall) langes in mental status due of received the wrong stated had planned to assess day (10/19/24). AM, during the phone all Director indicated that he emedication administration or Resident #1. He did not ome from the non-significant	F	358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X*		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345443	B. WING			· ·	08/2024
	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE 680 WINDY HILL DRIVE VINSTON SALEM, NC 27105	<u> 1170</u>	00/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	deficient practice. On Nursing (DON) identify potentially impacted by completing a 100% (palert and oriented ressor mental status (BIM (indicating the resider ensure there were not administration. This was the results included: medication orders have medication administration. This was the results included: medication administration administration. This was the results included: medication orders have medication administration. This was the results included: medication administration. This was the results included: medication administration. The results included and the status of the residents with not included and the pool of the poo	otential to be affected by the 10/18/24 the Director of fied residents that were by this practice by percent) audit on all current idents with brief interviews (1s) of 13 or greater at was interviewable) to issues with medication was completed on 10/18/24. 100 of 100 residents with dono concerns with ation. Audit was completed by the (ADON), and Unit everbal, non-alert residents were to ensure there were notication administration. This has or symptoms related to increased confusion, or so the results included: 48 to signs or symptoms, which is issues related to a possible diministration. On 10/18/24 docorrective action for those ded: no corrective action for those ded:	F	658			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		COMPLE	(X3) DATE SURVEY COMPLETED			
		345443	B. WING		C	10004
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	11/08	/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 658	reports for the last 1 medication errors. Treports were related Education: On 10/18 Clinician (SDC) began Nurses (RNs), Licen and medication aide Preventing Medication included all current straining included: Following the 6 right administration The right person The right medication. The right dose The right dose The right documentation The right documentation The right documentation The right documentation above identified staff in-service training by allowed to work until This education will be new hire and agency RNs, LPNs, and med Assistant DON, unit monitor medication aweekly for 2 weeks a using the Quality Assing the Quality A	No reviewed all incident 4 days to identify any recent the results: 0 of 8 incident to medication errors. /24, the Staff Development an in-servicing all Registered sed Practical Nurses (LPNs), s., (including agency) on on Error policy. This training staff including agency. This is of medication In gensured that any of the fewho did not complete the result of the training was completed. The endication aids of the endication aids. The DON, managers, and SDC, will administration passes 3 times and monthly for 3 months for surance (QA) monitoring tool ports will be presented to the end by the Administrator or one ensure corrective action is ate. Compliance will be	F 6	58		

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	ROVIDER OR SUPPLIER EST HEALTH AND REHA	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	E	•••		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE	
F 658	Manager. On 10/18/2 initiate this into the QQA. The completion date 10/23/24 On 11/8/24, the facility was validated on-site observations, and intwith a sample of residence their prescribed medimedication administration of more identification aides were the rights of medication aides were the rights of medication aides were the rights of medication aides were required to comprights of medication afacility's new process administration. Review of the in-serving medication administration administr	anagement, and the Dietary 4 the decision was made to A process and to review it in of the corrective action plan: y's corrective action plan by record review, erviews. Individual interviews dents revealed they received cations without concern. A ation observation was 1. The observation consisted nedications for 3 different s. The nurses and the e observed implementing on administration before dications from start to finish. entified. Interviews with cation aides revealed they plete in-services for the 5 administration and the for medication ice documents dated 4 noted the DON completed	F 6	·				
	provided to Nurse #1 medication aides that medication error, as v	hat the in-services were and all other nurses and had not worked since the well as to any new nurses before they were allowed to						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345443	B. WING _			l '	08/ 2024
	ROVIDER OR SUPPLIER EST HEALTH AND REHA	ABILITATION		568	REET ADDRESS, CITY, STATE, ZIP CODE 80 WINDY HILL DRIVE INSTON SALEM, NC 27105		
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F 658	Continued From page administer medication The corrective action 10/23/24 was validate	ns. plan's completion date of	F 6	658			
F 760 SS=J	CFR(s): 483.45(f)(2) The facility must ensure \$483.45(f)(2) Resider medication errors. This REQUIREMENT by: Based on record reviresident, staff, Nurse Medical Director, the resident from a signifi on 10/18/24, Nurse # administered the wror #1. On 10/18/24, Nurse # administered the wror morning administered medication promorning administered Resident #2 to Resident #2 to Reside administered medication administered (anticonvulsant medical (anticonvulsant medical (antidepressant me	is not met as evidenced dews, interviews with Practitioner (NP), and facility failed to protect a decant medication error when 1, an agency nurse, and medications to Resident arese #1 administered bed medications during the deass and then later in the defined medications prescribed for ent #1. The wrongly decions included olanzapine detion), lamotrigine deation), gabapentin deation), paroxetine deation), nand clonazepam deation), nand clonazepam deation). Nurse #1 identified the detion error to Resident 1's deterventions were put into desident. On 10/19/24, lethargic, he was sent to the	F 7	760	Past noncompliance: no plan of correction required.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION		E SURVEY PLETED
		345443	B. WING		44	C / 08/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	, ,	106/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 760	responses, was not for was unable to provide admitted to the hospitincluded acute kidney diagnoses including responses included and was documented discharge. This deficit of 3 residents reviews errors (Resident #1). The findings included Resident #1 was admit 2/19/24, with diagnost disorder, dementia, a and chronic kidney disorder resident received ant antianxiety and antibit assessment period. The plan of care for Findicated the risk for a psychotropic and antiwith interventions to provide to the provider. The prescribed morning physician's orders for physicia	collowing commands, and a cany information. He was tal with diagnoses which injury, differential nedication side effects, aired intravenous fluid ent #1 was discharged from er nursing home on 10/24/24 to be at his baseline upon ent practice was found for 1 ed for significant medication : contitled to the facility on es including bipolar esease. Ity Minimum Data Set (MDS) (2/24, revealed Resident #1 itively impaired. The ipsychotic, antidepressant, otic medications during the esease defects of depressant medications, provide treatment according monitor behavior, cts, and report the changes and medications per Resident #1 included: otic) 25 mg and sertraline	F 76			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION S	(X3) DATE SI COMPLE	
		345443	B. WING		C	2/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	11/08	3/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 760	Administration Recondocumented on 10/18 received his prescribe quetiapine 25 mg and The October 2024 promedications per the prescribe quetiapine 25 mg and The October 2024 promedications per the prescribe quetiapine 25 mg and The October 2024 promedications per the prescribe quetiapine 20 medications: Olanzapine 20 medication), lamotrig medication), gabaper medication), paroxeti medication), and cloral (antianxiety medication) and cloral (antianxiety medication) was seated. She add name of [Resident #2] went to the common was seated. She add name of [Resident #1]. Nurse which were within not 112/52 (normal blood pulse 65 beats per min 17 breath per minute 12-18 breaths per minute 12-18 b	d (MAR) for October 2024 B/24 at 9:58 AM, Resident #1 ed medications, including d sertraline 25 mg. escribed morning ohysician's orders for the following significant bine 10 mg (antipsychotic ine 100 mg (anticonvulsant of 100 mg (anticonvulsant of 100 mg (antipsychotic ine 20 mg (antipsychotic ine 100 mg (antipsychotic ine 10 mg (antip	F 76			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZI 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	P CODE	11/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD B O THE APPROPRIA	DATE
F 760	On 10/18/24 at 3:51 pressure (BP) becar to NP #1, who order saline (intravenous smilliliter (ml) per hour pressure). Review of physician' PM for Resident #1 saline at the rate of shypotension. The Medication Adm reflected the order for on 10/18/24 and document of the deciral properties on 10/18/24 was her sepuring the medication between 9:00 AM ar Resident #1 his pressures #1 continued and at approximately medications for Resident #2's name which she felt the reservance in the common area ar Resident #1. Nurse is medications to Resident #1. Nurse is medications to Resident would be resident to her medications to Resident to Nurse is nurse in Nurse is nurse in Nurse is	PM, Resident 1's blood ne low. Nurse #1 reported it ed one Liter (L) of normal colution) at the rate of 100 or for hypotension (low blood so orders on 10/18/24 at 3:51 revealed one L of normal 100 ml per hour for sinistration Record (MAR) or the normalsSaline solution numented it was completed. View on 11/5/24 at 10:10 AM he was an agency nurse and cond time in the facility. In administration on 10/18/24 dt 10:00 AM she gave cribed morning medications. The morning medication pass of 11:00 AM she prepared dent #2. Nurse #1 went to dt addressed Resident #1 by and the resident replied yes, sponse indicated he was #1 gave Resident 2's lent #1. When Nurse #1 cation administration cart to	F 7		ENCY)	
	wrong medications to immediately called the assessed Resident # distress and his vital	ted she accidently gave the conference of Resident#1. Nurse #1 are Unit Manager and #1. The resident was not in signs were within normal ied the Nurse Practitioner				

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		, ,	(X3) DATE SURVEY COMPLETED	
		345443	B. WING _		1	C 1/08/2024	
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105		1/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 760	order to check the rehours, monitor for hypressure), bradycard provider of any abnormal approximately one high the provider of any abnormal saline intraverse as the end of Nurse and reto the end of Nurse are ported the medical Nurse and the medical Nurse and the end of Nurse are ported the medical Nurse and the end of Nurse are ported the medical Nurse and the end of Nurse are ported the medical Nurse and the end of Nurse and the end of Nurse and the end of Nurse are ported the medical Nurse and the end of N	ant #1's family. NP #1 gave an esident's vital signs every four repotension (low blood dia (low heart rate), and notify armal results. After our of monitoring, Resident (BP) became low (98/51). She reported the low BP to the new order for one L of enously, at the rate of 100 ml maion. Resident #1 was mained with stable vital signs #1's shift at 7:00 PM. She tion administration error to shift change report. MM, during an interview, worked on 10/18/24 first shift 1), indicated Resident #1 was a needs known, was walking morning, and resting in bed de #1 mentioned that andered around the facility d to have a rest in his bed de #1 was aware the resident ications on 10/18/24, and check his vital signs several t. AM and interview with Nurse evealed she received report 1/18/24 at 12:30 PM about	F 7	60			

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		345443	B. WING _		C 11/08/2024
NAME OF PROVIDER OR SUPPLIER OAK FOREST HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CO 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (((EACH CORRECTIVE ACTIVE ACTI	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 760	by Nurse #1 and the fluids of one liter of not 100 ml per hour. Nurse fluids on Resident #1 bed, his vital signs state appeared to be in state Manager observed the 4:00 PM when she found had a BP 120/70 Review of the nurses documented at 12:53 notified NP #2 about condition, including a consciousness. Nurse resident was lying in had limited response an order to send Reshospital evaluation. On 11/5/24 at 10:45 A interview, Nurse #2 in PM, she received shir #1, who informed her administration error for stated usually, Reside around and talking. Not the monitoring, the resigns, however he was response to stimulating approximately 1:00 A Resident #1's altered received an order to semergency Department.	A Resident #1's blood (98/61). NP #1 was notified NP ordered intravenous ormal saline at the rate of se #1 started the intravenous . The resident remained in abilized and overall he ble condition. The Unit e resident approximately at und he was in bed, sleepy, . I notes, dated 10/19/24, AM, revealed Nurse #2 Resident 1's changes in litered level of e #2 documented the bed with eyes closed and to stimulation. NP #2 gave ident #1 to the hospital for AM, during a phone idicated on 10/18/24 at 7:00 ft change report from Nurse about the medication or Resident #1. Nurse #2 ent #1 was wandering Nurse #2 explained during sident had normal vital as sleepy with limited on. On 10/19/24 at M Nurse #2 communicated mental status to NP #2, and send Resident #1 to the ent (ED) for evaluation. The ing home via Emergency	F 7	760	

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NAME OF PROVIDER OR SUPPLIER OAK FOREST HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105		·			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 760	revealed at 12:56 AM Resident #1 to addre mental status after a medications. Nurse is she noticed the char behavior: he was am at baseline, but this did not eat or speak Resident #1 was abl delayed responses a during the conversat intravenous catheter just finished an intra At 12:56 AM his vita pulse 88 beats per n per minute, and oxyg oxygen saturation ra EMS took the reside Review of the hospit 1:55 AM, revealed R via EMS with chief of status. Per nursing h 9:00 AM, the resider wrong medications, alert/responsive, and the resident present he was not following blood pressure of 14 suggested a Urinary Resident #1 was add unit of the hospital for therapy, hydration, a including medication On 11/5/24 at 1:50 F conducted with Nurs	the port dated 10/19/24 If the EMS team arrived at the ess the resident's altered diministration of the wrong the incomplete in the policy informed the EMS team ages in Resident #1's abulatory and more talkative shift he remained in bed and much. Upon assessment, the to answer questions with and kept his eyes closed ion. He had the right forearm in place. The staff stated he wenous fluid administration. It signs were BP 162/104, aninute, respirations 14 breath agen saturation 98% (normal age is 95-100%) on room air. Into the ED. The staff on 10/19/24 at the esident #1 arrived at the ED complaint of altered mental and accidently received multiple became less at more confused. In the ED, and with "mumble" responses, commands, had an elevated	F 7				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345443	B. WING		C 11/08/2024	
NAME OF PROVIDER OR SUPPLIER OAK FOREST HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	11/00/2024		
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F 760	the time of the report with no distress and invital signs every four monitoring for hypote #1 did not expect a langative effect, or chook to the resident having medications. She exproncerned about the pressure becoming language PM the nursing staff in (98/61) for Resident #1 ordered intravenous in monitoring vital signs rate, and planned to a 10/19/24. During a phone intervate Medical Director in (could not recall the emedication administrate The Medical Director error with the NP #1 (date), who communite at the facility on 10/18 agreed with the order and hospital evaluation medications were additional to the single doses of with medical Director the single doses of with medications, he was negative outcome for On 11/5/24 at 11:55 A Director of Nursing (Ethe nurses and medication and in the facility of medication and m	Resident #1 was stable, NP #1 ordered to check his hours with continued insion and bradycardia. NP ong-term systemic (overall) anges in mental status due in received the wrong plained she was more possibility of his blood ow. At approximatelly 3:00 reported low blood pressure in the fluid administration, for hypotension, low heart eassess Resident #1 on write word in the pation error for Resident #1. Indiscussed the medication (could not recall the exact cated with the nursing staff in after the wrong ministered to Residnet #1. Indiscussed that considering rongly admininstared not worried about a potential Resident #1.	F 76			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		345443	B. WING _			C 11/08/2024
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F 760	Continued From pag	•	F 7	60		
	residents prior to me an agency nurse, w	tion), and identify the edication pass. Nurse #1 was ho recently started to work in not know the residents.				
	-	strator was notified of y on 11/5/24 at 3:30 pm.				
	The facility impleme action plan:	nted the following corrective				
	medication had the deficient practice. O Nursing (DON) iden potentially impacted completing a 100% alert and oriented refor mental status (B (indicating the residensure there were nadministration. This	(percent) audit on all current esidents with brief interviews IMs) of 13 or greater ent was interviewable) to so issues with medication was completed on 10/18/24. It 100 of 100 residents with ad no concerns with				
	DON, Assistant DOI Managers, on all no with BIMS of 12 or le issues related to me audit consisted of si change in condition, mental status change of 48 residents with were felt may indicate error in medication at the DON implement	r audit was completed by the N (ADON), and Unit n-verbal, non-alert residents ower to ensure there were no edication administration. This gns or symptoms related to increased confusion, or ges. The results included: 48 no signs or symptoms, which te issues related to a possible administration. On 10/18/24 ed corrective action for those uded: no corrective action				

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F 760	and Staff Developme interviewing nurses a med pass observation medication errors. The Registered Nurses (F. Nurses (LPNs), and rerrors including giving resident. On 10/18/24 The DO reports for the last 14 medication errors. The reports were related to Education: On 10/18/Clinician (SDC) began Nurses (RNs), Licens and medication aides Preventing Medication included all current station training included: Following the 6 rights administration. The right medication The right dose The right dose The right documentat. The Director of Nursing above identified staff in-service training by allowed to work until the document of the right down and the right down and the right documentat.	N, ADON, unit managers, and Coordinator (SDC) began and medication aids during as on if they had performed a results: 46 of 46 and aids denied medication as medications to the wrong and medications to the wrong and including and aids denied medication as medications to the wrong and includent and aids denied and aids denied medication as medication errors. 24, the Staff Development and in-servicing all Registered and Practical Nurses (LPNs), (including agency) on an Error policy. This training aff including agency. This affind including agency. This affind including agency affind the who did not complete the 10/22/24 would not be the training was completed. It is ongoing and included in our orientation packet for all	F 76			

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F 760	Continued From page		F 7	60			
	SDC, will monitor me passes 3 times week for 3 months for using (QA) monitoring tool I be presented to the w Administrator or Directorrective action is in Compliance will be mauditing program revi Meeting. The weekly the Administrator, DC Coordinator, Therapy Management, and the 10/18/24 the decision into the QA process at IJ Removal Date: 10/18/24, the facilit was validated on-site observations, and into with a sample of residential medication administration of monitorial conducted on 11/8/24 of administration of monitorial medication aides were the rights of medication aides were the rights of medication were required to complete to the complete the medication and the medication and the medication aides were required to complete the rights of medication aides were required to complete the required to complete the required to complete the residents and the medication aides were required to complete the residents and the medication aides were required to complete the residents and the medication aides were required to complete the residents and the medication aides were required to complete the residents and the medication aides were required to complete the residents and the medication aides were required to complete the residents and the medication aides were required to complete the residents and the medication aides were required to complete the residents and the residents are residents.	e Dietary Manager. On a was made to initiate this and to review it in QA. 23/24 y's corrective action plan by record review, erviews. Individual interviews dents revealed they received cations without concern. A ation observation was at the observation consisted redications for 3 different and the e observed implementing on administration before dications from start to finish. Entified. Interviews with cation aides revealed they plete in-services for the 6					
	rights of medication a facility's new process administration. Record review of the						

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F 760	10/18/24, 10/19/24 a completed the in-per rights of medication and facility's new process administration with the that the in-services wand all other nurses had not worked since well as to any new numberore they were allowedications.	and 10/22/24 noted the DON reson in-services for the 6 administration and the services and medication aides. DON on 11/8/24 revealed were provided to Nurse #1 and medication aides that the the medication error, as urses and medication aides owed to administer	F7	760			