

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Oak Forest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5680 Windy Hill Drive Winston Salem, NC 27105	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to allow residents who had been assessed as a safe independent smoker the choice to smoke unsupervised for 2 of 3 residents reviewed for choices (Resident #114 and Resident #117).</p> <p>The findings included:</p> <p>Review of Policy Title: Smoking Agreement signed and dated 12/23/24 by Resident #114 stated independent smoker may smoke in designated areas when they would like to smoke. They must also adhere to the rules as outlined.</p> <p>1. Resident #114 was admitted to the facility on [DATE] with diagnoses which included tobacco use.</p> <p>Review of Resident #114's quarterly Minimum Data Set (MDS) dated [DATE] revealed his cognition was intact.</p> <p>Review of Resident #114's care plan revised on 04/04/25 revealed Resident #114 was at risk for injuries related to the preference of smoking. The goal was Resident #114's smoking related injuries would be minimized.</p> <p>Review of Resident #114's quarterly smoking assessment dated [DATE] revealed Resident #114 was able to hold the cigarette safely without a device, extinguish cigarette safely, and ambulate independently. Resident #114 was assessed as able to smoke safely independently.</p> <p>An observation conducted on 05/20/25 at 12:30 PM revealed the designated smoking area door posted a sign that stated smoking was allowed from 8:00 AM- 8:00 PM daily.</p> <p>Observation and interview conducted with Resident #114 on 05/20/25 at 2:00 PM revealed Resident #114 was outside in the designated smoking area smoking independently. Resident #114 stated he was upset that times had been put in place and independent smokers were unable to smoke after 8:00 PM. Resident #114 stated he preferred to smoke independently in the evenings after 8:00 PM.</p> <p>An interview conducted with Nurse Aide (NA) #5 on 05/21/25 at 12:10 PM revealed she worked both 1st and 2nd shift. NA #5 stated multiple residents that smoked had complained that they were not able to smoke after 8:00 PM. NA #5 indicated Resident #114 had complained to her. NA #5 indicated she had spoken to multiple nursing staff before and told them that residents were upset.</p> <p>(continued on next page)</p>

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	TITLE	(X6) DATE
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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview conducted with the Director of Nursing (DON) and Administrator on 05/21/25 at 3:40 PM revealed Resident #117 was an independent smoker. The DON and Administrator stated they had not had any complaints from residents having to smoke at assigned times. It was indicated the assign times were implemented several months back and was a decision made by department heads.</p> <p>2. Resident #117 was originally admitted to the facility on [DATE] with diagnoses which included tobacco use.</p> <p>Review of Resident #117's annual MDS dated [DATE] revealed his cognition was intact and was coded for tobacco use.</p> <p>Review of Resident #117's care plan revised on 03/18/25 revealed Resident #117 was at risk for injuries related to the preference of smoking. The goal was Resident #117's smoking related injuries would be minimized.</p> <p>Review of Resident #117's quarterly smoking assessment dated [DATE] revealed Resident #117 was able to hold the cigarette safely without a device, extinguish cigarette safely, and ambulate independently. Resident #117 was assessed as able to smoke safely independently.</p> <p>Observation conducted on 05/20/25 at 12:30 PM revealed on the door going out to the designated smoking area revealed smoking was allowed from 8:00 AM- 8:00 PM daily.</p> <p>Observation and interview conducted with Resident #117 on 05/20/25 at 2:00 PM revealed Resident #117 was outside in the designated smoking area smoking independently. Resident #117 stated he was upset that times had been put in place and independent smokers were unable to smoke after 8:00 PM. Resident #117 stated he used to be able to go out anytime to smoke and liked to smoke before 8:00 AM and after 8:00 PM.</p> <p>An interview conducted with Nurse Aide (NA) #5 on 05/21/25 at 12:10 PM revealed she worked both 1st and 2nd shift. NA #5 stated multiple residents that smoked had complained that they were not able to smoke after 8:00 PM. NA #5 indicated Resident #117 had complained to her. NA #5 indicated she had spoken to multiple nursing staff before and told them that residents were upset.</p> <p>An interview conducted with the Director of Nursing (DON) and Administrator on 05/21/25 at 3:40 PM revealed Resident #117 was an independent smoker. The DON and Administrator stated they had not had any complaints from residents having to smoke at assigned times. It was indicated the assign times were implemented several months back and was a decision made by department heads.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and staff, Pharmacy Consultant and Medical Director interviews, the facility failed to protect the resident's right to be free from misappropriation of narcotic medications (Oxycodone) for 2 of 3 residents reviewed for misappropriation of property (Resident #2 and Resident #3).</p> <p>The findings included:</p> <p>a. Resident #2 was admitted to the facility on [DATE] with diagnoses that included chronic pain.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] indicated she was moderately cognitively impaired and received opioid medications.</p> <p>Physician's orders for Resident #2 revealed an order dated 5/28/25 for Oxycodone 5 milligrams (mg) every 8 hours by mouth as needed (PRN) for pain.</p> <p>Resident #2's Medication Administration Record (MAR) for May 2025 revealed that from 7:00 PM on 5/28/25 to 7:00 AM on 5/29/25, Resident #2 did not report pain and did not receive PRN Oxycodone.</p> <p>b. Resident #3 was admitted to the facility on [DATE] with diagnoses that included chronic pain.</p> <p>The admission MDS assessment dated [DATE] indicated she was moderately cognitively impaired and received opioid medications.</p> <p>Physician's order for Resident #3 revealed an order dated 5/8/25 for Oxycodone 5 mg every 8 hours via feeding tube for pain.</p> <p>Resident #3's MAR for May 2025 revealed that Nurse #5 administered 5 mg of Oxycodone tablet on 5/29/25 at 6:00 AM.</p> <p>The controlled drug form revealed Nurse #5 signed out Oxycodone 5 mg for Resident #3 on 5/29/25 at 6:00 AM.</p> <p>The Initial Allegation Report submitted to the State by the Administrator on 5/29/25 at 11:10 AM revealed an allegation of misappropriation of property was made on 5/29/25 when narcotic discrepancies were found on two residents (Resident #2 and Resident #3) narcotic records involving Nurse #5.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Investigation Report completed by the Administrator on 6/5/25 revealed that on 5/29/25 at 10:30 AM during the audit of narcotic process the Director of Nursing (DON) found that two cards of narcotics and the second page of Narcotic Count Sheet were missing from the C-100 hall medication administration cart: Oxycodone 5 mg tablets (30 tablets for Resident #2 and 54 tablets for Resident #3, 84 total). The DON initiated an investigation, suspended Nurse #5 who was assigned for C-100 hall medication administration cart from 7:00 PM on 5/28/25 to 7:00 AM on 5/29/25, and notified the Medical Director, Law Enforcement, the State, Adult Protective Service (APS), Drug Enforcement Administration (DEA), the Administrator, and Pharmacy. The DON conducted an interview with Nurse #5 who indicated that she counted narcotics during the shift change report with another nurse at the beginning and the end of her shift, and did not realize that two cards of narcotics were missing. The administration interviewed all the RN's, LPN's and Medication Aides, who had work on that specific medication cart, and there were no concerns related to Resident #2's and Resident #3's Oxycodone, and no suspicious behavior or narcotic discrepancies reported. All the staff members who worked on C-100 medication administration cart were sent for urine drug screens with negative results. Law Enforcement did not have charges related to the allegation and did not investigate further.</p> <p>On 6/11/25 at 10:30 AM during an interview, the DON indicated that the discrepancy with the narcotic count for the C-100 medication administration cart was discovered the morning of 5/29/25. She reported that during the narcotic process audit, the DON noted that on C-100 hall, two narcotic cards (30 tablets for Resident #2 and 54 tablets for Resident #3, 84 total) and the second page of the Narcotic Count Sheets were missing from the medication administration cart. The investigation started immediately and Nurse #5, the last nurse, assigned for this cart, was suspended. All medication carts were audited, and no additional missing narcotics were found. Nursing staff conducted pain assessments for all residents, including Residents #2 and #3, and no issues with pain on that shift were reported. Urine drug screen tests were conducted for all the staff who worked on C-100 hall medication administration cart with negative results. The DON interviewed Nurse #6 and Nurse #5, the outgoing and one oncoming nurses for 5/28/25 second shift, who reported no narcotic discrepancy. The DON notified the Medical Director, Law Enforcement, State, APS, DEA, the Administrator, and Pharmacy. The DON reviewed the facility cameras in the C-100 hall area, including the medication administration cart area. On 5/29/25, multiple employees were observed walking past the medication cart, but nobody had touched the medication cart, and no other suspicious behavior was noted. The pharmacy requested to bill the missing medications to the facility. The DON stated that two nurses were responsible for completion of the narcotic count at the change of shifts: one outgoing and one oncoming nurse. She further stated any discrepancy found must be reported immediately and an investigation would be started.</p> <p>On 6/11/25 at 2:45 PM during a phone interview, Nurse #7 indicated that she worked on 5/29/25 from 7:00 AM to 7:00 PM and received the change of shift report from Nurse #5 at 7:30 AM. Nurse #5 did not report a narcotic discrepancy. Nurse #7 indicated Both nurses counted the narcotics on C-100 hall medication administration cart, signed the narcotic book and did not see a problem. A couple of hours later, the DON notified her about two missing narcotic cards from the same medication administration cart. Nurse #7 did not know how the narcotics were lost.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/11/25 at 10:40 AM during a phone interview Nurse #5 indicated that from 7:00 PM on 5/28/25 to 7:00 AM on 5/29/25 she was assigned to C-100 hall medication administration cart. Nurse #5 stated that on 5/28/25 at 7:00 PM, she received the shift change report from Nurse #6 and the narcotic count was correct. On 5/29/25 at 7:30 AM, she gave the shift change report to Nurse #7 (agency) and did not find the discrepancy. After an hour and a half, the DON notified Nurse #5 that during the narcotic process audit, it was discovered that two Oxycodone tablets cards were missing from C-100 hall medication administration cart. Nurse #5 reported that during her shift, Resident #3 received her scheduled Oxycodone 5 mg at 6:00 AM, and Resident #2 did not require as needed pain medication. Nurse #5 confirmed that she did not leave the narcotic keys unattended and did not know how the narcotic loss occurred. Law Enforcement did not contact her in regards to missing narcotics.</p> <p>On 6/12/25 at 8:50 AM during a phone interview, Nurse #6 indicated that on 5/28/25 from 7:00 AM to 7:00 PM, she was assigned to C-100 hall medication administration cart. At the end of her shift, she reconciled the narcotics with the upcoming nurse, Nurse #5, and the count was correct. There was no problem with narcotics during her shift. She became aware of missing narcotics from the C-100 hall medication administration cart the next day (5/29/25).</p> <p>On 6/11/25 at 3:30 PM during a phone interview, the Pharmacist indicated that the pharmacy was notified of the missing narcotic cards by the DON, and helped the facility report the diversion to the DEA. She stated that the Pharmacy Consultant regularly performed monthly random narcotic audits of the medication carts, medication rooms, and did not report issues or concerns before or after this incident.</p> <p>On 6/12/25 at 10:00 AM during a phone interview, the Medical Director indicated that he was notified about the missing narcotics. He asked the staff to assess the residents for the pain. The staff reported that on 5/29/25, Resident #2 did not need her PRN narcotic, and Resident #3 received Oxycodone according to the order.</p> <p>On 6/12/25 at 10:30 AM during a phone interview, the Administrator indicated that her expectation was for the nursing staff to keep the narcotic drawer and medication cart locked at all times when not in use, medication cart keys on nurses at all times, for nursing staff to count narcotics on the cart each shift, and both ongoing and oncoming staff sign off the narcotic count was completed and was correct. The Administrator stated that the allegation of misappropriation of resident property was not substantiated because the investigation was unable to identify how the medications were missing.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interviews, the facility failed to develop and implement care plan interventions for 2 of 5 residents reviewed for smoking (Resident #30 and Resident #159).</p> <p>The findings included:</p> <p>1. Resident #30 was admitted to the facility on [DATE] with diagnoses which included hypertension and nicotine dependence.</p> <p>Review of Resident #30's most current smoking assessment was dated 04/29/25.</p> <p>Review of Resident #30's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #30 was cognitively intact and required limited assistance with activities of daily living (ADL).</p> <p>Review of Resident #30's care plan revealed no goals or interventions regarding Resident #30's smoking.</p> <p>Observation and interview conducted with Resident #30 on 05/20/25 at 2:00 PM revealed Resident #30 smoking independently. Resident #30 indicated he had been smoking since admission.</p> <p>An interview conducted with MDS Coordinator #1 on 05/21/25 at 3:20 PM revealed she was not aware Resident #30 had not been care planned for smoking. MDS Coordinator #1 stated through record review and communication with nursing staff Resident #30 should have been care planned for smoking.</p> <p>An interview conducted with the Director of Nursing (DON) and Administrator on 05/21/25 at 3:20 PM revealed Resident #30 smoked independently but they were not aware the resident had not been cared planned for smoking. The interview further revealed all residents that smoked were expected to be care planned for goals and interventions.</p> <p>2. Resident #159 was admitted to the facility on [DATE] with diagnoses which included hypertension and nicotine dependence.</p> <p>Review of Resident #159's admission Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact and required extensive assistance for ADL.</p> <p>Review of Resident #159's care plan revealed no goals or interventions regarding smoking.</p> <p>Review of Resident #159's most current smoking assessment was dated 04/29/25.</p> <p>Observation and interview conducted with Resident #159 on 05/20/25 at 2:10 PM revealed Resident #159 smoking independently. Resident #159 indicated he started smoking two weeks after he was admitted .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview conducted with MDS Coordinator #2 on 05/21/25 at 3:25 PM revealed she was not aware Resident #159 had not been care planned for smoking. MDS Coordinator #1 stated through record review and communication with nursing staff Resident #30 should have been care planned for smoking.</p> <p>An interview conducted with the Director of Nursing (DON) and Administrator on 05/21/25 at 3:20 PM revealed Resident #159 smoked independently but they were not aware the resident had not been cared planned for smoking. The interview further revealed all residents that smoked were expected to be care planned for goals and interventions.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interviews, the facility failed to shave facial hair for 1 of 3 dependent residents reviewed for assistance with activities of daily living (ADL) (Resident #56).</p> <p>The findings included:</p> <p>Resident #56 was admitted to the facility on [DATE] with diagnoses which included stroke, muscle weakness, hypertension, osteoporosis, and dysphagia.</p> <p>Review of Resident #56's care plan, revised 10/18/24, revealed the resident had an ADL self-care performance deficit due to left side hemiplegia (weakness on one side of the body), sequelae of poliomyelitis (Post-Polio Syndrome), muscle weakness, and a need for assistance with personal care. The goal was Resident #56 would receive staff assistance with all aspects of daily care to ensure that all needs are met. Interventions listed for Resident #56 included total assistance with bathing and required staff assistance with grooming and personal hygiene.</p> <p>Review of Resident #56's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact and required extensive assistance with bathing and personal hygiene.</p> <p>An observation and interview conducted with Resident #56 on 05/18/25 at 11:55 AM revealed the resident was laying in bed watching television. Resident #56 had several hairs located on her chin, at an estimated length of one inch. Resident #56 stated she did not like having chin hair and she preferred for her chin and face to be kept trimmed. Resident #56 indicated she often had to ask staff to shave her chin for her.</p> <p>An interview conducted with Nurse Aide (NA) # 5 on 05/21/25 at 12:10 PM revealed she had cared for Resident #56 consistently and was assigned to Resident #56 on this date. NA #5 indicated Resident #56 rarely refused care and preferred to have a clean shaved face. NA #5 stated she was unsure why Resident #56's face had not been shaved but it needed to be.</p> <p>An interview conducted with Nurse #3 on 05/21/25 at 12:30 PM revealed she was the nurse assigned to Resident #56 and was not aware the resident had facial hair. Nurse #3 did not recall Resident #56 being resistive to personal care and expected residents to be clean shaved if preferred.</p> <p>A follow up interview with Nurse #3 on 05/21/25 at 2:30 PM revealed she had observed Resident #56 and indicated the resident had long chin hairs that needed to be shaved. Nurse #3 stated she shaved Resident #56 without any issue.</p> <p>An interview conducted with the Administrator and Director of Nursing (DON) on 05/21/25 at 3:40 PM revealed they were unsure why Resident #56 had not been clean shaven and they expected residents to remain clean and shaved as preferred.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interviews, the facility failed to arrange or coordinate podiatry care for 1 of 3 dependent residents reviewed for assistance with activities of daily living (ADL) (Resident #134).</p> <p>The findings included:</p> <p>Resident #134 was admitted to the facility on [DATE] with diagnoses which included stroke and hypertension.</p> <p>Review of Resident #134's care plan, revised 01/08/25, revealed the resident had an activities of daily living self-care performance deficit due to Cerebrovascular Accident (CVA) (stroke). The goal was for Resident #134 to improve the current level of functioning, including improvement in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene.</p> <p>Review of Resident #134's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and required extensive assistance with personal hygiene. The MDS further revealed the resident was coded for not being ambulatory.</p> <p>An interview and observation with Resident #134 on 05/21/25 at 11:30 AM revealed the resident's great toenails on both feet to be extending beyond the end of her toes, and were thick, and yellow in color. Resident #134 stated she had an ingrown toenail and was unable to wear shoes or socks because it was hurting and uncomfortable and had been that way for several days. Resident #134 stated a Nurse Aide had trimmed a couple toenails on her smaller toes a couple days prior but had not been seen by podiatry and would like to have a podiatry visit.</p> <p>An interview conducted with Nurse #5 on 05/21/25 at 3:30 PM revealed she was not aware Resident #134's was supposed to be seen by podiatry last week but was not seen. Nurse #5 further revealed she was unsure why she had not been seen by podiatry but observed Resident #134's toenails and stated they needed to be done.</p> <p>An interview was conducted with the Director of Nursing (DON) and Resident #134 in conjunction with an observation of Resident #134 on 05/21/25 at 2:00 PM. Resident #134 stated she could not wear enclosed shoes due to her toes hurting and the length of her great toenails. The DON revealed the podiatrist the facility used created a list of which residents were to be seen for their visit. The DON indicated Resident #134 had an ingrown toenail and needed to be seen by the podiatrist. The DON further stated she was going to contact the Podiatrist and make sure Resident #134 was seen as soon as possible but she went ahead and put her on the list for the next scheduled podiatry visit on 6/26/25.</p> <p>An interview conducted with the Administrator and DON on 05/21/25 at 3:40 PM revealed Resident #134 had not been assessed by podiatry since admission. The DON stated Resident #134 was on the list to be seen during the previous podiatry visit in May 2025 but was unsure why she had not been seen. The interview further revealed they expected for residents' toenails to remain trimmed and if there were issues, podiatry would be consulted.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to provide care in a safe manner when Resident #71 was rolled out of her bed during incontinent care hitting the floor. Resident #71 was sent to the Emergency Department (ED) and diagnosed with a fracture of her left distal (away from the center) clavicle, a closed fracture of the second rib on the left side, and a large left-sided scalp hematoma. The facility also failed to conduct smoking assessments when Resident #117 was not assessed for smoking. The deficient practice occurred for 2 of 4 sampled residents reviewed for supervision to prevent accidents (Resident #71 and Resident #117).</p> <p>Findings included:</p> <p>1. Resident #71 was admitted to the facility on [DATE] with diagnoses which included dementia, adult failure to thrive, contractures of left and right extremities, right hip osteoarthritis, dysphagia, and a history of pulmonary embolism.</p> <p>The revised care plan dated 1/17/25 revealed Resident #71 had an activities of daily living (ADL) self-care performance deficit related to limited mobility and dementia. Interventions included: extensive, two-person staff assistance to re-position and turn in bed; and two-person assistance using a mechanical lift for transfers.</p> <p>Resident #71's physician orders revealed on 2/27/25 the Resident was ordered 5 milligrams of Eliquis (blood thinner medication) via a gastrostomy tube two times a day due to her history of pulmonary embolism/deep vein thrombosis (DVT).</p> <p>The annual Minimum Data Set assessment dated [DATE] indicated Resident #71 was severely cognitively impaired, dependent on staff for bed mobility and transfer, had impairment of bilateral upper and lower extremities, had an indwelling catheter, was always incontinent of bowel, had a feeding tube, and had no falls since her last annual assessment.</p> <p>Review of a progress note by Nurse #3 dated 4/13/25 documented that at 6:15 a.m. nursing assistant (NA#3) reported she was performing personal care on Resident #71 and when she turned the Resident on her side to place a brief on her, the Resident rolled off the opposite side of bed. NA#3 reported that the Resident's bed was waist level to her during this time. Resident #71 had a golf ball sized hematoma to the left side of her head. The on-call health provider was notified and ordered the Resident to be sent out for further evaluation. Resident #71's normal mental baseline remained the same. The Resident left facility via ambulance via stretcher at 7:15 a.m. NA#3 was educated on the importance of requesting assistance with residents that required the assistance of two people to help prevent falls or potential injuries while performing personal care and transferring residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Oak Forest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5680 Windy Hill Drive Winston Salem, NC 27105	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview was conducted on 5/20/25 at 5:30 p.m. with Nurse #3 who revealed she last worked at facility approximately 3.5 weeks ago. She revealed she worked at the facility on 4/13/25 during the 11:00 p. m. to 7:00 a.m. shift. Nurse #3 stated that at approximately 6:35 a.m. NA #3 informed her Resident #71 was on the floor in her room. The Nurse reported that she entered Resident #71's room and observed Resident #71 lying on her back, on the floor on the right side of the bed awake and moaning. Nurse #3 stated NA #3 informed her that as she was on the left side of the bed changing the Resident's brief, the NA #3 rolled the Resident away from her to apply the brief but Resident #71 rolled off the bed onto the floor. Nurse #3 stated she conducted a physical assessment of Resident #71 and noted a golf ball sized knot on the left side of her head, above her left ear but no bleeding. Nurse #3 stated she informed NA #3 that she should have requested her assistance with the Resident's care because the Resident required two staff for assistance with bed mobility and transfers due to the resident was very contracted and stiff. Nurse #3 stated she reminded NA #3 and pointed to a small note on yellow paper on the wall above the resident's head of bed which read two person assist. The Nurse reported NA #3 responded she did not notice the note. Nurse #3 stated that at approximately 6:45 a.m., with the use of the mechanical lift, she and NA#3 returned Resident #71 to her bed where her vital signs were taken and were within normal limits. Nurse #3 stated she notified the on-call physician of the incident who ordered the resident sent to the emergency room due to the large hematoma to her head. She revealed 911 was called and emergency medical services (EMS) arrived at approximately 7:15 a.m. Nurse #3 stated that throughout the incident, Resident #71 did not lose consciousness, had no bleeding, and was no longer moaning. Nurse #3 revealed she reported the resident's fall to the on-coming Charge Nurse (Nurse #4).</p> <p>On 5/20/25 at 8:47 a.m., an interview was conducted with Nurse #4 who stated she worked as the first shift Charge Nurse on 4/13/25. She recalled that upon her arrival to begin her shift (timecard indicated Nurse#4 reported to work at 6:51 a.m. on 4/13/25), Nurse #3 informed her Resident #71 had a fall and had an injury to the side of her head. Nurse #4 stated this prompted her to conduct an observation of the resident. Nurse #4 stated she observed the Resident was awake in bed, nonverbal (which was normal) at her baseline, with a large hematoma (palm size) to the left side of her head. Nurse #4 stated she immediately told Nurse #3 to phone the physician STAT (immediately). The physician gave orders to send the Resident to the emergency room, immediately. Nurse #4 revealed she was unsure if Resident #71 received blood thinning medication because she was not her assigned nurse; but there was no blood, and the hematoma was not purple and the Resident was not flinching in pain. Nurse #4 revealed she interviewed Nurse #3 and NA #3 on the amount of time since the resident was returned to her bed and both estimated no longer than thirty minutes. Nurse #4 stated she interviewed the NA #3 who reported that when she was providing incontinence care to Resident #71 she (NA) rolled the resident onto her side, and the Resident rolled off the other side of the bed. NA #3 admitted she did not have assistance and was aware Resident #71 was a two person assist with bed mobility and transfers but she had no help. When Nurse #4 asked if NA #3 asked assistance from her nurse, NA #3 response was no. Nurse #4 stated she immediately notified the Director of Nursing who instructed her to have the Scheduler notify NA#3 (who had left at end of the shift) that she was suspended pending investigation. Nurse #4 stated NA #3 had not returned to the facility since the incident on 4/13/25.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The review of the facility's Initial Falls Review form dated 4/13/25 documented Resident #71 rolled or fell out of the bed which was in the low position. NA#3 went in to perform personal care for Resident #71 and during the interaction NA#3 rolled the resident over to place brief on when the resident rolled off the opposite side of the bed resulting in a hematoma to left side of her head. The Resident remained alert, pupils were equally round and reactive to light, equal hand grasp, and moved all extremities. The Nurse Practitioner was notified and ordered to send the resident out to the emergency room.</p> <p>NA #3 was unable to be reached for an interview.</p> <p>The Hospital Discharge summary dated [DATE] revealed Resident #71 presented to the hospital's emergency room on 4/13/25 after a fall from the bed when being turned by staff at the nursing home. Reportedly staff was caring for the resident when they went to roll her back over they rolled her off the bed and the resident landed on her left side. As a result of the x-rays and computed tomography (CT scan), Resident #71 was diagnosed with a fracture of her left distal clavicle, a closed fracture of the second rib of the left side, and a large left-sided scalp hematoma. Also, a Complete Blood Count (CBC) test showed Resident #71 had a slightly elevated white count and a slightly elevated procalcitonin (a protein produced in response to bacterial infections). A urinalysis showed minimal infection. Resident #71 was diagnosed with possible sepsis along with her new fractures. The resident developed a low-grade temperature of 100.6 degrees Fahrenheit while in the emergency room. The Resident was hospitalized to allow for the administration of intravenous antibiotics before being discharged back to the facility.</p> <p>On 5/18/25 at 1:03 p.m., Resident #71 was observed in bed awake, nonverbal and covered with bed linen.</p> <p>An interview with the Administrator on 5/19/25 at 2:17 p.m. revealed NA #3 was terminated from the facility on 4/13/25 due to her failure to follow policy related to bed mobility. She also revealed Nurse #3 (an Agency nurse), last worked at the facility on 4/21/25.</p> <p>On 5/21/25 at 11:47 a.m., the Nurse Practitioner (NP) was interviewed and revealed she was not the on-call provider on 4/13/25 but based on the triage timing documented by the on-call provider, the time frame of the call was appropriate as well as the nurse's assessment. The NP indicated the nurse should always assess a resident before contacting the provider to be able to provide answers quickly to questions about a resident's injuries and/or health status.</p> <p>On 5/22/25 at 11:18 a.m. the Director of Nursing was interviewed and stated during admission, a resident's mobility and transfer ability would be assessed by nursing and therapy and the determination made if a resident required 1 or 2 staff assistance with bed mobility and the use of a mechanical lift for transfers. This determination would be documented in the Kardex (a resident's care plan used by staff when providing care) which all nursing assistants had been educated.</p> <p>2. Resident #117 was admitted to the facility on [DATE] with diagnoses which included tobacco use.</p> <p>Review of Resident #117's annual Minimum Data Set (MDS) dated [DATE] revealed the resident was alert and oriented and was coded for tobacco use.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #117's care plan revised on 03/18/25 revealed Resident #117 was at risk for injuries related to the preference of smoking. The goal was Resident #117's smoking related injuries would be minimized through current interventions.</p> <p>Review of Resident 117's smoking assessments revealed a smoking assessment was completed on 03/24/24 and the next assessment was not completed until 08/27/24. Smoking assessments were completed quarterly after 08/27/24. The smoking assessments from 03/24/24 and 08/27/24 concluded Resident #117 was an unsupervised smoker because he was able to demonstrate and understand the smoking policy, times, and place to smoke.</p> <p>An observation and interview conducted with Resident #117 on 05/20/25 at 2:00 PM revealed Resident #117 was outside in the designated smoking area smoking independently. Resident #117 stated he had always been an independent smoker in the facility. During the observation, Resident #117 was observed to safely ash his cigarette into an appropriate receptacle, and he was observed to not have any burns on his clothing, or his skin.</p> <p>An interview conducted with the Director of Nursing (DON) on 05/21/25 at 3:40 PM revealed she had expected quarterly smoking assessments to be completed. It was indicated nurses were notified by the medical record system what assessments were pending and needed to be completed during their shift, including smoking assessments, and they were expected to complete the assessments during their shift. The DON further revealed she was not aware Resident #117 had gone beyond the quarterly time frame without having had a smoking assessment conducted.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff interviews, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 1 of 5 residents reviewed with urinary catheters (Resident #14).</p> <p>The findings included:</p> <p>Resident #14 was admitted to the facility on [DATE] with diagnoses which included unspecified hydronephrosis (swelling of one or both kidneys due to a buildup of urine), presence of urogenital implants, and neuromuscular dysfunction of the bladder.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 was moderately cognitively impaired. The assessment indicated Resident # 14 was dependent upon staff for all his activities of daily living (ADL). Resident #14 was coded for an indwelling urinary catheter.</p> <p>Resident #14's care plan revised 3/7/25 indicated Resident #14 had a goal of being free from a urinary tract infection due to the presence of an indwelling suprapubic catheter. Interventions included keeping the urinary collection bag below the level of the urinary bladder.</p> <p>An initial observation was conducted on 5/18/25 at 10:39 AM of Resident #14 as he was lying in his bed. The bed was noted to be in a low position. A urinary catheter drainage bag was observed to be hanging off the bedframe on the resident's right side of the bed with a solid, blue-colored privacy flap covering the bag facing the window. The entire bottom of the urinary catheter drainage bag was resting on the floor.</p> <p>Additional observations were conducted on 5/19/25 at 11:25 AM and on 5/20/25 at 4:00 PM. Resident #14's bed was noted to be in the low position, and a urinary catheter drainage bag was observed to be hanging off the bedframe on the resident's right side of the bed. The entire bottom of the urinary catheter drainage bag was resting on the floor during both observations.</p> <p>During an interview with Nurse Aide (NA) #1 on 5/20/25 at 4:19, she stated urinary catheter bags were not supposed to be touching the floor to prevent risk of infection. NA #1 stated she had noticed Resident #14's urinary catheter bag had been on the floor several times during her shift, and she had picked it up and repositioned the urinary catheter drainage bag so that it was not resting on the floor.</p> <p>An interview was conducted with the Director of Nursing (DON) on 5/21/25 at 11:51 AM. She stated she had educated all staff to keep urinary catheter bags off the floor, and there was a hook on the bag to hang it on the resident's bed.</p> <p>The Unit Manager was interviewed on 5/21/25 at 4:50 PM. She stated the resident's urinary drainage bag should not touch the floor. She further stated she had placed a basin underneath Resident #14's urinary catheter bag that day to prevent it from touching the floor since the resident preferred to keep his bed low.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and Pharmacist interviews, the facility failed to have an effective system and safeguards in place to prevent drug diversion when they did not ensure narcotic medications for discharged residents were secured for 2 of 3 residents (Resident #1 and Resident #271) reviewed for medication management. As a result, a total of 75 doses of Oxycodone (a narcotic medication) 5 milligrams (mg) were unaccounted for.</p> <p>Findings included:</p> <p>a. Resident #122 was admitted to the facility on [DATE] and was readmitted on [DATE]. His diagnoses included diabetes and diabetic neuropathy.</p> <p>A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #122 was cognitively intact and received opioid medications.</p> <p>Resident #122 had a Physician's Order dated [DATE] for Oxycodone (narcotic/opioid pain medication) 5 mg every 4 hours as needed for pain.</p> <p>The Medication Administration Record for [DATE] for Resident #122 indicated he received Oxycodone 5 mg as needed for pain on [DATE], [DATE], and [DATE].</p> <p>On [DATE] a discharge with an anticipated return Minimum Data Set assessment indicated Resident #122 was discharged to the hospital.</p> <p>During an interview with the Director of Nursing (DON) on [DATE] at 11:06 am she stated the pharmacy had notified the facility on [DATE] when the pharmacy tote (a tote bag used to store medications to be returned to the pharmacy) was returned to the pharmacy there was a Narcotic Count Form for Oxycodone 5 mg with 45 doses ordered for Resident #122 and the medication correlating to the form was missing from the tote. The DON stated Resident #122 was discharged to the hospital on [DATE] and his medication should have been sent back to the pharmacy when he was discharged . The DON stated they immediately began an investigation. She stated Nurse #1 and Nurse #2 were interviewed and suspended pending an investigation; Nurse #1 and Nurse #2 both received narcotic drug tests; and the facility changed the process for returning unused narcotic medications to the pharmacy.</p> <p>Nurse #2 was interviewed by phone on [DATE] at 12:40 pm and she stated she counted 45 doses of Oxycodone 5 mg that was ordered for Resident #122 with Nurse #1 after the resident was discharged and placed the medication in the pharmacy tote and placed two numbered zip lock seals on the tote. Nurse #2 stated she left the tote in the Unit Managers office to be picked up by pharmacy. Nurse #2 stated when she worked as the night shift supervisor, she kept the Unit Manager's office door locked. Nurse #2 stated there were several staff (the Unit Managers and Administrative Staff) that had keys to the Unit Manager's office, but she was not aware of anyone leaving the Unit Manager's office unlocked.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nurse #1 was interviewed by phone on [DATE] at 11:37 am and stated she did not remember the date Nurse #2, the night shift supervisor, had asked her to reconcile narcotic medications with her that needed to be sent back to the pharmacy. Nurse #1 stated she did count the medications for Resident #122 with Nurse #2, and they put the medications in the pharmacy tote and placed the numbered zip lock tag on the tote. She stated she did not know when the pharmacy tote was returned to the pharmacy and did not know how long the pharmacy tote was left in the Unit Manager's office before it was sent back to the pharmacy. Nurse #1 stated on [DATE] she was suspended pending an investigation, she was drug tested, she received education regarding returning narcotic medication to the pharmacy, and the facility changed the process for sending unused narcotics back to the pharmacy.</p> <p>The Pharmacist was interviewed by phone on [DATE] at 2:59 pm and stated she received the facility's pharmacy tote on [DATE] and found a Narcotic Count Form for Oxycodone 5 mg, 45 doses, in the returned pharmacy tote. The Pharmacist stated the tote was sealed with two zip tie seals that were numbered, and the Medication Return Form in the tote had the corresponding numbers from the two zip ties. The Pharmacist stated she notified the facility that the narcotic medication was not in the tote when she received it at the pharmacy. The Pharmacist stated the Oxycodone 5 mg should have been secured under two locks to prevent diversion of the medication.</p> <p>During an interview with the DON on [DATE] at 11:06 am she stated that Resident #122 had not been charged for the medication and the medication was provided by the hospital when Resident #122 was admitted to the facility, so they had not considered the missing medication a misappropriation of Resident #122's property.</p> <p>b. Resident #271 was admitted to the facility on [DATE] with diagnoses that included and lung cancer.</p> <p>An admission Minimum Data Set assessment dated [DATE] indicated Resident #271 was cognitively intact and received opioid medications.</p> <p>A Physician's Order dated [DATE] indicated Oxycodone 5 mg for Resident #271 three times a day for pain.</p> <p>The Medication Administration Record for Resident #271 for [DATE] indicated he received Oxycodone 5 mg by mouth three times a day for pain from [DATE] to [DATE].</p> <p>The medical record indicated Resident #271 died in the facility on [DATE].</p> <p>The Director of Nursing was interviewed on [DATE] at 11:06 am and she stated during an investigation into missing narcotic medication for Resident #122 they discovered that a medication card of Oxycodone 5 mg that was ordered for Resident #271 was also missing. The Director of Nursing stated the Narcotic Count form for Resident #271's Oxycodone 5 mg with 30 doses was found in an unlocked desk drawer in the Unit Manager's office and the medication correlating to the form was missing.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nurse #2 stated she was the Night Shift Supervisor, and she was responsible for ensuring the narcotic medications were reconciled and sent back to the pharmacy when a resident was discharged . Nurse #2 stated after Resident #271's death, she placed the resident's medication in an unlocked desk drawer in the Unit Manager's office and the door to the office was locked but there were other staff members that had keys to the office. Nurse #2 stated all nurse management and supervisors had access to the office. Nurse #2 stated she kept the door to the office locked when she worked but she did not know if it was left open when she was not working. Nurse #2 stated she did not know that she should keep narcotic medications double locked until they were sent to the pharmacy.</p> <p>During an interview with the Pharmacist by phone on [DATE] at 2:59 pm she stated when the facility investigated the 45 missing doses of Oxycodone 5 mg for Resident #122, they notified her there was another card of 30 doses of Oxycodone missing for Resident #271.</p> <p>The Director of Nursing was interviewed on [DATE] at 11:06 am and she stated that the investigation into the missing Oxycodone for Resident #271 revealed Nurse #2, the night shift supervisor, had placed the medication in the drawer in the Unit Manager's office and had planned to return it to the pharmacy. She stated Nurse #2 stated she was not aware the medication should not be left in the desk drawer which was not locked. The Director of Nursing stated the facility changed the process for sending narcotic medications back to the pharmacy to prevent any further diversion of narcotic medications. The Director of Nursing stated Resident #271 was not charged for the 30 doses of Oxycodone 5 mg since the medication was provided by the hospital when Resident #271 was admitted to the facility and the facility did not investigate it as misappropriated for that reason.</p> <p>The Administrator was interviewed by phone on [DATE] at 2:25 pm and stated the facility should have ensured Resident #271 and Resident #122's narcotic medication was secured with two locks to prevent diversion of narcotic medications.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews with staff and the Pharmacist, the facility failed to store unused narcotics prescribed to Resident #122 and #271 in a separately locked, permanently affixed compartment. The narcotics for Resident #122 were stored in a pharmacy tote with a numbered zip lock tag and the doses for Rsd#271 were placed in an unlocked desk drawer in the Unit managers office by the Nurse #2, the night shift supervisor. The Unit Manager's office was not always locked and several staff had keys to the office. On 5/1/2025, the Pharmacy identified that 45 doses of oxycodone, 5 milligrams, were missing for Resident #122 when they received the narcotic count sheet without the narcotic medication in the medication tote that was delivered to the pharmacy. The facility initiated an investigation and discovered 30 doses of oxycodone, 5 milligrams, missing for Resident #271. This deficient practice affected two of two discharged residents reviewed for drug storage (Resident #122 and #271).</p> <p>Findings included:</p> <p>The facility's Controlled Medication Storage Policy stated all narcotic medications are stored under double lock in a locked cabinet or safe designated for that purpose.</p> <p>1. Resident #122 was admitted to the facility on [DATE] and had a recent readmission on [DATE].</p> <p>Resident #122 had a Physician's Order dated 2/6/2025 for Oxycodone 5 mg every 4 hours as needed for pain.</p> <p>On 3/25/2025 a discharge with an anticipated return Minimum Data Set assessment indicated Resident #122 was discharged to the hospital.</p> <p>Nurse #1 was interviewed by phone on 5/22/2025 at 11:37 am and stated she did not remember the date Nurse #2, the night shift supervisor, had asked her to reconcile narcotic medications with her that needed to be sent back to the pharmacy. She stated she did count the medications for Resident #122 with Nurse #2, and they put the medications in the pharmacy tote (a plastic bin that medications are place in to transport to and from the pharmacy) and placed the numbered zip lock tag on the tote. She stated she did not know when the pharmacy tote was returned to the pharmacy and did not know how long the pharmacy tote was left in the Unit Manager's office before it was sent back to the pharmacy.</p> <p>Nurse #2 was interviewed by phone on 5/22/2025 at 12:40 pm and she stated she counted 45 doses of Oxycodone 5 mg that was ordered for Resident #122 with Nurse #1 and placed the medication in the pharmacy tote with the numbered zip lock tag on the tote which Nurse #2 stored in the unit managers office. She stated she did not remember the date they put the medication in the pharmacy tote and did not know the date the pharmacy tote was sent to the pharmacy. Nurse #2 stated when she worked as the night shift supervisor, she kept the door to the Unit Manager's office locked at all times, but she knew there were several staff that had keys to the Unit Manager's office, but she was not aware of anyone leaving the Unit Manager's office unlocked.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Oak Forest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5680 Windy Hill Drive Winston Salem, NC 27105	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Pharmacist was interviewed by phone on 5/23/2025 at 2:59 pm and she stated when the facility's pharmacy tote was received in the pharmacy on 5/1/2025 the zip lock seals were in place and the Narcotic Return Form for Oxycodone 5 mg (45 doses) was not in the pharmacy tote. The Pharmacist stated she notified the facility's Director of Nursing (DON).</p> <p>During an interview with the DON on 5/22/2025 at 11:06 am she stated the pharmacy had notified the facility on 5/1/2025 when the pharmacy tote was returned to the facility there was a Narcotic Count Form for Oxycodone 5 mg with 45 doses ordered for Resident #122 and the medication was missing from the tote. The DON stated at that time the narcotics that were being sent back to the pharmacy were being stored in the Unit Manager's office and the door was not always locked, several people had keys to the office, and the medications were kept in an unlocked desk drawer. The DON stated they were not able to determine when the misappropriation occurred, but they had changed the process for sending narcotics back to the pharmacy. The DON stated the facility had installed a safe in the DON office, which was observed during the interview, and the process for storing and returning narcotic medications had changed. The DON stated the Assistant Director of Nursing (ADON) counted all narcotics that should be returned to the pharmacy (either when a resident was no longer taking them or the resident was discharged) and placed them in the safe and they were kept in the safe until the pharmacy courier picked them up to return them to the pharmacy. The DON stated she and the ADON put the seals on the pharmacy tote after they counted the medications again and sent them with the courier to the pharmacy.</p> <p>2. Resident #271 was admitted to the facility on [DATE].</p> <p>A Physician's Order dated 3/12/2025 indicated Resident #271 should have Oxycodone 5 mg three times a day for pain.</p> <p>Nurse #2 was interviewed by phone on 5/22/2025 at 12:40 pm and stated she was the Night Shift Supervisor, and she was responsible for ensuring the narcotic medications were reconciled and sent back to the pharmacy when a resident was discharged . Nurse #2 stated she put Resident #271's medication in an unlocked desk drawer in the Unit Manager's office and the door to the office was locked but there were other staff members that had keys to the office. Nurse #2 stated all nurse management and supervisors had access to the office. Nurse #2 stated she kept the door to the office locked when she worked but she did not know if it was left open when she was not working.</p> <p>The Director of Nursing was interviewed on 5/22/2025 at 11:06 am and she stated during an investigation into the missing narcotic medication for Resident #122 they discovered that a medication card of Oxycodone 5 mg that was ordered for Resident #271 was also missing. The Director of Nursing stated the Narcotic Count form for Resident #271's Oxycodone 5 mg with 30 doses was found in an unlocked desk drawer in the Unit Manager's office and the medication was missing. The Director of Nursing stated Nurse #2, the night shift supervisor, had placed the medication in the drawer and had planned to return it to the pharmacy. The DON stated Nurse #2 stated she was not aware the medication should not be left in the desk drawer which was not locked.</p> <p>The Administrator was interviewed by phone on 5/22/2025 at 2:25 pm and stated the facility should have ensured Resident #271 and Resident #122's narcotic medication was secured with two locks to prevent diversion of narcotics.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Oak Forest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5680 Windy Hill Drive Winston Salem, NC 27105	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility submitted a plan of correction for past noncompliance but it was not acceptable to the state agency.</p>