POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER			DATE OF REVISIT	
345284 Y1	A. Building B. Wing	Y2	8/26/2024	Y3
NAME OF FACILITY	•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE OAKS		901 BETHESDA ROAD		
		WINSTON SALEM, NC 27103		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEI	м	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	F0553 483.10(c)(2)(3)	Correction Completed 08/06/2024	ID Prefix Reg. # LSC	F0565 483.10(f)(5)(i)-(iv)(6)(7)	Correction Completed 08/06/2024	ID Prefix Reg. # LSC	F0690 483.25(e)(1)-(3)	Correction Completed 08/06/2024
ID Prefix	F0791 483.55(b)(1)-(5)	Correction	ID Prefix		Correction	ID Prefix		
Reg. # LSC		08/06/2024	Reg. # LSC		Completed	Reg. # LSC		Completed
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. # LSC		Completed	Reg. # LSC		Completed	Reg. # LSC		Completed
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. # LSC		Completed	Reg. # LSC		Completed	Reg. # LSC		Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction Completed
REVIEWE STATE AG		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	SURVEYOR		DAT	E
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATI	Ε
FOLLOWUP TO SURVEY COMPLETED ON 7/24/2024		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?				YES 🗌 NO		