A. BUILDING _____________________________

ID: 345284

B. WING _____________________________

DATE SURVEY COMPLETED: 05/19/2020

NAME OF PROVIDER OR SUPPLIER

THE OAKS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STREET ADDRESS, CITY, STATE, ZIP CODE

901 BETHESDA ROAD
WINSTON SALEM, NC  27103

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Electronically Signed: 05/25/2020