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

STATIONMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284  
(X2) MULTIPLE CONSTRUCTION A. BUILDING _____________________________  
B. WING _____________________________  
(X3) DATE SURVEY COMPLETED C 02/19/2021

(S) STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER THE OAKS

STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD  
WINSTON SALEM, NC 27103

PROVIDER'S PLAN OF CORRECTION

E 000 Initial Comments  
An unannounced complaint investigation survey was conducted on 2/16/2021 through 2/19/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # K3VX11.

F 000 INITIAL COMMENTS  
A complaint investigation survey was conducted from 02/16/2021 through 02/19/2021. Event ID# K3VX11.  
0 of the 6 complaint allegations were not substantiated.

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

Electronically Signed  
03/08/2021

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.