STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/11/25 through 8/15/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D30E7-H1.	E0000		09/11/2025
F0000	INITIAL COMMENTS An onsite recertification and complaint investigation survey was conducted from 8/11/25 through 8/15/25. Further information was obtained on 8/22/25 therefore the exit date was changed to 8/22/25. Event ID# 1D30E7-H1. The following intakes were investigated 837066, 837069, 837072, 837073, 837074, 837078, 837067, 837075, 837079, 837076, 837077, 837080, 2569146 0 of the 38 complaint allegations resulted in deficiency.	F0000		09/11/2025
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F0561	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F561 Corrective action for resident(s) affected by the deficient practice: The deficient practice occurred on 8/2/2025, when the dining room was shut down due to Covid-19 and residents #20, #63 and #110 were not able to eat in the communal dining area. On 8/18/2025, the communal dining area was open for all residents who wish to eat in the dining room. Corrective action for residents with the potential to be affected by the deficient practice.	09/11/2025

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0561 SS = D	Continued from page 1 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and staff and resident interviews, the facility failed to honor residents' preference for eating in the dining room for 9 days due to a COVID-19 outbreak when one employee tested positive on 8/2/25 for 3 of 5 residents reviewed for choices (Residents #20, #63, and #110). Review of the facility's policy "COVID-19 Response Program" last revised August 2025 revealed that the term "outbreak" was not defined and there was not any instruction for dining activity during an outbreak. The policy did state for the facility to notify the health department of any suspected or confirmed cases. During an observation of the dining room on 8/11/25 at 12:20 PM, there were not any residents eating lunch in the dining room. An interview with the Administrator on 8/11/25 at 12:45 PM revealed the facility was currently in outbreak status and the dining room had been closed since 8/2/25 when one employee tested positive. He stated he was instructed by someone from the county health department to temporarily cease all group interactions, including dining. a. Resident # 20 was readmitted to the facility on 8/21/24. Review of the comprehensive Minimum Data Set (MDS) assessment dated 6/17/25 revealed that Resident #20 was cognitively intact, had adequate vision/hearing, had clear speech, and understood/understands. She was independent with eating. During an interview with Resident #20 on 8/11/25 at 1:45 PM, she revealed that she often ate lunch and dinner in the dining room. She stated it upset her that	F0561	Continued from page 1 On 8/18/2025, the administrator identified residents who had the potential to be effected by this practice by completing a 100% audit of all current residents with BIMS of 13 or greater to ensure they were able to eat in the dining room if they desired to. This completed on 9/8/2025, the audit revealed 22 of 22 residents had no areas of concern with the dining room. There was no corrective action due to no deficient practice. Measures/Systemic changes to prevent reoccurrence of the deficient practice: On 9/8/2025, the Nurse Consultant began educating all administrative staff including the Administrator, Director of Nursing, Unit Manager, Treatment Nurse, Activities Director, Business Office Manager, Admissions Coordinator, Housekeeping Manager, Maintenance Director, Staff Development Coordinator, Social Worker, Therapy Manager, Dietary Manager, Health Information Manager and Minimum Data Set Nurses on Resident Choice, Self Determination and Dining. This education includes communal dining may continue during an outbreak unless specifically directed otherwise by the local or state health department. The Administrator or designee will be responsible for ensuring that this information will be integrated into the standard orientation training including agency for all staff identified above and will be reviewed by the quality assurance process to verify that the change has been sustained. Any of the above staff who does not receive in-service training will not be allowed to work until the training has been completed by 9/10/2025. Any newly hired Administrative Staff or Department Head Staff will be in serviced on communal dining may continue during an outbreak unless specifically directed otherwise by the local or state health department. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor the compliance by utilizing the Quality Assurance Tool Dining Room, monitoring 5 random residents weekly beginning the week of 9/8/2025. This monitoring will be weekly x 4 weeks and then monthly x 3 months to ensure compliance. Reports will be presented to the monthly Quality Assurance Committee by the Administrator to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0561 SS = D	Continued from page 2 the facility closed the dining room all last week (8/2/25 – 8/11/25) due to a COVID-19 outbreak. b. Resident #63 was admitted to the facility on 5/31/24. Review of the comprehensive MDS assessment dated 6/4/25 revealed that Resident #63 was cognitively intact, had adequate vision/hearing, had clear speech, and understood/understands. She was independent with eating. Resident #63 was interviewed on 8/11/25 at 1:47 PM. She revealed that she enjoyed eating lunch and dinner in the dining room every day. She stated that she was unhappy because the facility closed the dining room since 8/2/25 due to a COVID-19 outbreak. c. Resident #110 was readmitted to the facility on 11/2/22. Review of the comprehensive MDS assessment dated 6/20/25 revealed that Resident #110 was moderately cognitively intact, had adequate vision/hearing, had clear speech, and understood/understands. She was independent with eating. An interview was conducted with Resident #110 on 8/11/25 at 1:53 PM. She revealed that she was upset the dining room was closed since 8/2/25 due to a COVID-19 outbreak. She ate lunch and dinner in the dining room daily. The Director of Nursing (DON) was interviewed on 8/14/25 at 9:50 AM. She revealed that according to the facility's policy titled, "COVID-19 Response Program" last revised August 2025, one positive COVID-19 case was considered an outbreak and would remain in outbreak status until 14 days without a positive test result. The DON stated that the health department told her to suspend all group dining, and one positive result was considered an outbreak. She indicated that there were not any residents that complained to her about being upset with the dining room being closed for the last 9 days. Review of an email sent by the Communicable Disease Nurse to the Staff Development Coordinator on 8/4/25	F0561	Continued from page 2 ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, Dietary Manager and Social Worker	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0561 SS = D	Continued from page 3 revealed that guidance was provided about source control. However, there was not a suggestion to temporarily cease dining activities for residents with one positive case of COVID-19 in the building. During an interview with the Communicable Disease Nurse for the county on 8/15/25 at 9:09 AM, she revealed that she never spoke to anyone from the facility about the "outbreak" that started on 8/2/25. She indicated that she only received a voicemail from the facility notifying her that one employee tested positive for COVID-19 on 8/2/25. She explained if only one employee tested positive for COVID-19, then that would cause the facility to be under surveillance and should have conducted contact tracing and testing. The Communicable Disease Nurse for the county stated she would never give the facility advice to temporarily cease group dining, since an outbreak was considered 2 or more cases within a 14-day period. An interview was conducted with the Public Health Nursing Supervisor over Communicable Disease on 8/14/25 at 11:37 AM. She revealed that 2 or more cases of COVID-19 would be considered an outbreak. If there was only one positive case, the facility would be under observation, and the public health department would not suggest that group activities be ceased temporarily. The Administrator was interviewed on 8/14/25 at 11:56 AM. He stated that someone (unknown name) from the health department told him to temporarily cease all group dining for 14 days. The Administrator indicated that he “did what he was asked to do.” He stated that he was taking precautionary measures, and he expressed understanding that one positive case of COVID-19 was not considered an outbreak.	F0561		
F0565 SS = D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.	F0565	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility’s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F565 Corrective action for resident(s) affected by the deficient practice: The deficient practice occurred on 8/12/2025, when the Activities Director held Resident Council in the dining room which was not a private area in that there were	09/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0565 SS = D	Continued from page 4 (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident council member and staff interviews, the facility failed to conduct resident council meetings in a private area for 6 of the 6 resident council meetings reviewed in the last 6 months (2/19/25, 3/19/25, 4/16/25, 5/21/25, 6/18/25, and 7/23/25). The findings included: Review of the resident council minutes reviewed from 02/19/25 through 07/23/25 revealed resident council meetings had been held in the dining area. A resident council meeting was held on 08/12/25 at 3:00 PM with resident council members (Resident #2, Resident #20, Resident #22, Resident #30, Resident #33, Resident #61, Resident #63, Resident #99, Resident #110, Resident #113, and Resident #124.) The resident council members revealed they had their meetings in the lounge area next to the dining room. It was further revealed staff and visitors often disrupted the meeting due to not having any walls or doors. The resident council members stated they were unable to meet privately, and it was often frustrating.	F0565	Continued from page 4 not doors to secure privacy for residents #2, #20, #22, #30, #33, #61, #63, #99, #110, #113, and #124. On 8/20/2025, a Resident Council Meeting was held in the conference room behind closed doors. Corrective action for residents with the potential to be affected by the deficient practice. On 8/19/2025, the Administrator identified residents who had the potential to be affected by this practice by completing a 100% audit of all current residents with BIMS of 13 or greater to ensure that they had a private area to meet for Resident Council if they wanted to. The audit revealed 10 of 10 residents had no areas of concern with having Resident Council in a private area. The corrective action is that the Resident Council Meeting will take place in an enclosed area with a door for privacy. Measures/Systemic changes to prevent reoccurrence of the deficient practice: On 8/19/2025, the Nurse Consultant began educating all administrative staff including the Administrator, Director of Nursing, Unit Manager, Treatment Nurse, Activities Director, Business Office Manager, Admissions Coordinator, Housekeeping Manager, Maintenance Director, Staff Development Coordinator, Social Worker, Therapy Manager, Dietary Manager, Health Information Manager and Minimum Data Set Nurses on Resident Choice, Self Determination and Dining. This education includes Resident Council and the importance of Resident Council being held in a private area. The Administrator or designee will be responsible for ensuring that this information will be integrated into the standard orientation training including agency for all staff identified above and will be reviewed by the quality assurance process to verify that the change has been sustained. Any of the above staff who does not receive in-service training will not be allowed to work until the training has been completed by 9/10/2025. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0565 SS = D	Continued from page 5 An observation of the lounge area next to the dining room on 08/12/25 at 4:15 PM revealed the room to be one open area with no privacy. It addition, the entrance hallway from the front door of the facility is adjacent to the lounge with no divider or wall separating them. Staff and visitors in the hallway can hear conversations in the lounge and there is no privacy between the lounge, dining room and hallway. An interview conducted with the activity's director on 08/12/25 at 10:30 AM revealed resident council meetings were held in the dining area. It was further revealed she did not have an activity room or private area to hold meetings. The activity director indicated she tried to keep meetings private, but sometimes visitors and staff were not aware of the meeting and would disrupt. An interview conducted with the Administrator on 08/14/25 at 3:05 PM revealed he was not aware that resident council meetings needed to be held in a private area and was not aware residents had complained. The Administrator indicated he did not have a meeting place that was private for resident council meetings but would work on getting one.	F0565	Continued from page 5 compliance by utilizing the Quality Assurance Tool Resident Council Private Room Monitoring and monitor 5 random residents monthly beginning the week of 9/8/2025. This monitoring will be monthly x 3 months to ensure compliance. Reports will be presented to the monthly Quality Assurance Committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, Dietary Manager and Social Worker.	
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F0655	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F655 Corrective action for resident(s) affected by the deficient practice: The deficient practice occurred on 5/19/2025 when resident #51 was admitted and on 7/11/2025 when resident #106 was admitted and had no baseline care plan completed with-in 48 hours. The baseline care plan was completed on 5/27/2025 for resident #51 and 7/15/2025 for resident #106. Corrective action for residents with the potential to be affected by the deficient practice. On 8/19/2025, the Health Information Manager identified	09/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0655 SS = D	Continued from page 6 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete a baseline care plan that addressed the resident's immediate needs within 48 hours of admission for 2 of 30 sampled residents (Residents #51 and #106). The findings included: 1. Resident #51 was admitted to the facility on 5/19/25 with diagnoses that included diabetes, heart failure, and end stage chronic kidney disease. The nursing admission data collection assessment initiated and completed on 5/19/25 and revealed Resident #51 was on dialysis and also received	F0655	Continued from page 6 residents who had the potential to be affected by this practice by completing a 100% audit of all current residents admitted in the last 14 days. The audit revealed 16 of 18 residents did not have a baseline care plan in a 48-hour period. On 9/8/2025 we reviewed the residents and 7 had care plans completed and 5 had care plan updates and reviews. Measures/Systemic changes to prevent reoccurrence of the deficient practice: On 9/8/2025, the Nurse Consultant began educating all administrative nurses to include, the Director of Nursing, Unit Managers, Minimum Data Set, Staff Development Coordinator and Treatment Nurse. This education includes the residents care plan in Point Click Care will be initiated as soon as possible after the resident enters into the facility (no later than 48 hours). The Director of Nursing or designee will be responsible for ensuring that this information will be integrated into the standard orientation training including agency for all staff identified above and will be reviewed by the quality assurance process to verify that the change has been sustained. Any of the above staff who does not receive in-service training will not be allowed to work until the training has been completed by 9/10/2025. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor the compliance by utilizing the Quality Assurance Tool Baseline Care Plan and monitor 5 random residents weekly beginning the week of 9/8/2025. This monitoring will be weekly x 4 weeks and then monthly x 3 months to ensure compliance. Reports will be presented to the monthly Quality Assurance Committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, Dietary Manager and Social Worker.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0655 SS = D	Continued from page 7 antidepressant and diuretic medications. Review of Resident #51's electronic medical record on 8/13/25 revealed no evidence a baseline care plan that addressed her immediate needs was completed within 48 hours of her admission to the facility on 5/19/25. During an interview with the Minimum Data Set (MDS) Coordinator on 08/13/2025 at 3:10 PM, he stated the baseline care plans included the resident's standing orders, new medication orders, and their admitting diagnoses. He explained they were usually completed within 72 hours at the interdisciplinary care conference. The MDS Coordinator also stated that if a resident was admitted on a Thursday, the baseline care plan would be completed on the following Monday. During an interview with the Director of Nursing (DON) on 8/14/2025 at 9:44 AM, she stated the baseline care plan should be started immediately after admission and would include goals and interventions regarding the care of the resident. The DON reported that the baseline care plan should be completed within 72 hours of admission to the facility. During an interview with the Corporate Nurse Consultant on 8/14/25 at 3:37 PM she stated that the baseline care plans should be completed within 48 hours of a resident's admission. She stated the baseline care plan should contain pertinent information that addressed a resident's immediate care needs for staff until the comprehensive care plans were developed. 2. Resident #106 was admitted to the facility on 7/11/25 with diagnoses that included multiple sclerosis, polyneuropathy, depression, and pressure ulcers of left and right buttocks. The nursing admission data collection assessment initiated and completed on 7/11/25 and revealed Resident #106 received antidepressant medications, would begin physical therapy as tolerated, and required daily dressing changes for wound care. Review of Resident #106's electronic medical record on 8/13/25 revealed no evidence a baseline care plan that addressed her immediate needs was completed within 48	F0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0655 SS = D	Continued from page 8 hours of her admission to the facility on 7/11/25. During an interview with the Minimum Data Set (MDS) Coordinator on 08/13/2025 at 3:10 PM, he stated the baseline care plans included the resident's standing orders, new medication orders, and their admitting diagnoses. He explained they were usually completed within 72 hours at the interdisciplinary care conference. The MDS Coordinator also stated that if a resident was admitted on a Thursday, the baseline care plan would be completed on the following Monday. During an interview with the Director of Nursing (DON) on 8/14/2025 at 9:44 AM, she stated the baseline care plan should be started immediately after admission and would include goals and interventions regarding the care of the resident. The DON reported that the baseline care plan should be completed within 72 hours of admission to the facility. During an interview with the Corporate Nurse Consultant on 8/14/25 at 3:37 PM she stated that the baseline care plans should be completed within 48 hours of a resident's admission. She stated the baseline care plan should contain pertinent information that addressed a resident's immediate care needs for staff until the comprehensive care plans were developed.	F0655		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and resident and staff interviews, the facility failed to apply compression wraps to Resident #87's legs as ordered. The deficient practice occurred in 1 of 1 resident reviewed for providing services to meet professional standards (Resident #87). Findings included: Resident #87 was admitted to the facility on 8/9/18 and	F0658	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 Corrective action for resident(s) affected by the deficient practice: The deficient practice occurred on 8/13/2025 when nurse #1 signed that she had applied compression wraps to resident #87 lower extremities, however she did not apply the wraps. On 8/13/2025, compression wraps were attempted to be applied to resident #87 lower extremities by the Director of Nursing, however the resident refused.	09/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0658 SS = D	Continued from page 9 had cumulative diagnoses including congestive heart failure, morbid obesity and lymphedema. Review of records revealed a physician's order dated 5/28/25 for compression wraps to bilateral (both right and left) legs every morning and to be removed every evening for lymphedema. A quarterly Minimum Data Set (MDS) Assessment dated 7/10/25 revealed Resident #87 was cognitively intact. A revised care plan dated 7/21/25 revealed focus areas for congestive heart failure, lymphedema, and activities of daily living deficit. Review of Resident #87's Treatment Administration Record (TAR) for 8/13/25 revealed documentation by nursing staff that compression wraps were placed at 8:00 AM by Nurse #1. On 8/13/25 at 10:00 AM an interview with Resident #87 was conducted in conjunction with an observation. Resident #87 stated that she did not have compression wraps on her legs. Resident #87 stated she was "very worried" about the staff not putting the compression wraps on her legs and explained she did not want her lymphedema to get worse. Resident #87 stated historically that staff had put the wraps on in the morning and then took them off at night. Resident #87 then uncovered both of her legs which revealed no compression wraps in place to either of her legs. On 8/13/25 at 2:30 PM an interview and record review were conducted with Resident #87's primary nurse, Nurse #1. Nurse #1 reported she did not have anything to do with Resident #1's compression wraps. Nurse #1 stated she did not know how often the compression wraps should be applied or when they should be removed. Nurse #1 reviewed the TAR for 8/13/25, which had Nurse #1's initials documenting application of the compression wraps, and Nurse #1 confirmed that her initials were noted on the TAR as documenting that the compression wraps were applied on the resident by her at 08:00 AM. Nurse #1 stated she did not know how her initials "got there." Nurse #1 then acknowledged that she did not place the wraps on at 08:00 AM but said that the wraps were already on, and that was what she charted on at 08:00 AM. Nurse #1 stated she did not how or when Resident #87's leg wraps were removed or who may have removed them. On 8/13/25 at 3:05PM, an interview with the Director of Nursing (DON) was conducted. The DON stated if a task was ordered by the physician, it should be carried out	F0658	Continued from page 9 Corrective action for residents with the potential to be affected by the deficient practice. On 8/18/2025, the Director of Nursing identified residents that had the potential to be affected by this practice by completing a 100% audit of all current residents with orders for ace wraps. This completed on 8/18/2025. The audit revealed 2 of 115 residents had orders for ace wraps. There was no corrective action due to no deficient practice. Measures/Systemic changes to prevent reoccurrence of the deficient practice: On 8/18/2025, the Staff Development Coordinator began educating all staff to include administrative nurses, the Director of Nursing, Unit Managers, Minimum Data Set Nurses, Treatment Nurse and Med Aides. This education includes the correct documentation when giving medications and applying treatments including ace wraps. The Administrator or designee will be responsible for ensuring that this information will be integrated into the standard orientation training including agency for all staff identified above and will be reviewed by the quality assurance process to verify that the change has been sustained. Any of the above staff who does not receive in-service training will not be allowed to work until the training has been completed by 9/10/2025. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor the compliance by utilizing the Quality Assurance Tool Professional Standards Monitoring and monitor 5 random residents weekly beginning the week of 9/8/2025. This monitoring will be weekly x 4 weeks and then monthly x 3 months to ensure compliance. Reports will be presented to the monthly Quality Assurance Committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0658 SS = D	Continued from page 10 by nursing staff.	F0658	Continued from page 10 Manager, Dietary Manager and Social Worker.	
F0801 SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other	F0801	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F801 Corrective action for resident(s) affected by the deficient practice: Based on initial kitchen tour, observations, and interviews dietary services failed to demonstrate competency in operating the chemical sanitation dish machine. Corrective action for residents with the potential to be affected by the deficient practice. On 8/11/2025 Ecolab Service Technician serviced dish machine to meet proper PPM levels. Dietary Service Director and Dietitian tested temperature and sanitation of machine prior to restarting dish service. Measures/Systemic changes to prevent reoccurrence of the deficient practice: On 8/19/2025, the Dietary Service Director in-serviced all full time, part time, and to agency dietary staff. Topics included: Chemical Sanitation Dish Machine instructions and procedures and the importance of reporting to manager any temperature, PPM, or equipment concerns to Manager. The facility will ensure that any dietary staff who has not received this training will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency dietary staff that provide services for the facility.	09/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0801 SS = F	Continued from page 11 clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations and staff interviews, the facility dietary staff failed to demonstrate competency with monitoring the chemical sanitization level for the low temperature dish machine by not performing testing at least once per shift which could affect 111 of the 111 residents. The findings included: The program brochure for the low temperature dish machine was reviewed. It stated the minimum chemical sanitizer rinse requirements were 50 parts per million	F0801	Continued from page 11 Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Dietary Service Director will have all dietary staff sign off on education and have them demonstrate competency. Dish machine logs will be reviewed weekly x 4 weeks and then monthly x 3 months. Interventions will be implemented as appropriate. The Dietary Service Director will provide reports to Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0801 SS = F	Continued from page 12 (ppm) of chlorine. An observation of the dish machine with Dietary Manager (DM) was conducted on 8/11/25 at 9:46 AM and the DM confirmed the chlorine level of the low temperature dish machine measured 0 ppm. During an interview with the Dietary Manager on 8/11/25 at 9:48 AM, the Dietary Manager stated that dietary staff were supposed to test the chemical sanitization level daily. However, the dish machine temperature log only included temperatures of the rinse/wash cycles, and not the chemical sanitization level. During a follow up interview with the DM on 8/11/25 at 12:41 PM, she revealed that the vendor had fixed the dish machine an hour earlier. The DM stated the vendor reported the nozzle to the chemical sanitization was not working properly. The DM indicated that she was able to wash and sanitize all dishes prior to lunch meal service on 8/11/25. An observation and interview were conducted with Dietary Aide #1 on 8/12/25 at 9:45 AM. The low temperature dish machine measured 272 ppm, which was in the optimal range. Dietary Aide #1 stated she had never measured the chemical sanitization level of the dish machine before, only the 3-part sanitization sink for the pots/pans. Dietary Aide #2 was interviewed on 8/13/25 at 11:56 AM. She revealed that she did not always record the temperatures of the dish machine but had never measured the chemical sanitization level. During a follow-up interview with the Dietary Manager on 8/14/25 at 8:00 AM, she revealed that she had never used a low temperature dish machine before and was not aware of the minimum chemical sanitization level. An interview was conducted with the Administrator on 8/14/25 at 12:08 PM. He revealed that the dish machine chemical sanitization level should be checked every morning and documented appropriately. If any issues were found where the level was below 50 ppm, then the vendor should have been contacted immediately.	F0801		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary	F0812	To remain in compliance with all federal and state	09/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = F	Continued from page 13 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to 1) to maintain the minimum chemical sanitization level of the low temperature dish machine according to the manufacturer's recommendations 2) clean the convection ovens, the fryer, the toaster, steamer, stove and plate warmer for 3 of 3 observations 3) allow cooking pans and dishes to completely dry prior to assemblage and stacking for two of two observations, 4) remove cracked and dirty plates prior to meal service for 1 of 1 observation and clean 2 of 3 meal carts. These practices had the potential to affect food served to residents. 1. The manufacturer program brochure for the low temperature dish machine was reviewed and specified the minimum chemical sanitizer rinse requirements were 50 parts per million (ppm) of chlorine. An observation and interview with the Dietary Manager (DM) were conducted on 8/11/25 at 9:46 AM. During dish service, the chlorine level of the low temperature dish machine measured 0 ppm. The DM stated that she needed to contact the Maintenance Director.	F0812	Continued from page 13 regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 Corrective action for resident(s) affected by the deficient practice: Based on initial tour of kitchen it was noted the facility had failed to maintain proper storage, preparation, and sanitation in the main kitchen; maintain chemical sanitation of dish machine, clean large equipment, prevent wet nesting, remove cracked dishes, and clean 2 of 3 meals carts. On 8/11/2025 dish machine fixed by Ecolab Technician and cracked plate removed. On 8/12/2025 deep cleaning completed. Corrective action for residents with the potential to be affected by the deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 8/12/2025 the Dietary Service Director and Dietitian completed a walk-through of the kitchen and nourishment rooms to ensure all areas met standards to store, prepare, and serve sanitary food/beverages. Measures/Systemic changes to prevent reoccurrence of the deficient practice: In-service education was provided to Dietary Staff, Nursing Staff, and Environmental Service Staff on 8/19/2025 Topics included: Food storage, preparation, and sanitation within dietary services. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = F	Continued from page 14 During an interview with the Maintenance Director on 8/11/25 at 9:47 AM, he revealed that the chemical sanitization was serviced by the vendor. During a follow up interview with the DM on 8/11/25 at 9:48 AM, she revealed that the vendor last came to service the low temperature dish machine about 3 weeks ago. She stated they were supposed to test the chemical sanitization level daily. However, the dish machine temperature log only included temperatures of the rinse/wash cycles, and not the chemical sanitization level. During a follow up interview with the DM on 8/11/25 at 9:57 AM, she revealed that all breakfast dishes would be rewashed and sanitized in the 3-part sink that measured within the desirable range chemical sanitization level. The DM stated she planned to purchase paper goods to serve at lunch, so the sanitized dishes could air dry prior to dinner service. During a second follow up interview with the DM on 8/11/25 at 12:41 PM, she revealed that the vendor had fixed the dish machine an hour earlier. The DM stated the vendor reported the nozzle to the chemical sanitization was not working properly. The DM indicated that she was able to wash and sanitize all dishes prior to lunch meal service on 8/11/25. During an additional follow up interview with the DM on 8/14/25 at 8:00 AM, she revealed that she had never used a low temperature dish machine before and was not aware of the minimum chemical sanitization level. An interview was conducted with the Administrator on 8/14/25 at 12:08 PM. He revealed that the dish machine chemical sanitization level should be checked every morning and documented appropriately. If any issues were found where the level was below 50 ppm, then the vendor should have been contacted immediately. 2. An observation of the kitchen and interview with Cook #1 was conducted on 8/11/25 at 9:51 AM. The doors of the two convection ovens were coated with a light brown substance, and a darker brown substance was seen on the inside of both ovens. The bottom of the fryer was covered with a dark brown liquid and food crumbs. The food crumbs were also seen along all inside walls of the fryer. Cook #1 stated that the kitchen equipment should be cleaned weekly; however, he could not say when the ovens were cleaned last. He stated the fryer was used within the last two days, and it was cleaned sometime last week. Cook #1 indicated the fryer would	F0812	Continued from page 14 has been sustained. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Dietary Service Direction or assignee will monitor procedures for proper food storage, preparation, and sanitation in kitchen weekly x 4 weeks and then monthly x 3 months using the Dietary QA Tool Sanitation Monitoring. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = F	Continued from page 15 not be used today. An observation of the kitchen and interview with Cook #2 was conducted on 8/12/25 at 9:38 AM. The doors of the two convection ovens were coated with a light brown substance, and a darker brown substance was seen on the inside of both ovens. The bottom of the fryer was covered with a dark brown liquid and food crumbs. The food crumbs were also seen along all inside walls of the fryer. A white residue covered the outer surfaces of the steamer and the stove. Cook #2 stated the kitchen equipment was cleaned every 3 weeks and was due to be cleaned tomorrow (8/13/25). An interview was conducted with the Dietary Manager on 8/12/25 at 9:39 AM. She stated the kitchen equipment should be cleaned daily, but only she and Cook #2 were the staff willing to do so. The DM stated the last time the kitchen equipment was cleaned was two weeks ago. An observation of the kitchen and interview with Dietary Aide #1 was conducted on 8/13/25 at 7:07 AM. The plate warmer was noted to have white residue covering the entire top of the equipment, and a stiff, yellow piece of food and other brown pieces of food were seen near one of the plate openings. Dietary Aide #1 stated the evening staff on 8/12/25 were supposed to clean it. During a follow up appointment with the Dietary Manager on 8/14/25 at 8:02 AM, she revealed that she expected dietary staff to clean the kitchen equipment daily and after use. The Dietary Manager indicated that dietary staff had been very resistant to any instructions they were given. She stated she had been working on building a better team in the kitchen since she was hired at the facility five weeks ago. The Administrator was interviewed on 8/14/25 at 12:14 PM. He revealed that the cooks should follow the Dietary Manager's expectations of kitchen equipment cleaned daily and deep cleaned weekly. The Administrator stated that the Dietary Manager was new to the facility, and it would take time to improve the kitchen. 3. An observation of the kitchen and interview with the Dietary Manager were conducted on 8/11/25 at 9:55 AM. Observed on the cooks' clean rack were two large silver pans approximately 4 inches deep, and two smaller silver pans approximately 4 inches deep, were seen with wet nesting. The Dietary Manager apologized and went to rewash them. She stated the cooks were responsible for cleaning the pans they used.	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = F	Continued from page 16 During a follow up interview with Cook #1 on 8/11/25 at 9:56 AM, he stated he normally let the pans air dry on the rack in the dish room prior to storage. However, he must not have let the pans air dry fully prior to placing them ready for use. An observation of the kitchen and interview with Cook #1 was conducted on 8/11/25 at 10:01 AM. Sixteen cereal bowls and eighteen small plates had wet nesting next to the tray line. Cook #1 confirmed the dishes were wet and brought them back to the dish machine area. During a follow up interview with the Dietary Manager on 8/14/25 at 8:05 AM, she revealed that dietary staff should air dry all pots, pans, and dishes prior to storage for use. She stated she did not have enough time during dishwashing to air dry because the nursing staff did not bring the dirty dishes to the kitchen in a timely manner. The Dietary Manager indicated that the staff from the kitchen had to stop what they were doing daily to retrieve the meal trays and meal carts from each hall after service. An observation of the kitchen and interview with the Dietary Manager was conducted on 8/12/25 at 9:41 AM. Six silver pans approximately 4 inches deep, and three smaller silver pans approximately 4 inches deep, were seen with wet nesting on the clean rack in the cooks' area. The Dietary Manager stated she had educated the cooks numerous times about letting the pans air dry, but they have not complied. She further stated that she would rewash the pans that were wet. The Administrator was interviewed on 8/14/25 at 12:07 PM. He revealed that all dishes and pots/pans should not have wet nesting and be air dried prior to use. The Administrator indicated that the Dietary Manager was new to the facility, and it would take time for her to improve the dietary department. 4. An observation of the kitchen and interview with Dietary Aide #1 on 8/13/25 at 7:04 AM. Thirteen plate holders had food residue on them, and twenty-seven dinner plates had cracks. She stated that the Dietary Manager told her to throw them away, but if she did that then they would not have any plates for meal service. During a follow up interview with the Dietary Manager on 8/13/25 at 7:08 AM, she revealed that she had new dinner plates available in storage and went to go wash them.	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = F	Continued from page 17 During a follow up interview with the Dietary Manager on 8/13/25 at 7:15 AM, she revealed that she educated all dietary staff about cracked dishes and proper cleaning of the dishes. An observation of the 100 hall and interview with the Dietary Manager was conducted on 8/13/25 at 8:29 AM. The meal cart had white residue marks all over the inside and outside. The Dietary Manager stated that she told Dietary Aide #3 to clean all meal carts yesterday. An observation of the 200 hall and interview with Dietary Aide #3 was conducted on 8/13/25 at 8:31 AM. The meal cart had marks of white residue that covered the inside and outside. Dietary Aide #3 stated he was supposed to clean all meal carts yesterday but forgot. During a follow-up interview with the Dietary Manager on 8/14/25 at 8:08 AM, she revealed that she expected that the meal carts would be cleaned daily and deep cleaned on the weekends. The Administrator was interviewed on 8/14/25 at 12:12 PM. He revealed that if plates were chipped, they should not be used during meal service and should have been replaced. The Administrator indicated that all dishware should be clean before use, including meal carts.	F0812		
F0814 SS = F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to ensure debris was removed from behind the dumpsters for 3 of 3 dumpsters observed. This practice had the potential to attract pests and rodents. An observation of the dumpster area was conducted on 8/11/25 at 10:04 AM. Behind all 3 dumpsters, used debris items such as straws, cup lids, empty chip bags, and empty milk cartons were observed. An interview was conducted with the Maintenance Director on 8/11/25 at 10:07 AM. He stated that he normally picked up debris items in the parking lot, but the dietary department was responsible for the dumpster area. He stated he would grab a shovel and pick up the debris behind the dumpsters.	F0814	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F814 Corrective action for resident(s) affected by the deficient practice: The deficient practice occurred on 8/11/2025 when it was identified that 3 of 3 dumpsters failed to have debris cleaned around them. On 8/11/2025, the Maintenance Director cleaned the debris from 3 of 3 dumpsters. Corrective action for residents with the potential to be affected by the deficient practice.	09/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0814 SS = F	Continued from page 18 During an interview with the Dietary Manager on 8/12/25 at 9:52 AM, she revealed that the Maintenance Director was responsible for cleaning the dumpster area. The Maintenance Director told her that when the garbage truck emptied the dumpsters, debris would often get left behind the dumpsters. During a follow up interview with the Maintenance Director on 8/14/25 at 9:42 AM, he revealed that he was unsure of who was assigned to clean behind the dumpsters, but it was most likely him. However, he requested clarification by the Administrator. The Administrator was interviewed on 8/14/25 at 12:05 PM. He revealed that the dietary department was responsible for cleaning the dumpster area. However, maintenance and housekeeping currently cared for the dumpster area. The Administrator stated that the debris should not be left behind the dumpsters even after the dumpsters were emptied. Managing the dumpster area should be a daily cleaning task.	F0814	Continued from page 18 The deficient practice occurred on 8/11/2025 when it was identified that 3 of 3 dumpsters failed to have debris cleaned around them. On 8/11/2025, the Maintenance Director cleaned the debris from 3 of 3 dumpsters. Measures/Systemic changes to prevent reoccurrence of the deficient practice: On 8/19/2025, the Administrator began educating all staff to include administrative nurses, the Director of Nursing, Unit Managers, Minimum Data Set, Staff Development Coordinator, Treatment Nurse, Certified Nursing Assistants and Dietary Staff. This education includes ensuring that the dumpster area is clean from debris. The Administrator or designee will be responsible for ensuring that this information will be integrated into the standard orientation training including agency for all staff identified above and will be reviewed by the quality assurance process to verify that the change has been sustained. Any of the above staff who does not receive in-service training will not be allowed to work until the training has been completed by 9/10/2025. The Maintenance Director will place a cleaning schedule in the facility's Maintenance Monitoring System to check the dumpster area monthly to ensure dumpster area is cleaned. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor the compliance by utilizing the Quality Assurance Tool Dumpster Monitoring beginning the week of 9/8/2025. This monitoring will be weekly x 4 weeks and then monthly x 3 months to ensure compliance. Reports will be presented to the monthly Quality Assurance Committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, Dietary Manager and Social Worker.	
F0825 SS = D	Provide/Obtain Specialized Rehab Services	F0825	To remain in compliance with all federal and state regulations the facility has taken or will take the	09/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0825 SS = D	Continued from page 19 CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and resident, staff and physician interviews, the facility failed to provide ordered physical therapy for a resident with history of stroke and spastic contractures in 1 of 1 resident reviewed for rehabilitation services (Resident #5). Findings included: Resident #5 was admitted to the facility on 4/3/24 with diagnoses of cerebral vascular accident with right sided hemiparesis and hemiplegia with spasticity (weakness and paralysis with muscle spasms), type II diabetes, neuropathy, atrial fibrillation and depression. A quarterly Minimum Data Set (MDS) Assessment dated 6/30/25 revealed Resident #5 was cognitively intact. A revised care plan dated 6/24/25 showed focus areas for stroke, with hemiplegia/hemiparesis, contractures, falls, diabetes, atrial fibrillation, depression, activities of daily living deficits, psychotropic medication monitoring, braces for contractures and physical therapy.	F0825	Continued from page 19 actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F825 Corrective action for resident(s) affected by the deficient practice: The deficient practice occurred on 7/25/2025 when rehab services did not initiate therapy services on resident #5 within 14 days of the physician order. On 8/15/2025 a Physical Therapy screen was completed on resident #5 and the resident was referred to Occupational Therapy. Corrective action for residents with the potential to be affected by the deficient practice. On 9/9/2025, the Director of Nursing identified residents that had the potential to be affected by this practice by completing a 100% audit of all current residents for change of condition to include increase/decrease range of motion, contractures and splint management. This completed on 9/9/2025. The audit revealed 11 of 113 residents required referrals for rehab. The corrective action was that therapy referral forms were completed and given to the therapy manger for follow up. Measures/Systemic changes to prevent reoccurrence of the deficient practice: On 9/9/2025, the Administrator began educating the Rehab Manager. This education includes ensuring that residents are screened within a timely manner of being notified. The Administrator or designee will be responsible for ensuring that this information will be integrated into the standard orientation training including agency for all staff identified above and will be reviewed by the quality assurance process to verify that the change has been sustained. Any of the above staff who does not receive in-service training will not be allowed to work until the training has been completed by 9/10/2025. Monitoring Procedure to ensure that the plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0825 SS = D	Continued from page 20 Review of records revealed a facility “physical therapy functional maintenance program” sheet dated “December 2024”. The functional maintenance program specified that Resident #5 was to be up in his wheelchair for three to four hours daily, was to perform wheelchair mobility exercises and to maintain proper sitting posture while in his wheelchair. The functional maintenance program sheet contained no stipulations or benchmarks to assess for decline in function or who to notify if needs arose. A Neurology physician office note dated 7/25/25 revealed Resident #5 had spastic quadriparesis following multiple strokes and during the same visit, received botox injections to various muscle groups in his left arm and his right arm due to spasticity which had adversely affected his function. The physician noted Resident #5’s strokes in 2024 which rendered his left side weaker than his right side. The physical assessment noted restriction of left shoulder flexion, restriction of left elbow extension and supination as well as restriction of finger extension of the left and right hands due to spasticity. The physician then noted the in-office botox injection procedure and Resident #5’s need for continued physical therapy. Review of records also revealed that on 7/25/25, the Neurology physician ordered a physical therapy referral and that Resident #5 was to wear his left elbow and left wrist brace for 4 hours every day and for four hours every night. Further review of records revealed no documentation pertaining to initiation of physical therapy services following the order on 7/25/25. In an interview with Resident #5 on 8/11/25 at 10:30 AM, Resident #5 was observed sitting up in bed. He was awake, alert, groomed and watching TV. He said that he got up to his wheelchair as often as he could. Resident #5 reported that he was very concerned that the doctor had ordered physical therapy for him “a few weeks ago but I haven’t had any therapy yet”. On 8/13/25 at 09:30 AM, Resident #5 was observed in his room, awake, sitting up in bed, watching TV conversing with visitors at his bedside. In an interview with the Rehabilitation Manager on 8/13/25 at 10:30 AM, the Rehabilitation Manager informed that the 7/25/25 order for the Physical Therapy (PT) referral had not been completed yet. The Rehabilitation Manager stated that Resident #5 was on a wait list because there was only one physical therapist	F0825	Continued from page 20 correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor the compliance by utilizing the Quality Assurance Tool Rehab Monitoring and monitor 5 random residents beginning the week of 9/8/2025. This monitoring will be weekly x 4 weeks and then monthly x 3 months to ensure compliance. Reports will be presented to the monthly Quality Assurance Committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, Dietary Manager and Social Worker.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0825 SS = D	Continued from page 21 working in the building. The Rehabilitation Manager stated that when they received an order for PT, rehab services first conducted a “rehab screening”. Then if the screening gave indication that a referral was needed, then the referral was completed. The Rehabilitation Manager stated that only once the screening and referral deemed a resident was appropriate for PT services, would a resident be accepted for PT. The Rehabilitation Manager stated that there was no set timeframe for when an order was received and when services began and this varied based on a resident’s needs. The Rehabilitation Manager further stated that specific findings that moved a resident from screening to referral, to formal physical therapy also varied based on resident’s needs. The Rehabilitation Manager stated that the timeframe from 7/25/25 to 8/12/25 was longer than usual but that they were very behind schedule because there was only one therapist working on PT screenings. The Rehabilitation Manager stated that Resident #5 was last seen by PT in December 2024 and was discharged at that time with a functional maintenance program. The Rehab Manager further stated that nursing staff was to notify the physician and rehabilitation services of any need for additional therapy. On 8/13/25 at 11:00 AM, an interview with the Physical Therapist was conducted. The Physical Therapist stated that she was not contracted but was a facility staff member. The Physical Therapist confirmed that Resident #5 had received an order for a physical therapy referral on 7/25/25 and Resident #5 was on a wait list for the referral. The Physical Therapist stated that when they received an order for physical therapy, a screening was done first, then a referral, then the decision was made whether or not a resident was appropriate to “picked up” for formal physical therapy services. The Physical Therapist stated that because she was the only physical therapist in the building, she had not yet been able to screen Resident #5, but that there were only two other residents ahead of him as of today. The Physical Therapist stated that Resident #5 had been on the physical therapy schedule before but was discharged in December 2024. When he was discharged from therapy he was placed on a “functional maintenance program” in order to prevent functional decline. The Physical Therapist stated that the functional maintenance programs varied based on specific needs of residents and there was no standard criteria for how or when a resident was moved through the process of screening, to referral and then to being formally accepted for physical therapy services. The Physical Therapist further stated that because Resident #5 was on a functional maintenance program, he would be	F0825		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0825 SS = D	Continued from page 22 a lower priority for screening in the event of long wait lists, but that she was doing her best to get to all the residents on the wait list. In a follow up interview with Resident #5 on 8/13/25 at 2:00 PM, Resident #5 was observed in his room. Resident #5 stated that he had a doctor's appointment a few weeks ago, he had been feeling worse, his arms were very stiff before that appointment. The doctor gave him some injections and that helped a lot, and his arms did not feel that stiff now. Resident #5 stated that he felt better right now because of the injections he received but that the doctor told him that he “needed therapy so his arms didn’t get worse again”. He wanted to get his therapy so his arm would stay limber. Resident #5 said he wore his arm braces on his left elbow and left wrist every day for 4 hours like his doctor told him to. Resident #5 stated his family helped him put his braces on some of the time and that staff helped him at other times. Attempts to contact the ordering Neurology physician were unsuccessful. Attempts to interview Resident #5's assigned nurse (Nurses #1) were not successful. Attempts to interview the Director of Nursing were unsuccessful. In an interview with the Administrator on 8/14/25 10:45 AM, the Administrator stated that he did not know the expectations or expected timeframes of when a physical therapy order was placed and when the order should be implemented, but that sometimes the timeframes were different based on resident needs. The Administrator stated that the therapist does a screening, but he did not know anything else because that was out of his scope of practice. In an interview with the Medical Director on 8/14/25 at 2:30 PM, the Medical Director stated that the timeframe of when Resident #5’s physical therapy referral order was placed, and the current date was too long. The Medical Director said that she would have expected that order to be carried out within one week and “we dropped the ball and there was a breakdown in communication, and I will be following up on that today.”	F0825		
F0842 SS = B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F0842	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility’s allegation of compliance such that all alleged deficiencies cited	09/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = B	Continued from page 23 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F0842	Continued from page 23 have been or will be corrected by the dates indicated. F842 Corrective action for resident(s) affected by the deficient practice: The deficient practice occurred on 8/13/2025 when nurse #1 signed that she had applied compression wraps to resident #87 lower extremities, however she did not apply the wraps. On 8/13/2025, compression wraps were attempted to be applied to resident #87 lower extremities by the Director of Nursing, however the resident refused. The Director of Nursing fixed the documentation by striking out the signed Medication Administration Record on 9/5/2025. Corrective action for residents with the potential to be affected by the deficient practice. On 8/18/2025, the Director of Nursing identified residents that had the potential to be affected by this practice by completing a 100% audit of all current residents with orders for ace wraps. This completed on 8/18/2025. The audit revealed 2 of 115 residents had orders for ace wraps. There was no corrective action due to no deficient practice. Measures/Systemic changes to prevent reoccurrence of the deficient practice: On 8/18/2025, the Staff Development Coordinator began educating all staff to include administrative nurses, the Director of Nursing, Unit Managers, Minimum Data Set Nurses, Treatment Nurse and Med Aides. This education includes the correct documentation when giving medications and applying treatments including ace wraps. The Administrator or designee will be responsible for ensuring that this information will be integrated into the standard orientation training including agency for all staff identified above and will be reviewed by the quality assurance process to verify that the change has been sustained. Any of the above staff who does not receive in-service training will not be allowed to work until the training has been completed by 9/10/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = B	Continued from page 24 §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and resident and staff interviews, the facility failed to ensure accurate medical records regarding the documentation of the application of compression wraps to Resident #87's legs. The deficient practice occurred in 1 of 1 resident reviewed for resident records (Resident #87). Findings included: Review of records for Resident # 87 revealed a physician's order dated 5/28/25 for compression wraps to bilateral (both right and left) legs every morning and to be removed every evening for lymphedema. Review of Resident #87's Treatment Administration Record (TAR) for 8/13/25 revealed documentation by nursing staff that compression wraps were placed at 8:00 AM.	F0842	Continued from page 24 Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor the compliance by utilizing the Quality Assurance Tool Professional Standards Monitoring and monitor 5 random residents beginning the week of 9/8/2025. This monitoring will be weekly x 4 weeks and then monthly x 3 months to ensure compliance. Reports will be presented to the monthly Quality Assurance Committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, Dietary Manager and Social Worker.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = B	Continued from page 25 On 8/13/25 at 10:00 AM an interview with Resident #87 was conducted in conjunction with an observation. Resident #87 stated that she did not have compression wraps on her legs. Resident #87 uncovered both of her legs which revealed no compression wraps in place to either of her legs. On 8/13/25 at 2:30 PM an interview and record review, with Resident #87's primary nurse, Nurse #1, was conducted. Nurse #1 informed that she did not have anything to do with the Resident's compression wraps. Nurse #1 stated she did not know how often the compression wraps should be applied or when they should be removed. Nurse #1 reviewed the TAR for 8/13/25, which had Nurse #1's initials documenting application of the compression wraps. Nurse #1 confirmed that her initials were noted on the TAR as documenting that the compression wraps were applied on the resident by her at 08:00 AM. Nurse #1 stated she did not know how her initials "got there." Nurse #1 then acknowledged that she did not place the wraps on at 8:00 AM but said the wraps were already on, and that was what she charted on at 8:00 AM. Nurse #1 stated she did not how or when Resident #87's leg wraps were removed or who may have removed them. On 8/13/25 at 3:05PM, an interview with the Director of Nursing (DON) was conducted. The DON stated nurses should always document what they do accurately. The DON further explained the expectation was for the nurses to chart what they did and that if a task was charted as having been completed, the expectation was that particular staff member actually completed the task. In an interview with the Administrator on 8/14/25 at 11:55 AM, the Administrator stated his expectation regarding nursing documentation on a TAR was that the initials documented for an order or task at a given time would be the initials of the nurse or staff member completing the task. The Administrator further explained if the nurse or staff member's initials were present, it would indicate the nurse or staff member was the person who completed that task.	F0842		
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and	F0851	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F851	09/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0851 SS = F	Continued from page 26 contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule.	F0851	Continued from page 26 Corrective action for resident(s) affected by the deficient practice: The deficient practice occurred on 2/22/2025, 2/23/2025, 3/10/2025 and 3/16/2025 when the Payroll Based Journal revealed that there was not a Registered Nurse on site for at least 8 hours a day, however the daily staff schedules for the facility revealed that there was a Registered Nurse present on 2/22/2025, 2/23/2025, 3/10/2025 and 3/16/2025. On 9/9/2025, the Scheduler entered in time for the Registered Nurses for the dates 2/22/2025, 2/23/2025, 3/10/2025 and 3/16/2025 in the facility timecard system for at least 8 hours a day. Corrective action for residents with the potential to be affected by the deficient practice. On 9/5/2025, the Administrator completed a 100% audit the time detail report from 7/1/2025 to 9/5/2025 to ensure that there was atleast 8 consecutive hours of Registered Nursing coverage. This completed on 9/5/2025. The audit revealed 67 of 67 days with at least 8 consecutive hours of Registered Nursing coverage. There is no corrective action due to no deficient practice. Measures/Systemic changes to prevent reoccurrence of the deficient practice: On 9/5/2025, the Administrator began educating the Scheduler. This education includes ensuring that there is at least 8 consecutive Registered Nursing hours that are input into the facility's timecard system. The Administrator or designee will be responsible for ensuring that this information will be integrated into the standard orientation training including agency for all staff identified above and will be reviewed by the quality assurance process to verify that the change has been sustained. Any of the above staff who does not receive in-service training will not be allowed to work until the training has been completed by 9/10/2025. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0851 SS = F	Continued from page 27 The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to submit accurate payroll data on the Payroll Based Journal (PBJ) report to the Centers for Medicare and Medicaid Services (CMS) related to Registered Nurse (RN) hours. This was for 1 of 3 Federal Fiscal Year quarters reviewed for sufficient nurse staffing (Quarter 2: January 1-March 31, 2025). Findings included: The PBJ report for the Federal Fiscal Year Quarter 2 2025 (January 1 through March 31, 2024) revealed there were no Registered Nurse (RN) hours for 2/22/25, 2/23/25, 3/10/25, and 3/16/25. The nursing staff time detail reports for 2/22/25, 2/23/25, 3/10/25, and 3/16/25 revealed there was not a RN onsite for at least 8 hours a day. The daily staff schedules for 2/22/25, 2/23/25, 3/10/25, and 3/16/25 revealed there was a RN onsite for at least 8 hours a day. During an interview on 8/14/25 at 2:27 PM with the Scheduling Coordinator, she provided documentation of an agency RN on 2/22/25, 2/23/25, 3/10/25, and 3/16/25. The Scheduling Coordinator explained that sometimes the agency nurses don't clock in when they arrive at the facility for work. She further stated that when they fail to clock in, that information doesn't get transcribed into the PBJ report. During an interview on 8/14/25 at 4:25 PM with the Administrator, he stated he was unaware that some agency nurses were not clocking in at the facility and it resulted in inaccurate data being submitted to the PBJ. He stated that all staff, regardless of agency status, should be documenting their time in the facility timecard system.	F0851	Continued from page 27 The Administrator or designee will monitor the compliance by utilizing the Quality Assurance Tool Rehab Monitoring beginning the week of 9/8/2025. This monitoring will be weekly x 4 weeks and then monthly x 3 months to ensure compliance. Reports will be presented to the monthly Quality Assurance Committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, Dietary Manager and Social Worker.	
F0914 SS = D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v)	F0914	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan	09/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0914 SS = D	Continued from page 28 §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is NOT MET as evidenced by: Based on observations, and resident and staff interviews, the facility failed to provide a privacy curtain for 2 of 16 rooms on the 200-hall reviewed for privacy (Resident #27 and Resident #40). The findings included: a. Resident #27 was admitted to the facility on 12/07/24. The annual Minimum Data Set (MDS) dated 07/07/25 revealed Resident #27 was cognitively intact. An observation and interview conducted with Resident #27 on 08/11/25 at 10:00 AM revealed Resident #27 did not have a privacy curtain and shared a room with another resident. Resident #27's room was closest to the door and provided no privacy if the Resident's door was open. Resident #27 further revealed he had not had a privacy curtain in a while and could not recall why he did not have one. An observation conducted on 08/12/25 at 11:35 AM revealed Resident #27 did not have a privacy curtain hanging. b. Resident #40 was admitted to the facility on 07/25/25. The admission MDS dated 07/31/25 revealed Resident #40 was cognitively intact. An observation and interview conducted with Resident #40 on 08/11/25 at 10:15 AM revealed Resident #40 did not have a privacy curtain and shared a room with another resident. Resident #40's room was closest to the door and provided no privacy if the Resident's door was open. Resident #40 further revealed he had not had a privacy curtain since admission and had asked nursing staff, but they had yet to bring one. Resident #40 stated he would like a privacy curtain due to his	F0914	Continued from page 28 of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F914 Corrective action for resident(s) affected by the deficient practice: The deficient practice occurred on 8/12/2025 when it was identified that resident #27 and #40 did not have privacy curtains placed in their room. On 8/12/2025, the Housekeeping Supervisor placed privacy curtains in resident #27 and #40's room. Corrective action for residents with the potential to be affected by the deficient practice. On 8/19/2025, the Housekeeping Supervisor identified residents who had the potential to be affected by this practice by completing a 100% audit of all current resident's rooms in the facility. The audit revealed 2 of 81 resident's rooms did not have privacy curtains in their room. Measures/Systemic changes to prevent reoccurrence of the deficient practice: On 8/19/2025, the Administrator began educating all staff to include administrative nurses, the Director of Nursing, Unit Managers, Minimum Data Set, Staff Development Coordinator, Treatment Nurse, Certified Nursing Assistants and Dietary Staff. This education includes the resident's dignity and respect, HIPAA and Confidentiality and Psychological Well-being. The Administrator or designee will be responsible for ensuring that this information will be integrated into the standard orientation training including agency for all staff identified above and will be reviewed by the quality assurance process to verify that the change has been sustained. Any of the above staff who does not receive in-service training will not be allowed to work until the training has been completed by 9/10/2025. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD , WINSTON SALEM, North Carolina, 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0914 SS = D	Continued from page 29 roommate and staff constantly entering. An observation conducted on 08/12/25 at 11:10 AM revealed Resident #40 did not have a privacy curtain hanging. An observation and interview conducted with the Director of Housekeeping on 08/12/25 at 11:20 AM revealed she was not aware Resident #27 and Resident #40 did not have a privacy curtain. It was further revealed housekeeping should be checking for curtains daily and making sure they are clean and hanging. An interview conducted with the Administrator on 08/14/25 at 3:05 PM revealed he was not aware Resident #27 and Resident #40 did not have a privacy curtain. It was further revealed it was housekeeping's responsibility to make sure each resident had a privacy curtain. The Administrator stated he expected rooms to be checked daily for privacy curtains and the cleanliness of the privacy curtains.	F0914	Continued from page 29 regulatory requirements. The Administrator or designee will monitor the compliance by utilizing the Quality Assurance Tool Privacy Curtains Monitoring and monitor 5 random rooms beginning the week of 9/8/2025. This monitoring will be weekly x 4 weeks and then monthly x 3 months to ensure compliance. Reports will be presented to the monthly Quality Assurance Committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, Dietary Manager and Social Worker.	