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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks	901 Bethesda Road Winston-Salem, NC 27103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE]. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] 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 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 [DATE]. Review of the comprehensive MDS assessment dated [DATE] 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 [DATE]. Review of the comprehensive MDS assessment dated [DATE] 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 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.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 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.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.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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 [DATE] 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 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.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] and 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 [DATE] 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 by nursing staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 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 (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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 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 [NAME] #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. [NAME] #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. [NAME] #1 indicated the fryer would not be used today.An observation of the kitchen and interview with [NAME] #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. [NAME] #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 [NAME] #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

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 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. 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.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE] 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.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 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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks	901 Bethesda Road Winston-Salem, NC 27103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 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.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.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE].The annual Minimum Data Set (MDS) dated [DATE] 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 [DATE].The admission MDS dated [DATE] 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 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.