A. BUILDING ____________________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345462

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____________________________
B. WING ____________________________

(X3) DATE SURVEY COMPLETED
C 08/17/2018

NAME OF PROVIDER OR SUPPLIER
THE OAKS-BREvard

STREET ADDRESS, CITY, STATE, ZIP CODE
300 MORRIS ROAD
BREvard, NC  28712

(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

F 000 INITIAL COMMENTS

No deficiencies were cited as a result of survey event ID# T1DE11.

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

TITLe

(X6) DATE

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.
## Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:**

**The Oaks-Brevard**

**Address:**

300 Morris Road
Brevard, NC 28712

**Provider's Plan of Correction**

(Each corrective action should be cross-referenced to the appropriate deficiency)

### Laboratory Director's or Provider/Supplier Representative's Signature

| Event ID: PI0313602671 | Facility ID: 922980 |

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**Summary Statement of Deficiencies**

*Each deficiency must be preceded by full regulatory or LSC identifying information*

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>On August 16, 2018 through August 17, 2018, The Division of Health Service Regulation, Nursing Home Licensure and Certification conducted an on-site revisit. The facility was found to be in compliance effective July 26, 2018.</td>
<td></td>
</tr>
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