STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345462	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks-Brevard	300 Morris Road Brevard, NC 28712

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to obtain consent and inform the resident or Responsible Party in advance of the risks and benefits of psychotropic medications prior to initiation for 6 of 6 residents reviewed for unnecessary medications (Residents #3, #7, #6, #51, #2, and #10). The findings included:1. a. Resident #3 was admitted to the facility on [DATE] with diagnoses that included generalized anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had severe cognitive impairment. He displayed no behavioral symptoms and received antianxiety medications during the MDS assessment look-back period. Review of the March 2026 Medication Administration Record for Resident #3 revealed an active physician order dated 03/02/26 for lorazepam (antianxiety medication) 0.5 milligrams 1 tablet every 12 hours as needed for anxiety disorder. The order had a stop date of 03/16/26.Review of Resident #3's electronic medical record revealed no documentation that Resident #3's Responsible Party was informed in advance of the risks and benefits of initiating Lorazepam 0.5 mg and consented to the treatment. b. Resident #6 was admitted to the facility on [DATE] with cumulative diagnoses that included major depressive disorder, anxiety disorder, borderline personality disorder, hallucinations, and unspecified psychosis not due to a substance or known physiological condition. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had intact cognition. She displayed no behaviors and received antidepressant and antipsychotic medications during the MDS assessment look-back period. Review of the March 2026 Medication Administration Record for Resident #6 revealed the following active physician orders: -10/20/25 for risperidone (antipsychotic medication) 1 milligram (mg) at bedtime for borderline personality disorder. -10/21/25 for duloxetine (antidepressant medication) 60 mg once a day for major depressive disorder. -10/21/25 for lamotrigine (anticonvulsant and mood stabilizer) 100 mg once a day for vascular dementia, severe with mood disturbance. Review of Resident #6's electronic medical record revealed no documentation that Resident #6 or her Guardian were informed in advance of the risks and benefits of initiating risperidone 1 mg, (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	duloxetine 60 mg or lamotrigine 100 mg and consented to the treatment. c. Resident #7 was admitted to the facility on [DATE] with cumulative diagnoses that included schizophrenia, anxiety disorder, bipolar disorder, and schizoaffective disorder, bipolar type. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had moderate cognitive impairment. She had no behavioral symptoms and received antipsychotic and antidepressant medication during the MDS assessment look-back period. Review of the March 2026 Medication Administration Record for Resident #7 revealed the following active physician orders: -10/29/25 for trazodone (antidepressant medication) 100 mg at bedtime for insomnia due to other drug disorder. -10/30/25 for venlafaxine (antidepressant medication) 225 mg once a day for bipolar disorder. -01/22/26 for quetiapine (antipsychotic medication) 50 mg once a day for schizophrenia. -02/13/26 for haloperidol (antipsychotic medication) 2 milligrams (mg) twice a day for schizoaffective disorder, bipolar type. Review of Resident #7's electronic medical record revealed no documentation that Resident #7's Responsible Party was informed in advance of the risks and benefits of initiating haloperidol 2 mg, quetiapine 50 mg, trazodone 100 mg, or venlafaxine 225 mg and consented to the treatment. During interviews on 03/04/26 at 10:13 AM and 03/05/26 at 2:13 PM, the Administrator revealed they were unable to find any psychotropic consent forms for Resident #3's lorazepam 0.5 mg, Resident #6's risperidone 1 mg, duloxetine 60 mg or lamotrigine 100mg, and Resident #7's haloperidol 2 mg, quetiapine 50 mg, trazodone 100 mg, or venlafaxine 225 mg. The Administrator stated either the Social Worker (SW) or MDS Coordinator were responsible for obtaining consents for psychotropic medication use. He was not sure why the consents weren't obtained prior to initiating the medications or where the breakdown occurred. During an interview on 03/04/26 at 11:28 AM, the MDS Coordinator confirmed that either she or the SW were responsible for obtaining psychotropic medication consents. She explained when there was a new psychotropic medication order or when a change was made to an existing psychotropic medication order a consent form was obtained from the Resident or their RP; however, she stated they were not always informed of new orders or medication changes. The MDS Coordinator verified they were not able to find psychotropic medication consent forms for Resident #3, Resident #6, or Resident #7. During an interview on 03/04/26 at 3:24 PM, the SW confirmed that she or the MDS Coordinator were responsible for obtaining psychotropic medication consents. The SW explained the Psychiatric provider exited with her after seeing residents to discuss any changes to the treatment plan, such as new orders or medication changes, and then sent her the progress notes usually within 48 hours. She stated she reviewed the psychiatric progress notes when received and if there was a new psychotropic medication order, she worked on obtaining consent. The SW stated there were times that providers would add or change psychiatric medications and not let her or the MDS Coordinator know. The SW verified they were not able to find psychotropic medication consent forms for Resident #3, Resident #6, or (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #7 and was not sure where the breakdown occurred. During an interview on 03/05/26 at 12:55 PM, the Assistant Director of Nursing (ADON)/Interim Director of Nursing (DON) revealed she was aware of obtaining consents for antipsychotic medications but not for psychotropic medications. The ADON/Interim DON stated the SW was responsible for reviewing medications and provider notes and implementing appropriate measures to obtain the necessary consent. The ADON/Interim DON explained there had been a lot of changes within positions and obtaining the psychotropic consents just slipped through the cracks. 2. Resident #51 was admitted to the facility on [DATE] with diagnosis that included Alzheimer's disease, major depressive disorder, anxiety disorder, and insomnia. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #51 was severely cognitively impaired with wandering for 1 to 3 days. The MDS indicated that she took antipsychotic, antianxiety, antidepressant, and anticonvulsant medications on a routine basis during the 7 day look back period. Review of the March 2026 Medication Administration Record for Resident #51 revealed the following active physician orders:-8/2/25 for mirtazapine (antidepressant medication) 15 milligrams (mg) 1 tablet at bedtime for insomnia. -12/25/25 for fluoxetine (antidepressant medication) 40 mg 1 capsule once a day for Alzheimer's disease and major depressive disorder. -1/13/26 for lamotrigine (anticonvulsant medication used to stabilize mood disorders and treat depression) 100 mg 1 tablet once a day for major depressive disorder.-2/13/26 lorazepam (antianxiety medication) 0.5 milligrams 1 tablet twice a day for anxiety disorder. Review of Resident #51's electronic medical record revealed no documentation that Resident #51's Responsible Party was informed in advance of the risks and benefits of initiating mirtazapine 15 mg, fluoxetine 40 mg, lamotrigine 100 mg, or lorazepam 0.5 mg and consented to the treatment. During an interview on 03/04/26 at 11:28 AM, the MDS Coordinator confirmed that either she or the SW were responsible for obtaining psychotropic medication consents. She explained when there was a new psychotropic medication order or when a change was made to an existing psychotropic medication order a consent form was obtained from the Resident or their RP; however, she stated they were not always informed of new orders or medication changes. The MDS Coordinator verified they were not able to find psychotropic medication consent forms for Resident #51. During an interview on 03/04/26 at 3:24 PM, the SW confirmed that she or the MDS Coordinator were responsible for obtaining psychotropic medication consents. The SW explained the Psychiatric provider exited with her after seeing residents to discuss any changes to the treatment plan, such as new orders or medication changes, and then sent her the progress notes usually within 48 hours. She stated she reviewed the psychiatric progress notes when received and if there was a new psychotropic medication order, she worked on obtaining consent. The SW stated there were times that providers would add or change psychiatric medications and not let her or the MDS Coordinator know. The SW verified they were not able to find psychotropic medication consent forms for Resident #51 and was not sure where the breakdown occurred. During an interview on 03/05/26 at 12:55 PM, the Assistant Director of Nursing (ADON)/Interim Director of Nursing (DON) revealed she was aware of obtaining consents for antipsychotic medications but not for psychotropic medications. The ADON/Interim DON stated the SW was responsible for reviewing (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications and provider notes and implementing appropriate measures to obtain the necessary consent. The ADON/Interim DON explained there had been a lot of changes within positions and obtaining the psychotropic consents just slipped through the cracks. During interviews on 03/04/26 at 10:13 AM and 03/05/26 at 2:13 PM, the Administrator revealed they were unable to find any psychotropic consent forms for Resident #51's mirtazapine 15 mg, fluoxetine 40 mg, lamotrigine 100 mg, or lorazepam 0.5 mg. The Administrator stated either the Social Worker (SW) or MDS Coordinator were responsible for obtaining consents for psychotropic medication use. He was not sure why the consents weren't obtained prior to initiating the medications or where the breakdown occurred. 3. Resident #2 was admitted to the facility on [DATE] with diagnoses that included dementia, major depressive disorder and hallucinations. Resident #2's physician orders revealed an order dated 12/13/25 for olanzapine (an antipsychotic medication) 5 milligrams, one (1) tablet daily, for hallucinations. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had severe cognitive impairment and had received antipsychotic medications daily during the MDS look-back period. A Psychiatric Nurse Practitioner progress note dated 02/27/26 indicated Resident #2 was stable on her current medication regimen and that any reduction in the regimen would likely have risked decompensation for Resident #2. In addition, the Nurse Practitioner noted there was no indication for a gradual dose reduction of Resident #2's olanzapine 5 milligrams. Review of the Medication Administration Record (MAR) from 02/17/26 through 03/04/26 indicated an active physician order dated 12/13/25 for olanzapine 5 milligrams, one (1) tablet daily, for hallucinations. Review of Resident #2's electronic medical record revealed no documentation indicating that Resident #2's Responsible Party (RP) was informed in advance of the risks and benefits of receiving olanzapine 5 milligrams and had consented to the treatment. During an interview on 03/05/26 at 12:24 PM, the MDS Coordinator stated she was not able to locate psychotropic medication consent forms for Resident #2. She confirmed she shared responsibility for obtaining psychotropic medication consents with the Social Worker (SW). She explained that when there was a new psychotropic medication order or when a change was made to an existing order, she explained the risks and benefits of the medication with the resident or RP and then obtained a consent form. She stated she was not sure where the breakdown had occurred with Resident #2's consent for olanzapine 5 milligrams. During an interview on 03/05/26 at 12:53 PM, the SW stated she was not able to locate the psychotropic medication consent form for Resident #2. She stated she shared responsibility for obtaining psychotropic medication consents with the MDS Coordinator. The SW stated she was not sure where the breakdown had occurred with Resident #2's consent for olanzapine 5 milligrams. She stated she met with the psychiatric provider to discuss any changes to the treatment plan. In addition, she reviewed the psychiatric progress notes for new psychotropic medications and worked on obtaining consent forms for any new psychotropic medications. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/05/26 at 12:34 PM, the Interim Director of Nursing (DON) stated the SW was responsible for reviewing provider notes for psychotropic medication changes and for obtaining the necessary consents from residents or their RP. The Interim DON explained there had been many position changes and obtaining the psychotropic consents had slipped through the cracks. During an interview with the Administrator on 03/05/26 at 2:13 PM, the Administrator confirmed the MDS Coordinator and the SW shared responsibility for obtaining consents for psychotropic medication use. The Administrator stated they were unable to find the psychotropic consent form for Resident #2's olanzapine 5 milligrams. He stated he expected the consent to be obtained before initiating the medication and was not sure where the breakdown had occurred. 4. Resident #10 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, generalized anxiety disorder, major depressive disorder and cognitive communication deficit. A Psychiatric Nurse Practitioner order dated 09/04/25 specified Resident #10 to be administered olanzapine (antipsychotic medication) 5 milligrams (mg) once daily given at bedtime for unspecified dementia with other behavioral disturbance. A Psychiatric Nurse Practitioner order dated 09/12/25 specified Resident #10 to be administered lamotrigine (anticonvulsant medication) 100 mg once daily for unspecified dementia with other behavioral disturbance. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was severely cognitively impaired. The MDS indicated the resident received antidepressant, antipsychotic and anticonvulsant medication on a routine basis during the 7-day look back period. On 12/23/25 the Psychiatric Nurse Practitioner ordered trazadone (antidepressant medication) 50 mg once daily given at bedtime for unspecified dementia with other behavioral disturbance. The Medication Administration Record (MAR) from 03/01/26 through 03/05/25 indicated Resident #10 was administered olanzapine, lamotrigine and trazadone as ordered by the physician. A Psychiatric Nurse Practitioner progress note dated 02/13/26 indicated that Resident #10 was taking olanzapine 5 mg at bedtime for hallucinations and was stable with no medication changes needed. He was also taking lamotrigine 100 mg daily for anxiety and depression and reported his mood as pretty good. Resident #10 was taking trazodone 50 mg at bedtime for insomnia, and staff reported no sleep concerns. A review of Resident #10's medical record revealed no documentation that Resident #10's representative consented to or was informed in advance of the risks versus benefits of initiating olanzapine, lamotrigine or trazadone. An interview with the MDS Nurse was conducted on 03/04/26 at 11:28 AM. The MDS Nurse stated that when a new psychotropic medication was ordered or changed, corporate policy required the MDS Nurse or the Social Worker to obtain the psychotropic consents. She stated that new medication orders were reviewed during daily clinical meetings. She also stated that the Social Worker was responsible for reviewing the Psychiatric Nurse Practitioner progress notes. An interview with the Social Worker was conducted on 03/04/26 at 3:24 PM. The Social Worker stated (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that Psychiatric Nurse Practitioners hold an exit meeting with her after seeing residents to discuss any changes or new medications. The Social Worker reported that the Psychiatric Nurse Practitioners send her a copy of the progress notes within 24 to 48 hours. The Social Worker also stated that she and the MDS Nurse were responsible for obtaining consents. An interview with the Director of Nursing (DON) was conducted on 03/05/26 at 12:55 PM. The DON stated that the Social Worker was responsible for reviewing medications and provider notes and implementing appropriate measures to obtain consents. An interview with the Nursing Home Administrator was conducted on 03/05/26 at 2:13 PM. The Nursing Home Administrator stated the Social Worker and the MDS Nurse were responsible for obtaining consents and he was not sure where the breakdown occurred.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews and resident and staff interviews, the facility failed to maintain advance directives in both locations designated by the facility for 1 of 21 residents reviewed for advance directive (Resident #23).The findings included:Resident #23 was admitted to the facility on [DATE]. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 was cognitively intact.During an interview on [DATE] at 10:42 AM, Resident #23 stated he was a Do Not Resuscitate (DNR) and had informed the facility upon admission he had a DNR in place. Resident #23 stated that DNR meant staff would not provide Cardiopulmonary Resuscitation (CPR) if needed.A review of Resident #23's physician orders revealed an order for an advanced directive of DNR dated [DATE].A review of Resident #23's Electronic Medical Record (EMR) revealed the advanced directive banner at the top of Resident #23's EMR page documented DNR as his advance directive.Review of the advance directive notebook kept at the nurse's station revealed there was no advance directive on file for Resident #23.On [DATE] at 2:41 PM, an interview was conducted with Nurse #1, who was assigned to Resident #23 on [DATE]. Nurse #1 explained that if she had needed to immediately determine a resident's advanced directives, she would have looked in the advance directives notebook kept at the nurse's station or in the resident's EMR on the computer. Nurse #1 indicated the Interim Director of Nursing (DON) was responsible for ensuring the code forms were in the notebook stored at the nurse's station.An observation and interview were conducted with the Interim DON on [DATE] at 2:55 PM. The Interim DON confirmed she was responsible for ensuring the advanced directives notebook matched the orders in the EMR and for obtaining the provider's signature on the DNR form for residents with DNR orders in the EMR. After review and observation of the advanced directives binder, the Interim DON confirmed Resident #23 had a DNR order in the EMR and his DNR form was not present in the advanced directives notebook. She stated the DNR form should have been in the advanced directives binder, but with all the changes at the facility, it had been missed.An interview was conducted with the Administrator on [DATE] at 2:12 PM. The Administrator stated the code status information in the advanced directives binder and the EMR should have matched. He expected staff to check for code status in the advanced directives binder or in the EMR.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide a Notice of Medicare Non-Coverage (NOMNC, a form used by skilled nursing facilities to inform residents of the last day of Medicare Part A coverage and provides instructions on how to file an expedited appeal) and/or a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN, a form used by skilled nursing facilities to inform residents about potential costs and coverage limitations for services that may not be covered by Medicare) prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary notification review (Residents #97 and #6).Findings included:1. Resident #97 was admitted to the facility on [DATE].Review of the Beneficiary Notice worksheet provided by the Administrator on 03/03/26 revealed Resident #97's Medicare Part A coverage for skilled services ended on 10/31/25. Resident #97 discharged home to the community on 10/31/25.Review of Resident #97's medical record revealed no evidence a NOMNC was reviewed with or provided to Resident #97 or her Responsible Party (RP).During an interview on 03/04/26 at 11:28 AM, the Minimum Data Set (MDS) Coordinator revealed she was responsible for issuing NOMNCs and SNF ABNs. She explained therapy staff informed her when a resident's Medicare Part A skilled coverage was scheduled to end and she consulted with the provider to determine whether any additional skilled services, such as wound care, were required. If no further skilled needs were identified, she completed and reviewed the applicable notices with the resident or their RP. The MDS Coordinator stated when Resident #97 discharged home, the Social Worker (SW) and Financial Counselor were covering for her while she was on vacation and the issuance of the NOMNC was overlooked. She confirmed they were unable to locate any documentation showing that a NOMNC was issued to Resident #97. During an interview on 03/05/26 at 2:13 PM, the Administrator revealed the MDS Coordinator was responsible for issuing a NOMNC at least two days in advance of skilled services ending. The Administrator stated he would have expected Resident #97 to have received a NOMNC when her Medicare Part A skilled services ended, per regulatory guidelines.2. Resident #6 was admitted to the facility on [DATE].A Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with and signed by Resident #6 on 11/13/25 which indicated her Medicare Part A coverage for skilled services would end on 11/15/25. Resident #6 remained in the facility.Review of Resident #6's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #6.During an interview on 03/04/26 at 11:28 AM, the Minimum Data Set (MDS) Coordinator revealed she was responsible for issuing NOMNCs and SNF ABNs. She explained therapy staff informed her when a resident's Medicare Part A coverage for skilled services were ending and she spoke with the provider to make sure there wasn't something else the resident could be skilled for that therapy wasn't aware of, such as wounds. If there was nothing else that could be skilled, she then completed and reviewed the applicable notices with the resident or their RP. The MDS Coordinator stated she just forgot to provide a SNF ABN to Resident #6 when the NOMNC was issued.During an interview on 03/05/26 at 2:13 PM, the Administrator revealed the MDS Coordinator was responsible for issuing a NOMNC at least two days in advance of skilled services ending and a SNF ABN if the resident remained in the facility and/or appealed the NOMNC. The Administrator stated he would have expected Resident #6 to have received a SNF ABN when her Medicare Part A skilled services ended, per regulatory guidelines.

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation after a new serious mental illness disorder was identified for a resident previously determined to have a Level I PASRR status (Resident #71) and failed to develop a care plan that incorporated the PASRR Level II determination recommendations for a resident with an active diagnosis of a serious mental illness (Resident #6) for 2 of 3 residents reviewed for PASRR.The findings included:.1. A PASRR Determination Notification letter dated 03/01/23 revealed Resident #71 had a Level I PASRR with no expiration date that indicated no further PASRR screening is required unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness or if present, suggests a change in treatment needs for those conditions.Resident #71 admitted to the facility on [DATE] with diagnoses that included anxiety disorder.A psychiatric progress note dated 05/22/24 noted in part, Resident #71's daughter reports that [Resident #71} had a past psychiatric history of PTSD related to witnessing her son die at their home. No reports of flashbacks or nightmares. No psychotropic medications are indicated at this time. Will continue to monitor for signs and symptoms of PTSD.A psychiatric progress note dated 11/22/24 revealed Resident #71 had diagnoses of major depressive disorder that was chronic and stable with the plan to continue the current dose of sertraline (antidepressant medication) 50 milligrams (mg) once a day. It was also noted she had a diagnoses of PTSD that was chronic and stable with no reported anxiety or traumatic reoccurrences with the plan to continue monitoring.The annual Minimum Data Set (MDS) assessment dated [DATE] Resident #71 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Her active diagnoses included anxiety disorder, depression (other than bipolar) and PTSD. She received antianxiety and antidepressant medication during the MDS assessment look-back period.A psychiatric progress note dated 12/05/25 revealed Resident #71 had a diagnosis of major depressive disorder that was chronic and stable with the plan to continue the current dose of sertraline 75 mg once a day. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 had moderate impairment in cognition. Her active diagnoses included depression and she received antidepressant medication during the MDS assessment look-back period.The facility was unable to provide documentation that a request was submitted for a Level II PASRR evaluation for Resident #71 following the new mental illness diagnoses of major depressive disorder and PTSD.During interviews on 03/04/26 at 3:24 PM and 03/05/26 at 10:37 AM, the Social Worker (SW) revealed she was responsible for submitting requests for Level II PASRR evaluations, however, she was not always notified when a resident was diagnosed with a new mental illness. She explained the psychiatric provider typically sent her the progress notes usually within 48 hours of seeing residents and when she reviewed the progress notes, if she noticed a new mental illness diagnosis, she submitted a request for Level II PASRR evaluation. The SW stated she did not submit a request for a Level II PASRR evaluation following the new diagnoses of major depressive disorder and PTSD for Resident #71 and it was an oversight.During an interview on 03/05/26 at 2:13 PM, the Administrator stated the SW as responsible for submitting requests for Level II PASRR evaluations. The Administrator stated he would expect for the SW to abide by the regulatory guidance and submit requests for Level II PASRR evaluations with any new mental illness diagnosis or change in a resident's condition.2. Resident #6 was admitted to the facility on [DATE]. Her cumulative diagnoses included major depressive disorder, anxiety disorder, borderline personality disorder, hallucinations, and unspecified psychosis not due to a substance or known physiological condition.The quarterly Minimum Data Set (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345462	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks-Brevard	300 Morris Road Brevard, NC 28712

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(MDS) dated [DATE] revealed Resident #6 had severe cognitive impairment. She displayed delusions, verbal behavioral symptoms directed toward others 4 to 6 days, and other behavioral symptoms not directed toward others 1 to 3 days during the MDS assessment look-back period.A PASRR Determination Notification letter dated 11/03/25 revealed Resident #6 had a Level II PASRR with no expiration date and noted nursing placement was appropriate with specialized services determination of psychological testing and psychiatric evaluation.Review of Resident #6's comprehensive care plan, last reviewed/revised 01/12/26, revealed no care plan that addressed the Level II PASRR specialized services determination.During an interview on 03/04/26 at 3:24 PM, the Social Worker revealed she submitted requests for Level II PASRR evaluations when needed and the MDS Coordinator was responsible for developing the care plan if a resident had a Level II PASRR.During an interview on 03/04/26 at 4:05 PM, the MDS Coordinator confirmed she was responsible for developing resident care plans. She confirmed Resident #6 had a Level II PASRR and a care plan should have been developed. The MDS Coordinator stated it was an oversight.During an interview on 03/05/26 at 2:13 PM, the Administrator revealed it was his expectation that residents with a Level II PASRR determination would have care plans developed per regulatory guidance.