STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345066	A. Building B. Wing	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davidson Health & Rehab Center	4748 Old Salisbury Road Lexington, NC 27295

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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with staff, Medical Director, Nurse Practitioner (NP) and emergency room Physician, the facility failed to provide treatment and services to replace an old, discolored, and leaking gastric feeding tube after 5/04/25 when approximately 5 inches of the tube broke off during routine feeding tube care. In addition, the facility failed to schedule an appointment with a gastroenterologist to assess for a feeding tube replacement. On 6/18/25, the feeding tube site was found with approximately 25 maggots in the skin surrounding her feeding tube during care. Resident #1 was sent to the Emergency Department (ED), where approximately 5 more maggots were removed, and it was noted there was some induration (thickening and hardening of the skin) and erythema (abnormal redness of the skin or mucous membranes) concerning for cellulitis (bacterial infection of the skin and the tissue beneath the skin). The ED provider documented the feeding tube appeared aged and soiled and a new feeding tube was inserted. Resident #1 was admitted to the hospital for treatment of sepsis (a life-threatening response to infection) with acute hypoxia (low levels of oxygen in the tissue) due to abdominal wall cellulitis, a catheter-associated urinary tract infection (UTI), and bacteremia (presence of bacteria in the blood). She was treated with intravenous (IV) antibiotics and was discharged on 6/23/25 with orders to continue IV antibiotics for 2 additional weeks. A reasonable person has an expectation of receiving treatment and care to prevent an infestation of maggots and would have experienced feelings such as embarrassment, anger, and disgust. The deficient practice occurred for 1 of 3 residents reviewed for feeding tubes (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses including vascular dementia, cognitive communication deficit, neuromuscular dysfunction of the bladder, a gastrostomy (a surgical procedure for inserting a tube through the abdomen wall and into the stomach) tube and dysphagia (difficulty swallowing). Resident #1's current comprehensive care plan noted she had a feeding tube to maintain adequate nutrition and hydration. Interventions included for staff to monitor for abdominal pain, distension, tenderness, and nausea or vomiting. Resident #1's quarterly Minimum Data Set (MDS) dated [DATE] documented she had short- and long-term memory problems and severely impaired cognition for decision-making, inattention, disorganized thinking, and altered level of consciousness constantly present. The MDS noted she had limited range of motion in both upper extremities and was dependent on staff for completion of her activities of daily living (ADLs). The MDS indicated she had an indwelling catheter and a feeding tube, received 51% or more of her calories and 501 cc of fluid daily by the feeding tube. Resident #1's May 2025 and June 2025 Medication Administration Record (MAR) noted Resident #1 received Isosource (tube-feeding formula) 1.5 Cal formula at 55 milliliters an hour through her gastric tube starting at 5:00 AM and continuing until 3:00 AM the next morning. An additional entry noted for the nurse to provide 200 cubic centimeters (cc) of water every 4 hours and to flush the tube with 60 cc of water before administering medications and 30 cc of water between each medication administered. Resident #1's May 2025 through June 2025 nursing progress notes, MAR, and the Treatment Administration Record (TAR) did not document any abnormalities with Resident #1's feeding tube. The TAR noted for the nurse to cleanse Resident #1's skin surrounding the feeding tube site daily with normal saline, apply T-drain sponge, and secure with tape. The daily site care was signed as being completed daily on the MAR until 6/18/25 when she went to the hospital. Nurse #3 documented on 5/4/25 and 5/5/25 during the night shift for providing feeding tube care and flushes. Resident #1's nursing progress notes dated 5/04/25 at 9:46 PM written by Nurse #3 documented that when she was de-clogging and flushing the feeding tube, several inches of the tube broke off, but noted the feeding tube was still patent and functioning. In a phone interview on 6/27/25 at 10:09 AM, Nurse #3 said in May, while providing medications and flushes, approximately 5 inches of the end of Resident #1's feeding tube broke off into her hand. Nurse #3 stated at that time, the feeding tube tubing was thicker silicone, and it appeared old and was no longer transparent. Nurse #3 indicated the tubing was very long, and there was still more than an inch of tubing available to provide flushes and formula. She stated she wrote the incident to the provider in the communication log and reported the incident to the oncoming nurse (Nurse #2) for a referral to a gastroenterologist. Nurse #3 explained when she documented she was de-clogging the tubing, it was not due to an obstruction, it was due to a small amount of residual formula left in the tube that she needed emptied into the stomach. Nurse #3 said she had not observed any leaks or abnormalities, such as a sweet smell from the formula, prior to the tubing breaking or in the following days before she was hospitalized. The