STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345160	A. Building B. Wing	10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davis Health Care Center	1011 Porters Neck Road Wilmington, NC 28411

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 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 observation, record review, and interviews with staff, resident, Physician and Wound Care Specialist, the facility failed to identify an environmental hazard and supervise Resident #1. Resident #1 was newly admitted to the nursing home, severely cognitively impaired and blind. On 10/11/25, Nurse Aide (NA) #1 placed Resident #1, who was seated in his wheelchair, in front of the lit fireplace in the dining room after he expressed feeling cold. NA #1 then left to assist another nurse aide, leaving Resident #1 unsupervised. While unattended, Resident #1 tipped his wheelchair over backward, falling against the fireplace. His head, back, and shoulders came into contact with the hot mesh grate. Resident #1 yelled out. Resident #2 was on the other side of the fireplace and yelled for help from staff. NA#1 responded and alerted Nurse #1. Resident #1 told NA #1 his head was burning. Nurse #1 responded, and moved Resident #1 away from the fireplace. Emergency Medical Services (EMS) were contacted. Upon arrival, EMS assessed the resident's pain level at 10 out of 10 and administered three doses of narcotic pain medication during transport to the hospital. At the hospital, Resident #1 was diagnosed with second-degree burns (damage to the outer layer of skin and part of the underlying layer caused by contact with a hot object with redness, swelling, blisters and pain which may be severe) with blistering to the back of his scalp (approximately palm-sized), right shoulder, upper back, and left index finger. He also sustained a hematoma to the back of his head. A burn center consultation determined that acute intervention or transfer was not required, and topical antibiotic ointment was recommended. Resident #1 remained hospitalized until 10/13/25 and required additional narcotic pain medication during his stay. On 10/15/25, the Wound Care Specialist performed a sharp selective debridement procedure to remove the necrotic or dead tissue from the wounds to the scalp and shoulder. Additionally, the facility lacked safety precautions to prevent residents from accessing or activating the fireplaces or coming into contact with the hot mesh grates. turning on the fireplace or touching the mesh grate of the fireplace. This deficient practice affected 1 of 4 residents reviewed for supervision to prevent accidents (Resident #1). There were six households in the nursing home and two of which had free-standing, double-sided fireplaces in the middle of the common area dividing the living and dining room. The other four households had single-sided wall fireplaces in the common living room areas with no precautions in place to prevent residents access to touching the grates in front. Immediate jeopardy began on 10/11/25 when staff left Resident #1 without staff supervision in the dining room with a lit fireplace that had no physical barrier to restrict access from the hot surfaces. Immediate jeopardy was removed on 10/18/25 when the facility implemented an acceptable plan of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of D (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure that education is completed and monitoring systems are in place and are effective. Findings included:The owner's manual for the gas fireplace indicated that children and other individuals may be susceptible to accidental contact burns. The fireplace consisted of tempered glass and a decorative mesh grate barrier in front of the decorative logs and heating elements. Important safety and operating information indicated that the tempered glass will become hot and the hot glass will cause burns. Safety information further indicated to not touch the glass until cooled and keep a clear space of 3 feet in front of the fireplace. A physical barrier is recommended if there are individuals at risk in the area. To restrict access to the fireplace an adjustable safety gate should be installed to keep individuals at risk away from the hot surfaces of the fireplace. A switch lock or wall remote control with a child protection lockout feature should be installed. Never leave children or at-risk adults alone near a hot fireplace whether it is operating or cooling down. High temperatures may ignite clothing or other flammable materials. Clothing, furniture, draperies and other flammable materials must not be placed on or near the fireplace. Children and adults should be alerted to the hazard of high surface temperatures and should be kept away to avoid burns or clothing ignition. The manual further indicated that when the wall switch is turned to the on position the fireplace will ignite and run continuously at the high flame setting with no adjustment of the flame height or temperature setting possible. Resident #1 was admitted on [DATE] with diagnoses of vascular dementia, history of falls and glaucoma. Resident #1's care plan, dated 10/8/25, identified a problem of highly impaired vision related to glaucoma. Interventions included adapting the environment to resident's needs, assessing loss of vision on resident's functional status, orienting to changes in environment and providing an environment that is free of clutter. The care card dated 10/8/25 used by the Nurse Aides revealed Resident #1 had a diagnosis of vascular