

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Davis Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>Based on record review, and staff and resident interviews, the facility failed to provide a resolution and communicate the efforts to address grievances reported during Resident Council meetings for 10 of 12 months reviewed (June 2024, July 2024, August 2024, September 2024, October 2024, November 2024, December 2024, January 2025 February 2025, March 2025).</p> <p>Findings included.</p> <p>The Resident Council meeting minutes were reviewed for the period of April 2024 through March 2025. The meeting minutes did not include resolutions to the concerns expressed by the residents for the following months:</p> <p>6/26/24: The Resident Council minutes noted concerns regarding not getting evening showers that were scheduled. Staff wearing headphones during their shift and having snacks available.</p> <p>7/10/24: The Resident Council minutes did not include a discussion regarding resolution of old business including the concerns that were reported. Concerns were reported again regarding receiving scheduled showers and staff being on their phones and having ear buds in during resident care.</p> <p>8/10/24: The Resident Council minutes did not include a discussion regarding resolution of old business including the concerns that were reported during the July meeting. No new concerns were reported.</p> <p>9/4/24: The Resident Council minutes did not include a discussion regarding resolution of old business including concerns reported during July 2024 meeting. New concerns were reported regarding short staffing and answering call lights.</p> <p>10/16/24: The Resident Council minutes did not include a discussion regarding resolution of old business. Concerns were reported regarding timeliness of medications, answering call lights, and getting breakfast served late.</p> <p>11/13/24: The Resident Council minutes did not include a discussion regarding resolution of old business. Concerns were reported regarding timeliness of medications, answering call lights, and Nurse Aides being disrespectful, and staff using headphones and cell phones during shift.</p> <p>12/11/24: The Resident Council minutes did not include a discussion regarding resolution of old business. Concerns were reported regarding shower schedules not being adhered to, and getting breakfast served to late and earlier than 10:00 AM.</p> <p>(continued on next page)</p>

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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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1/29/25: The Resident Council minutes did not include a discussion regarding resolution of old business. No new concerns were reported in the meeting minutes.</p> <p>2/12/25: The Resident Council minutes did not include a discussion regarding resolution of old business from previous months meetings. Concerns were voiced regarding shower schedules not being followed.</p> <p>3/5/25: The Resident Council minutes did not include a discussion regarding resolution of old business. No repeat concerns were reported during the meeting.</p> <p>During the Resident Council meeting interviews on 4/16/25 at 10:05 AM residents in attendance stated that they had ongoing concerns that had been voiced for months during the Resident Council meetings. Residents stated their concerns were not being addressed and there was no discussion held at the beginning of each monthly meeting to address any resolutions regarding concerns voiced from the previous month. Residents reported breakfast continued to be served late on one of the units. Shower schedules continued to not be adhered to. Call lights were not being responded to within a reasonable time, and staff continued to use headphones or ear buds during care.</p> <p>During an interview with the Activity Director on 4/16/25 at 11:00 AM she stated she was recently hired two weeks ago and was now the full-time Activities Director. She stated she did not know how the meetings were being conducted prior to her taking on this role. She stated she would be including a discussion regarding resolution of any concerns at the beginning of each meeting moving forward. She indicated she had been instructed to notify the appropriate department of any concerns voiced during the monthly Resident Council meetings and would ensure that the concerns were being addressed.</p> <p>During an interview on 04/16/25 at 2:42 PM the Administrator stated she became the Administrator in January 2025. She stated she did not know how the previous Administrator and Activities Director handled the concerns voiced during the Resident Council meetings. She stated she had no documentation that could show the grievances reported during the monthly meetings had been addressed. She stated the process now included that the department managers typically attend the monthly Resident Council meetings, and the concerns voiced were sent to each department to address. She stated moving forward she would ensure that Resident Council minutes were being addressed each month. She indicated staff education would be held on Resident Rights and resolving and following up on grievances reported during the monthly Resident Council meetings.</p>

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<p>F 0640</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to transmit Annual Minimum Data Set (MDS) assessments (Resident #14, Resident #58, and Resident #27) and a Discharge MDS assessment (Resident #80) to the Centers for Medicare and Medicaid Services (CMS) system 14 days after completion of the assessment for 4 of 23 residents reviewed for MDS assessments.</p> <p>Findings included:</p> <p>a. Resident #14 was admitted on [DATE].</p> <p>Resident #14's Annual MDS assessment with an assessment reference date (ARD) of 1/31/25 was listed as production batch. The Annual MDS assessment had not been transmitted to CMS within the required timeframe.</p> <p>b. Resident #58 was admitted on [DATE].</p> <p>Resident #58's Annual MDS assessment dated [DATE] status indicated finalized. The Annual MDS assessment had not been transmitted to CMS within the required timeframe.</p> <p>c. Resident 27 was admitted on [DATE].</p> <p>Resident #27's Annual MDS assessment dated [DATE] status was listed as production batch. The Annual MDS assessment had not been transmitted to CMS within the required timeframe.</p> <p>d. Resident #80 was admitted on [DATE].</p> <p>Review of Resident #80's MDS assessments indicated a discharge return not anticipated MDS assessment dated [DATE] had a status listed as finalized. This discharge MDS assessment had not been transmitted to CMS within the required timeframe.</p> <p>An interview was conducted with the Director of Nursing (DON) on 4/15/25 at 1:15 PM. The DON stated she was new to the position, the MDS nurses were all new and she oversaw the MDS calendar of assessments. The DON stated she was responsible for the management and coordination of the assessments. The DON stated there were 3 new nurses that had not worked in MDS previously and they were being trained but were not functioning yet in the role of MDS. The DON stated the term finalized indicated that the MDS assessment was completed but not transmitted and the term production batch indicated the MDS assessment was not sent. The DON indicated that the assessments were to be transmitted within the regulatory time frame which was 14 calendar days after the completion date. The DON stated the assessments were not transmitted within the required time frame due to changes in personnel in the MDS department.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>Based on observations, and staff, Ombudsman, Director of Dining Services, Certified Dietary Manager, Club Cook, Compliance Coordinator, and Registered Dietitian (RD) interviews, and record review, the facility failed to have no greater than a 14-hour lapse between the provision of a substantial evening meal and breakfast the following day for residents served their meals on 5 of 8 meal carts (Club area Cart-1&2; Pavilion area Cart; Haven area Cart, and River Bend area Cart) utilized for meal service. This practice had the potential to affect all the residents (91 of 91) in the facility for meal delivery.</p> <p>The findings included:</p> <p>An interview with the Ombudsman on 04/11/25 at 9:43 AM indicated that there were problems with the meal service times. The Ombudsman stated lunch and dinner meals were served early and breakfast was late.</p> <p>A schedule of the Dining Service Times was provided by the facility on 04/15/25. A review of this schedule indicated the meal cart delivery times allowed as much as 15 - 16 hours to lapse between the last meal of the day and first meal of the following day.</p> <p>An observation was conducted at the Rehabilitation Hall on 04/17/25 at 8:47 AM and indicated the breakfast trays were being served.</p> <p>An interview with Nursing Assistant (NA#1) on 04/17/25 at 8:47 AM revealed that they started serving breakfast between 8:15 AM and 8:45 AM.</p> <p>An observation in the Club Dining Room on 04/17/25 at 8:49 AM revealed the residents were being served breakfast.</p> <p>An interview with the Hospitality Aide (HA#1) 04/17/25 at 8:49 AM revealed they started serving the breakfast meal at 8:30 AM.</p> <p>An interview and observation with Resident #14 on 04/17/25 at 8:50 AM revealed the resident sitting in the Club dining room eating breakfast. Resident #14 stated breakfast was good, but anything would taste good when you were really hungry. The resident stated that it was a long time between dinner and breakfast, and she was hungry in the morning at breakfast.</p> <p>An observation on 04/17/25 at 8:55 AM revealed residents on the Riverbend Hall were being served breakfast trays.</p> <p>An observation in the Club Dining Room on 04/17/25 at 8:59 AM revealed meal trays were being plated to be served.</p> <p>On 04/17/24 at 9:30 AM, Director of Dining Services provided a copy of the facility's current Dining Service Times. A review of the facility's current Dining Service Times (not dated) were scheduled as follows: Breakfast 8:00 AM, Lunch 12:00 PM, and Dinner 5:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The Club area Cart #1 delivered at 4:30 PM for dinner and 9:30 AM for Breakfast, indicative of a 17-hour and time span between the two meals.</p> <p>-The Club area Cart #2 was delivered at 4:30 PM for dinner and 9:30 AM for Breakfast, indicative of a 17-hour time span between the two meals.</p> <p>-The Pavilion area Cart was delivered at 4:30 PM for dinner and 8:30 AM for Breakfast, indicating a 16-hour time span between the two meals.</p> <p>-The Haven Hall meal cart was delivered at 4:30 PM for dinner and 8:30 AM for Breakfast, indicative of a 16-hour time span between the two meals.</p> <p>-The River Bend Hall meal cart was delivered at 4:30 PM for dinner and 8:30 AM for Breakfast, indicative of a 16-hour time span between the two meals.</p> <p>An interview with the Compliance Coordinator on 04/17/25 at 9:35 AM revealed the interdisciplinary team had discussed mealtimes in recent Quality Assurance (QA) meetings but had not come up with a conclusion as to how to ensure that meals are served timely and within the appropriate time frames. The Compliance Coordinator stated that there needs to be a process in place to ensure that meals are served within the appropriate time frames.</p> <p>An interview conducted on 04/17/25 at 9:40 AM with the Director of Dining Services and the Certified Dietary Manager revealed that residents' breakfast and dinner meals were currently served 15 hours or greater between the dinner meal and breakfast meal service times, which should be less than 14 hours.</p> <p>An interview conducted on 04/17/25 at 12:40 PM with the facility's Registered Dietitian (RD). During the interview, the RD was shown the facility's Dining Service Times schedule provided and asked what her thoughts were with regards to the time lapse between the evening meal and breakfast the following day. The RD stated, 15 hours or more, is not okay. The RD acknowledged that the facility would need to offer a nourishing snack to everyone if greater than 14 hours elapsed between Dinner and Breakfast the next day. She reported that to her knowledge, the facility did not meet these requirements.</p> <p>An interview was conducted on 04/17/25 at 12:50 PM with Club [NAME] #1. She said breakfast in the Club Dining Room was served usually between 9 AM - 9:30 AM. She said the facility staff does not pass out evening snacks to residents. She said facility staff used to go around with carts of substantial snack carts in the evenings, but no more. The [NAME] said dinner to breakfast meals from 5:00 PM to 9:00AM (16 hours) was way too long between meals, without a substantial evening snack. She said if they had the snack carts back, they would be able to go around and offer residents an evening substantial snack like a peanut butter or ham sandwich, like they used to, which according to her would be a great idea. Upon review, the [NAME] stated she was not sure why the dinner carts were delivered from the main kitchen around 4:30 PM or why breakfast was ready around 9:00 AM, which was over 15 hours between dinner and breakfast meals. The [NAME] also said she was not sure why the facility stopped using the snack carts or stopped offering residents a significant evening snack, like sandwiches, and now if the residents ask, they offer them a package of crackers or maybe a small plastic fruit cup.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interviews, the facility failed to coordinate a plan of care with the Hospice provider for 2 of 2 residents (Resident #54 and #21) reviewed for Hospice care.</p> <p>The findings included:</p> <p>a. Resident #54 was admitted to the facility on [DATE] with medical diagnoses which included in part: Hospice, senile degeneration of the brain, influenza, malnutrition, abnormal weight loss, and dementia.</p> <p>An Election of Hospice Benefit form was signed by Resident #54's Responsible Party (RP) on 02/07/25.</p> <p>Review of the 02/20/25 significant change Minimum Data Set (MDS) assessment revealed Resident #54 had severe cognitive impairments, and Hospice care was indicated.</p> <p>Review of the care plan dated 04/10/25 included activities for daily living (ADL) self-deficit related to dementia, chronic pain related to the history of fractures, and a nutritional deficit problem. No facility care plan problems indicated that Resident #54 received Hospice services.</p> <p>A review of Resident #54's electronic care plan record did not reveal a current hospice plan of care, only Hospice progress notes.</p> <p>b. Resident #21 was admitted to the facility on [DATE] with medical diagnoses which included in part: encephalopathy (brain dysfunction or damage), polymyalgia (widespread muscle pain and stiffness), anorexia, depression, pleural effusion, dementia, pain, hypertension, and heart disease.</p> <p>Review of the 04/03/25 Minimum Data Set (MDS) assessment revealed Resident #21 had severe cognitive impairments, and Hospice care was indicated.</p> <p>An Election of Hospice benefit was signed by the resident and resident's power of attorney (POA) on 04/04/25.</p> <p>Review of the care plan dated 04/10/25 included activities for daily living (ADL) self-deficit related to dementia, acute and chronic pain related to the history of fractures, and a nutritional deficit problem due to diagnosis of dementia and weight loss. No facility care plan problems indicated that Resident #21 received Hospice services.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the MDS Nurse Instructor/Director of Nursing (DON) on 04/15/25 at 1:15 PM. She confirmed that Residents #54 elected Hospice benefit on 02/07/25, and Resident #21 elected Hospice benefit on 04/04/25, and that the Hospice benefit services were ongoing. The MDS Nurse/DON stated that the facility care plan should contain information regarding Hospice services and interventions provided for the two residents but did not. The DON could not locate any documentation to show that the facility's care plan had been collaborated with the Hospice staff for either Resident #54 or Resident #21. She further indicated that she was training two new MDS Nurses, and that the two new MDS Nurses must have overlooked updating the facility's care plans for Resident #54 and Resident #21 to include a Hospice section. The DON said she was ultimately responsible for not following up with Hospice as she should have, and for the facility of not having a clear process in place to obtain and coordinate a Hospice care plan. She said after the MDS Nurse received resident's complete Hospice admission documentation, including a Hospice care plan, the nurse would collaborate with the Hospice Nurse, to develop a facility Hospice care plan. The care plan should be developed and entered into the resident's electronic medical record within 3 to 5 days after receiving the Hospice documentation and care plan, which the MDS Nurse failed to do.</p> <p>An interview was conducted with the Clinical Compliance Administrator on 04/17/25 at 10:20 AM. She said it was her expectation that the MDS Nurses to incorporate Hospice documentation and care plan into their care plan, which they did not do.</p> <p>An interview was conducted with the Hospice Nurse on 04/17/25 at 10:30 AM. She stated that she kept most of Resident #54 and Resident #21's Hosice orders, assessments, and notes in her computer, which were scanned to the facility timely. The Hospice Nurse stated she was not aware that Resident #54 and Resident #21's Hospice care plans were not added to the facility's care plans by the facility's MDS nurses. She said the MDS nurses should have updated the facility's care plan to include her Hospice care plan, so that all facility and Hospice staff were all on the same page regarding residents' plan of care.</p> <p>An interview was conducted with the Administrator and Director of Nursing (DON) on 04/17/25 at 10:00 AM. The DON and Administrator revealed that there should have been Hospice information included in the facility's care plan for Resident #54 or #21 and there was not.</p> <p>An interview was conducted with the Administrator on 04/17/25 at 10:05 AM. She indicated it was her expectation that the Hospice section be available in the facility's care plan for all residents receiving Hospice services. She further explained that her expectation was for Hospice care plan to have been developed and available in the facility's care plan for Resident #54 and Resident #21, which there wasn't.</p>		