STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345568	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davis Health and Wellness Center at Cambridge Vill	83 Cavalier Drive Ste 200 Wilmington, NC 28405

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop a person-centered care plan in the area of falls for 2 of 3 residents reviewed for falls (Resident #1 and Resident #2).The findings included:1. Resident #1 was admitted to the facility on [DATE] with diagnoses which included a left knee fracture.The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #1 was cognitively intact and required partial to moderate assistance for transfers. Resident #1 was coded for a fall with fracture prior to admission and one fall without injury since admission to the facility. The MDS admission assessment further noted the care area assessment (a standardized assessment tool to identify potential problems and need in specific areas, such as falls, used to develop individualized care plans) for falls was triggered for a care plan to be initiated.Review of Resident #1's care plan initiated on 9/01/25 and last revised on 9/16/25 revealed no care plan was in place for fall risk.The nursing progress note dated 9/08/25 at 6:21 am revealed Resident #1 was observed on the floor near the room door. Resident #1 denied any pain or discomfort and had no injuries noted.The nursing progress note dated 9/09/25 at 6:30 am revealed Resident #1 was observed by the Nurse Aide (NA) to be on the floor next to the bed. The bed was noted to be in the lowest position possible. Resident #1 reported left knee pain and was administered acetaminophen for the pain.The event report dated 9/21/25 at 8:38 am revealed Resident #1 had an unwitnessed fall in the room. The event report further noted Resident #1 did not report any pain and did not have any injury noted.A telephone interview was conducted with the MDS Nurse on 10/07/25 at 2:24 pm. The MDS Nurse revealed when she completed the MDS assessment she would look at nursing progress notes, therapy notes, and provider notes to determine if a specific care area required a care plan to be initiated. The MDS Nurse further stated she normally would do the care plan for the items triggered by the CAA (care area assessment) at the same time as she completed the MDS assessment. The MDS Nurse confirmed the CAA for falls was triggered to have a care plan initiated for Resident #1. The MDS Nurse stated she was not sure why she did not enter a fall risk care plan for Resident #1, but she stated she must have just missed it. The MDS Nurse stated the facility conducted a weekly interdisciplinary team (IDT) meeting that she did not attend, and the facility would have been able to update the care plan as needed at the meeting.An interview was conducted with the Interim Director of Nursing (DON) on 10/08/25 at 12:21 pm, who revealed the IDT team had a weekly meeting at which time each resident was discussed and the goal was to ensure that the care plan reflected what was discussed for each resident. The Interim DON stated the care plan should have been updated during the weekly IDT meeting by the MDS Nurse, but she stated the MDS Nurse was not present for the weekly IDT meetings to ensure the care plans reflected the needs of the resident.During an interview on 10/08/25 at 1:00 pm with the Administrator she revealed the MDS Nurse was responsible to develop the fall risk care plan for Resident #1.2. Resident #2 was admitted to the facility on [DATE] with diagnoses which included dementia. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #2 had severe cognitive impairment and required partial to moderate assistance for transfers. Resident #2 was coded for a fall prior to admission and one fall without injury since admission to the facility. The MDS admission assessment further noted the care area assessment (CAA) for falls was triggered for a care plan to be initiated.Review of Resident #2's care plan initiated on 9/17/25 revealed no care plan was in place for fall risk. The nursing progress note dated 9/18/25 at 8:04 am revealed Resident #2 was found on the floor in room with no apparent injury.The nursing progress note dated 10/02/25 at 3:30 pm revealed Resident #2 had a witnessed fall with no injury noted.The nursing progress note dated 10/03/25 at 7:00 pm revealed Resident #2 had a witnessed fall in room with no injury noted.A telephone interview was conducted with the MDS Nurse on 10/08/25 at 12:26 pm who confirmed Resident #2 did not have a care plan for fall risk in place. She stated she would normally have developed the fall risk care plan when she completed the MDS and care area assessment, but she must have missed it. An interview was conducted with the Interim Director of Nursing (DON) on 10/08/25 at 12:21 pm, who revealed the IDT team had a weekly meeting at which time each resident was discussed and the goal was to ensure that the care plan reflected what was discussed for each resident. The Interim DON stated the care plan should have been updated during the weekly IDT meeting by the MDS Nurse, but she stated the MDS Nurse was not present for the weekly IDT meetings to ensure the care plans reflected the needs of the resident.During an interview on 10/08/25 at 1:00 pm with the Administrator she revealed the MDS Nurse was responsible to develop the fall risk care plan for Resident #2