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	03/26/2026

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

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record reviews and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least eight consecutive hours per day seven days a week for 9 of 172 days reviewed for sufficient staffing (4/12/25, 4/25/25, 4/26/25, 5/9/25, 6/7/25, 6/8/25, 8/2/25, 8/3/25 and 9/21/25).Finding included:The Payroll Based Journal (PBJ) report for the Federal Fiscal third quarter of 2025 (April, May, June) and the Federal Fiscal fourth quarter of 2025 (July, August, September) reported the facility was without RN coverage for eight consecutive hours per day.A review of the daily census posting sheets for the months of 4/12/25 to 9/30/25, indicated a consistent census less than 60 residents in the facility and no RN coverage for eight consecutive hours for the following dates: 4/12/25, 4/25/25, 4/26/25, 5/9/25, 6/7/25, 6/8/25, 8/2/25, 8/3/25, 9/21/25. A review of the daily nursing staffing sheets for the months of 4/1/25 to 9/30/25 indicated there was no RN scheduled for at least eight consecutive hours for the following dates: 4/12/25, 4/25/25, 4/26/25, 5/9/25, 6/7/25, 6/8/25, 8/2/25, 8/3/25, 9/21/25. There was no RN recorded as working eight consecutive hours on the timecard records reviewed for the following dates 4/12/25, 4/25/25, 4/26/25, 5/9/25, 6/7/25, 6/8/25, 8/2/25, 8/3/25, 9/21/25.During an interview with the Administrator on 3/26/26 at 8:55 AM, she stated that she was responsible for ensuring that an RN was scheduled to work eight consecutive hours each day in the facility. She acknowledged that since beginning her role last year, she had been aware of ongoing difficulties in maintaining this required RN coverage. She explained that the facility relied on agency nurses for RN shifts, and when an agency RN failed to report for a scheduled shift, she was often unable to secure a replacement and the previous Director of Nursing was unavailable, resulting in gaps in the required eight consecutive hours of RN coverage. The Administrator reported that she had since hired additional Registered Nurses and had a new Director of Nursing who understood the responsibility to ensure consistent RN coverage.

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 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 and Physician interviews the facility failed to obtain consent and inform the resident or Responsible Party in advance of the risks and benefits of psychotropic medications (medications that alter brain chemicals and are used to treat conditions such as anxiety and depression and include the medications classified as antidepressants) prior to initiation for 7 of 7 residents reviewed for unnecessary medications (Residents #13, #4, #16,#1,#26, #12, #3). Findings included: a). Resident #13 was admitted on [DATE] with a diagnosis of depression. Review of Resident #13's physician orders revealed an order dated 2/13/26 for the antidepressant medication duloxetine delayed release 30 milligrams (mg) twice per day for depression. A review of Resident #13's electronic medical record (EMR) indicated no documentation that the resident or resident representative was informed in advance of the risks or benefits of initiating the psychotropic antidepressant medication duloxetine prescribed for depression. Review of Resident #13's admission Minimum Data Set (MDS) assessment dated [DATE] indicated that the resident was cognitively intact and received an antidepressant medication. A review of Resident #13's electronic Medication Administration Record from February 2026 and March 2026 revealed that the resident received the antidepressant duloxetine as ordered. b). Resident #4 was admitted on [DATE] with diagnosis which included stroke and depression. A review of Resident #4's physician orders revealed an order dated 8/24/24 for the psychotropic antidepressant medication sertraline (antidepressant) 75 milligrams at bedtime for depression. Review of Resident #4's quarterly Minimum Data Set assessment dated [DATE] indicated that the resident had mild cognitive impairment and received an antidepressant on a regular basis during the assessment period. A review of Resident #4's physician orders revealed an order dated 3/11/26 for the psychotropic antidepressant medication amitriptyline 25 milligrams at bedtime for insomnia. A review of Resident #4's electronic medical record (EMR) indicated no documentation that the resident or resident representative was informed in advance of the risks or benefits of initiating the psychotropic antidepressant medications sertraline or amitriptyline. A review of Resident #4's electronic Medication Administration Record for March 2026 revealed that the resident received the psychotropic antidepressant medication amitriptyline daily as ordered. c). Resident #16 was admitted on [DATE] with diagnosis which included stroke and depression. A review of Resident #16's physician orders revealed an order dated 8/25/25 for the psychotropic antidepressant medication sertraline 150 milligrams daily for recurrent depressive disorder. The order was discontinued on 1/19/26. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #16's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that the resident was cognitively intact and received an antidepressant during the past 7 days. A review of Resident #16's electronic Medication Administration Record from 8/25/25 through 1/19/26 revealed that the resident received the psychotropic antidepressant medication sertraline daily as ordered. A review of Resident #16's physician orders revealed an order dated 1/19/26 for the psychotropic antidepressant medication sertraline 100 milligrams daily. A review of Resident #16's electronic Medication Administration Record for 1/19/26 through 3/24/26 revealed that the resident received the psychotropic antidepressant medication sertraline daily as ordered. A review of Resident #16's electronic medical record (EMR) indicated no documentation that the resident or resident representative was informed in advance of the risks or benefits of initiating the psychotropic antidepressant medication sertraline. d). Resident #1 was admitted on [DATE] with diagnosis which included major depressive disorder, anxiety, falls and muscle weakness. Review of Resident #1's electronic health record revealed a physician order dated 3/4/26 for the psychotropic antidepressant medications trazadone 50 milligrams at bedtime as needed for insomnia and bupropion hydrochloride sustained release 12 hour 150 milligrams once per day for depression. A review of Resident #1's electronic medical record (EMR) indicated no documentation that the resident or resident representative was informed in advance of the risks or benefits of initiating the psychotropic antidepressant medications trazadone and bupropion. Review of Resident #1's electronic Medication Administration Record for March 2026 revealed that resident received the psychotropic antidepressant medications bupropion 150 milligrams once per day daily and received trazadone as needed on 3/4/26, 3/5/26, 3/9/26, 3/17/26 and 3/18/26. A review of Resident #1's admission Minimum Data Set (MDS) assessment dated [DATE] indicated that the resident was cognitively intact and received an antidepressant during the last 7 days. e.) Resident #26 was admitted to the facility on [DATE] with diagnoses including dementia and insomnia. A physician's order dated 3/13/26 for Resident #26 revealed to continue Trazodone (an antidepressant medication) 50 milligrams (mg) at bedtime for insomnia. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #26 was cognitively intact and received an antidepressant medication. A review of the Medication Administration Record (MAR) dated March 2026 revealed Resident #26 received Trazodone 50 mg tablets as ordered by the Physician from 3/13/26 through 3/24/26. A review of the electronic medical record contained no documentation that Resident #26 or his (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Responsible Party (RP) was provided information regarding: the name of the medication, the purpose of the medication, risks and benefits, alternatives, and the right to refuse. There was no signed informed consent form and no progress note documenting an informed consent discussion. f). Resident #12 was admitted to the facility on [DATE] with a diagnosis of major depression. A physician's order dated 3/10/26 for Resident #12 revealed to continue Prozac (an antidepressant medication) 10 mgs by mouth once a day. The Minimum Data Set admission assessment dated [DATE] revealed Resident #12 was cognitively intact and received an antidepressant medication. A review of the Medication Administration Record dated March 2026 revealed Resident #12 received Prozac 10 mg tablets as ordered by the Physician from 3/11/26 through 3/24/26. A review of the electronic medical record contained no documentation that Resident #12 or his Responsible Party (RP) was provided information regarding: the name of the medication, the purpose of the medication, risks and benefits, alternatives, and the right to refuse. There was no signed informed consent form and no progress note documenting an informed consent discussion. g). Resident #3 was admitted to the facility on [DATE] with a diagnosis of major depression. A physician's order dated 3/23/25 for Resident #3 revealed Duloxetine (an antidepressant medication) 20 mg tablets by mouth twice a day for major depressive disorder. The Minimum Data Set annual assessment dated [DATE] revealed Resident #3 was cognitively intact and received an antidepressant medication. A review of the Medication Administration Record dated March 2025 through March 2026 revealed Resident #3 received Prozac 10 mg tablets twice a day as ordered by the Physician. A review of the electronic medical record contained no documentation that Resident #3 or her Responsible Party (RP) was provided information regarding: the name of the medication, the purpose of the medication, risks and benefits, alternatives, and the right to refuse. There was no signed informed consent form and no progress note documenting an informed consent discussion. During an interview on 3/23/26 at 3:15 PM the Case Manager stated that she was not aware that consents were required for psychotropic medications and she did not obtain consents prior to the medications being initiated. During an interview with the Director of Nursing (DON) on 3/23/26 at 3:30 PM she stated that she was not aware that consent was required for psychotropic medications. The DON stated that the facility had not been obtaining informed consent prior to initiating psychotropic medications, and they did not currently have consent forms in place. During a phone interview on 3/25/26 at 3:45 PM the Physician stated that she was unaware that consent had not been obtained prior to initiating a psychotropic medication. The Physician stated that obtaining informed consent from the resident and/or the Responsible Party was essential prior to initiating psychotropic medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to discard expired food items stored in 1 of 2 reachˆin refrigerators. This deficient practice had the potential to affect the safety of food served to residents. Findings included: During the initial tour of the Kitchen on 03/22/26 at 10:20 AM along with [NAME] #1 the following expired food items were observed in the reach-in refrigerator: - A plastic container of sauerkraut that was opened with a discard date of 2/24/26.- A plastic container of canned pears that was opened with a discard date of 3/12/26.- A plastic container of canned tuna that was opened with a discard date of 3/19/26.- A plastic container of canned pork and beans that was opened with a discard date of 3/21/26. During an interview on 3/22/26 at 10:25 AM [NAME] #1 stated all kitchen staff were responsible for checking for and discarding expired foods. He stated he was the weekend cook and had not gone through the refrigerator this morning (3/22/26) to check it. He stated he also worked yesterday (3/21/26) and the expired food items were overlooked. During an interview on 03/24/26 at 12:42 PM the Dietary Manager stated perishable foods were to be discarded after 3 days and staff should have removed the foods from the refrigerator on the discard date. He stated the kitchen staff were aware of this. During an interview on 03/24/26 at 12:52 PM the Administrator stated she expected the kitchen staff to check for expired foods daily and remove any foods by the discard date.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and Physician interviews, the facility failed to notify the Physician when Resident #13 missed 8 doses of the antibiotic doxycycline for 1 of 1 resident reviewed for notification (Resident #13). Findings included: Resident #13 was admitted on [DATE] with diagnosis which included chronic osteomyelitis (bone infection) and diabetes. Review of a physician order dated 2/13/26 indicated Resident #13 was ordered doxycycline 100 milligrams (mg) by mouth twice per day indefinitely for chronic osteomyelitis. Review of Resident #13's Medication Administration Record (MAR) for March 2026 revealed the following documentation for the medication doxycycline 100 mg twice a day. On 3/9/26 the lunch dose was documented by Nurse #6 as the medication was unavailable and the medication was not administered. On 3/9/26 PM (evening) dose was documented by Nurse #1 as the medication was unavailable and the medication was not administered. There was no documentation in the nursing progress notes that the physician was notified of the missed medication.On 3/10/26 lunch dose was documented by Nurse #7 as the medication was unavailable and the medication was not administered. There was no documentation in the nursing progress notes that the physician was notified of the missed medication.On 3/10/26 PM dose was documented by Nurse #1 as waiting pharmacy delivery and the medication was not administered. On 3/11/26 lunch dose was documented by Nurse #5 as the medication was unavailable, awaiting pharmacy refill and the medication was not administered. On 3/11/26 PM dose was documented by Nurse #2 as the medication was unavailable and the medication was not administered. On 3/12/26 lunch dose was documented by Nurse #7 as medication was unavailable and the medication was not administered. On 3/12/26 PM dose was documented by Nurse #2 as medication was unavailable and the medication was not administered. An interview conducted with Nurse #6 on 3/23/26 at 11:20 AM revealed that she was assigned to Resident #13 on 3/9/26 from 7:00 AM to 7:00 PM and she did not administer the prescribed antibiotic. Nurse #6 stated that she did not call the physician to report the medication was not administered and she did not recall why she did not report this to the physician. Attempts were made to interview Nurse #1 via telephone with voicemail messages left on 3/24/26 and 3/25/26 with no return call received. Attempts were made to interview Nurse #7 via telephone with voicemail messages left on 3/24/26 and 3/25/26 with no return call received. An interview with Nurse #5 on 3/25/26 at 1:50 PM revealed that she was assigned to Resident #13 on 3/11/26 from 7:00 AM to 7:00 PM. She stated that the doxycycline was not available for Resident #13 on 3/11/26, and she did not notify the physician that the resident did not receive the prescribed dose. Nurse #5 stated that she did not think it was necessary to inform the physician that the resident did not receive the prescribed antibiotic. An interview was conducted with Nurse #2 on 3/25/26 at 12:15 PM. Nurse #2 was assigned to resident #13 on 3/11/26 and 3/12/26 from 7:00 PM to 7:00 AM. Nurse #2 stated that the medication doxycycline was unavailable for Resident #13 on 3/11/26 so she did not administer it. Nurse #2 stated that she did not inform the physician that the antibiotic doxycycline was not administered as ordered on 3/11/26 and 3/12/26. Nurse #2 acknowledged that she should have informed the physician of the missed doses of antibiotic, but at the time she did not realize it was necessary. An interview with the Director of Nursing (DON) on 3/25/26 at 2:30 PM revealed that she expected medications to be administered as ordered by the physician. The DON stated she would expect nursing staff to notify the provider when a medication was not available so that an alternate medication could be prescribed, if necessary. An interview conducted with the Physician on 3/25/26 at 3:45 PM revealed that she was unaware that Resident #13 had missed 8 doses of the prescribed antibiotic. The Physician stated that medications should be available and administered as ordered. The Physician further stated that if a medication was not available the provider should be notified to determine if another medication should be ordered.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, the Pharmacy Manager and the Physician, the facility failed to obtain the antibiotic doxycycline, which was prescribed for Resident #13 twice daily for the treatment of chronic osteomyelitis (a bone infection). As a result, Resident #13 missed a total of eight doses of the medication on 3/9/26, 3/10/26, 3/11/26, and 3/12/26. According to the Physician, the resident did not experience an adverse outcome; however, the failure to provide the prescribed antibiotic placed the resident at risk for potential complications. This occurred for 1 of 1 resident reviewed for pharmacy services.Findings included:Resident #13 was admitted on [DATE] with diagnosis which included chronic osteomyelitis and diabetes. Review of a physician order dated 2/13/26 indicated Resident #13 was ordered doxycycline 100 milligrams (mg) by mouth twice per day indefinitely for chronic osteomyelitis.Review of Resident #13's Medication Administration Record (MAR) for March 2026 revealed the following documentation for the doxycycline 100 mg twice a day. On 3/9/26 the lunch dose was documented by Nurse #6 as the medication was unavailable and the medication was not administered. On 3/9/26 PM (evening) dose was documented by Nurse #1 as the medication was unavailable and the medication was not administered. On 3/10/26 lunch dose was documented by Nurse #7 as the medication was unavailable and the medication was not administered.On 3/10/26 PM dose was documented by Nurse #1 as waiting pharmacy delivery and the medication was not administered. On 3/11/26 lunch dose was documented by Nurse #5 as the medication was unavailable, awaiting pharmacy refill and the medication was not administered. On 3/11/26 PM dose was documented by Nurse #2 as the medication was unavailable and the medication was not administered. On 3/12/26 lunch dose was documented by Nurse #7 as medication was unavailable and the medication was not administered. On 3/12/26 PM dose was documented by Nurse #2 as medication was unavailable and the medication was not administered. An interview conducted with Nurse #6 on 3/23/26 at 11:20 AM revealed that she was assigned to Resident #13 on 3/9/26 from 7:00 AM to 7:00 PM and she did not administer the prescribed antibiotic. She stated that the doxycycline was not available for Resident #13 on 3/9/26 in the resident's medication cabinet. She acknowledged that she did not check the automated medication dispensing machine and she did not contact the pharmacy to obtain the medication from the local back up pharmacy. Nurse #6 stated that she did not recall why she did not call the pharmacy to obtain the medication doxycycline for Resident #13.Attempts were made to interview Nurse #1 via telephone with voicemail messages left on 3/24/26 and 3/25/26 with no return call received.Attempts were made to interview Nurse #7 via telephone with voicemail messages left on 3/24/26 and 3/25/26 with no return call received.An interview with Nurse #5 on 3/25/26 at 1:50 PM revealed that she was assigned to Resident #13 on 3/11/26 from 7:00 AM to 7:00 PM. She stated that the doxycycline was not available for Resident #13 on 3/11/26 in the resident's medication cabinet, and she did not check the automated medication dispensing machine and did not contact the pharmacy to obtain the medication from the local back up pharmacy. Nurse #5 stated that she documented awaiting pharmacy refill as she assumed that the medication would be delivered later that day or the next day.An interview was conducted with Nurse #2 on 3/25/26 at 12:15 PM. Nurse #2 reported that she was assigned to Resident #13 on 3/11/26 and 3/12/26 for the 7:00 PM to 7:00 AM shift. She stated that the doxycycline was unavailable on 3/11/26 and therefore she did not administer it. Nurse #2 stated that when she determined the doxycycline was not in Resident #13's medication cabinet, she checked the automated medication dispensing machine however the correct dose of the medication was not available in the machine. Nurse #2 acknowledged that she did not contact the pharmacy on 3/11/26 to obtain the medication but did place a call on 3/12/26. She also stated that she did not request that the medication be sent through the backup system. Nurse #2 reported that she informed the pharmacy the medication was (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not available in the facility and was told that the pharmacy had the order listed as once per day instead of twice daily. She acknowledged that she should have requested immediate delivery to ensure that Resident #13 did not miss any doses. She further stated that she did not report to the Director of Nursing or Physician that there was a discrepancy with the frequency of the medication between the pharmacy and the facility.Attempts were made to interview Nurse #7 with voicemail messages left with no return call received.An interview with the Director of Nursing (DON) on 3/25/26 at 2:30 PM revealed that she expected medications to be administered as ordered by the physician. The DON stated she would expect nursing staff to notify the pharmacy when a medication was not available in the facility so that the medication could be obtained through the local backup pharmacy. The DON further explained that the facility utilized an automated medicationˆdispensing machine that housed an emergency supply of select medications. She stated that once the nurses determined the medication was not in the resident's medication cabinet, they should have checked the automated dispensing machine. If the medication was not available there, the next step should have been to contact the pharmacy to obtain the medication from the local backup pharmacy. The DON stated that she had since learned that the automated medication-dispensing machine did not contain the correct dose of doxycycline.An interview conducted with the Physician on 3/25/26 at 3:45 PM revealed that she was unaware that Resident #13 had missed 8 doses of the prescribed antibiotic. The Physician stated that medications should be available and administered as ordered. The Physician indicated that there was a potential for the infection that the antibiotic was ordered to treat to worsen if it was not administered for several days. An interview with the Pharmacy Manager was conducted on 3/26/26 at 12:00 PM. The Pharmacy Manager stated that the pharmacy had systems in place to ensure medications were available daily, including twiceˆdaily deliveries and backup processes when necessary. The Pharmacy Manager indicated that if the pharmacy was notified that the doxycycline was not available in the facility, it would have been sent to the facility through the backup system. The Pharmacy Manager was unable to explain why the pharmacy had entered the order for doxycycline as once daily rather than twice daily. He stated that the pharmacy reconciled the orders sent to the pharmacy with what was entered by the nursing staff into the computer, after which a label was generated and the prescription was filled. He indicated that although missing eight doses of doxycycline was not expected to result in a significant clinical outcome, there was a potential risk for worsening of the infection for which the medication had been prescribed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interviews the facility failed to act on the Consultant Pharmacist's monthly medication regimen review and change the frequency of Resident #8's hydroxyzine 25 milligrams (an antihistamine used to treat anxiety, allergic reactions, and induce sleep) from three times a day to twice a day after the physician signed to change the medication order. This occurred for 1 of 2 residents reviewed for medication administration (Resident #8). Findings included: Resident #8 was admitted to the facility on [DATE] with diagnoses including pruritus (persistent itching). A physician's order dated 7/10/23 for Resident #8 revealed hydroxyzine 25 milligram tablets three times a day for pruritus. The Consultant's Pharmacist's Medication Regimen Review dated 1/12/26 noted that the Physician signed the pharmacy consult report on 12/12/25 to change Resident #8's hydroxyzine to 25 milligrams every morning and midday and discontinue three times a day. This order was not changed in the electronic medical record. Please correct and report the medication error. Review of Resident #8's Medication Administration Record (MAR) dated 12/12/25 through 1/18/26 revealed Resident #8 continued to receive hydroxyzine 25 mgs three times a day as evidenced by the nurse's signatures. The physician's order was updated by the Director of Nursing on 1/19/26 and entered into Resident #8's electronic medical record for hydroxyzine 25 mgs twice a day morning and midday. During an interview on 3/25/26 at 2:35 PM the Director of Nursing (DON) stated the Consultant Pharmacist emailed her the medication regimen reviews each month. The DON stated the process now included that once she received the monthly Pharmacy reports, she would address the nursing recommendations and place the physician recommendations in the Physician's notebook for review unless there was something that needed immediate attention then she would call the Physician. Once the Physician signed off on any medication order changes from the Pharmacy recommendations the DON would make the order change in the resident's electronic medical record. The DON stated she was new to the facility in December 2025 and did not realize the importance of addressing the pharmacy reviews promptly and therefore there was a delay in addressing the December (2025) reports. She stated she did not implement the new order to reduce the hydroxyzine 25 mg dose to twice a day until she was notified by the Consultant Pharmacist the following month (January 2026) that she had not changed the frequency. The DON stated she should have acted on the Pharmacy reports once she received them. During an interview on 3/26/26 at 11:00 AM the Clinical Compliance Administrator stated that the Consultant Pharmacist's medication regimen reviews should be addressed as soon as the DON received the monthly reports. She indicated the DON had received education on the importance of addressing the medication regimen reviews promptly. The Consultant Pharmacist was on leave during the survey and unavailable for an interview.

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	03/26/2026

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

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and residents, staff, Physician and Pharmacy Manager interviews, the facility failed to ensure residents were free from significant medication errors when 1.) Eight doses of the antibiotic doxycycline, prescribed twice daily for the treatment of chronic osteomyelitis (bone infection), were omitted on 3/9/26, 3/10/26, 3/11/26 and 3/12/26 for Resident #13. 2.) Resident #5 received 15 milligrams (mg) of mirtazapine (a psychotropic medication primarily prescribed for depression) instead of the physicianˆordered 7.5 mg dose. 3.) Resident #8 continued to receive hydroxyzine 25 mg (an antihistamine that directly affects the central nervous system and used to treat anxiety, allergic reactions, and induce sleep) three times a day instead of the reduced dose of twice a day. The residents did not experience any significant outcome, however this failure placed Resident #13 at risk for potential complications, and the potential for altered sedation levels, and an increased risk of adverse effects for Resident #5 and Resident #8. This occurred for 3 of 3 residents reviewed for medication administration (Resident #13, Resident #5, and Resident #8). Findings included: 1.) Resident #13 was admitted on [DATE] with diagnosis which included chronic osteomyelitis and diabetes. Review of a physician order dated 2/13/26 indicated Resident #13 was ordered doxycycline 100 milligrams (mg) by mouth twice per day indefinitely for chronic osteomyelitis. Review of Resident #13's admission Minimum Data Set assessment dated [DATE] indicated the resident was cognitively intact and received an antibiotic. Review of Resident #13's Medication Administration Record (MAR) for March 2026 revealed the following documentation for the medication doxycycline 100 mg twice a day. On 3/9/26 the lunch dose was documented by Nurse #6 as the medication was unavailable and the medication was not administered. On 3/9/26 PM (evening) dose was documented by Nurse #1 as the medication was unavailable and the medication was not administered. On 3/10/26 lunch dose was documented by Nurse #7 as the medication was unavailable and the medication was not administered. On 3/10/26 PM dose was documented by Nurse #1 as waiting pharmacy delivery and the medication was not administered. On 3/11/26 lunch dose was documented by Nurse #5 as the medication was unavailable, awaiting pharmacy refill and the medication was not administered. On 3/11/26 PM dose was documented by Nurse #2 as the medication was unavailable and the medication was not administered. On 3/12/26 lunch dose was documented by Nurse #7 as medication was unavailable and the medication was not administered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/26 PM dose was documented by Nurse #2 as medication was unavailable and the medication was not administered. An interview conducted with Nurse #6 on 3/23/26 at 11:20 AM revealed that the pharmacy normally delivered to the facility in the afternoon and at night. Nurse #6 acknowledged that she was assigned to Resident #13 on 3/9/26 from 7:00 AM to 7:00 PM and did not administer the prescribed antibiotic. Nurse #6 stated that she did not recall why she did not call the pharmacy to obtain the ordered medication for Resident #13. Attempts were made to interview Nurse #1 via telephone with voicemail messages left on 3/24/26 and 3/25/26 with no return call received. Attempts were made to interview Nurse #7 via telephone with voicemail messages left on 3/24/26 and 3/25/26 with no return call received. An interview with Nurse #5 on 3/25/26 at 1:50 PM revealed that she was assigned to Resident #13 on 3/11/26 from 7:00 AM to 7:00 PM. She stated that the medication doxycycline was not available for Resident #13 on 3/11/26, and she did not contact the pharmacy to obtain the medication. An interview was conducted with Nurse #2 on 3/25/26 at 12:15 PM. Nurse #2 was assigned to Resident #13 on 3/11/26 and 3/12/26 from 7:00 PM to 7:00 AM. Nurse #2 stated that the medication doxycycline was unavailable for Resident #13 on 3/11/26 so she did not administer it. Nurse #2 stated that she thought that the medication would come from the pharmacy and indicated that the medication was not available in the facility's back up medication system. Nurse #2 stated that on 3/12/26 when the medication was again not available, she called the pharmacy to find out where it was. Nurse #2 stated that the pharmacy stated that they thought the medication was ordered once per day and did not think that the prescription should have run out. Nurse #2 stated that she informed the pharmacy that the medication was ordered twice per day. An interview with the Pharmacy Manager was conducted on 3/26/26 at 12:00 PM. The Pharmacy Manager stated that the pharmacy had systems in place to ensure medications were available daily, including regular deliveries and backup processes when needed. He indicated that although missing eight doses of the antibiotic doxycycline was not expected to result in a significant clinical outcome, there was a potential risk for worsening of the infection for which the medication was prescribed. An interview with the Director of Nursing (DON) on 3/25/26 at 2:30 PM revealed that she expected medications to be administered as ordered by the physician. The DON stated she would expect nursing staff to contact the pharmacy to obtain any medication that was not available. An interview conducted with the Physician on 3/25/26 at 3:45 PM revealed that she was unaware that Resident #13 had missed 8 doses of the prescribed antibiotic. The Physician stated that not administering prescribed doses of an antibiotic was a significant medication error that needed to be addressed. The Physician stated that medications should be available and administered as ordered. The Physician indicated that there was a potential for the infection that the antibiotic was ordered to treat to worsen if it was not administered for several days. 2.) Resident #5 was admitted to the facility on [DATE] with diagnoses including major depression and Parkinson's disease. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5's hospital Discharge summary dated [DATE] revealed medication orders for Mirtazapine 15 milligrams (mg) take one half tablet by mouth at 11:00 PM. A review of Resident #5's electronic medical record revealed on 2/27/26 the Director of Nursing entered an order for Mirtazapine 15 mgs by mouth at bedtime for dementia associated with Parkinson's disease. The Medication Administration Record (MAR) dated 2/27/26 through 3/10/26 revealed that Mirtazapine 15 mg tablets were administered to Resident #5 nightly as evidenced by the nurses' signatures. Review of Resident #5's electronic medical record from 2/27/26 through 3/10/26 contained no documentation indicating the mirtazapine dose had been changed, clarified, or corrected by the prescriber. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #5 was cognitively intact and received antidepressant medication. During an interview on 3/23/26 Resident #5 stated he felt pretty good, he was scheduled to discharge home tomorrow (3/24/26). He indicated he was not aware of the dosage of his medications and stated he had no concerns regarding his medications. During an interview on 3/24/26 at 2:00 PM the Director of Nursing (DON) stated she entered the order for Resident #5's mirtazapine. She entered one tablet (15 mg) of mirtazapine instead of one-half tablet (7.5 mg). The DON stated they had a two-step system to verify that physician orders were entered accurately. This included that the admission nurse entered medication orders from the hospital discharge summary, if the admission nurse was not available the DON would enter the medication orders which was what happened when Resident #5 was admitted . Then a second nurse, which was typically the residents assigned nurse, was responsible for double checking the orders to ensure accuracy. The DON stated she transcribed the order wrong, and the two-step process was missed, and a second check was not done for this order. She stated she did not know who the second nurse was who should also have verified the orders. She was notified of the medication error by the Consultant Pharmacist and corrected the dose on 3/10/26. The DON stated Resident #5 has had no change in condition and was to be discharged home today. During a phone interview on 3/26/26 at 12:00 PM the Pharmacy Manager stated receiving 15 mgs of mirtazapine instead of 7.5 mgs was generally considered safe and 15 mgs was considered to be a low dose. He stated mirtazapine had dose dependent effects and sometimes lower doses were more sedating than higher doses. During a phone interview on 3/25/26 at 3:30 PM the Physician stated Resident #5 receiving mirtazapine 15 mgs instead of 7.5 mgs would cause no concern and Resident #5 had not experienced any outcome from receiving the medication. 3.) Resident #8 was admitted to the facility on [DATE] with diagnoses including pruritus (persistent itching). A physician's order dated 7/10/23 for Resident #8 revealed hydroxyzine 25 milligrams (mg) three times a day for pruritus. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Consultant Pharmacist's Medication Regimen Review dated 1/12/26 noted that the Physician signed the pharmacy consult report from 12/12/25 to change Resident #8's hydroxyzine to 25 mg every morning and midday and discontinue three times a day. This order was not changed in the electronic medical record. Please correct and report the medication error. Review of Resident #8's Medication Administration Record (MAR) dated 12/12/25 through 1/18/26 revealed Resident #8 continued to receive hydroxyzine 25 mgs three times a day as evidence by the nurses' signatures. The physician's order was updated by the Director of Nursing on 1/19/26 and entered into Resident #8's electronic medical record for hydroxyzine 25 mgs twice a day morning and midday. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #8 had moderately impaired cognition. During an interview on 3/25/26 at 10:00 AM Resident #8 stated she took hydroxyzine for itching. She indicated she did not know the dosage or how often it was given but stated the medication helped with itching. Resident #8 stated she did not feel the medication made her excessively drowsy. During an interview on 3/25/26 at 2:35 PM the Director of Nursing (DON) stated she started working in the facility in November 2025 and was new to the role of DON. She received the medication regimen reviews monthly that were done by the Consultant Pharmacist. The DON stated she did not realize the importance of addressing the pharmacy reviews promptly and therefore there was a delay in addressing the December (2025) reports. She stated she did not implement the new order to reduce the hydroxyzine 25 mg dose to twice a day until she was notified by the Consultant Pharmacist the following month (January 2026) that she had not changed the frequency. The DON stated Resident #8 continued to receive hydroxyzine 25 mg three times a day until she corrected the order on 1/19/26. The DON stated Resident #8 has had no change in her condition from receiving the medication. The Consultant Pharmacist was on leave during the survey and unavailable for an interview. During a phone interview on 3/26/26 at 12:00 PM the Pharmacy Manager stated due to the length of time Resident #8 had received the hydroxyzine 25 mgs it would have no clinical effects on the resident for continuing to receive the medication three times a day. He stated a dose reduction was indicated due to the length of time Resident #8 had been receiving the medication. During a phone interview on 3/26/26 at 3:30 PM the Physician stated Resident #8 was a long-term care resident and had received hydroxyzine for itching for a long period. She stated Resident #8 had not experienced any outcome and had no change in condition.