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 _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HEALTH CARE CENTER	1011 PORTERS NECK ROAD WILMINGTON, NC 28411

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F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 02/05/2024 through 02/08/2024. Event ID # 8B2G11. The following intakes were investigated: NC00198205, NC00194406, NC00202994, NC00210252, NC00200378, NC00199807, NC00201131, NC00203326, NC00198649, NC00210965, NC0027262. 2 of the 15 complaint allegations resulted in a deficiency.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		2/26/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/27/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to treat a resident with dignity and respect when Nurse #3 spoke to a resident (Resident #41) in a demeaning way when she demanded the cognitively impaired resident to pick up food and dishes that the resident had thrown on the floor for 1 of 2 residents observed for dignity. This action would have caused a reasonable person psychosocial harm such as feelings of shame, humiliation, agitation, and degradation. Findings included: Resident #41 was admitted to the facility on 11/18/21. Diagnoses included, in part, vascular dementia with behavioral disturbance, restlessness and agitation, Alzheimer's Disease, mild intellectual disabilities, and anxiety. A review of Resident #41's care plan written on	F 550	Davis Healthcare Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction ais submitted as a written allegation of compliance. Davis Healthcare Centers response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Davis Healthcare Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings.	

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F 550	Continued From page 2 11/30/21 and last reviewed on 01/30/24 revealed a plan of care for the ability to self-propel in wheelchair with approaches to include that staff will allow resident to self-propel wheelchair as desired. Resident has episodes of verbal outbursts/verbal abuse toward staff at times with approaches to include staff will redirect resident with snack, stuffed bear, TV shows or drink when verbal outbursts occur. Staff should try to listen carefully to her requests when she displays outbursts. Resident displays behaviors related to particular dining habits, wants, needs, including pushing plates, food, and glassware when she determines she is finished. Approaches include remove dinner ware when resident requests or yells that she is finished. The Minimum Data Set (MDS) quarterly assessment dated 01/05/23 revealed Resident #41 was moderately cognitively impaired and demonstrated no behaviors during this assessment. Resident #41 was coded as having adequate hearing. Resident #41 required supervision with one staff physical assistance with bed mobility and was dependent with one staff physical assistance with transfers, independent with locomotion on the unit requiring no assistance, and independent with set up with meals. She had impairment to both sides to lower extremities and used a wheelchair. She was always continent of bowel and bladder and on hospice care. A written statement by the Hospice Social Worker (no date) revealed "During a visit with a hospice resident in the [memory care household], I witnessed an event that occurred in the dining room while I was seated in the TV area facing the dining room. I heard a very loud clatter come	F 550	F 550 Hospice Social worker notified Administrator on March 15,2023 of witnessed events involving Nurse #3. A 24-hour report was submitted to the Department of Health and Human Services and Adult Protective Services was notified per regulation. An investigation was completed, and a 5-day investigation report was submitted to the Department of Health and Human Services. Nurse #3 was removed from the work schedule in that house and EAP services were initiated. The facility recognizes that all residents have the potential to be affected. The Community Nurse Educator initiated training related to Abuse and Neglect, Recognizing Signs of Caregiver Burnout and the availability of Employee Assistance Program for all staff. Davis Healthcare Staff received this education with 100% of the staff against payroll completed on 2/26/2024. Agency staff will also be educated prior to working. An audit has been put in place to observe staff/resident interactions to ensure interaction is appropriate. This audit is being completed by the Administrator, DON or designee daily for three weeks and will be reviewed by the QA committee for further action.	

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F 550	Continued From page 3	F 550		

from the dining room, and when I looked up I saw [Resident #41] in front of the kitchen counter waving her hands towards the kitchen staff member. The kitchen staff member spoke loudly back at [Resident #41] regarding her behavior and accusing the resident of being rude/mean/not nice. The kitchen staff member went to go around the counter and the Social Worker could then see a bowl and spoon on the floor along with some cake realizing [Resident #41] had thrown these items on the floor. [Resident #41] turned her chair and went back towards her room out of sight from me. I heard the [kitchen staff member] speaking loudly at someone else out of sight and then saw [Nurse #3] come towards the kitchen staff member asking her what happened. The staff member spoke to [Nurse #3] who then turned around out of site and returned quickly with [Resident #41) and pushed wheelchair up to where the dish was on the floor. [Nurse #3] proceeded to speak in a very loud voice to [Resident #41] that she needed to get out of her chair and pick up the items from the floor. [Nurse #3] stood next to [Resident #41] pointing at the items and repeatedly telling [Resident #41] to get up out of her chair and pick up her mess. I then started to stand and head toward them to see if I could help. [Nurse #3] looked up at me and then stopped what she was doing, turned [Resident #41]'s chair around back towards the resident's room stating loudly that she would be calling the resident's family."

A phone interview was conducted with the Hospice Social Worker on 02/08/24 at 9:45 AM. The Hospice Social Worker stated she remembered she was in the common area and Resident #41 was in her wheelchair by the dining area and Resident #41 threw her dessert on the

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F 550	Continued From page 4	F 550		

floor. The Hospice Social Worker stated she heard Nurse #3 yelling at Resident #41 and recalled that Nurse #3 was being insensitive and rude. The Hospice Social Worker added, Nurse #3 was telling Resident #41 she needed pick up the mess she made which Resident #41 would not have been able to do because she was in a wheelchair. The Hospice Social Worker stated, Nurse #3 said loudly to Resident #41, "pick it up! Pick it up, now!" The Hospice Social Worker stated she proceeded to the dining area to see if she could help and Nurse #3 took Resident #41 to her room in her wheelchair. The Hospice Social Worker stated Resident #41 was not crying or yelling out and she could not recall if she said anything back to Nurse #3, but she mumbled. The Hospice Social Worker stated Resident #41 would mumble when she spoke and it was difficult to understand what she was saying. The Hospice Social Worker stated a dietary cook was in the kitchen serving food but she could not remember if the dietary cook said anything or not. She added, I remember "awful person" being said but I do not recall who said it. She stated if I put it in my statement, then she [the dietary cook] must have said it."

A written statement by Nurse #3 dated 03/15/23 revealed "at approximately 12:30 PM, this nurse was asked by Resident [#41] for a spoon. I gave her a fork because I did not hear her ask for a spoon. I walked off from dining room and was walking back toward office when the resident threw her cake on the floor. Resident stated that she wanted a spoon. Resident started to leave. I pushed the resident back in her wheelchair toward the food on the floor and said I should make you get down and clean it up. The resident looked at me and I pushed her in her wheelchair

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F 550	Continued From page 5	F 550		

toward her room as I cleaned cake off of the floor. When I entered the resident's room she proceeded to spit food from her mouth on the floor which I then picked up. I told the resident that was unacceptable behavior. Resident apologized to this nurse and asked for a hug."

An interview with Nurse #3 on 02/07/24 at 2:30 PM revealed Resident #41 had behaviors and would get agitated very easily. Nurse #3 stated Resident #41 could stand and pivot from her wheelchair with assistance. Nurse #3 reported on 03/15/23 shortly after lunch, Resident #41 was having a piece of cake and she asked for a utensil to eat her cake with. Nurse #3 reported she got a fork from the kitchenette and that was not what Resident #41 wanted so she threw the cake that was in the bowl and the fork and yelled she wanted a spoon. Nurse #3 stated she informed Resident #41 that she did not hear her ask for a spoon and that it was unacceptable for her to be throwing dishes and food. Nurse #3 stated she had elevated her voice because Resident #41 was hard of hearing and stated to the resident that she should make her pick up the bowl and spoon, but added, she was not yelling she was just speaking loudly due to her hearing loss. Nurse #3 stated Resident #41 did not cry or seem upset, but there was no excuse for speaking to Resident #41 that way and she asked to be removed from the household due to burn out. Nurse #3 stated she received education regarding treating dementia residents with dignity and respect and obtained additional training through human resources on more effective ways to manage dementia residents with behaviors.

A written statement by Dietary Cook #1 dated 03/16/23 revealed "yesterday 03/15/23 after lunch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 6	F 550		

Resident [#41] was at the bar area and wanted a piece of chocolate cake. I put it in a bowl and Resident [#41] asked for a spoon. I was about to give her a spoon but nurse [Nurse #3] gave her a fork. I asked her why she did not give her a spoon and [Nurse #3] said she could use a fork. [Resident #41] then threw the bowl with the cake and fork. I was behind the bar in the kitchenette and asked [Resident #41] why she threw the bowl and said, "that was not very nice." At that time, [Nurse #3] took the resident in wheelchair to bowl and told her to pick it up. Resident was about to stand up from wheelchair and pick it up and nurse looked like she changed her mind and wheeled resident to her room. I am not sure where the nursing aides were at this time."

An interview with the Dietary Cook #1 on 02/07/24 at 10:30 AM revealed someone reported her about a violation and what they said happened was not what happened. Dietary Cook #1 stated Resident #41 had behaviors and would throw stuff sometimes and was aggressive with staff. She added, as she could recall, Resident #41 did not want a fork to eat her cake and Nurse #3 gave her a fork and she got mad and violently threw everything on the floor in the dining room. Dietary Cook #1 stated she recalled telling Resident #41 not to throw things because that was not nice and someone said she yelled at Resident #41 and that was not true. Dietary Cook #1 stated she was from another country and she did not speak English very well and when she spoke she spoke loudly, but she was not yelling. She stated she was on the other side of the counter when she saw Resident #41 throw the cake and she was speaking loudly so Resident #41 could hear her. Dietary Cook #1 stated she never said to Resident #41 she was an "awful or

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F 550	Continued From page 7	F 550		

mean person." Dietary Cook #1 stated she could not remember what Nurse #3's reaction was. She stated if she wrote in her statement Nurse #3 told Resident #41 to pick up the cake, then that is what she must have said.

Review of a 5 day investigation report submitted to the Department of Health and Human Services dated 03/22/23 by the Administrator revealed the following investigation was conducted regarding Resident #41:

"Resident #41 was admitted to the memory support household in November 2021 with diagnoses to include vascular dementia with behavioral disturbance, anxiety disorder, and mild intellectual disabilities with a history of verbal and physical outbursts. Resident [#41] threw cake in a bowl in the dining room as she asked a fork rather than a spoon to eat the cake and nurse [#3] and household cook [Dietary Cook #1] spoke sharply to the resident. It was reported the nurse [#3] pushed resident in wheelchair to the cake and stated that she should have to clean it up. Resident then wheeled herself back to her room and staff cleaned up the cake. During an interview with Nurse [#3], she stated she felt she could have handled the situation better and she had had a particularly rough weekend in the household as some of the residents' behaviors were increased. The nurse [#3] voiced that she felt like she had become very burnt out and "hit the wall." During this investigation, it became apparent that Nurse [#3] had been experiencing caregiver burn out.

While interviewing the [Dietary] cook, it became apparent that related to her cultural back ground she is naturally a bit louder and animated than

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F 550	Continued From page 8 some of our other staff. This cook did state that after the resident threw the cake, she did ask the resident why she threw the cake and stated, "that was mean." She was behind the kitchen counter during this interaction. The facility determined that this incident was not a willful act to harm a resident in any way but rather a cultural difference. An interview was conducted with the Administrator on 02/08/24 at 2:30 PM. The Administrator reported she expected any staff that was providing care for residents with cognitive impairments with behaviors needed to step away from situations that were escalating and reapproach. The Administrator added if a nurse or staff member was demonstrating burn out and was having challenges she would expect to be notified so that she would take steps to help support them and protect the residents.	F 550		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information	F 636		2/22/24

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F 636	Continued From page 9	F 636		

(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section,

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F 636	Continued From page 10 "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a comprehensive Minimum Data Set (MDS) admission assessment within the regulatory time frame as specified in the Resident Assessment Instrument (RAI) manual for 1 of 1 resident reviewed for completion of a comprehensive MDS assessment (Resident # 219). Findings included. Resident #219 was admitted to the facility on 09/22/22 with diagnoses of a fractured wrist and respiratory disease. A review of the Minimum Data Set (MDS) admission assessment dated 09/28/22 revealed the assessment was signed as completed on 01/18/23. During an interview on 02/07/24 at 12:45 PM MDS Coordinator #1 stated many of the MDS assessments were behind. She stated she and MDS Coordinator #2 were trying to get the MDS assessments up to date. She indicated she was aware of the time frame to complete the admission assessments. She stated the assessments were late getting completed due to both MDS nurses having medical issues and due to a change in staff. During an interview on 02/08/24 at 9:29 AM the Director of Nursing (DON) stated she was aware	F 636	F 636 Resident #219 assessment was signed as completed 1/18/23. An audit of all residents in the facility on 2/22/24 was conducted on 2/22/24 to ensure that all assessments were current. It was noted that 48 residents had open assessments greater than 14 days. Education was initiated by the Administrator and completed with 100% of the MDS nurses against payroll regarding timely submission of MDS assessments on 2/22/23. An audit to review current and late assessments was initiated on 2/22/24 and will be completed daily by the Administrator for 14 days and will be reviewed by QA committee for further review.	

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F 636	Continued From page 11 the MDS assessments were behind. She stated the MDS nurses were going to start attending Interdisciplinary Team (IDT) meetings to help with their process in gathering information to complete the assessments. She indicated the assessments should have been completed in full and completed in a timely manner according to the regulations. During an interview on 02/08/24 at 3:45 PM the Administrator indicated she was aware the MDS assessments were behind. She stated MDS assessments were to be completed within the regulatory timeframe.	F 636		
F 637 SS=B	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete the Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) assessment within the regulatory timeframe as specified in the Resident Assessment Instrument (RAI) manual for 1 of 1	F 637	F 637 Resident #12 Significant change in status was completed 2/6/24. An Audit of all residents in the facility	2/27/24

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 _____	02/08/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 12 resident reviewed for Significant Change in Status Assessments MDS assessments (Resident #12). Resident #12's SCSA MDS assessment was completed 27 days after the assessment reference date which was past the specified 14-day timeframe. Findings included: Resident #12 was admitted to the facility on 10/15/22 with diagnosis which included in part Alzheimer's dementia. Review of Resident #12's 1/11/24 Significant Change in Status Assessment Minimum Data Set (MDS) revealed a completion date of 2/6/24. The RN Assessment Coordinator signed the assessment as completed on 2/6/24. Interview on 2/7/24 at 1:00 PM with MDS Coordinator #1 revealed she was behind on assessments. MDS Coordinator #1 stated she was trying to catch up on the assessments and complete them in a timely manner. She stated she was aware of the time frame required for assessments to be completed. She indicated there were changes in staff completing the MDS assessments and that she had medical issues which contributed to late assessment completion. Interview on 2/8/24 at 9:25 AM with the Director of Nursing (DON) revealed she was in the position at the facility for one year. The DON stated she was aware the MDS assessments were completed late and further revealed the assessments were late for the past year. The DON stated the MDS Coordinators cannot get a handle on completion of the assessments timely. The DON indicated she expected that MDS	F 637	regarding Significant Change in Status Assessments was completed 2/23/24 and 1 resident was noted to need completion of this assessment. This assessment was completed on 2/27/24. Education was initiated by the Administrator with 100% of the MDS nurses against payroll regarding Significant Change in Status Assessments initiation and completion on 2/22/24. MDs nurses have been attending weekly IDT meeting weekly to ensure that any information regarding resident significant changes will be recognized and a significant change in status assessment initiated and completed within the regulated 14 days. Weekly audit tool initiated to ensure capture/ completion of resident significant change in status. This will be completed weekly in IDT meeting and reviewed weekly by QA comiteee for a minimum of three months.	

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 _____	02/08/2024

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F 637	Continued From page 13 assessments to be completed accurately and timely according to the RAI manual. Interview on 2/8/24 at 3:30 PM with the facility Administrator revealed she was aware the MDS assessments were completed late for a while now. The Administrator indicated she expected MDS assessments to be completed within the regulatory timeframe specified in the RAI manual.	F 637		
F 638 SS=B	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the regulatory timeframe as specified in the Resident Assessment Instrument (RAI) manual for 2 of 12 residents reviewed for quarterly MDS assessments (Resident #52 and Resident #22). Findings included: a). Resident #52 was admitted to the facility on 10/14/22. Review of Resident #52's 1/5/24 quarterly Minimum Data Set (MDS) revealed the assessment was signed as completed by the MDS Coordinator on 1/23/24, 19 days after the assessment reference date (ARD).	F 638	F 638 Resident #52 quarterly assessment was signed as completed on 1/23/24. Resident #22 quarterly assessment was signed as completed on 12/29/23. An Audit of all residents in the facility regarding Quarterly and Annual Assessments was completed 2/23/24 and 8 residents were noted to need completion of an up-to-date assessment. These assessments were completed on 2/27/24. Education was initiated by the Administrator with 100% of the MDS nurses against payroll regarding Quarterly	2/27/24

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F 638	Continued From page 14 b). Resident #22 was admitted to the facility on 4/11/22. Review of Resident #22's 12/15/23 quarterly MDS assessment revealed the assessment was completed on 12/29/23, 15 days after the ARD. Interview on 2/7/24 at 1:00 PM with MDS Coordinator #1 revealed that she and the other MDS Coordinator were behind on assessments. MDS Coordinator #1 stated she and the other MDS Coordinator were trying to catch up on the assessments and complete them timely. MDS Coordinator #1 stated she was aware of the time frame required for assessments to be completed. MDS Coordinator #1 indicated there were MDS nurses that quit and that she and the other MDS Coordinator had medical issues which contributed to late assessment completion. Interview on 2/8/24 at 9:25 AM with the Director of Nursing (DON) revealed she was aware of MDS assessments being completed late. The DON stated the MDS Coordinators cannot get a handle on completing the assessments timely. The DON stated MDS assessments had been late for a while. The DON indicated she expected all MDS assessments would be completed accurately and timely according to the RAI manual. Interview on 2/8/24 at 3:30 PM with the facility Administrator revealed the MDS assessments were completed late for a while. The Administrator stated she expected MDS assessments to be completed within the regulatory timeframe specified in the RAI manual.	F 638	and Annual assessment frequency on 2/22/24. Weekly audit of Assessment calendar to ensure compliance to be completed by DON, Administrator or designee during IDT meeting. This audit tool will be reviewed weekly by QA committee for a minimum of three months.	
F 761 SS=D	Label/Store Drugs and Biologicals	F 761		2/12/24

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F 761	Continued From page 15 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to dispose of an expired box of acetaminophen 650 milligram suppositories (Rehab medication storage room) and an expired bottle of tuberculin solution (Riverbend medication storage room) for 2 of 3 medication storage rooms observed. Findings included:	F 761	F 761 An audit of all medication storage to identify and remove any expired medications from all medication storage areas was initiated and completed on 2/8/24 by Southern Pharmacy Nurse Consultant, DON and Clinical Coordinators.	

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F 761	Continued From page 16 Observation of the Rehab medication storage room on 2/7/24 at 10:10 AM was made with Nurse #2 in attendance. Observation revealed a box of acetaminophen 650 milligram suppositories with a printed expiration date of 12/23. Interview on 2/7/24 at 10:10 AM with Nurse #2 revealed she did not know why the expired suppositories were in the cabinet and that they should have been removed. Observation of the Riverbend medication storage room on 2/7/24 at 10:15 AM with Nurse #3 in attendance revealed an opened bottle of tuberculin solution with a label which indicated an opened date of 12/6/23 and an expiration date of 1/6/24. An interview with Nurse #3 was conducted on 2/7/24 at 10:15 AM. Nurse #3 revealed the nurses try to check the medication expiration dates but they must have missed the bottle of tuberculin solution. An interview was conducted on 2/8/24 at 9:23 AM with the Director of Nursing (DON). The DON revealed she expected there would not be any expired medications in the facility. The DON further indicated she expected that expired medications would be discarded.	F 761	Education of 100% of nurses against payroll was initiated on 2/9/24 and completed 2/12/24 regarding drug expiration dates and removal of expired drugs by the DON. Agency nurse education initiated 2/9/24 and any new agency nurses will complete education prior to working. A daily audit of all medication storage areas was initiated on 2/12/24 to identify and remove expired medications. This audit is completed by the DON, Clinical Coordinators or designees daily and will continue for three weeks. Results of this audit will be reviewed by QA committee for further action.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		2/9/24

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F 812	Continued From page 17 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to ensure perishable food items were labeled with a date when stored in 1 of 1 walk in refrigerator, and 1 of 1 reach in refrigerator. These practices had the potential to affect food served to residents. Findings included. During the initial tour of the kitchen conducted on 02/05/24 at 10:00 AM along with the Head Chef and the Director of Kitchen Services the following perishable food items were observed: a.) A cardboard box containing 3 large bags of raw chicken thighs that were not labeled with a date to show when the chicken was placed into the walk-in refrigerator. b.) A plastic sealed raw pork roast that was not labeled with a date to show when the pork was placed into the walk-in refrigerator.	F 812	F812 An audit of all kitchens to include household and main kitchens was initiated and completed by the director of food services and designees to ensure all food items were in date and labeled correctly on 2/8/24. All residents had the potential to be affected. The dietary staff was educated on food labeling and storage against payroll on 2/9/24. All new staff will receive this education during orientation. The education was completed by the Food Service director and designees. A daily audit of expiration dates and correct labeling of all food in all kitchens was initiated on 2/9/24. The audit is	

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F 812	Continued From page 18 c.) Three plastic sealed tubes of raw hamburger meat that were not labeled with a date to show when the hamburger was placed into the walk-in refrigerator. d.) A container of liquid eggs was observed along with the Director of Kitchen Services in the reach in refrigerator located in the kitchen on the 300 hall. The container was not labeled with an opened date. The container read that it was recommended to discard the eggs 3 days after opening. During an interview on 02/05/24 at 10:30 AM the Head Chef stated the chicken thighs were placed in the walk-in refrigerator on 02/02/24, and the pork shoulder was placed in the walk-in refrigerator on 02/03/24. He stated both the chicken, and the pork were fresh and not frozen when they were placed in the refrigerator. He stated the 3 packs of hamburger meat were frozen and were placed in the walk-in refrigerator that morning on 02/05/24 to thaw. He stated he should have dated the meat when it was placed in the refrigerator, and it was an oversight. During an interview on 02/05/24 at 10:30 AM the Director of Kitchen Services stated the perishable meat was good to stay in the refrigerator for up to 7 days. He stated the meats should have been labeled with the date of when it was placed in the walk-in refrigerator. He stated the liquid eggs should have also been labeled with an opened date and agreed that the eggs were to be discarded 3 days after opening. He indicated additional education would be provided to the Kitchen staff regarding food storage.	F 812	completed by the Food Service director and/or designees. The results of these audits are presented to the QA committee for further action. These audits will be reviewed weekly by the QA committee. The audit will continue for a minimum of three months.	

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F 812	Continued From page 19 During an interview with the Administrator on 02/08/24 at 1:44 PM she indicated food should be labeled and dated when placed in the refrigerators for use according to the recommended guidelines.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F 867		2/9/24

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F 867	Continued From page 20	F 867		

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy,

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F 867	Continued From page 21	F 867		

resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on

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	345160	A. BUILDING _____ B. WING _____	02/08/2024

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F 867	Continued From page 22 available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) Program failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation survey of 6/21/21 and the recertification and complaint investigation survey of 8/9/22. This was for one recited deficiency on the current recertification and complaint investigation survey of 2/8/24 in the area of food preparation and storage (F812). The continued failure during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance program. Findings included: This tag is cross referenced to: F812 Based on observations, record review, and staff interviews the facility failed to ensure perishable food items were labeled with a date when stored in the walk in and reach in refrigerators. These practices had the potential to affect food served to residents. During the recertification and complaint investigation survey of 6/21/21 the facility failed to ensure frozen items were sealed. Additionally, the facility failed to allow stainless steel pans and glasses to dry prior to stacking or placing the items in a cupboard. During the recertification and complaint investigation survey of 8/9/22 the facility failed to	F 867	F867 The Davis Community (to include Champions and Cambridge Village locations) revised QAPI program in December 2023 to include weekly QAPI meetings and continuation of quarterly QAPI meetings. Weekly review on ongoing PIPs to ensure efficacy of current audits and processes in place and revision of audits and processes as needed. New PIPs to be introduced weekly as needed as priorities are identified. IDT team will include a variety of departments as needed. Ad-Hoc QAPI meetings to occur for urgent challenges as they arise. Weekly and quarterly minutes will be maintained by QAPI committee members and housed in QAPI binders for communication of information.	

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F 867	Continued From page 23 store handheld plastic scoops outside of dry food storage bins. An interview on 2/8/24 at 3:30 PM with the Administrator revealed ongoing monitoring and education was required to ensure that food was properly labeled and stored. The Administrator indicated the facility had changed to a corporate food service company to staff the dietary department. The Administrator stated that she would be working closely with the corporate food service company to ensure that regulations were followed and staff were properly trained.	F 867		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345160	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/8/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HEALTH CARE CENTER	**1011 PORTERS NECK ROAD WILMINGTON, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge Minimum Data Set (MDS) assessment within 14 days of discharge for 1 of 17 residents reviewed for resident assessments (Resident #63). The findings included: Resident #63 was admitted to the facility on 12/22/2023. She was discharged to the hospital on 1/5/2024.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345160	A. BUILDING: _____ B. WING _____	2/8/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HEALTH CARE CENTER	1011 PORTERS NECK ROAD WILMINGTON, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Continued From Page 1

The discharge MDS assessment for Resident #63 was dated 1/5/2024 and was signed as completed on 1/30/2024 by MDS Coordinator #1. The discharge MDS was listed as process pending on 2/7/2024.

A nurse's note written on 1/5/2024 at 12:06 PM revealed Resident #63 was discharged to the hospital at 11:50 AM.

An interview was conducted with Nurse #2 on 2/7/2024 at 9:40 AM. Nurse #2 stated Resident #63 was discharged to the hospital on 1/5/2024 and she never returned to the facility.

An interview was completed with MDS Coordinator #1 on 2/8/2024 at 10:36 AM. MDS Coordinator #1 stated Resident #63's discharge MDS assessment should have been transmitted within 14 days and it was late.

An interview was completed with the Director of Nursing (DON) on 2/8/2024 at 9:25 AM. The DON stated she was aware of MDS assessments being completed and transmitted late. She further stated that she expected the MDS assessments to be transmitted within the designated time period.

An interview was completed with the Administrator on 2/8/2024 at 3:17 PM. The Administrator stated that she expected the MDS assessments to be transmitted on time.