**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/CLIA Identification Number:**

345180

**Multiple Construction**

A. Building

**Completion Date**

01/07/2014

**Name of Provider or Supplier:**

Davis Health Care Center

**Street Address, City, State, Zip Code:**

1011 Porters Neck Rd

Wilmington, NC 28411

<table>
<thead>
<tr>
<th>ID Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID Tag</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>No deficiencies were cited as a result of the complaint investigation of 1/7/14 Event ID PFM611. Complaint #94162, #92973, #91850, #91486, and #89834.</td>
<td>F 000</td>
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</tr>
</tbody>
</table>

**Laboratory Director's or Provider/Supplier Representative's Signature**

**Title**

**Date**

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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.