Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0443	A. BUILDING: ______ B. WING ______	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT DAVIDSON	400 AVINGER LANE DAVIDSON, NC 28036

(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) COMPLETE DATE
L 000	INITIAL COMMENTS The survey team entered the facility on 10/07/25 to conduct a licensure survey and exited on 10/09/25. The credible allegation for removal of the Type A2 violation was validated on 10/14/25. Therefore, the exit date was changed to 10/14/25. Therefore, the exit date was 10/14/25. Event ID# U9QK11. A Type A2 Violation was identified at 10A NCAC 13D .2208 (e)(2). The Type A2 Violation began on 04/18/25 and was removed on 10/14/25.	L 000		
L 039	.2208(E) SAFETY 10A-13D.2208 (e) The facility shall ensure that: (1) the patients' environment remains as free of accident hazards as possible; and (2) each patient receives adequate supervision and assistance to prevent accidents. This Rule is not met as evidenced by: Based on observation, record review, and interviews with Family Member #1, staff and Physician, the facility failed to supervise Resident #1, who was moderately cognitively impaired, exhibited exit-seeking behavior, was identified as being at risk for wandering, and used an electric	L 039		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Elyse M. Pisatelli TITLE LNHA (X6) DATE 10/27/25