

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Chapel Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E Franklin Street Chapel Hill, NC 27514	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48945</p> <p>Based on record review, and interviews with the resident, Responsible Party (RP), and staff, the facility failed to facilitate the inclusion of a cognitively intact resident and her RP in the care planning process for 1 of 1 resident reviewed for the care planning process (Resident #71).</p> <p>The findings included:</p> <p>Resident #71 was admitted to the facility on [DATE].</p> <p>The medical record indicated Resident #71's family member was her RP.</p> <p>A review of Resident #71's care plan dated 6/9/23 revealed it was last revised on 3/20/24 at 5:21 pm.</p> <p>Review of the care conference note dated 12/14/23 indicated a care plan meeting was held regarding Resident #71. The attendees listed were the Minimum Data Set (MDS) Nurse and the Social Services Director (SSD).</p> <p>The care conference note dated 3/7/24 indicated a care plan meeting was held regarding Resident #71. The attendees listed were the MDS Nurse, SSD, and Unit Manager #1.</p> <p>The record did not reveal evidence that Resident #71 or her RP had been invited to or involved in the care planning and review process.</p> <p>Review of the quarterly MDS dated [DATE] revealed Resident #71 was cognitively intact.</p> <p>During an interview on 4/8/24 at 10:33 am, Resident #71 revealed nobody had talked with her about her care plan.</p> <p>During a follow-up interview on 4/10/24 at 7:19 pm, Resident #71 stated her RP may know more about the care plan meeting. Resident #71 explained she could not get out of bed and wondered how the facility could include her during the care plan meetings. She stated nobody offered other ways for her to attend the meetings.</p> <p>(continued on next page)</p>

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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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 4/10/24 at 4:49 pm, Resident #71's RP revealed she had not received any invitation to a care plan meeting this year. She stated could not remember the exact date, but last year she had been called and invited to a care plan meeting after Resident #71 was admitted to the facility. She explained she had not received any further invitations.</p> <p>During an interview on 4/09/24 at 2:36 pm, the SSD revealed Resident #71, or the RP did not attend the care plan meetings on 12/14/23 and 3/7/24. She stated she usually talked to the residents and invited them to care plan meetings and called to invite the representatives. The SSD could not recall the reason Resident #71, or the RP were unable to attend. She could not recall if any reasonable adjustments were made to accommodate Resident #71's or her RP's schedule. She stated it was either they did not want to attend, or she did not get an answer in time. She stated they could conduct the care plan meeting in the resident's room or in her office depending on the resident's preference. The SSD stated the invitation, the reason for the resident's or RP's absence and any attempts to work with them to facilitate their attendance were not documented in the medical records.</p> <p>During an interview on 4/10/24 at 1:57 PM, the MDS Nurse stated she created the list of residents that were due for care plan meetings and gave them to the SSD. The SSD sent letters to the representatives or verbally invited the residents to their care plan meetings. The MDS Nurse stated all refusals were documented in their care plan. She checked Resident #71's care plan and revealed there were no refusals documented in the resident's care plan. She stated she was not aware of the reason for Resident #71's or the RP's absence during the care plan meetings on 12/14/23 and 3/7/24.</p> <p>During an interview on 4/10/24 at 9:40 am, the Director of Nursing stated the care plan meetings were held quarterly, annually, and as needed. She stated the residents, and their RP should be encouraged to always attend and participate in their care plan.</p> <p>During an interview on 1/24/24 at 1:42 PM, the Administrator stated he expected all the residents to be involved in their care. Any contact with the resident or RP regarding their care should be documented.</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48945</p> <p>Based on observations, record review, interviews with resident and staff, the facility failed to assess if a cognitively impaired resident could self-administer eye drops kept at the bedside for 1 of 1 resident reviewed for self-administration (Resident #6).</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on [DATE]. Her diagnoses included glaucoma (increased pressure within the eyeball causing gradual loss of vision), and dry eyes syndrome.</p> <p>Review of the physician order dated 7/15/20 revealed Resident #6 was to receive one drop of latanoprost 0.005%, a prescription eye drop, in each eye each night between the hours of 7:00 pm to 11:00 pm to treat glaucoma. Another order on 3/14/24 revealed Resident #6 was to receive two drops of artificial tears, an over-the-counter eye drop, for dry eyes four times a day at 8:00 am, 12:00 noon, 4:00 pm and 8:00 pm. There was no physician order for Resident #6 to self-administer medications.</p> <p>Review of Resident #6's annual Minimum Data Set, dated dated [DATE] revealed she had impaired vision and was cognitively intact.</p> <p>Review of Resident #6's medical records revealed no assessment was completed to determine if the resident could administer medications independently to herself.</p> <p>Resident #6's care plan revised on 3/15/24 revealed potential for impaired vision related to glaucoma. Interventions included assessing the effect of vision loss on resident's functional status, assuring floor was free of glare, liquids, or foreign objects, and always keeping the call light within reach. The resident's care plan did not include medication self-administration.</p> <p>Review of the April 2024 Medication Administration Record for the period of 4/1/24 through 4/9/24 revealed the latanoprost eyedrops were initialed by Nurse #1 to indicate it was administered on 4/7/24 between 7:00 pm to 11:00 pm. The artificial tears were initialed by Nurse #1 on 4/7/24 at 8:00 pm and Medication Aide #1 on 4/8/24 at 8:00 am and 12:00 noon to indicate it was administered at those dates and times.</p> <p>During the initial observation on 4/8/24 at 11:33 am, Resident #6 had a vial of artificial tears eye drop and a vial of latanoprost 0.0005% eye drop on her bedside table. Resident #6 stated she administered both eye drops to herself. She stated she used the eye drops for her dry eyes two times a day in the morning and at night. She stated she used her glaucoma eyedrops at night only.</p> <p>During a follow up interview by Medication Aide #1 and the surveyor on 4/8/24 at 3:32 pm, Resident # 6 stated the evening nurse (Nurse #1) left both eye drops with her on 4/7/24 and gave her instructions. She stated she used both eye drops the night of 4/7/24 and used only the artificial tears the morning of 4/8/24.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 4/8/24 at 3:33 pm, Medication Aide #1 stated Resident #6 was not supposed to have eye drops at bedside. She stated the resident did not have an order to self-administer medications. Medication Aide #1 was observed to take both eye drops and proceeded to lock them in her medication cart.</p> <p>The evening nurse was not in the facility during the survey and was unavailable for telephone interview.</p> <p>During an interview on 4/9/24 1:09 pm, the interim Unit Manager for the Blue Hall explained the facility's medication self-administration process. She stated the if a resident was requesting to self-administer medications, the nurses completed the Self-Administration Assessment form. This was filed under the Clinical Observation tab in the resident's medical record. The interim Unit Manager stated the doctor or the physician's assistant was notified if the resident was assessed they were capable of medication self-administration. The provider had to order that a resident could self-administer medications. The medications had to be in a locked box so only the resident could access the medications. The resident's new order for self-administration was discussed during the clinical morning meeting. The Minimum Data Set Nurse or the nurse who received the order updated the resident's care plan to address self-administration of medications.</p> <p>During an interview on 4/10/24 at 9:34 am, the Director of Nursing stated the evening nurse was an agency nurse. She stated the agency nurses got checked off with medication administration before they were assigned a cart. She stated Resident #6 was not assessed for medication self-administration. The agency nurse must have left those eye drops on the resident's bedside by accident.</p>

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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725</p> <p>Based on record review, resident interview and staff interviews, the facility failed to allow a resident the right to manage personal funds for 1 of 3 sampled residents reviewed for personal funds. (Resident #40)</p> <p>The findings included:</p> <p>Resident # 40 was admitted to the facility on [DATE] with diagnoses that included contracture to the right knee and type 2 diabetes.</p> <p>A review of the Admission Minimum Data Set assessment dated [DATE] revealed Resident #40 was cognitively intact.</p> <p>An interview was conducted with Resident #40 on 4/6/24 at 9:50 am and she revealed the Business Office Manager had changed the banking location of where her social security check was to be deposited from her private banking account to the facility's account. Resident #40 added the Business Office Manger did this without her permission.</p> <p>An interview was conducted with the Business Office Manager on 4/9/24 at 2:30 pm and she confirmed that she applied for the facility to become Resident #40's representative payee so that her money would come directly to the facility and did not get Resident #40's written permission. She further revealed that she did not offer Resident #40 the opportunity to manage her own funds because she thought the money needed to come to the facility directly because it was owed to the facility. The Business Office Manager also revealed that she did not keep a copy of the representative payee application and did not recall the physician deeming Resident #40 as cognitively impaired or unable to manage her personal funds.</p> <p>An interview was conducted with the facility Administrator on 4/11/23 at 12:20 pm and he indicated that alert and oriented residents should be given the opportunity to manage their personal funds.</p> <p>An interview was conducted with the facility Administrator on 4/11/23 at 12:20 pm and he indicated that alert and oriented residents should be given the opportunity to manage their personal funds</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725</p> <p>Based on record review, law enforcement interview and staff interviews, the facility failed to report an allegation of abuse to law enforcement and adult protective services (Resident #242) and failed to report an allegation of misappropriation of resident property to adult protective services (Resident #66). In addition, the facility policy failed to include procedures for reporting allegations of abuse/misappropriation of resident property to adult protective services. This was for 2 of 3 residents reviewed abuse/misappropriation of resident property.</p> <p>The findings included:</p> <p>A review of the facility's policy titled, Abuse, Neglect, and Misappropriation of Property dated and revised 9/15/23 indicated every stakeholder shall immediately report any allegation of abuse, injury of unknown origin, or suspicion of a crime to the facility Administrator or designee as assigned by the facility administrator in his/her absence. The policy also indicated that any abuse allegation must be reported to the State within 2 hours from the time the allegation was received and any reasonable suspicion of a crime with serious bodily injury must be reported to the State and Police. Additionally, the policy stated any allegation of neglect, exploitation, mistreatment, or misappropriation resulting in serious bodily injury must be reported to the State Regulatory Agency and Police within 2 hours.</p> <p>1. Resident #242 was admitted to the facility on [DATE].</p> <p>A review of the facility's 24-Hour Initial Report dated 11/13/23 indicated there was an allegation of staff to resident abuse made by Resident #242. The report indicated that Resident #242 said she was pushed down into her bed but did not name a perpetrator at that time. The incident occurred on 11/12/23 but was not reported to the facility staff until 11/13/23 and did not result in serious bodily injury. The facility reported the allegation to the state agency within 2 hours. The initial report indicated law enforcement was not notified.</p> <p>A review of the Investigation Report dated 11/20/23 indicated law enforcement and adult protective services (APS) was not notified.</p> <p>An interview was conducted with the Administrator on 4/11/24 at 2:45 pm and he indicated that he thought he had reported this incident to law enforcement, but he did not report the incident to APS. The Administrator did not explain why he did not report the allegation of abuse to APS.</p> <p>A telephone interview was conducted on 4/11/24 at 9:26 am with the local law enforcement's community safety specialist. He indicated there was no record that the facility or facility administrator had reported this incident to law enforcement.</p> <p>2. Resident #66 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's 24-Hour Initial Report dated 11/13/23 revealed there was an allegation of misappropriation of resident funds made by Resident #66. The report further revealed that Resident #66 reported that his bank card was stolen but no perpetrator was noted. The report indicated that law enforcement had been notified but APS was not notified.</p> <p>A review of the Investigation Report dated 11/17/23 indicated law enforcement and adult protective services (APS) was not notified.</p> <p>An interview was conducted with the Administrator on 4/11/24 at 2:45pm and he indicated that he did report this incident to law enforcement and the ombudsman but did not report it to APS. The Administrator did not explain why he did not report the allegation of misappropriation of resident funds to APS.</p>

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48945</p> <p>Based on observations, record review, and staff interviews, the facility failed to arrange podiatry services and/or provide toenail care for 1of 1 resident reviewed for foot care (Resident #70).</p> <p>Findings Included:</p> <p>Resident #70 was admitted to the facility on [DATE]. His diagnoses included left hemiplegia (weakness on one side) and hemiparesis (paralysis on one side) following a stroke.</p> <p>Review of the facility's skin alert form indicated Mr. Downey's nails were trimmed on 12/5/23, 12/19/23 and 12/29/23.</p> <p>A review of Resident #70's quarterly Minimum Data Set, dated dated [DATE] revealed he was cognitively intact and had an impairment on one side of his body. He was assessed as requiring supervision or touch assistance for showers. He was independent in performing personal hygiene and in putting on and taking off his footwear.</p> <p>Resident #70's care plan dated 3/11/24 revealed a risk for self-care deficit or decline due to his medical conditions. Interventions included encouraging him to participate in activities of daily living, allowing him to do as much as possible and assisting him as needed.</p> <p>During the initial assessment on 4/8/24 at 10:53 am, Resident #70 stated nobody cut his toenails and he was needing an ingrown nail pulled out. He had reported this two months ago to Unit Manager #1, but nothing was done. The resident's toenails were observed to be long and extending over the tip of his toes. They were thick and grayish in color. His toenails on both of his big toes were curling downwards. No redness or inflammation were observed. He denied any pain in his toes during the survey.</p> <p>Unit Manager #1 no longer worked at the facility and attempts to interview her were unsuccessful.</p> <p>During an interview on 4/9/24 at 12:52 pm, Nurse Aide (NA) #2 stated she had been assisting Resident #70 with his showers and personal hygiene. She stated she cut residents' nails after their shower or as needed. She stated she tried cutting the resident's toenails before, but they were too thick. NA #2 stated she did not have the tools to do it. She stated there was a list for the podiatrist in the nurses' station and she would add the resident's name on the list.</p> <p>During an interview on 4/9/24 at 2:24 pm, the Social Services Director (SSD) stated she scheduled the residents' podiatry appointments. The podiatrist came to the facility every three months. She stated she referred residents to the podiatrist if they were diabetic or if the provider informed her of a resident's need for the service. The nursing staff also provided her with the names of residents that needed their nails cut by the podiatrist. The SSD was unable to provide a date when the resident was last seen by podiatry. She offered to check and schedule Resident #70 for podiatry service.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/24 at 8:54 am, the Director of Nursing (DON) stated Resident #70 did not verbalize any complaints to her. The staff usually cut the residents' nails after shower. She stated Resident #70 was getting showers so they should have been trimming his nails. She provided the resident's shower logs and added three skin care alert forms that were filled out by the nurse aides. The forms indicated the resident's nails were trimmed on 12/5/23, 12/19/23 and 12/29/23. The DON stated that was all the forms she found.</p> <p>During an interview on 4/11/24 at 11:22 am, the Administrator stated it was his expectation that the residents' nails well groomed. If staff were unable to cut a resident's nails or if the resident was diabetic, the resident should be referred to the podiatrist or sent to a specialist as needed.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>28265</p> <p>Based on staff interview, and record review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented effective procedures and monitor the interventions that the committee put into place following a recertification and complaint investigation survey on 04/11/24, the complaint investigation survey on 11/3/23 and the complaint investigation survey on 6/23/22. This was for one deficiency in the area of Resident Self-Administer Medication (554) recited on the current recertification and complaint investigation survey on 4/11/24. The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program.</p> <p>Findings included.</p> <p>This citation is cross referenced to:</p> <p>F 554: Based on observations, record review, interviews with resident and staff, the facility failed to assess if a cognitively impaired resident could self-administer eye drops kept at the bedside for 1 of 1 resident reviewed for self-administration (Resident #6).</p> <p>During a the complaint investigation survey of 11/03/23, the facility failed to assess the ability of residents to self-administer medication.</p> <p>During a the complaint investigation survey of 06/23/22, the facility failed to assess the ability of a resident to self-administer medications left at bedside.</p> <p>An interview was conducted with the Administrator on 04/11/24 at 4:30pm, during which he indicated that his expectations for Quality Assurance were for the facility to conduct an on-going Quality Assurance/Performance Improvement program to systematically monitor, evaluate and improve quality and appropriateness of resident care. Areas of concern were identified through meetings, grievances, observations during rounding, care plan meetings, etc. The QAPI committee was composed of but not limited to the Administrator, Director of Nursing, Medical Director, Consultant Pharmacist, Registered Dietician, Medical Records Director, and Infection Control Preventionist. The Administrator explained the committee met quarterly and/or as needed. Any identified areas of non-compliance were corrected and monitored until compliance was maintained.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48945</p> <p>Based on record review, residents and staff interviews, the facility failed to follow the current Centers for Disease Control (CDC) recommendations for coronavirus disease 2019 (COVID-19) vaccination for 5 of 5 residents reviewed for COVID-19 vaccination (Resident #53, Resident #4, Resident #43, Resident #6, and Resident #46).</p> <p>The findings included:</p> <p>The facility's infection control vaccination program revised on 9/17/23 stated The company intends to and will follow all governing regulations and strives to follow all official COVID-19 recommendations for the health and welfare of our residents and stakeholders.</p> <p>The CDC COVID-19 vaccine recommendations for long term care residents updated on 2/7/24 stated Everyone aged 5 years and older, including people who live and work in Long-term Care (LTC) settings, get 1 updated COVID-19 vaccine .People aged [AGE] years and older who received 1 dose of any updated 2023-2024 COVID-19 vaccine (Pfizer-BioNTech, Moderna or Novavax) should receive 1 additional dose of an updated COVID-19 vaccine at least 4 months after the previous updated dose . People who are moderately or severely immunocompromised can get additional updated COVID-19 vaccine doses . People who live in LTC settings must give consent or agree to getting a COVID-19 vaccine.</p> <p>Review of the facility's vaccine information sheet (VIS) from the CDC dated 10/19/23 revealed the current recommendations for 2023-2024 COVID-19 vaccines. The recommendations on the VIS were consistent with the CDC recommendations.</p> <p>a. Resident #53 was admitted to the facility on [DATE].</p> <p>Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #53 was cognitively intact.</p> <p>Review of Resident #53's medical record revealed no information about the resident being offered the 2023-2024 COVID-19 vaccine or receiving education related to the vaccine.</p> <p>During the interview on 4/10/24 at 2:39 pm, Resident #53 stated she did not recall anybody coming to discuss the 2023-2024 COVID-19 Vaccine and get consent.</p> <p>b. Resident #4 was admitted to the facility on [DATE].</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 was cognitively intact.</p> <p>Review of Resident #4's medical record revealed no information about the resident being offered the 2023-2024 COVID-19 vaccine or receiving education related to the vaccine.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Chapel Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E Franklin Street Chapel Hill, NC 27514	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the interview on 4/10/24 at 2:33 pm, Resident #4 stated nobody told her about a new vaccine. She stated, I want one.</p> <p>c. Resident #43 was admitted to the facility on [DATE].</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #43 was cognitively intact.</p> <p>Review of Resident #43's medical record revealed no information about the resident being offered the 2023-2024 COVID-19 vaccine or receiving education related to the vaccine.</p> <p>During an interview on 4/10/23 at 2:13 pm, Resident #43 stated nobody came since fall to talk to him about the new COVID-19 vaccine and would like to have it.</p> <p>d. Resident #6 was admitted to the facility on [DATE].</p> <p>Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #6 was cognitively intact.</p> <p>Review of Resident #6's medical record revealed no information about the resident being offered the 2023-2024 COVID-19 vaccine or receiving education related to the vaccine.</p> <p>During an interview on 4/10/24 at 2:42 pm, Resident #6 stated she heard about the new vaccine that came out last year, but nobody ever came to talk to her about it. She stated she would like to have it.</p> <p>e. Resident #46 was admitted to the facility on [DATE].</p> <p>Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #46 was cognitively intact.</p> <p>Review of Resident #46's medical record revealed no information about the resident being offered the 2023-2024 COVID-19 vaccine or receiving education related to the vaccine.</p> <p>During an interview on 4/10/24 at 7:18 pm, Resident #46 shook his head when asked if any staff updated him on the new 2023-2024 COVID-19 vaccine that was released last fall.</p> <p>During an interview on 4/10/24 at 9:15 am, the Director of Nursing revealed she was the Infection Preventionist for the facility and she was responsible for the vaccination process. She stated she was aware of the new 2023-2024 COVID vaccine and had been vaccinating residents who wanted it. She stated the facility's COVID-19 vaccination consent was in the residents' admission packets.</p> <p>During a follow up interview on 4/11/24 at 10:00 am, the DON stated she believed the residents were offered the new vaccine but after she checked, there were no documents in the residents' medical records related to the new 2023-2024 COVID-19 vaccine. All five residents were not offered or educated on the new vaccine.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the interview on 4/11/24 at 11:17 am, the Administrator stated the residents were offered immunizations on admission. He stated he was not aware of the new vaccination and that corporate office did not send the CDC updates.</p>