| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345225 | A. Building<br>B. Wing | 06/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Signature Healthcare of Chapel Hill | 1602 E Franklin Street<br>Chapel Hill, NC 27514 |

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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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on observations and staff interviews, the facility failed to ensure the furniture and floors were maintained in a clean state, free from drainage from an enteral feeding (Resident #76) and the insulated outer covering of the bed control wires was intact (Resident #31) for 2 of 6 rooms on 1 of 2 halls observed for a safe, clean and homelike environment.<br><br>Findings included:<br><br>1. An initial observation completed on 6/16/25 at 11:28 AM revealed a large brown semi-solid puddle of dried fluid trailing towards the windows on the left side of Resident #76's bed. The floor was sticky underfoot as well. In addition, there was a brown dried substance on the casing of the bedside television monitor that spanned the width of the lower lip with drip marks dried on the controls.<br><br>Additional observations of Resident #76's room on 6/18/25 at 8:30 AM and on 6/19/25 at 1:06 PM continued to reveal the brown substance remained on the bedside television monitor and the equipment as it had from the initial observation on 6/16/25.<br><br>An interview was conducted with Housekeeper #1 on 6/19/25 at 1:40 PM who was responsible for cleaning the hall where Resident #76. She stated the process of cleaning a resident's room included emptying trash, sweeping the floor and mopping the floor. She stated she wiped down the dresser, nightstand, and overbed table as well. She indicated housekeeping was not allowed to clean up bodily fluids but was able to clean up spills such as water, juices, or food items. She stated the last time she cleaned Resident #76's room was on 6/18/25.<br><br>The Director of Housekeeping was interviewed on 6/19/25 at 1:46 PM, and he stated this past Monday 6/16/25 he had to do an extra scrub of Resident #76's floor because a puddle of tube feed was left to dry over the weekend. He stated the puddle was underneath the wheel of the pole the tube feeding hung from and ran out towards the window. He stated he had to soak and really scrape to get the spill up. After being shown the brown substance on Resident #76's television monitor, he stated he wasn't aware tube feeding had leaked onto the television as well, but he would have it cleaned up. The Director of Housekeeping indicated housekeeping worked seven days on weekdays from 7:00 AM to 4:00 PM, but on the weekends housekeeping left at 2:00 PM. The Director stated tube feeding spills were difficult to clean up once they were dried, and it would be helpful if staff wiped up the spill while it was still wet once they noted one happened.<br><br>On 6/19/25 at 1:55 PM the Administrator toured the resident rooms with this writer in the hall where Resident #76 resided and stated housekeeping would clean the room that day.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. On 6/18/25 at 1:02 PM an observation was made of the bed control that operated Resident #31's bed wrapped around the left upper bar of the resident's bed and resting on the pillow. The outer insulation casing over the wiring was stripped away leaving three individual wires exposed, a red wire, a white wire, and a black wire. Resident #31 was lying in bed at the time of the observation.<br><br>An interview was conducted with the Maintenance Director in conjunction with the Administrator on 6/19/25 at 11:02 AM. The Maintenance Director stated bed controls were checked monthly to make sure they were working. The Maintenance Director further stated if the staff noted a problem with bed controls they would notify maintenance for repairs. The Administrator provided documentation from the maintenance logbook that indicated the bed controls were inspected by maintenance on 5/2/25 and to make sure the bed control operated the bed correctly, checked for any cracked or frayed wires, and ensured bed control wires were not wrapped around rails. The Administrator further indicated Resident #31's bed was a rental and would be replaced. The Administrator provided a copy of quality improvement projects for the rooms of the facility that included plans for repairs, painting, and maintenance. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observations and staff interviews the facility failed to (1) remove expired medication and date open medication for 1 of 2 medication storage refrigerators reviewed (Blue Hall), and (2) failed to date open medications for 1 of 2 medication carts reviewed (Red Hall).<br><br>The findings included:<br><br>1. During an observation of the Blue Hall medication storage refrigerator with Unit Manager #1 on 6/17/25 at 11:23 am the following was observed. Unit Manager #1 confirmed all findings before the removal of the identified items.<br><br>- One glargine (long-acting) insulin injector pen was observed to be open with approximately 180 units of the 300 units of insulin remaining. There was no open date noted on the insulin pen. The manufacturer's recommendation for the storage of insulin glargine was to discard unused insulin 28 days after first use.<br><br>- One vial of tuberculin purified protein derivative (used in the diagnosis of tuberculosis) was observed to be open with approximately one third of the medication remaining. The vial had an open date of 5/05/25. The medication box noted to discard open product after thirty (30) days.<br><br>An interview was conducted with Unit Manager #1 on 6/17/25 at 11:30 am who revealed all medications were to be dated when opened by the nurse that opened the medication. Unit Manager #1 further reported that all nurses were responsible for checking medications for expiration dates when they were used and the medication should have been removed from the medication storage refrigerator when expired.<br><br>During an interview on 6/18/25 at 12:44 pm with the Director of Nursing (DON) she revealed that all nurses were responsible for dating medications when they were opened. The DON stated Unit Manager #1 was responsible for ensuring the medication storage refrigerator was monitored for expired medications.<br><br>2. During an observation of the Red Hall medication cart with Medication Aide (MA) #2 on 6/17/25 at 1:35 pm the following was observed. MA #2 and Unit Manager #2 confirmed all findings before the removal of the identified items.<br><br>-One glargine (long-acting) insulin injector pen was observed open with approximately 140 units of the 300 units insulin remaining. There was no open date noted on the insulin injector pen. The manufacturer's recommendations for glargine insulin injector pen was to discard the unused insulin 28 days after first use.<br><br>- One insulin lispro (rapid-acting) injector pen was observed open with approximately 220 units of the 300 units of insulin remaining. There was no open date noted on the insulin injector pen. The manufacturer's recommendations for insulin lispro injector pen was to discard the unused insulin after 28 days of opening.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - One fluticasone furoate, umeclidinium and vilanterol 100 micrograms (mcg)/62.5 mcg/25 mcg inhalation powder (medication used to treat chronic obstructive pulmonary disease (COPD) and asthma) was observed open with no open date noted. The manufacturer's recommendations for the fluticasone furoate, umeclidinium and vilanterol inhalation powder was to discard after 6 weeks of opening.<br><br>- One fluticasone propionate and salmeterol 500 mcg/50 mcg inhalation powder (medication used to treat COPD and asthma) was observed open with no open date noted. The manufacturer's recommendation for the fluticasone propionate and salmeterol inhalation powder was to discard 1 month after the foil pouch was opened.<br><br>- One plastic squeeze bottle of timolol maleate ophthalmic solution 0.25% (medication used to treat eye conditions like glaucoma) was observed open with no open date noted. The manufacturer's recommendation for the timolol maleate ophthalmic solution was to be used within 4 weeks of opening.<br><br>- One plastic squeeze bottle of prednisolone acetate ophthalmic solution 1% (medication used to treat eye inflammatory conditions of the eye) was observed open, with no open date noted. The manufacturer's recommendation for the prednisolone acetate ophthalmic solution was to discard 28 days after opening.<br><br>- One plastic squeeze bottle of moxifloxacin ophthalmic solution 0.5% (medication used to treat bacterial eye infections) was observed open with no open date noted. The manufacturer's recommendation for the moxifloxacin ophthalmic solution was to discard any unused drops 4 weeks after the first opening.<br><br>- One plastic squeeze bottle of eye drops ultra (used to treat dry eyes) was observed open with no open date noted. The manufacturer's recommendation for the eye drops ultra was to discard any remaining drops 3 months after opening.<br><br>An interview was conducted with MA #2 on 6/17/25 at 2:00 pm. MA #2 revealed all medications were to be dated when they were opened. She stated when she opened a medication she wrote the date on the medication. MA #2 stated she was not permanently assigned to the Red Hall medication cart and she did know why the medications did not have an open date noted.<br><br>An interview was conducted on 6/17/25 at 2:02 pm with Unit Manager #2 who stated medications should be dated by the nurse when they were opened. Unit Manager #2 stated there was no one specifically assigned to check the medication cart to ensure medications had an open date noted.<br><br>During an interview on 6/18/25 at 12:44 pm with the Director of Nursing (DON) she revealed that all nurses were responsible to date medications when they were opened. The DON stated all nurses were responsible to check the medication carts to make sure medications were dated and removed if expired. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to remove expired fortified nutritional supplements stored for use in 1 of 2 nourishment rooms (Nourishment Kitchenette at Blue side). These practices had the potential to affect 2 of 2 residents who received tube feeding.<br><br>The findings included:<br><br>On [DATE] at 10:35 AM, during an observation with the Dietary Manager of the nourishment kitchenette on the Blue side hallway, in the cabinet, there were 18 packs of fortified nutritional supplement that expired on [DATE], and 6 packs of fortified nutritional supplements that expired on [DATE].<br><br>On [DATE] at 9:45 AM, during an interview, the Dietary Manager indicated that the Central Supply staff was responsible for restocking the nutritional supplements in the Nourishment Kitchenettes and checking the expiration date.<br><br>On [DATE] at 2:45 PM, during an interview, the Central Supply staff indicated that she was responsible for ordering nutritional supplements for the facility. She checked the nutritional supplements for expiration date weekly. The Central Supply staff indicated the last time she checked the Nourishment Kitchenette rooms on Red and Blue side hallways on [DATE]. The Central Supply staff mentioned that she was very busy on [DATE] and probably overlooked a few expired items.<br><br>On [DATE] at 9:05 AM, during an interview, the Director of Nursing indicated that the Central Supply staff member was responsible for ordering nutritional supplements for the residents. The Central Supply staff member made rounds weekly and as needed and communicated the nutritional supplement needs with the units' coordinators. Currently, none of the residents with tube feeding received the order for fortified nutritional supplements. The Central Supply staff member had a responsibility to restock the Nourishment Kitchenettes and remove the expired items.<br><br>On [DATE] at 10:25 AM, during an interview, the Administrator expected the staff to restock the nourishment rooms and remove the expired items in a timely manner. |

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| F 0842<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with residents and staff, the facility failed to maintain an accurate Medication Administration Record (MAR) when insulin that was administered by licensed nursing staff was signed off on the MAR as administered by Medication Aide (MA) #2. This deficient practice affected 3 of 27 sampled residents whose medical records were reviewed (Resident #11, Resident #43, and Resident #80).<br><br>The findings included:<br><br>a. Resident #11 was admitted to the facility on [DATE] with diagnoses which included diabetes.<br><br>A physician order dated 4/09/24 for insulin lispro (fast acting) administer 10 units subcutaneous before meals every day for diabetes.<br><br>A physician order dated 4/09/24 for insulin lispro administer subcutaneous before meals every day for diabetes; per sliding scale: If Blood Sugar is 150 to 199, give 2 Units. If Blood Sugar is 200 to 249, give 4 Units. If Blood Sugar is 250 to 299, give 6 Units. If Blood Sugar is 300 to 349, give 8 Units. If Blood Sugar is 350 to 399, give 10 Units. If Blood Sugar is 400 to 449, give 12 Units. If Blood Sugar is greater than 449, call MD.<br><br>Review of Resident #11's MAR for June 2025 revealed the following:<br><br>- 6/04/25 at 7:00 am Resident #11 was administered insulin lispro 10 units as ordered by the physician. The insulin lispro was signed out by MA #2.<br><br>- 6/04/25 at 7:00 am Resident #11 was administered insulin lispro sliding scale coverage of 2 units for a blood sugar of 174 milligram per deciliter (mg/dl) as ordered by the physician. The insulin lispro sliding scale coverage was signed out by MA #2.<br><br>- 6/04/25 at 11:15 am Resident #11 was administered insulin lispro 10 units as ordered by the physician. The insulin lispro was signed out by MA #2.<br><br>- 6/08/25 at 7:00 am Resident #11 was administered insulin lispro 10 units as ordered by the physician. The insulin lispro was signed out by MA #2.<br><br>- 6/08/25 at 7:00 am Resident #11 was administered insulin lispro sliding scale coverage of 2 units for a blood sugar of 188 mg/dl as ordered by the physician. The insulin lispro sliding scale coverage was signed out by MA #2.<br><br>- 6/08/25 at 11:15 am Resident #11 was administered insulin lispro 10 units as ordered by the physician. The insulin lispro was signed out by MA #2.<br><br>- 6/08/25 at 11:15 am Resident #11 was administered insulin lispro sliding scale coverage of 2 units for a blood sugar of 183 mg/dl as ordered by the physician. The insulin lispro sliding scale coverage was signed out by MA #2.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #11 had moderate cognitive impairment and was coded for use of insulin.<br><br>An interview was conducted with Resident #11 on 6/19/25 at 11:35 am who revealed at times a different person would give her insulin than the person that gave her the pills.<br><br>An interview was conducted with MA #2 on 6/18/25 at 11:11 am who revealed she was not able to administer insulin to residents because it was outside her scope of practice as a Medication Aide. MA #2 stated that when she was assigned a resident that required insulin she was only able to check blood sugar but a nurse would have to administer the insulin when needed. MA #2 stated she would normally sign out the insulin administration by the Nurse supervising her because she was giving the other medications and signed everything out at the time the medications were administered. MA #2 stated that the Nurse that was assigned to supervise her would come and give the insulin while she was present and when she saw it was administered she would sign it out on the MAR.<br><br>A telephone interview was conducted with Nurse #1 on 6/19/25 at 10:22 am who was assigned to supervise MA #2 on 6/04/25. Nurse #1 revealed when she had a MA assigned to work with her she administered all insulin to residents. Nurse #1 stated the MA was not able to administer insulin but they were able to check blood sugar levels and then she, as the nurse, would administer the insulin. Nurse #1 stated the MA would sign out the insulin after she (Nurse #1) administered it and she would just confirm all medications were signed out and completed. Nurse #1 stated it would be ideal for her to sign out the insulin, but she stated at times the MA would sign out the insulin.<br><br>A telephone interview was conducted on 6/18/25 at 3:22 pm with Nurse #2 who was assigned to supervise MA #2 on 6/08/25. Nurse #2 revealed that he administered insulin to the residents for the Medication Aides because they were not allowed to administer insulin. Nurse #2 stated he would normally sign out the insulin after he administered it but he stated it could have been an error that he did not sign out Resident #11's insulin on 6/08/25.<br><br>b. Resident #43 was admitted to the facility on [DATE] with diagnoses which included diabetes.<br><br>The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #43 was cognitively intact and was coded for use of insulin.<br><br>Resident #43 had a physician order dated 6/04/25 for insulin lispro (rapid-acting) insulin pen every shift before meals; amount to administer per sliding scale: If Blood Sugar is less than 60, call MD. If Blood Sugar is 100 to 150, give 0 Units. If Blood Sugar is 151 to 199, give 2 Units. If Blood Sugar is 200 to 249, give 4 Units. If Blood Sugar is 250 to 299, give 6 Units. If Blood Sugar is 300 to 349, give 8 Units. If Blood Sugar is 350 to 399, give 10 Units. If Blood Sugar is 400 to 449, give 12 Units. If Blood Sugar is greater than 450, call MD.<br><br>Review of Resident #43's June 2025 MAR revealed the following:<br><br>- 6/07/25 at 7:00 am Resident #43 was administered the insulin lispro sliding scale coverage of 2 units for a blood sugar of 180 mg/dl (milligrams per deciliter) as ordered as ordered by the physician. The insulin lispro sliding scale coverage was signed out by MA #2.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | - 6/07/25 at 5:00 pm Resident #43 was administered the insulin lispro sliding scale coverage of 8 units for a blood sugar of 331 mg/dl as ordered as ordered by the physician. The insulin lispro sliding scale coverage was signed out by MA #2.<br><br>During an interview on 6/18/25 at 12:23 pm with Resident #43 he confirmed that MA #2 had never administered insulin to him at the facility. Resident #43 stated he knew she was not allowed to give him insulin and he would not allow it even if she tried.<br><br>An interview was conducted with MA #2 on 6/18/25 at 11:11 am who revealed she was not able to administer insulin to residents because it was outside her scope of practice as a Medication Aide. MA #2 stated that when she was assigned a resident that required insulin she was only able to check blood sugar but a nurse would have to administer the insulin when needed. MA #2 stated she would normally sign out the insulin administration by the Nurse supervising her because she was giving the other medications and signed everything out at the time the medications were administered. MA #2 stated that the Nurse that was assigned to supervise her would come and give the insulin while she was present and when she saw it was administered she would sign it out on the MAR.<br><br>An attempt to conduct a telephone interview on 6/18/25 at 3:28 pm and 6/19/25 at 10:33 am with Nurse #4 who was assigned to supervise MA #2 on 6/07/25 was unsuccessful.<br><br>c. Resident # 80 was admitted to the facility on [DATE] with diagnoses which included diabetes.<br><br>Resident #80 had a physician order dated 3/12/25 for insulin glargine (long-acting insulin) insulin pen; administer 15 units subcutaneous once day. The insulin glargine was to be administered between 7:00 am and 11:00 am.<br><br>Review of the Medication Administration Record (MAR) revealed Resident #80's blood glucose was noted by Medication Aide (MA) #2 as 150 mg/dl (milligrams per deciliter) and he was administered insulin glargine 15 units as ordered by the physician on 6/09/25. The insulin glargine was signed out by MA #2.<br><br>The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #80 was cognitively intact and was coded for use of insulin.<br><br>An interview was conducted with Resident #80 on 6/18/25 at 11:41 am who revealed he got his pills and insulin from a nurse but he did get them from different people on some days. He stated he was not sure why that happened, but he stated it happened at times that a different nurse would give him insulin.<br><br>An interview was conducted with MA #2 on 6/18/25 at 11:11 am who revealed she was not able to administer insulin to residents because it was outside her scope of practice as a Medication Aide. MA #2 stated that when she was assigned a resident that required insulin she was only able to check blood sugar but a nurse would have to administer the insulin when needed. MA #2 stated she would normally sign out the insulin administration by the Nurse supervising her because she was giving the other medications and signed everything out at the time the medications were administered. MA #2 stated that the Nurse that was assigned to supervise her would come and give the insulin while she was present and when she saw it was administered she would sign it out on the MAR.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | A telephone interview was conducted with Nurse #3 on 6/19/25 at 10:52 am who was assigned to supervise MA #2 on 6/09/25. Nurse #3 stated she administered insulin to the residents when MA #2 worked with her. Nurse #3 stated that when the MA would enter the blood sugar number in the MAR it would prompt the MA to complete all sections of the order before they could move on to sign out the next medication. Nurse #3 stated that it would put the MA initials for completion of the order. Nurse #3 stated that although she (Nurse #3) administered the insulin it would show that MA #2 administered the insulin because she was entering the blood sugar. Nurse #3 stated MA #2 did not administer insulin to any residents when she was assigned to supervise her on 6/09/25.<br><br>During an interview on 6/18/25 at 12:25 pm Unit Manager #2 revealed a Medication Aide was not able to administer insulin and would get the nurse assigned to supervise their shift to administer all insulin. Unit Manager #2 stated the nurse that administered the insulin should sign out the medication not the Medication Aide.<br><br>An interview was conducted with the Director of Nursing (DON) on 6/18/25 at 12:53 pm who revealed all Medication Aides at the facility know they were not able to administer insulin and she had never witnessed any Medication Aide administer any insulin. The DON stated each Medication Aide had a supervisory nurse assigned to them for their entire shift and that nurse was responsible to administer the insulin to the residents and document the administration. |