

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345225</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/22/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SIGNATURE HEALTHCARE OF CHAPEL HILL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1602 E FRANKLIN STREET</b> <b>CHAPEL HILL, NC 27514</b>		
(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 241 SS=E	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on the record review and interview with residents and staff, the facility failed to answer the call bells in a timely manner for residents needing assistance with activities of daily and/or other assistance, to maintain dignity for 3 of 3 residents (Resident #3, Resident #2 and Resident #1) reviewed for dignity.</p> <p>Finding included:</p> <p>1. Resident #3 was admitted to the facility on 6/3/2013. Her diagnoses included Neurogenic Bladder, Heart Murmur, Renal Stones and Hemorrhoids.</p> <p>The Minimum Data Set (MDS) dated 1/14/2015 indicated she was cognitively intact Resident #3 had adequate hearing and vision, clear speech, and was able to be understood and understand others. She was frequently incontinent of bladder and frequently incontinent of her bowels requiring care from staff. Resident #3 had impairment on both the upper and lower extremities of her left side. She required extensive assistance of one person for toileting and two people for transfer from bed and to the wheelchair.</p> <p>During an interview with Resident #3 on 1/20/2015 at 8pm, Resident #3 stated that her</p>	F 241	<p>1. The actions taken for the residents affected by the alleged deficient practice was for the Director of Nursing (DON) to interview residents #1 and #3 to ensure the resident's needs are being met and any concerns identified were addressed. Resident #2 no longer resides in the facility. The DON identified that staffing assignments are divided so that one staff member is on a short hallway and at times of high call bell usage that this staff member may be in a room and not easily available. Staffing assignments have been evaluated and changes made to ensure we are able to meet the needs of our residents.</p> <p>2. The steps we took to assure no other residents would be affected by the alleged deficient practice was to evaluate the process for assignments of the Certified Nursing Assistants (CNA) and to perform an audit relating to answering call bells in a timely manner for residents needing assistance with their activities of daily living and/or other assistance to maintain dignity. The staff assignments have been redistributed to better accommodate resident needs providing better response</p>	2/19/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/13/2015

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.

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F 241	<p>Continued From page 1</p> <p>call bells were not being answer in a timely manner. Resident # 3 indicated that today (1/20/2015) she put her call bell on before lunch and it took about 45 minutes for someone to come in her room. She also stated that a staff member cut off the bell and told Resident #3 that she would check her after lunch. Resident # 3 revealed that she waits about 2 hours each day to be changed. Resident #3 stated " only 2 or 3 nurse aides during the day and we all [residents] need a little help. " Resident #3 revealed that she wet on herself a lot because it takes staff so long to help her. Resident stated that " it ' s not a good feeling when you are wet.</p> <p>Observations of the resident rooms on 1/21/2015 at 11am revealed digital clocks on the walls. The correct time was observed. The clock was within view of the residents ' bed and wheelchair.</p> <p>On 1/21/2015 at 11am Resident #3 indicated the clock was how she knew how long it took for staff to answer her call bell and provide care for her. Resident #3 again revealed that she had waited up to two hours or longer to be changed before, and revealed that this has been going on for months.</p> <p>A review of the Resident Council Meeting minutes dated 11/21/2014 revealed that Resident# 1 was at the meeting and asked if the facility could get a staff member just to float to answer the call bell because the staff was not answering the bell. A total of 21 residents were present at the meeting and agreed with the request for a floating staff member to answer call bells.</p> <p>During an interview with the Unit Manger on</p>	F 241	<p>times to resident call bell requests for assistance.</p> <p>3. The systematic process and changes we have instituted was to have the Staff Development Coordinator (SDC) to re-educate all staff on timely response of call bells and providing timely care/assistance for our residents. The DON, ADON, SDC, and Unit Supervisors have begun audits of call bell responses. They will complete 6 call bell audits 5 days per week for 1 month, then 6 call bell audits weekly for 2 months, then 6 call bell audits twice monthly for 3 months. We will have the Quality of Life Services Director to follow up during the monthly Resident Council Committee Meetings to obtain feedback on improvement on timeliness of call bell responses.</p> <p>4. The results of the findings of the audits will be reviewed by the DON and Administrator on a weekly basis for compliance. The results of the audits will be brought to our monthly QA/PI meeting to be reviewed for compliance. Any issues or concerns that were identified will have been addressed and corrected immediately.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	<p>Continued From page 2</p> <p>1/22/2015 at 9:30am she indicated that Resident #2 had informed her several times during her stay that staff was not answering call bells in a timely manner and she [Resident #2] was not getting the assistance she needed for toileting. The Unit Manager indicated that she did not have a formal in-service with staff but she reminded them daily to answer the call bells within a timely manner. She indicated that timely manner to her was 7 to 15 minutes of the Resident placing the call bell on. The Unit Manager also indicated that this had been brought to her attention more than one time.</p> <p>An interview with the DON on 1/22/2015 at 11am revealed that she had only been the DON since 1/12/2015. Her expectation of staff was the call bells were answered within a time manner and the staff should have provided care to residents every two hours as needed.</p> <p>During an interview with the Administrator on 1/22/2015 at 11:30am he indicated his expectations of staff was to answer the call bell within a time manner and the staff should provide care to residents every two hours as needed. The Administrator stated a resident call him last month concern about the issues presented at the Resident Council meeting about call bells not being answered. The resident [name not provided by the Administrator] indicated that no one addressed the call bell issues and we [residents] are still having problems with the call bell not being answered. Administrator also indicated that he talked with the person who was in charge of Resident Council concerns and that person was terminated because the problems were not being address or handled. It was stated that he had just hired a new DON and indicated the call bell concern would be put in a plan of correction.</p>	F 241			

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F 241	<p>Continued From page 3</p> <p>2. Resident #2 was admitted to the facility on 11/6/2014. Her diagnoses included End Stage Renal Disease, Osteoarthritis, Gout and Hypertension.</p> <p>The Minimum Data Set (MDS) dated 11/12/2014 indicated she was cognitively intact, had adequate hearing and vision, clear speech, was able to be understood and understand others. Resident #2 was continent of bladder and continent of bowel. She required extensive assistance of one person for toileting and one person for transfer from bed and to the wheelchair.</p> <p>Review of a Progress Note dated 12/16/2014 for Resident # 2 included [Resident #2] " stated she has been frustrated with the staff here, stating they don ' t listen and don ' t attend to her needs. Staff did enter the room shortly after the interview and attended to Resident ' s needs. As the staff member left the room, she asked for an additional favor in a very soft tone of voice, which was not heard by the [nurse aid], When the [nurse aid walked away, she started crying and said that no one helps her. "</p> <p>Review of a complaint/grievance report dated 12/15/2014 revealed that Resident # 2 reported that Nurse #1 was being mean to her. The grievance included Resident #2 reported Nurse #1 would not help her to the bathroom saying " she [Resident #2] should do it on her own and you ' re capable. If you got out of bed you can get back in. " Nurse #1 also told Resident #2 " this is good physical therapy for you. "</p> <p>Resident # 2 was discharged on 12/21/2014.</p>	F 241			

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F 241	Continued From page 4  During an interview with Unit Manger on 1/22/2015 at 9:30am she indicated that Resident #2 had informed her several times during her stay that staff was not answering call bells in a timely manner and she [Resident #2] was not getting the assistance she needed for toileting. The Unit Manage indicated that she did not have a formal in-service with staff but she reminded them daily to answer the call bells within a timely manner. She indicated that timely manner to her was 7 to 15 minutes of the Resident placing the call bell on. The Unit Manager also indicated that this had been brought to her attention more than one time and Resident #2 reported that the staff was not treating her with respect. The Unit Manager reported she did discuss with Nurse #1 the concern Resident #2 reported and the Unit Manger indicated that Nurse #1 was encouraged to apologize to Resident #2.  During an interview on 1/22/2015 at 11:45am Nurse # 1 revealed that she had no knowledge of the incident with Resident #2 on 12/15/2014. Nurse #1 stated she had informed Resident #2 information relayed by a Physician about an appointment.  An interview with the DON on 1/22/2015 at 11am revealed that she had only been the DON since 1/12/2015. Her expectation of staff was the call bells were answered within a time manner and the staff should have provided care to residents every two hours as needed.  During an interview with the Administrator on 1/22/2015 at 11:30am he indicated his expectations of staff answering the call bell within a time manner and the staff should provide care	F 241			

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F 241	<p>Continued From page 5</p> <p>to residents every two hours as needed. The Administrator stated a resident call him last month concern about the issues presented at the Resident Council meeting about call bells not being answered. The resident [name not provided by the Administrator] indicated that no one addressed the call bell issues and we [residents] are still having problems with the call bell not being answered. Administrator also indicated that he talked with the person who was in charge of Resident Council concerns and that person was terminated because the problems were not being address or handled. It was stated that he had just hired a new DON and indicated the call bell concern would be put it in a plan of correction.</p> <p>3. Resident #1 was admitted to the facility on 6/11/2013. Her diagnoses included Hypertension, Congestive Heart Failure, Chronic Respiratory Failure and chronic Obstructive Pulmonary Disease.</p> <p>The Minimum Data Set (MDS) dated 12/12/2014 indicated she was cognitively intact, had adequate hearing and vision, clear speech, was able to be understood and understand others. She was frequently in continent of bladder and frequently incontinent of her bowels. Resident #1 required extensive assistance of one person for toileting and one people for transfer from bed and to the wheelchair.</p> <p>An interview with Resident #1 on 1/20/2015 at 8:15pm revealed that she was the Resident Council President and her concern with the staff answering the call bells was the staff comes in and cut the call bell off and then takes about 45min to 1 hr to come back and provide the care for us [residents]. Resident # 1 revealed that this</p>	F 241			

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F 241	<p>Continued From page 6</p> <p>has been discussed in Resident Council Meeting on several occasion and nothing had been done about the concern. Resident # 1 revealed she asked the facility back in November to hire a staff member just to answer the call bell and the concern had not been address. Resident # 1 indicated that this made her feel bad for herself and the other residents in worst condition. Resident # 1 also indicated that she had waited over an hour for care to be provided to her by staff.</p> <p>A review of the Resident Council Meeting minutes dated 11/21/2014 revealed that Resident# 1 was present at the meeting and asked if the facility could get a staff member just to float to answer the call bell because the staff was not answering the bell. A total of 21 residents were present at the meeting and agreed with the request for a floating staff member to answer call bells.</p> <p>During an interview with the Unit Manger on 1/22/2015 at 9:30am she indicated that Resident #2 had informed her several times during her stay that staff was not answering call bells in a timely manner and she [Resident #2] was not getting the assistance she needed for toileting. The Unit Manage indicated she did not have a formal in-service with staff but she reminded them daily to answer the call bells within a timely manner. She indicated that timely manner to her was 7 to 15minutes of the Resident placing the call bell on. The Unit Manager also indicated that this had been brought to her attention more than one time.</p> <p>An interview with the DON on 1/22/2015 at 11am revealed that she had only been the DON since 1/12/2015. Her expectation of staff was the call bells were answered within a time manner and</p>	F 241			

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F 241	Continued From page 7 the staff should have provided care to residents every two hours as needed.  During an interview with the Administrator on 1/22/2015 at 11:30am he indicated his expectations of staff answering the call bell within a time manner and the staff should provide care to residents every two hours as needed. The Administrator stated a resident call him last month concern about the issues presented at the Resident Council meeting about call bells not being answered. The resident [name not provided by the Administrator] indicated that no one addressed the call bell issues and we [residents] are still having problems with the call bell not being answered. Administrator also indicated that he talked with the person who was in charge of Resident Council concerns and that person was terminated because the problems were not being address or handled. It was stated that he had just hired a new DON and indicated the call bell concern would be put it in a plan of correction.	F 241			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide incontinent care, when requested from 1 of 3 residents (Resident # 3) who required extensive assisted with toileting;	F 312	1. Resident #1 and #3 were interviewed by the DON on 02/05/15 to ensure the resident' needs were being met and any concerns identified were addressed.	2/19/15	



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F 312	<p>Continued From page 8</p> <p>and failed to attend to the needs of a resident and provide assistance to 1 of 3 residents (Resident# 2) who requested assistance going to the bathroom .</p> <p>Finding included:</p> <p>1. Resident #3 was admitted to the facility on 6/3/2013. Her diagnoses included Neurogenic Bladder, Heart Murmur, Renal Stones Pressure Ulcer and Hemorrhoids.</p> <p>The Minimum Data Set (MDS) dated 1/14/2015 indicated she was cognitively intact Resident #3 had adequate hearing and vision, clear speech, and was able to be understood and understand others. She was frequently incontinent of bladder and frequently incontinent of her bowels requiring care from staff. Resident #3 had impairment on both the upper and lower extremities of her left side. She required extensive assistance of one person for toileting and two people for transfer from bed and to the wheelchair.</p> <p>A Review of Resident #3 ' s care plan dated 1/21/2015 revealed that Resident had a stage 2 ulcer to the sacrum and staff needed to provide incontinence care after incontinence episodes and apply barrier cream. Resident # 3 had the potential for complications associated with incontinence of bowel and/or bladder. The staff was to provide peri care after each incontinent episode.</p> <p>During an interview with Resident #3 on 1/20/2015 at 8pm, Resident #3 stated that her call bells were not being answer in a timely manner. Resident # 3 indicated that today (1/20/2015) she put her call bell on before lunch</p>	F 312	<p>Resident #2 no longer resides in the facility.</p> <p>2. An audit was completed on alert and oriented residents by the DON, SDC and ADON to ensure that the residents Activity of Daily Living needs were being met. Any issues identified were addressed and corrected by either the DON, SDC or ADON at that time.</p> <p>3.The systematic process and changes we have instituted was to have the SDC to re-educate all staff on timely response of call bells and providing timely care/assistance for our residents. The DON/ADON/SDC/Unit Supervisors have begun audits of call bell responses and responses for ADL assistance. The DON/ADON/SDC/Unit Supervisors will complete 6 of these audits 5 days per week for 1 month, then 6 audits weekly for 2 months, then 6 audits twice monthly for 3 month. We will have the Quality of Life Services Director to follow up as well during the Resident Council Committee Meetings to obtain feedback on improvement on timeliness of call bell responses and to ensure our resident's needs are being met.</p> <p>4. The results of the findings of the audits will be reviewed by the DON and Administrator on a weekly basis. The results of the audits will be brought to our monthly QA/PI meeting to be reviewed for compliance. Any issues identified form the audits will be discussed to ensure they have been addressed and corrected.</p>		

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F 312	<p>Continued From page 9</p> <p>and it took about 45 minutes for someone to come in her room. She also stated that a staff member cut off the bell and told Resident #3 that she would check her after lunch. Resident # 3 revealed that she waits about 2 hours each day to be changed. Resident #3 stated there were " only 2 or 3 nurse aides during the day and we all [residents] need a little help. " Resident #3 revealed that she urinates on herself a lot because it takes staff so long to help her. Resident stated that " it ' s not a good feeling when you are wet. ' "</p> <p>Observations of the resident rooms on 1/21/2015 at 11am revealed digital clocks on the walls. The correct time was observed. The clock was within view of the residents ' bed and wheelchair.</p> <p>On 1/21/2015 at 11am Resident #3 indicated the clock was how she knew how long it took for staff to answer her call bell and provide care for her. Resident #3 again revealed that she had waited up to two hours or longer to be changed before, and revealed that this has been going on for months.</p> <p>An interview with the DON on 1/22/2015 at 11am revealed that she had only been the DON since 1/12/2015. Her expectation of staff was the call bells were answered within a time manner and the staff should have provided care to residents every two hours as needed.</p> <p>2. Resident #2 was admitted to the facility on 11/6/2014. Her diagnoses included End Stage Renal Disease, Osteoarthritis, Gout and Hypertension.</p> <p>The Minimum Data Set (MDS) dated 11/12/2014</p>	F 312			

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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 312	<p>Continued From page 10</p> <p>indicated she was cognitively intact, had adequate hearing and vision, clear speech, was able to be understood and understand others. Resident #2 was continent of bladder and continent of bowel. She required extensive assistance of one person for toileting and one person for transfer from bed and to the wheelchair.</p> <p>Review of Resident # 2 ' s care plan dated 11/14/2014 revealed that Resident # 2 had a self care deficit with activity of daily living (ADL) and was at risk for complication. The staff was to provide assistance/supervision to meet Resident #2 ' s need for all ADL.</p> <p>Review of a Progress Note dated 12/16/2014 for Resident # 2 included [Resident #2] " stated she has been frustrated with the staff here, stating they don ' t listen and don ' t attend to her needs. Staff did enter the room shortly after the interview and attended to Resident ' s needs. As the staff member left the room, she asked for an additional favor in a very soft tone of voice, which was not heard by the [nurse aid], When the [nurse aid walked away, she started crying and said that no one helps her. "</p> <p>Review of a complaint/grievance report dated 12/15/2014 revealed that Resident # 2 reported that Nurse #1 was being mean to her. The grievance included Resident #2 reported Nurse #1 would not help her to the bathroom saying " she [Resident #2] should do it on her own and you ' re capable. If you got out of bed you can get back in. " Nurse #1 also told Resident #2 " this is good physical therapy for you. "</p> <p>Resident # 2 was discharged on 12/21/2014.</p>	F 312			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345225</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/22/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SIGNATURE HEALTHCARE OF CHAPEL HILL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1602 E FRANKLIN STREET</b> <b>CHAPEL HILL, NC 27514</b>		
(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 312	<p>Continued From page 11</p> <p>During an interview with Unit Manger on 1/22/2015 at 9:30am she indicated that Resident #2 had informed her several times during her stay that staff was not answering call bells in a timely manner and she [Resident #2] was not getting the assistance she needed for toileting. The Unit Manage indicated that she did not have a formal in-service with staff but she reminded them daily to answer the call bells within a timely manner. She indicated that timely manner to her was 7 to 15 minutes of the Resident placing the call bell on. The Unit Manager also indicated that this had been brought to her attention more than one time and Resident #2 reported that the staff was not treating her with respect. The Unit Manager reported she did discuss with Nurse #1 the concern Resident #2 reported and the Unit Manger indicated that Nurse #1 was encouraged to apologize to Resident #2.</p> <p>An interview with the DON on 1/22/2015 at 11am revealed that she had only been the DON since 1/12/2015. Her expectation of staff was the call bells were answered within a time manner and the staff should have provided care to residents every two hours as needed.</p>	F 312			