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

PRINTED: 10/22/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345225	B. WING _			09/28/2020
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF CHAPEL HILL			,	STREET ADDRESS, CITY, STAT 1602 E FRANKLIN STREET CHAPEL HILL, NC 27514	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments		EC	000		
F 000	Survey was conductor Medicare & Medicard 9/21/20-9/22/20 and	9/28/20. The facility was ance with 42 CFR §483.73 (6).	F	100		
F 000	The surveyor entere conduct an infection exited on 09/22/20.	ed the facility on 09/21/20 to control focus survey and Additional information was D. Therefore, the exit date				
F 880 SS=F	Infection Prevention	& Control	F 8	80		10/12/20
	infection prevention a designed to provide comfortable environr	ablish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable				
	program. The facility must esta	prevention and control ablish an infection prevention (IPCP) that must include, at wing elements:				
	reporting, investigating and communicable distaff, volunteers, visit providing services urarrangement based in	em for preventing, identifying, ng, and controlling infections liseases for all residents, tors, and other individuals ander a contractual upon the facility assessment to §483.70(e) and following				
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE

Electronically Signed 10/12/2020

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 880	procedures for the property but are not limited to: (i) A system of surveity possible communication infections before they persons in the facility (ii) When and to who communicable disease reported; (iii) Standard and transto be followed to preventy (iv) When and how is cresident; including but (A) The type and durate depending upon the involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstance must prohibit employed disease or infected should be staff involved in disease with the system of the factories of the province of the prov	a standards, policies, and ogram, which must include, allance designed to identify pole diseases or a can spread to other; m possible incidents of se or infections should be assisted precautions arent spread of infections; polation should be used for a set not limited to: attended to a set the isolation, and the isolation should be the ble for the resident under the ses with a communicable win lesions from direct as or their food, if direct the disease; and procedures to be followed arect resident contact.	F 8	80			

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	345225	B. WING		09/28/2020	
OVIDER OR SUPPLIER	CHAPEL HILL		1602 E FRANKLIN STREET	1 00/20/2020	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
Continued From pa	ge 2	F 880	0		
The facility will cond IPCP and update the This REQUIREMENT by:  Based on observation of the facility's COV to implement their prosted at the facility screening or a compusitors of new proceptive COVID-19 pand onsite portion of the This failure occurrence pandemic.	duct an annual review of its leir program, as necessary.  IT is not met as evidenced lion, staff interview and review l'ID 19 policy the facility failed policy by having no signage ly's main entrance for munication plan to alert ledures or restrictions during lemic for 2 of 2 days of the e survey (9/21/20 and 9/22/20). It is not met annual lemic for 2 of 2 days of the e survey (9/21/20 and 9/22/20).		This plan of correction constitutes a written allegation of compliance. Preparation and submission of this placorrection does not constitute an admission or agreement by the provid truth of the facts alleged or the correct of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.	er of cions	
Coronavirus (COVII revised 8/18/20 on facility should increate entrances and exits.)  Observation on 9/2 facility's main entrance utilized by signage posted for nor a plan to common observation on 9/2 signage posted at the screening, facility recommunicate with volume of the signage posted at the communicate with volume of the signage posted at the screening of the	D-19)" dated 3/4/20 and last page 5 read in part: The ase visible signage at  1/20 at 11:40 AM revealed the nee which was the only visitors and staff had no screening, facility restrictions unicate with visitors.  1/20 at 3:00 PM revealed no ne facility entrance for estrictions nor a plan to visitors.		1. No residents were found to be affected by the cited deficient practice Signage was posted at the front entrar for screening/communication to alert visitors of new procedures during the Covid 19 pandemic.  2. All residents had the potential to be affected by the deficient practices. Education will be provided to administrative staff, housekeeping and maintenance staff on the following infection control topics: Signage locat purpose of signage information regards screening/restrictions and any communication plans/revisions along the expectation that signage must be visible at entrances used by visitors/staff.	nce d ion, ling with	
	SUMMARY'S (EACH DEFICIENT REGULATORY OF CACHE DEFICIENT REGULATORY	E HEALTHCARE OF CHAPEL HILL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the facility's COVID 19 policy the facility failed to implement their policy by having no signage posted at the facility's main entrance for screening or a communication plan to alert visitors of new procedures or restrictions during the COVID-19 pandemic for 2 of 2 days of the onsite portion of the survey (9/21/20 and 9/22/20). This failure occurred during the COVID19 pandemic.  The findings included:  Record review of the facility policy: "Novel Coronavirus (COVID-19)" dated 3/4/20 and last revised 8/18/20 on page 5 read in part: The facility should increase visible signage at entrances and exits.  Observation on 9/21/20 at 11:40 AM revealed the facility's main entrance which was the only entrance utilized by visitors and staff had no signage posted for screening, facility restrictions nor a plan to communicate with visitors.  Observation on 9/21/20 at 3:00 PM revealed no signage posted at the facility entrance for screening, facility restrictions nor a plan to communicate with visitors.  Observation on 9/22/20 at 10:16 AM continued to reveal no signage posted at the facility entrance	E HEALTHCARE OF CHAPEL HILL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the facility's COVID 19 policy the facility failed to implement their policy by having no signage posted at the facility's main entrance for screening or a communication plan to alert visitors of new procedures or restrictions during the COVID-19 pandemic for 2 of 2 days of the onsite portion of the survey (9/21/20 and 9/22/20). This failure occurred during the COVID19 pandemic.  The findings included:  Record review of the facility policy: "Novel Coronavirus (COVID-19)" dated 3/4/20 and last revised 8/18/20 on page 5 read in part: The facility should increase visible signage at entrances and exits.  Observation on 9/21/20 at 11:40 AM revealed the facility's main entrance which was the only entrance utilized by visitors and staff had no signage posted for screening, facility restrictions nor a plan to communicate with visitors.  Observation on 9/21/20 at 3:00 PM revealed no signage posted at the facility entrance for screening, facility restrictions nor a plan to communicate with visitors.  Observation on 9/21/20 at 10:16 AM continued to	STREET ADDRESS, CITY, STATE, ZIP CODE  1802 E FRANKLIN STREET CHAPEL HILL, NC 27514  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  COntinued From page 2  \$483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview and review of the facility's main entrance for screening or a communication plan to alert visitors of new procedures or restrictions during the COVID-19 pandemic for 2 of 2 days of the onsite portion of the survey (9/21/20 and 9/22/20). This failure occurred during the COVID19 pandemic.  The findings included:  Record review of the facility policy: "Novel Cornavirus (COVID-19)" dated 3/4/20 and last revised 8/18/20 on page 5 read in part. The facility should increase visible signage at entrances and exits.  Observation on 9/21/20 at 11:40 AM revealed the facility should increase visitle signage at entrance which was the only entrance utilized by visitors and staff had no signage posted for screening, facility restrictions nor a plan to communicate with visitors.  Observation on 9/21/20 at 3:00 PM revealed no signage posted at the facility entrance for screening, facility restrictions nor a plan to communicate with visitors.  Observation on 9/22/20 at 10:16 AM continued to reveal no signage posted at the facility entrance for screening, facility restrictions nor a plan to communicate with visitors.  Observation on 9/22/20 at 10:16 AM continued to reveal no signage posted by the calculation shall be provided to administrative staff, housekeeping an maintenance staff on the following infection control topics: Signage locat purpose of signage information regard screening/restrictions and any communicate with visitors.	

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	ROVIDER OR SUPPLIER	HAPEL HILL	•	16	TREET ADDRESS, CITY, STATE, ZIP CODE 502 E FRANKLIN STREET HAPEL HILL, NC 27514		
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F 880	Director of Nurses of entrance which had no signage that provided that provided the contract of the contract o	2/20, the Administrator and bserved the facility's front 2 red colored stop signs, but rided information related to ing, or a communication plan w procedures or restrictions.  2/20 at 11:01 AM revealed no e facility entrance.  at 12:55 PM with the Plant POD) in the presence of the ed he had removed the stand (ID19 signage on 9/21/20 at AM, so the floor could be moved it back to the facility histrator nor the POD were build have been responsible	F	380	3. Education on the Infection Control Policy as it relates to signage location, purpose of signage information regardi screening/restrictions and any communication plans/revisions along with the expectation that the signage must livisible at entrances used by visitors/stawas provided to the targeted staff. This training will also be provided to administrative, housekeeping and maintenance staff upon hire. All datawabe summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issuor trends identified will be addressed by the QAPI committee as they are arise at the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrato DON, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Direct Director of Social Services, and Environmental Services. Other member may be assigned as the need should arise.  4. The Root Cause Analysis was conducted by the Infection Preventionic QAPI Team and Governing Board and root cause of the cited deficient practic was determined to be a need for further education and observations regarding signage location, purpose of signage information regarding screening/restrictions and any communication plans/revisions along with expectation that the signage must be expectation that the signage must be a signage as signage must be a signage must be a signage as signage as	ng vith pe aff s vill les y and r, tor, or, ers	

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F 880	Continued From page	÷ 4	F	visible at entrances used by vorthe RCA also revealed there more frequent observations to required signage is in place a all times. Due to the findings the above education will be conditioned and then ongoing audits will be by the Administrator, Director Business Office Manager and Maintenance to ensure complimese audits and observation conducted 5 days a week for weekly for four weeks, weekly weeks and then monthly x 3 mincident of non-compliance will be and presented to the facility of the observer. All data will be and presented to the facility of Assurance and Performance Improvement meeting monthly Administrator. Any issues or identified will be addressed by committee as they arise, and be revised to ensure continue compliance. The QAPI commiconsists of the Administrator, Development Coordinator, MI Coordinator, Admission Coordinator, Admission Coordinator, Admission Coordinator, Admission Coordinator, Social Services, and Environmental Services. Other and be assigned as the need arise.  5. The Administrator and Di Nursing is responsible for impand maintaining the acceptab correction. Corrective action to the correction of the the corre	is a need of ensure the ind visible of the RC completed of econduction of Nursing Illiance. It is will be 4 weeks, if or four months. An ith Infection is to visible orrected be summarized unality by the QAP the plan were different of column of the plan of th	for he at EA, ted g, 2 x ny on e by zed Pl will aff or, ers	

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F 880	Continued From page	e 5	F8				