STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345225	A. BUILDING _____ B. WING _____	09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF CHAPEL HILL	1602 E FRANKLIN STREET CHAPEL HILL, NC 27514

(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
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 9/21/20-9/22/20 and 9/28/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).	E 000		
F 000	INITIAL COMMENTS The surveyor entered the facility on 09/21/20 to conduct an infection control focus survey and exited on 09/22/20. Additional information was obtained on 09/28/20. Therefore, the exit date was changed to 09/28/20.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		10/12/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/12/2020

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F 880	Continued From page 1 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	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 for screening, facility restrictions nor a plan to	F 880	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections 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. 1. No residents were found to be affected by the cited deficient practices. Signage was posted at the front entrance 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 location, purpose of signage information regarding screening/restrictions and any communication plans/revisions along with the expectation that signage must be visible at entrances used by visitors/staff. This was completed by 10/12/20.	

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F 880	Continued From page 3 communicate with visitors. At 10:45 AM on 9/22/20, the Administrator and Director of Nurses observed the facility's front entrance which had 2 red colored stop signs, but no signage that provided information related to COVID19 for screening, or a communication plan to alert visitors of new procedures or restrictions. Observation on 9/22/20 at 11:01 AM revealed no signage posted at the facility entrance. Interview on 9/22/20 at 12:55 PM with the Plant Operation Director (POD) in the presence of the Administrator revealed he had removed the stand with the posted COVID19 signage on 9/21/20 at approximately 6:00 AM, so the floor could be cleaned, but no one moved it back to the facility entrance. The Administrator nor the POD were able to state who would have been responsible for replacing the signage. Interview via telephone on 9/28/20 at 11:36 AM with the Housekeeper/Floor technician stated he was responsible for cleaning floors on 9/21/20 and was not responsible for replacing the signage back.	F 880	3. Education on the Infection Control Policy as it relates to signage location, purpose of signage information regarding screening/restrictions and any communication plans/revisions along with the expectation that the signage must be visible at entrances used by visitors/staff was provided to the targeted staff. This training will also be provided to administrative, housekeeping and maintenance staff upon hire. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they are arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 4. The Root Cause Analysis was conducted by the Infection Preventionist, QAPI Team and Governing Board and the root cause of the cited deficient practices 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 the expectation that the signage must be	

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F 880	Continued From page 4	F 880	visible at entrances used by visitors/staff. The RCA also revealed there is a need for more frequent observations to ensure the required signage is in place and visible at all times. Due to the findings of the RCA, the above education will be completed and then ongoing audits will be conducted by the Administrator, Director of Nursing, Business Office Manager and/or Maintenance to ensure compliance. These audits and observations will be conducted 5 days a week for 4 weeks, 2 x weekly for four weeks, weekly for four weeks and then monthly x 3 months. Any incident of non-compliance with Infection Control guidelines as it relates to visible signage will be immediately corrected by the observer. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be	

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F 880	Continued From page 5	F 880	completed by 10/12/20.	