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	345225	A. BUILDING _____ B. WING _____	C 08/19/2022

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

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E 000	Initial Comments An unannounced COVID-19 Focused Survey and complaint investigation was conducted on 08/18/2022 through 08/19/2022. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID # SI8911	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 08/18/2022 through 08/19/2022. Event ID# SI8911. The following intakes were investigated: NC00191258 and NC00192186. Four of the four complaint allegations were not substantiated.	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	F 880		9/1/22

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

Electronically Signed | 08/30/2022

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F 880	Continued From page 1 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following 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.	F 880		

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F 880	Continued From page 2 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 record review, observation and staff interview the facility failed to: 1) assure staff wore eye protection as source control for COVID-19 during a time period when the county COVID-19 transmission rate was high on 4 of 4 halls in the facility and 2) follow transmission-based precautions for 1 (Resident #4) of 2 residents on transmission-based precautions for COVID-19. This occurred during a coronavirus pandemic. The findings included: 1.Review of the facility's "Novel Coronavirus (COVID-19)" clinical policy last revised on 3/8/2022 revealed under general preventative measures, "Requiring eye protection (face shield or goggles) to be worn by [staff] (in addition to masks) in resident/patient care areas (as defined by each facility) should be based on requirements by local and/or state health departments, in accordance with CDC, state and/or federal regulations." Review of CDC guidelines for Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) during the Coronavirus Disease 2019 Pandemic, last updated on 2/2/2022, revealed HCP working in facilities located in counties with substantial or high transmission should use eye protection during all patient (resident) encounters.	F 880	F-880 1. Resident #4 continues to reside in the facility and no longer requires transmission-based precautions. Facility policy for COVID-19 infection control and prevention and CDC recommendations were immediately implemented. 2. Current residents had the potential to be affected by the alleged deficient practices, however, the current resident population continued to have daily monitoring for COVID 19 signs and symptoms in place during the survey and this continues presently. A review of the current resident population has been completed to validate residents had not exhibited a potential change in condition related to the alleged deficient practice. The current facility policy for Infection Control Novel Coronavirus has been reviewed with not changes required. 3. It is the responsibility of the facility staff to practice infection control practices as established via facility policy, local and state health department recommendations, and CDC recommendations. Education on COVID-19 infection control and	

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F 880	Continued From page 3 A review of CDC's Data Tracker of COVID-19 transmission rates for the facility's county revealed a rate of transmission was high for the current dates of 8/18/2022 and 8/19/2022 as well as data from 7/11/2022 to 8/19/2022. During the entrance conference on 8/18/2022 at 11:15 AM the facility Administrator revealed the facility was not in a COVID-19 outbreak status and did not have any residents at that time diagnosed with COVID-19 but had two residents on transmission-based precautions for COVID-19. a. Review of the staffing schedule for 8/18/2022 revealed Nurse #1 was assigned to the front red hall for the 7:00 AM to 7:00 PM shift. An observation and interview with Nurse #1 were conducted on 8/18/2022 at 1:11 PM. Nurse #1 was observed to be wearing a surgical mask and no face shield or goggles. Nurse #1 stated the facility required her to wear eye protection such as goggles or a face shield only if the facility was in COVID-19 outbreak status. b. Review of the nursing staff schedule for 8/18/2022 revealed Nurse #2 was scheduled to work on the 7:00 AM to 7:00 PM shift on back blue hall. Nurse #2 was observed and interviewed on 8/18/2022 at 1:32 PM. Nurse #2 was observed to be wearing a N-95 mask with no face shield or googles. Nurse #2 stated she was wearing a N-95 mask because it was her preference, and nobody had told her she needed goggles or a face shield.	F 880	prevention based on facility policy, local and state health department recommendations, and CDC recommendations, was initiated on 8/19/2022 by the Director of Nursing, the Administrator, Unit Manager, or Staff Development Coordinator for staff including administrative, nursing, housekeeping, maintenance, dietary, rehabilitation, as well as contract staff. The education emphasized using recommended personal protective equipment (PPE) of face mask, eye protection in resident care areas for potential resident encounters, and donning / doffing gown, mask, eye protection, and gloves when entering isolation precaution rooms. This will be completed by 9/1/2022. This education will also be provided to staff by the DON, Unit Manager, or Staff Development Coordinator upon hire during new hire orientation. Staff who have not received the education, by 09/01/22, will not be allowed to work until they receive the education. The Interdisciplinary Team, consisting of Administrator, Director of Nursing, Unit Manager, Social Services, Quality of Life, and Medical Records, will be responsible to conduct auditing 5 times a week for two weeks, 3 times a week for 2 weeks, weekly for 4 weeks, then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed for individual, up to and including disciplinary action as determined necessary by the Administrator and Director of Nursing.	

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F 880	Continued From page 4 c. Review of the nursing staff schedule for 8/18/2022 revealed Nurse #3 was scheduled to work on the 7:00 AM to 7:00 PM shift on the front red hall. Nurse #3 was observed and interviewed on 8/18/2022 at 1:42 PM. Nurse #3 was observed to be wearing a surgical mask but no face shield or goggles. Nurse #3 stated that only when the facility was in outbreak status, she would have to wear goggles and a N-95 mask and only if she was working on the Covid-19 hall. d. Nurse Aide (NA #2) was observed and interviewed on 8/18/2022 at 5:24 PM. NA #2 was observed to be wearing a surgical mask and no face shield or goggles. NA #2 stated he was only required to wear a face shield and/or goggles when he was caring for a resident with COVID-19 otherwise a surgical mask was enough. An interview was conducted with the Infection Preventionist/Staff Development Coordinator (IP/SDC) and the Director of Nursing (DON) on 8/18/2022 at 4:00 PM. The IP/SDC and the DON both confirmed the facility staff collectively were currently and had not been wearing face shields or goggles because the facility was not going by the county transmission rate for COVID-19 but, wore face shields/goggles if the facility was in COVID-19 outbreak status. 2. Resident #4 was readmitted to the facility from the hospital on 8/11/2022. Resident #11 had a physician's order dated 8/11/2022 stating, "Isolation type (Droplet) precautions every shift every day."	F 880	4. The Administrator will be responsible to review the completed auditing process as per the timeline above. Data and audits will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting weekly for 4 weeks and then monthly for three months. 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 if the need arises. An Ad Hoc QAPI meeting was conducted on 8/23/22 with the Administrator, Director of Nursing, and Medical Director to review survey findings and action plans. An additional Ad Hoc QAPI meeting was conducted on 08/29/2022 with the Administrator, Director of Nursing, Unit Manager, Medical Director, and Governing Body representatives, to further review actions and education, with recommendations addressed/implemented. The Administrator is responsible for implementing and maintaining the acceptable plan of correction. Alleged Compliance Date is	

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F 880	Continued From page 5	F 880	09/01/2022	

Documentation in the electronic medical record reveled Resident #4 was not up to date on immunizations and had only had the first dose of a COVID-19 vaccination despite being eligible for the second dose.

An observation was made on 8/18/2022 at 1:01 PM of the closed door of Resident #4. On the door of Resident #4 was signage entitled "Special Contact/Droplet Precautions." The instructions on the sign gave the following instructions: "All Healthcare personnel must clean hands before entering and when leaving the room, wear gown when entering room and remove before leaving, wear N-95 or higher level respirator before entering the room and remove before exiting, protective eyewear (face shield or goggles), wear gloves when entering room and remove before leaving, place in private room, keep door closed."

a. Housekeeper (HK #1) was observed on 8/18/2022 at 1:19 PM to put on a protective gown and gloves from a set of drawers located outside of the room for Resident #4. HK #1 did not put on goggles or a face shield or an N-95 or higher-level respirator before entering the room but did already have on a surgical mask. HK #1 entered and exited the room returning to her cleaning cart as she performed cleaning tasks in the room. Upon completing her cleaning tasks HK #1 exited the room, removed her protective gown and gloves disposing of them in her cleaning cart garbage bin and performed hand sanitation.

HK #1 was interviewed on 8/18/2022 at 1:27 PM after she completed cleaning the room of Resident #4. HK #1 revealed she was told all she needed to wear to clean the room of Resident #4 was a surgical mask, gloves, and a gown.

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F 880	Continued From page 6	F 880		

b. An observation was made on 8/18/2022 at 2:56 PM. NA #1 was observed to approach the room of Resident #4. NA #1 already had on a surgical mask and her personal glasses. NA #1 donned a protective gown and put on gloves prior to entering the room of Resident #4. At 3:04 PM NA #1 exited the room without the protective gown but carrying two bags with soiled linen and trash in her gloved hands. NA #1 disposed of the bags and her gloves behind a closed door on the hallway and was observed to perform hand hygiene in another adjacent room.

NA #1 was interviewed at 3:06 PM on 8/18/2022. NA #1 revealed Resident #4 was just back from the hospital and he did not have COVID-19. NA #1 further stated that Resident #4 was just in one of the isolation rooms for 10 days and if he did have COVID-19 he would be on the Red side of the building. NA #1 stated that precautions like a N-95 mask and goggles only needed to be followed if a resident had COVID-19.

c. An observation was made on 8/18/2022 at 5:34 PM. NA #3 was observed to be wearing a surgical face mask and no gloves. NA #3 removed a meal tray from a cart in the hallway and brought it into the room of Resident #4. NA #3 did not put on a N-95 mask, goggles, gloves, or a protective gown prior to delivering the tray to Resident #4. NA #3 assisted Resident #4 with set up of his meal tray and exited the room returning to the meal cart in the hallway. NA #3 performed hand hygiene and then poured a drink into a mug before returning to the room of Resident #4. NA #3 again did not put on a N-95 mask, goggles, gloves, or a protective gown. NA #3 gave the drink to Resident #4 and then exited the room, performing hand hygiene

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F 880	Continued From page 7 after leaving. NA #3 was interviewed at 5:36 PM. NA #3 stated he did not know if he needed to wear a N-95 mask, goggles, gloves, and/or a protective gown when entering the room of Resident #4 but he would ask a nurse. NA #3 added that he thought Resident #4 was no longer on contact precautions because he was back from the hospital. d. An observation was made on 8/19/2022 at 8:34 AM. NA #1 was observed to already have on a surgical mask. NA #1 put on a protective gown, goggles, and then gloves but not an N-95 mask outside of the room of Resident #4. NA #4 entered the room of Resident #4 with a breakfast tray and closed the door. NA #1 was interviewed after the observation and stated she thought she had on everything she needed to enter the room of Resident #4. An interview was conducted on 8/18/2022 at 4:00 PM with the Infection Preventionist/Staff Development Coordinator (IP/SDC) and the Director of Nursing (DON). Both the IP/SDC and the DON confirmed the staff who go in the room of Resident #4 must follow the required infection prevention measures on the signage on the door for droplet/contact precautions.	F 880		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum,	F 886		9/1/22

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F 886	Continued From page 8	F 886		

for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:

§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not
limited to:
(i) Testing frequency;
(ii) The identification of any individual specified in this paragraph diagnosed with
COVID-19 in the facility;
(iii) The identification of any individual specified in this paragraph with symptoms
consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the
transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate
to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an

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F 886	Continued From page 9 individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to base their routine staff testing schedule for COVID-19 on the county transmission rate. This was for 6 (Housekeeper #1, Nurse #3, Nurse Aide #1, Nurse Aide #2, Housekeeper #2, and Nurse #4) of 8 employees reviewed for COVID-19 vaccination status and testing. The findings included: Review of the facility's COVID-19 clinical policy and procedures, dated as last revised on 3/8/2022, the facility was conducting testing based on the parameters set forth by CMS. Review of CDC guidelines for Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) during the Coronavirus Disease 2019 Pandemic, last updated on 2/2/2022, revealed HCP working in facilities located in counties with substantial or	F 886	F-886 1. No residents were listed as being affected by the cited deficient practices, in the 2567. Facility policy for COVID-19 testing schedule based on transmission rate, local and state health department recommendations, and CDC recommendations were immediately re-implemented. 2. Current residents had the potential to be affected by the alleged deficient practice, however, current resident population continues to have daily monitoring for COVID 19 signs and symptoms. A review of the current resident population has been completed to validate residents have not exhibited a potential change in condition related to the alleged deficient practice. 3. It is the responsibility of the facility	

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F 886	Continued From page 10 high transmission should have a viral test twice a week. A review of CDC's Data Tracker of COVID-19 transmission rates for the facility's county revealed a rate of transmission was high for the current dates of 8/18/2022 and 8/19/2022 as well data from 7/11/2022 to 8/19/2022. a. Review of the facility's Staff Vaccination Status Roster revealed Light Housekeeper (HK #1) had the first dose of a vaccine but was not due yet for the second dose or the booster. HK #1 was interviewed on 8/18/2022 at 1:27 PM. HK #1 revealed she was a new employee and she was tested once a week for COVID-19. b. Nurse #3 was interviewed on 8/18/2022 at 1:42 PM. Nurse #3 stated she was tested once a week at the facility. The Director of Nursing (DON) provided the vaccination status of Nurse #3 verbally on 8/18/2022 at 4:29 PM. The DON revealed Nurse #3 had the first and second doses of the vaccination but not had the booster despite being eligible. c. Review of the facility's Staff Vaccination Status Roster revealed Nurse Aide (NA #1) was vaccinated for COVID-19 and was eligible for the booster but had not yet received it. NA #1 was interviewed on 8/18/2022 at 3:06 PM and confirmed she was tested once a week at the facility for COVID-19. d. Review of the facility's Staff Vaccination Status	F 886	staff to provide COVID 19 testing as per local transmission rate, local and state health department recommendations, and CDC recommendations. Education on COVID-19 testing based on facility policy, local and state health departments, and CDC recommendations regarding frequency of testing for health care personnel (HCP) was initiated by the Director of Nursing, Unit Manager, the Administrator, or regional / corporate staff starting on 8/19/2022 for staff including administrative, nursing, housekeeping, maintenance, dietary, rehabilitation, as well as contract staff. Education will be completed by 9/1/22. Staff that have not received the education by 09/01/22 will not be allowed to work, until they receive the education. Newly hired staff will be educated by the DON, Unit Manager, or Staff Development Coordinator during new hire orientation. HCP will be tested 2 times weekly regardless of the vaccination status when the community transmission rate is high. Ongoing audits and observations will be completed by the Director of Nursing, the Administrator, or designee to ensure testing is conducted as determined necessary by the transmission rate, facility policy, local and state health departments, and CDC recommendations. These audits will be conducted 5 times a week for two weeks, 3 times a week for 2 weeks, weekly for 4 weeks, then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed for individual, up to and including disciplinary action as determined necessary by the	

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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
F 886	Continued From page 11 Roster revealed NA #2 was vaccinated for COVID-19 and was eligible for the booster but had not yet received it. NA #2 was interviewed on 8/18/2022 at 5:24 PM. NA #2 revealed he was tested for COVID-19 once a week at the facility. e. Review of the facility's Staff Vaccination Status Roster revealed Nurse #4 was vaccinated for COVID-19 and was eligible for the booster but had not yet received it. Nurse #4 was interviewed on 8/19/2022 at 8:45 AM. Nurse #4 revealed she was vaccinated so she was tested once a week at the facility for COVID-19. f. Review of the facility's Staff Vaccination Status Roster revealed Heavy Housekeeper (HK #2) was vaccinated for COVID-19 and was eligible for the booster but had not yet received it. HK #2 did not answer questions about the frequency of testing. An interview was conducted with the Infection Preventionist/Staff Development Coordinator (IP/SDC) on 8/18/2022 at 4:00 PM. The IP/SDC revealed the facility was conducting testing at the facility based on outbreak status and not by the county transmission rate. The IP/SDC stated the facility had not had an outbreak since April 2022. The IP/SDC further explained that apart from one nurse aide and one nurse who were not vaccinated but had religious exemptions, the facility was testing the employees once a week for COVID-19.	F 886	Administrator and Director of Nursing. 4. Audits will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting weekly for four weeks then monthly for 3 months. The QAPI committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Minimum Data Set coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement committee as they arise, and the plan will be revised to ensure continued compliance. 5. An Ad Hoc QAPI meeting was conducted on 8/23/22 with the Administrator, Director of Nursing, and Medical Director to review survey findings and action plans. An additional Ad Hoc QAPI meeting was conducted on 08/29/22 with the Administrator, Director of Nursing, Unit Manager, Medical Director, and Governing Body representatives, to further review actions and education, with recommendations addressed/implemented. The Administrator is responsible for implementing and maintaining the acceptable POC. Alleged Compliance Date is 09/01/2022	