	-	ND HUMAN SERVICES			FOF	RM APPROVED
						O. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY IPLETED
		345225	B. WING		0,	C 4/26/2017
NAME OF PI	ROVIDER OR SUPPLIER		· [	STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CI	HAPEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F 00	0		
	through 4/23/17 and interview occurred w	was conducted from 4/18/17 4/26/17. On 4/26/17 an ith the Paramedic who for Resident #67. An				
	Immediate Jeopardy was id CFR 483.10 at tag F155 at (J) CFR 483.13 at tag F224 at (J) CFR 483.25 at tag F309 at (J) CFR 483.25 at tag F323 at (J)	155 at a scope and severity 224 at a scope and severity 309 at a scope and severity				
	Substandard Quality Immediate Jeopardy	for tags F155, F224				
	removed on 4/22/17. Immediate Jeopardy	09 began on 4/5/17 and was for tag F224 (Example #2) d was removed on 4/22/17.				
F 155 SS=J	4/10/17 and was rem 483.10(c)(6)(8)(g)(12	for tag F323 began on loved on 4/22/17. 2), 483.24(a)(3) RIGHT TO NTE ADVANCE DIRECTIVES	F 15	5		6/5/17
	483.10 (c)(6) The right to rec discontinue treatmen	quest, refuse, and/or t, to participate in or refuse				
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					05/19/2017

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.

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	): 06/08/2017 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED	
		345225	B. WING				C 26/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	APEL HILL		1602 E FRANKLIN STREE CHAPEL HILL, NC 275			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 155	Continued From page	1 imental research, and to	F 15	5			
	formulate an advance						
	-	of the resident to receive al treatment or medical					
	(g)(12) The facility mu requirements specifie subpart I (Advance Di	d in 42 CFR part 489,					
	inform and provide wr residents concerning medical or surgical tre	s include provisions to itten information to all adult the right to accept or refuse eatment and, at the nulate an advance directive.					
		itten description of the plement advance directives aw.					
	time of admission and information or articula has executed an adva may give advance dire	al is incapacitated at the l is unable to receive te whether or not he or she ance directive, the facility ective information to the epresentative in accordance					
		elieved of its obligation to n to the individual once he					

If continuation sheet Page 2 of 125

	S FOR MEDICARE &	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO	M APPROVE <u>0. 0938-03</u>
	CORRECTION	IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED C	
		345225	B. WING			26/2017
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
0.01.47.11				1602 E FRANKLIN STREET		
SIGNATUR	RE HEALTHCARE OF C			CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 155	Continued From pag	e 2	F 15	5		
	Follow-up procedure the information to the	eive such information. Is must be in place to provide e individual directly at the				
	appropriate time. 483.24					
	including CPR, to a	vide basic life support, resident requiring such r to the arrival of emergency				
	medical personnel a	ency care prior to the arrival of emergency al personnel and subject to related an orders and the resident's advance res.				
	by:	T is not met as evidenced				
		views, staff interviews and		F155:		
		the facility failed to initiate		A. On 4/5/17 Resident # 67 wer		
		nt (Resident #67) that was		outing with activity assistant and		
	0 1 0	eating an ice cream cone redical services arrived.		interns, resident # 67 began gasp air, activity assistant went to obta approximately 100 feet away, inte	in water	
	Immediate ieopardv	began on 4/5/17 when		911, emergency personnel arrive		
		It of the facility on an activity		the resident with agonal breathing		
		cream shop and began		Emergency Medical Service (EM	-	
		eating an ice cream cone.		initiated emergency protocol whic		
	The nursing home st			included bagging the resident. R		
		not initiate emergency		#67 was transported to the hospit		
		nediately. Resident #67		EMS. Activity assistant was educ	•	
		y Emergency Medical		the Staff Development Coordinate		
	. ,	was hospitalized. The		4/22/17 on identifying an emerger		
		was removed on 4/22/17		situation which included recogniz	•	
		vided an acceptable credible nce. The facility will remain		emergency situation episode that characterized by apnea, difficulty		
		a scope and severity level of		breathing, respiratory distress, co		
	•	vith the potential for more		change, change in muscle tone, c		
	than minimal harm th	•		or gagging, calling 911 immediate	-	
		monitoring systems put into		staying with the resident.		
	place are effective.			B. All other residents that went	on the	
				outing were assessed by the Dire		
	Findings Included:			Nursing (DON), Assistant Directo		1

Facility ID: 923268

If continuation sheet Page 3 of 125

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 06/08/2017 RM APPROVED O. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		345225	B. WING		04	C 1/26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				1602 E FRANKLIN STREET		
SIGNATU	RE HEALTHCARE OF CH			CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 155	Continued From page 3		F 15	Nursing (ADON), Unit Managers		
	<ul> <li>9/12/12 and her diage torticollis (a chronic n disorder causing the the left, right, upward dysphagia and posture A review of the April 2 Resident #67 revealed status (all resuscitation performed).</li> <li>A quarterly minimum 2/10/17 for Resident was intact and she reperson physical assiss An entry in the nursin revealed Resident #67 while taking her media</li> </ul>	2017 physician orders for ed an order for full code on measures will be data set (MDS) dated #67 revealed her cognition equired supervision and one		Supervisor or Charge nurse by 4 ensure that they had not been m affected and had no health or sa concerns. No other concerns we identified. All current residents th in the facility could be affected b deficient practice at any time. F currently residing in the facility w assessed for any signs and sym distress by the Director of Nursir Development Coordinator, Charg or Regional Nurse Consultant or for any possible need for emerge medical assistance. No residents identified with the need for emerge services. C. Change of condition policy w reviewed on 4/21/17 regarding li threatening events which may be characterized by apnea, difficulty	4/22/17 to egatively ifety ere nat reside y this Residents vere ptoms of ng, Staff ge Nurse, n 4/22/17 ency s were gency was fe	
	cardiopulmonary resuscitation (CPR) was initiated. She was able to start breathing normally again. An order was received to obtain a chest x-ray which came back negative for aspiration. An entry in the nursing notes on 4/5/17 revealed Resident #67 was on an outing today with activities. No nurse was made aware that resident was going. Scheduled pm meds held until return. An entry in the nursing notes on 4/5/17 revealed Resident #67 was sent by ambulance to the hospital from an activity outing at a local ice cream shop due to potential aspiration. A review of the EMS patient care report dated 4/5/17 for Resident #67 revealed that they arrived			breathing, respiratory distress, c change, change in muscle tone, or gagging. Education was initia 4/21/17 regarding the policy to Administrator, nursing staff, nurs assistants, business office staff, rehabilitation staff, dietary staff, maintenance, housekeeping and staff by the Staff Development Coordinator, Director of Nursing Regional Nurse Consultant rega immediate notification of emerge services by dialing 911 in an em situation for a resident. Staff me that are on an outing will be requ have a cell phone at all times. S education also included remaining	olor choking ated on sing d activities , or rding the ency ergency embers uired to Staff	

Facility ID: 923268

If continuation sheet Page 4 of 125

						10.0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		· · ·	TE SURVEY MPLETED
			A. BUILDING	<u> </u>		
		345225	B. WING			C
	ROVIDER OR SUPPLIER	545225		STREET ADDRESS, CITY, STATE, ZIP CODI		4/26/2017
	ROVIDER OR SUPPLIER			1602 E FRANKLIN STREET	=	
SIGNATUI	RE HEALTHCARE OF CH	IAPEL HILL		CHAPEL HILL, NC 27514		
				-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 155	Continued From page	e 4	F 15	5		
		o at 2:45 pm. The report		the resident until the arrival of	Emergency	
		dispatched for cardiac		Management Services person		
	arrest. The Fire Resc	ue (FR) arrived on scene		Licensed Nursing staff are cer		
		nd obtained history of the		Heimlich maneuver. All staff		
	event from bystander			by the Staff Development Coc		
		volunteer). Patient (Resident		Human Resources on 4/21/17	•	
		ce cream with a group from		could not work until receiving		
	-	her bystanders stated she		education. Education regarding	•	
	became apneic (temp	ponsive. CPR was initiated		stated policies and procedure processes will be included in t	-	
		time. FR arrived at the		orientation process for all new		
	scene and found the patient breathing but			members. No newly hired em		
	responsive only to pa			be allowed to work until educa		
	discontinued CPR. A			been obtained.		
		of oxygen and status post				
	oxygen saturation lev	vel was 90%. Patients		D. Director of Nursing, Staff		
		onsiveness was not known,		Development Coordinator, AD		
		per bystanders. Per FR		Regional Nurse Consultant wi		
	bystanders knew ver			Activity Monitoring Tool prior to		
	-	nt by Medic revealed upon		four outings. The Activity Out	-	
		ting in her wheelchair. She		consist of (Physician Summar		
		esponsive to painful stimuli. allow and abnormally slow		which contains the resident s consistency, and code status)	-	
		e of 8 per minute. She had		also list cell phone on hand, L		
	strong radial pulses p	-		Nurse/ADON/DON that appro		
	appeared pale and w			outing and approval of Quality		
		nt were documented as		Director (QOL. The Activity Me		
		s of oxygen, respirations		Tool will be completed by the	-	
	-	e mask, administration of 5		Life Director prior to the outing		
	milligrams (mg) of all			Assurance meeting will begin		
		cubic centimeters (cc) of		ensure compliance, then weel		
		nsport to the hospital		weeks, then monthly x 2 mont		
	emergency departme	ent.		further follow up regarding the		
	A nhone interview we	as conducted with Paramedic		stated plan. At that time based evaluation of the findings the		
		0 am. She confirmed that		Committee will determine at w		
		o the call on 4/5/17 at the ice		frequency any ongoing audits		
	-	dent #67. She stated that		education or revision of plan v		
	-	the scene Resident #67 was		continue. A nurse from the re		

Facility ID: 923268

		MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	G	· · ·	MPLETED
						С
		345225	B. WING			4/26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
SIGNATUI	RE HEALTHCARE OF CH	IAPEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 155	Continued From page	e 5	F 15	55		
	sitting in her wheelch responsive. She stated very bad. She stated on oxygen and intrav Resident #67 require respirations and that ambulance trip to the she did not observe t and that it was not ind #67 was breathing, n and did not require C not observe that the r not perform any sucti She stated that she v facility staff members did not seem to know condition and they was from the facility to bri stated that it was 5 to from the facility arrive A review of the hospi 4/5/17 for Resident # unresponsive in the e that Resident #67 was 4/5/17 with her friend suddenly became un bystander CRP - unk pulse. When EMS arr rate of 5 and was bag A review of the hospi 4/8/17 for Resident # septic shock seconda (UTI).	air and was minimally ed that Resident #67 looked that she had been started enous fluids. She stated that d manual help with was conducted during the hospital. She stated that he resident receiving CPR dicated because Resident ot well, but was breathing PR. She stated that she did resident was choking and did oning or treatment for that. vas concerned that the that were with Resident #67 v anything about her health ere trying to get someone ng her medical records. She o 10 minutes before anyone ed with her medical records. tal admission records dated 67 revealed she presented emergency room. It stated us at an ice cream parlor on s from her facility when she responsive. She received nown if she ever lost a rived, she had a respiration		or corporate office has been 4/21/17 and will remain on s 4/22/17, then onsite 3 times weeks. The nurses from the or home office are reviewing with above stated plan alon reviewing compliance with p procedure of any Emergent occurs and reviewing comp Administrator has the overs an effective plan is in place resident wellbeing and ensu- rights are being honored as effective plan to identify cor- implement a plan of correcti all staff of the facility. Corpo Administrative oversight of the Assurance meeting will be of the Special Projects Admini Regional Vice President of member of Regional staff w weeks, then monthly times the	site daily until a weekly for 4 a regional team g compliance g with policy and Event that liance. The ight to ensure to meet ure resident well as an acerns and ion to involve orate the Quality completed by strator, the Operations, or eekly times 4	
	Activity Director revea	aled that she was not on 4/5/17. She stated that				

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INTERPORTOR DEPENDENCES AND PLAN OF CORRECTION     (X) INCURPE CONSTRUCTION A BULDING			ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/2017 MAPPROVED O. 0938-0391
345226         IN.WING         04/26/2017           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, 20° CODE           SIGNATURE HEALTHCARE OF CHAPEL HILL         STREET ADDRESS, CITY, STATE, 20° CODE           OWNED         SUBMATURE HEALTHCARE OF CHAPEL HILL.         STREET ADDRESS, CITY, STATE, 20° CODE         CODE           OWNED         SUBMATURE HEALTHCARE OF CHAPEL HILL.         STREET ADDRESS, CITY, STATE, 20° CODE           OWNED         SUBMATURE HEALTHCARE OF CHAPEL HILL         COMODERS PLAN OF CORRECTION           OWNED         SUBMATURE HEALTHCARE OF CHAPEL HILL         COMODERS PLAN OF CORRECTION           OWNED         COMODERS PLAN OF CORRECTION         COMODERS PLAN OF CORRECTION           OWNED STATE OF CHAPEL HILL, NC 27541         COMODERS PLAN OF CORRECTION           OWNED STATE OF CORRECTION OF CORRECTION         CREAT OTHER OF CORRECTION           OWNED STATE OF CORRECTION OF CORRECTION         CREAT OTHER OF CORRECTION         CREAT OTHER OF CORRECTION           OWNED STATE OF CORRECTION OF CORRECTION         CREAT OTHER OF CORRECTION           OWNED STATE OF CORRECTION OF CORRECTION <td>STATEMENT O</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td>, <i>i</i></td> <td></td> <td></td> <td>(X3) DATI</td> <td>E SURVEY PLETED</td>	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, <i>i</i>			(X3) DATI	E SURVEY PLETED
1802 E FRANKLIN STREET CHAPEL HILL, NC 27514       PAGE TRAPEL PROVIDERS PLAN OF CORRECTION RECONDERSENT OR LSC DENTRYING INFORMATION     Intervention     In			345225	B. WING			04	-
CHAPEL HILL       CHAPEL HILL, NC 27514         IMUID PRETIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PRETIX TAG       PRECEDED BY FULL PRETIX TAG       DPROVIDENS FLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTION OF CORRECTION DEFICIENCY WISE BE PRECEDED BY FULL TAG       DPROVIDENS FLAN OF CORRECTION (EACH CORRECTION CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY)         F 155       Continued From page 6 When she returned to work on 4/6/17 she learned that the Activity Assistant and 2 voluneers had taken Resident #67 on an outing to the ice cream shop on 4/5/17. She stated that they had written statements of the incident and the statements were provided to the Director of Nursing (DON). She stated that typically when residents are taken out of the facility for an activity she would provide a list of residents that were going to the DON. She stated that anyse acompany them on the outings and that it depended on the type of outing they were going on. She stated that the Activity Assistant and the intern volunteers went through general orientation when they started at the facility.         An interview on 4/20/17 at 10.45 am with the Assistant Activity Director revealed she had been of he douling with Resident #67 on 4/5/17. She stated that she had come in to work at 1:00 pm on 4/5/17 and fooded to take for nesidents to the ice cream shop. She was accompanied by 2 volunteer interns that were recreational therapy students at a local college. She stated that Resident #67 ordered to take a for residents to the ice active stated Resident #67 did not appear to have any trouble eating her ice residents were in	NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
Oracity of the construction of DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY NULST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PRETX TAG       PROVIDENS FULL OF CORRECTION (EACH DEVIDENTIAL NULST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRETX TAG       PRETX TAG       CROSENETTER ACTION SHOULD BE CROSENET ACTION THE STATEMATION TO AFS/17. She stated that the for Content at A the facility.       F 155         An interview on 4/20/17 at 10:45 am with the Assistant Activity Director revealed as her ad been on the outing with Resident # 67 on 4/5/17. She stated that she had come in to work at 1:00 pm on 4/5/17. The stated that the clouded to the facility of the correar shop. She was accompanied by 2 volunteer interns that were recreational therapy students at a local college. She stated that her idee cream shop she was accompanied by 2 volunteer interns that were recreational therapy students at a local college. She stated that her idee cream she she addeent #67 of the adage and therading aday (Resident #67 and the bate? Creamen in a waf						1602 E FRANKLIN STREET		
PREFIX TAG     (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. DENTIFYING INFORMATION)     PREFIX TAG     CACAT CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F 155     Continued From page 6 when she returned to work on 4/6/17 she learned that the Activity Assistant and 2 volunteers had taken Resident #67 on an outing to the ice cream shop on 4/5/17. She stated that they had written statements of the incident and the statements were provided to the Director of Nursing (DON). She stated that typically when residents are taken out of the facility for an activity she would provide a list of residents that were going to the DON. She stated that a nurse or nursing assistant (NA) did not always accompany them on the outings and that it depended on the type of outing they were going on. She stated that the Activity Assistant and the intern volunteers went through general orientation when they started at the facility.     An interview on 4/20/17 at 10:45 am with the Assistant Activity Director revealed she had been on the outing with Resident # 67 on 4/5/17. She stated that she docome in to work at 1:00 pm on 4/5/17 and decided to take a few residents to the ice cream shop. She was accompanied by 2 volunteer interns that were recreational therapy students at a local college. She stated that Resident #67 ordered butter pecan ice cream in a waffie cone and they all sat outside to eat their ice cream. She stated Resident #67 did not appear to have any trouble eating her ice cream cone. When they finished they started to wak back to the facility as it was national waking day (Resident #67 and the other 2 residents were in	SIGNATU	RE HEALTHCARE OF CH				CHAPEL HILL, NC 27514		
<ul> <li>when she returned to work on 4/6/17 she learned that the Activity Assistant and 2 volunteers had taken Resident #67 on an outing to the ice cream shop on 4/5/17. She stated that they had written statements of the incident and the statements</li> <li>were provided to the Director of Nursing (DON). She stated that trypically when residents are taken out of the facility for an activity she would provide a list of resident sthat were going to the DON. She stated that a nurse or nursing assistant (NA) did not always accompany them on the outings and that it depended on the type of outing they were going on the type of outing they were going on. She stated that the Activity Assistant and the intern volunteers went through general orientation when they started at the facility.</li> <li>An interview on 4/20/17 at 10:45 am with the Assistant Activity Director revealed she had been on the outing with Resident #6 70 an 4/5/17. She stated that she had come in to work at 1:00 pm on 4/5/17 and decided to take a few residents to the series shop. She was accompanied by 2 volunteer interns that were recreational therapy students at a local college. She stated that Resident #67 or 4/5/17 with the Resident #67 or 4/5/17. She stated that the recer am in a waffle cone and they all sato utside to eat their ice cream. She stated Resident #67 or 4/5/17 with repean to character and a local college. She stated that herapy students at a local college. She stated that herapy students at local college. She stated that free recean the recer and they all sato utside to walk back to the facility as they all sato utside to walk back to the facility as the other 2 residents were in the statement of the statement and walking day (Resident #67 and the other 2 residents were in the statement on the outing they started to walk back to the facility as it was national walking day (Resident #67 and the other 2 residents were in the statement on the outing they and they facility as it was national walking day (Resident #67 and the other 2 resi</li></ul>	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DBE	COMPLETION
wheel chairs and the activity assistant and 2         volunteers were pushing them). She stated that         Resident #67 started to gasp for air and she         asked her if she needed something to drink and         Resident #67 said yes. The Activities Assistant         went to a drugstore to get her a bottle of water	F 155	when she returned to that the Activity Assist taken Resident #67 o shop on 4/5/17. She s statements of the inci- were provided to the She stated that typical out of the facility for a a list of residents that She stated that a nur- did not always accom- and that it depended were going on. She s Assistant and the inte- general orientation will facility. An interview on 4/20/ Assistant Activity Dire on the outing with Re- stated that she had co on 4/5/17 and decided the ice cream shop. S volunteer interns that students at a local co Resident #67 ordered waffle cone and they cream. She stated Re- have any trouble eatin When they finished th the facility as it was n (Resident #67 and the wheel chairs and the volunteers were push Resident #67 started asked her if she need Resident #67 said year	work on 4/6/17 she learned tant and 2 volunteers had n an outing to the ice cream stated that they had written dent and the statements Director of Nursing (DON). ally when residents are taken in activity she would provide were going to the DON. se or nursing assistant (NA) ipany them on the outings on the type of outing they stated that the Activity ern volunteers went through hen they started at the 17 at 10:45 am with the ector revealed she had been sident # 67 on 4/5/17. She ome in to work at 1:00 pm d to take a few residents to She was accompanied by 2 were recreational therapy llege. She stated that I butter pecan ice cream in a all sat outside to eat their ice esident #67 did not appear to ng her ice cream cone. hey started to walk back to ational walking day e other 2 residents were in activity assistant and 2 hing them). She stated that to gasp for air and she led something to drink and s. The Activities Assistant	F	155			

Facility ID: 923268

If continuation sheet Page 7 of 125

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILD	ING			C
		345225	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>	
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 155	Continued From page	97	F	155	5		
		f the store Resident #67					
		ith, gasping for air, was not emed to be less responsive.					
		interns was calling 911 and					
	· ·	ed for medical information					
		She called the facility to try on. She stated the 911					
	operator told them to	try and get her laying down					
		lay her wheelchair back. ed and they placed a tube					
		sucked out a piece of waffle					
	-	tant from the facility arrived					
		s after she had called the rse from red hall came (didn					
		She stated that Resident #67					
		She stated that she had not					
		urse know that she was ated that she did not have					
		ency medical response.					
	A review of the "Off-P	remise Activities" policy					
		ty Director on 4/20/17					
	revealed procedure # more members of nur	3 stated "At least one or rsing services will					
		ty director / coordinator on					
	field trips."						
	An interview with the	DON on 4/20/17 at 4:20 pm					
		s not in the facility on 4/5/17					
	and was not aware of happened with Reside						
	referred me to the Un						
		t Manager #1 on 4/20/17 at					
	-	t she was returning to the					
		break on 4/5/17 and a (could not remember who)					
	stopped her and told	her that Resident #67 was					
	unresponsive down th	ne street at the ice cream					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345225	B. WING				C 26/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 155	shop. She stated she medical information a staff. She stated Res put in the ambulance the medical informatio full code, to EMS. Sh aware of any further i the facility after the in An interview on 4/21/ activities intern / volu accompanied Reside ice cream shop. She finished their ice crea the residents back to #67 was gasping for a Activity Assistant wen something to drink. W #67 seemed to be ge 911. She stated the re breathing. She stated volunteering at the fac and that she did atter orientation. She state any training at the fac response or the Heim The facility new hire of by the Staff Developm reviewed. The genera staff (Parts 1 and 2) of areas of CPR, Heimlife mergency response general orientation ag CPR and the Heimlife Nurses and Nursing A	e obtained Resident #67 ' s and brought it to the EMS sident # 67 had already been by that time. She provided on, including that she was a ne stated that she was not nterventions or follow-up by cident. 17 at 1:00 pm with the nteer revealed that she had nt #67 on the outing to the stated that everyone had m and they were walking the facility when Resident air. She stated that the at to get Resident #67 /hile she was gone Resident tting worse and she called esident did not stop I that she had been cility since January 2017 nd the facility general d that she did not receive cility on emergency medical dich maneuver. prientation agenda, provided nent Coordinator, was al orientation agenda for all did not include training in the ch maneuver or medical . Parts 3 and 4 of the genda did include training in h maneuver, this was for	F	155			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345225	B. WING				C 26/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	APEL HILL			1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 155	activity staff are not tr technique or how to re emergencies because clinical capacity. She attend the facility gen does not include any such as the Heimlich A follow-up interview the Assistant Activity I had not received any maneuver or any eme An interview on 4/21/ Administrator revealer aware of the incident involving Resident #6 discussed Resident # the next day in the mo that this was an isolat additional investigatio stated that he assume and the intern volunte orientation, but that he at that time. He was n training in the area of response for them. On 4/21/17 at 4:25 pm informed of the immed The facility provided a 4/23/17 at 2:00 pm. T indicated: On 4/5/17 Resident #	ained in the Heimlich espond in medical e they don't work in a stated that volunteers do eral orientation, but this medical emergency training maneuverer. on 4/21/17 at 2:30 pm with Director revealed that she training on the Heimlich ergency medical training. 17 at 3:45 pm with the d that he was somewhat that occurred on 4/5/17 7. He stated that they had 67's swallowing difficulty prining meeting. He stated ed incident and that no n was completed. He ed that the Activity Assistant theres went through general e was not the Administrator not aware of any other emergency medical	F	155			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345225	B. WING	ING .			C
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	04/	26/2017
					1602 E FRANKLIN STREET		
SIGNATUI	RE HEALTHCARE OF CH	APEL HILL			CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 155	called 911, emergence the resident with agor emergency protocol w resident. Resident #6 hospital by EMS. Act by the Staff Developm on identifying an eme included recognizing a episode that maybe of difficulty breathing, re change, change in mo gagging, calling 911 in the resident. All other residents that assessed by the DON Nursing Supervisor of ensure that they had and had no health or concerns were identiff that reside in the facil deficient practice at a currently residing in th any signs and sympto Director of Nursing, S Coordinator, Charge I Consultant on 4/22/17 emergency medical a were identified with th services Change of condition p 4/21/17 regarding life may be characterized breathing, respiratory change in muscle ton Education was initiate policy to Administrato	y personnel arrived noted hal breathing. EMS initiated which included bagging the 57 was transported to the ivity assistant was educated hent Coordinator on 4/22/17 rgency situation which an emergency situation haracterized by apnea, spiratory distress, color uscle tone, choking or mmediately and staying with at went on the outing were 1, ADON, Unit Managers, Charge nurse by 4/22/17 to not been negatively affected safety concerns. No other ied. All current residents ity could be affected by this ny time. Residents he facility were assessed for oms of distress by the taff Development Nurse, or Regional Nurse 7 for any possible need for ssistance. No residents he need for emergency	F	155	5		

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FOR	ED: 06/08/2017 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
	345225	B. WING		04	C 4/26/2017
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
			1602 E FRANKLIN STREET		
SIGNATURE HEALTHCARE OF CH	IAPEL HILL		CHAPEL HILL, NC 27514		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
<ul> <li>and activities staff by Coordinator, Director Nurse Consultant reg notification of emerge in an emergency situat members that are on have a cell phone at a also included remainin arrival of Emergency personnel. Licensed the Heimlich maneuw the Staff Developmer Resources on 4/21/1 until receiving above regarding the above s procedures along with in the orientation proc members. No newly fallowed to work until obtained.</li> <li>The credible allegation 5:02 PM. The Activity on 4/23/17 at 4:16 PM the education she red residents who attended those who had not at reviewed. Communic created for every resis The change of condit it was noted life thread In-service topics inclu- emergency events. S staff in the nursing ho secretary, licensed m assistant were intervity</li> </ul>	aintenance, housekeeping the Staff Development of Nursing, or Regional aarding the immediate ency services by dialing 911 ation for a resident. Staff an outing will be required to all times. Staff education ing with the resident until the Management Services Nursing staff are certified in er. All staff were notified by nt Coordinator or Human 7 that they could not work education. Education stated policies and h processes will be included cess for all newly hired staff nired employee will be education has been on was verified on 4/23/17 at y Assistant was interviewed M and was able to describe ceived. Assessments of the ed the activity, as well as tended the activity were cation forms (SBAR) were dent that was assessed. ion policy was reviewed and itening events were defined. uded elder outings and Sign-in sheets. Random ome including a unit urse, nurse aide/activity ewed between 4:32 PM and hey had received in-services.	F 1	55		

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	-	ND HUMAN SERVICES MEDICAID SERVICES					MAPPROVE D. 0938-039
TATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COME	E SURVEY PLETED
		345225	B. WING				C / <b>26/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
SIGNATU	RE HEALTHCARE OF CH	HAPEL HILL			02 E FRANKLIN STREET HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 155	Continued From page	e 12	F	155			
		n there was a system to train ting to duty. The immediate ed on 4/22/17.					
F 224 SS=J	483.12(b)(1)-(3) PRC	)-(3) PROHIBIT MENT/NEGLECT/MISAPPROPRIATN		224			5/31/17
	abuse, neglect, misa property, and exploit subpart. This include freedom from corpora seclusion and any ph	t has the right to be free from ppropriation of resident ation as defined in this s but is not limited to al punishment, involuntary hysical or chemical restraint the resident's symptoms.					
	483.12(b) The facility implement written po	must develop and licies and procedures that:					
		event abuse, neglect, and nts and misappropriation of					
	(b)(2) Establish polici investigate any such	ies and procedures to allegations, and					
	§483.95,	g as required at paragraph Γ is not met as evidenced					
	interviews and param neglected to provide medical services for that was gasping for responsive. The facil	ons, record review, staff nedic interview the facility immediate emergency a resident (Resident #67) air and becoming less ity failed to identify the cause m being activated as a			F224: A. On 4/10/17 at 2156, Resident #166 was observed outside the facility on the sidewalk near the rehab side of the building. It was determined that the do alarm had sounded as resident #166 exited the facility. Nurse #1 heard the	ne oor	
	resident with exit-see building for 1 of 1 sar	eking behavior exited the mpled resident (Resident e at risk for elopement.			alarm sounding, but did not attempt to identify the cause of the alarm, and silenced the alarm utilizing a reset but	)	

Event ID: HXZN11

Facility ID: 923268

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		MEDICAID SERVICES				<u>IO. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	<u> </u>		
			D MINO			С
		345225	B. WING			4/26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH			1602 E FRANKLIN STREET		
				CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
E 004		10				
F 224	Continued From page	e 13	F 22			
				at the nurses station. Nurse #		
		began on 4/5/17 when		suspended pending investigati		
		it of the facility on an activity		4/21/2017. A skin assessment		
		ream shop. After consuming		completed for Resident #166 c		
		he began gasping for air and		with no injury identified. The ph	•	
		nsive. The nursing home		responsible party was notified	, ,	
		unattended and did not		Nurse on 4/10/2017. Resident		
		edical services immediately.		placed on every one hour mon	itoring by	
		ardy was removed on 4/22/17		the charge nurse.		
		vided an acceptable credible		On 4/5/17 Resident # 67 went	-	
		nce. The facility will remain		with activity assistant and two		
		a scope and severity level of		resident # 67 began gasping fo		
	than minimal harm th	ith the potential for more		activity assistant went to obtair approximately 100 feet away, I		
		nonitoring systems put into		Resident # 67 with interns, inter	-	
	place are effective.	nonitoring systems put into		911, emergency personnel arri		
	place alle ellective.			suctioned Resident # 67, appli		
	The findings included	4.		bagged due to agonal breathin		
		1.		Resident #67 was transported		
	1) Resident #67 was	admitted to the facility on		hospital by EMS. Resident # 6		
		noses included spasmodic		care plan was reviewed on 4/2		
	-	neurological movement		Director of Nursing (DON) or R	-	
		neck to involuntarily turn to		Nurse to ensure resident s qu		
		ls, and/or downwards),		and quality of life were being m		
	dysphagia and postu			other concerns identified.		
				B. All residents have the poten	tial to be	
	A quarterly minimum	data set (MDS) dated		affected by this deficient practi		
		#67 revealed her cognition		count was completed on 4/11/		
		equired supervision and one		am for the entire facility by the		
	person physical assis			nurse to ensure no other reside	-	
		5		affected by the potentially negl		
	A care plan dated 1/2	24/17 revealed Resident #67		behavior. All residents were ac	-	
	-	k for behavior problems as		and safe. On 4/11/17, 8 reside		
		to follow Medical Doctor		guards were checked for place		
	-	ner (NP) orders related to		functioning by the charge nurse		
		uralgia. Resident #67 refused		central supply clerk. All were for		
		de and a swallow study. The		in place and functioning proper		
	-	ent #67 would have fewer		other potential areas of neglec	-	
		aspiration as evidenced by	1	identified.		

Facility ID: 923268

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ID PLAN OF (	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(-	X3) DATE SURVEY
			A BUILDING	;		COMPLETED
						С
		345225	B. WING			04/26/2017
SIGNATUR	OVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE	
JONATON	E HEALTHCARE OF CH			1602 E FRANKLIN	STREET	
				CHAPEL HILL, N	C 27514	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLE <sup>-</sup> DATE
F 224	Continued From page	2 14	F 22	4		
		ss than weekly. Interventions	1 22		have the potential to be	
	included report to phy				his deficient practice.	
		ticipate care needs and		-	h Resident #67 was reviewe	d
		nt. Refer to Registered		with Activity	Director on 4/6/17, by the	
	Dietitian (RD) and Sp	eech Therapist (ST) as			lursing. Change in condition	1
	needed.				ding life threatening events	
					ed with the activity assistant	
	A review of the April 2 Resident #67 revealed	2017 physician 's orders for			by the Staff Development	
		's heart stops beating or if			. Starting on 4/21/2017 Staff t coordinator, Assistant	
	the patient stops brea				lursing (ADON), Regional	
					ultant and Regional team	
	An entry in the nursing	g notes dated 1/27/17			e policy and procedure	
	-	7 had an episode of choking			e threatening events, to	
		cations which were crushed			pisode that may be	
		de blue was called and			d by apnea, difficulty	
	cardiopulmonary resu			-	espiratory distress, color	
		e to start breathing normally			nge in muscle tone, choking	
	•	received to obtain a chest ck negative for aspiration.			and proper emergency th priority of who to call first,	
	x-ray which came bac	a negative for aspiration.			iediately. All residents	
	A telephone interview	on 4/21/17 at 9:45 am with			iding in the facility were	
		esident #67 revealed she			r any signs and symptoms o	f
	had last treated her in	n late January for about a		distress by t	he Director of Nursing, Staff	
		t Resident #67 had a history			nt Coordinator, Charge Nurse	
	of choking.				ignature Care Consultant, or	n
					any possible need for	
		g notes on 4/5/17 revealed nt by ambulance to the			medical assistance. No are identified with the need for	or I
		arolina (UNC) hospital from		emergency		
	-	n ice cream shop due to				
	potential aspiration.			C. The Staff	Development Coordinator	
					Vorker educated the	
	-	gency medical services			or, DON, ADON, Minimum	
	(EMS) patient care re				nator (MDS), Dietary	
		d that they arrived at local			usiness Office Manager,	
		5 pm. The report stated that		-	inistrative Assistant, Central	
		for cardiac arrest. The Fire on scene prior to ambulance			keting/Admissions, Rehab ager, Medical Records, Plar	

Facility ID: 923268

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED
			A. DOILDING		с
		345225	B. WING		04/26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
				1602 E FRANKLIN STREET	
SIGNATU	RE HEALTHCARE OF CH			CHAPEL HILL, NC 27514	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE
F 224	Continued From pag	e 15	F 22	24	
1 227			F 22		hy of Life
		of the event from bystanders sistant and intern volunteer).		Operations Director, Qualit Director, and Environment	-
		7) had just gotten ice cream		Director starting on 4/11/17	
		r care facility when her		regarding the abuse/negle	
		e became apneic (temporary		responding immediately to	
	-	ing) and unresponsive.		ensure resident safety. A p	
		uscitation (CPR) was		regarding the abuse/negle	
		rs at that time. FR arrived at		administered to the above	
		the patient breathing but		department managers. On	
	responsive only to pa			Administrator, Director of N	
	discontinued CPR. A			Assistant Director of Nursi	
	resident on 10 liters of	of oxygen and status post		Data Set Coordinators, Sta	aff Development
	oxygen saturation lev	vel was 90%. Patients		Coordinator, Dietary Mana	ger, Business
	-	oonsiveness was not known,		office manager, Payroll/Ad	ministrative
		per bystanders. Per FR		Assistant, Social Services	-
		y little about resident.		Central Supply, Marketing/	
		nt by Paramedic revealed		Rehab Service Manager, N	
		vas sitting in her wheelchair.		Records, Plant Operation,	<b>,</b>
		and responsive to painful		and Environmental Service	
	stimuli. Her breathing			educated and received 100	
	· ·	a respiration rate (RR) of 8		abuse policy and procedur	-
	and her skin appeare	strong radial pulses present		they were assigned to edu nursing assistants, dietary	
	Treatments administe			housekeeping staff regard	
		ered to patient were ement on 10 liters of oxygen,		abuse/neglect policy and p	-
	respirations assisted			responding immediately to	
		illigrams (mg) of albuterol,		ensure resident safety. Al	
	intravenous administ			complete a post-test regar	
		ormal saline and transport to		abuse/neglect policy and p	•
	the hospital emergen			education. Staff will not be	
				work until the education is	
	A phone interview wa	as conducted with Paramedic		score of 100% has been of	btained on the
	#1 on 4/26/17 at 10:4	10 am. She confirmed that		posttest. If stakeholder die	d not score
	she had responded t	o the call on 4/5/17 at the ice		100% on post-test, then st	akeholder was
	cream parlor for Res	ident #67. She stated that		immediately re-educated a	
	when she arrived on	the scene Resident #67 was		re-administered. This proc	ess continued
	sitting in her wheelch	air and was minimally		until all stakeholders obtair	ned a 100%
	responsive. She state	ed that Resident #67 looked		score on post-test. All post	-tests were
				reviewed for compliance b	

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0 (X3) DATE SU	RVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLET	ΓED		
		345225	B. WING		С			
	ROVIDER OR SUPPLIER	545225		STREET ADDRESS, CITY, STATE, ZIP	04/26/	2017		
	ROVIDER OR SUPPLIER			1602 E FRANKLIN STREET	CODE			
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL		CHAPEL HILL, NC 27514				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE C	(X5) COMPLETIO DATE		
F 224	Continued From page	e 16	F 22	24				
F 224	on oxygen and intrave Resident #67 required respirations and that ambulance trip to the she did not observe th and that it was not ind #67 was breathing, m and did not require C not observe that the r not perform any sucti She stated that she w facility staff members did not seem to know condition and they we from the facility to brin stated that it was 5 to from the facility arrived A review of the hospit 4/5/17 for Resident #4 unresponsive in the e that Resident #67 wa 4/5/17 with her friend suddenly became unit bystander CRP - unktion pulse. When EMS arrives A review of the hospit 4/8/17 for Resident #4 septic shock seconda (UTI). An interview on 4/20/	enous fluids. She stated that d manual help with was conducted during the hospital. She stated that he resident receiving CPR dicated because Resident of well, but was breathing PR. She stated that she did resident was choking and did oning or treatment for that. vas concerned that the that were with Resident #67 r anything about her health ere trying to get someone ing her medical records. She of 0 minutes before anyone ed with her medical records. tal admission records dated 67 revealed she presented emergency room. It stated is at an ice cream parlor on is from her facility when she responsive. She received nown if she ever lost a rived, she had a RR of 5 and ninutes. tal discharge summary dated 67 revealed a diagnosis of ary to a urinary tract infection	F 22	Nurse Consultant, Region ADON, Staff Development Administrator. The Staff Development Co Social Worker educated th DON, ADON, MDS Coord Manager, Business Office Payroll Administrative Ass Supply, Marketing/Admiss Service Manager, Medical Operations Director, Quali Director, and Environment Director starting on 4/22/1 abuse/neglect policy, and Life threatening situations regarding the abuse/negle administered to the above department managers. Or Administrator, DON, ADO coordinators, Staff Develo Coordinators, Staff Develo Coordinator, Dietary Mana office manager, Payroll/Ac Assistant, Social Services Central Supply, Marketing Rehab Service Manager, I Records, Plant Operation, and Environmental Servic educated and received 10 abuse policy and procedu they were assigned to edu nursing assistants, dietary housekeeping staff regard abuse/neglect policy and procedu	t Coordinator or bordinator and he Administrator, inators, Dietary Manager, istant, Central ions, Rehab Records, Plant ty of Life tal Services 7 regarding the responding to . A post-test ect policy was stated nee the facility N, MDS pment ager, Business dministrative Director, /Admissions, Medical Quality of Life, es were 0% on the re post-test, icate nursing, maintenance, ding the porcedure, and o life threatening			
	when she returned to that the Activity Assis	aled that she was not on 4/5/17. She stated that work on 4/6/17 she learned tant and 2 volunteers had n an outing to the ice cream		events to include an episo characterized by apnea, d breathing, respiratory distr change, change in muscle or gagging and proper em	de that may be ifficulty ress, color tone, choking			

Facility ID: 923268

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						O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY IPLETED
			A. BUILDING	3		
		345225	B. WING			С
		345225	B. WING		04	1/26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL		1602 E FRANKLIN STREET		
				CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 224	Continued From page	e 17	F 22	4		
		stated that they had written		protocols with priority of who to c	all first	
		ident and the statements		call 911 immediately. All staff w		
		Director of Nursing (DON).		complete a post-test regarding th		
		ally when residents are taken		abuse/neglect policy and proced		
		an activity she would provide		education. Staff will not be allow		
	a list of residents that	t were going to the DON.		work until the education is received	ed and a	
	She stated that a nur	se or nursing assistant (NA)		score of 100% has been obtaine	d on the	
		pany them on the outings		posttest. If stakeholder did not s		
		on the type of outing they		100% on post-test, then stakeho		
	were going on.			immediately re-educated and po		
				re-administered. This process co		
		Premise Activities" policy		until all stakeholders obtained a		
	<b>U</b>	revision date January 2009		score on post-test. All post-tests		
		ity Director on 4/20/17 3 stated "At least one or		reviewed for compliance by the F Nurse Consultant, Regional Tear		
	more members of nu			ADON, Staff Development Coord		
		ty director / coordinator on		Administrator.		
	field trips."			D. Staff post-test regarding the a	abuse	
		17 at 10:45 am with the		policy and procedure is being		
		ector revealed she had been		administered daily, starting on 5/	17/2016	
	on the outing with Re	sident # 67 on 4/5/17. She		by Administrator, DON, ADON, M	//DS	
	stated that she had c	ome in to work at 1:00 pm		coordinator, Staff Development		
	on 4/5/17 and decide	d to take a few residents to		Coordinator, Director of Dining S	ervices,	
		She was accompanied by 2		Business office manager,		
		were recreational therapy		Payroll/Administrative Assistant,		
		llege. She stated that		Services Director, Central Supply		
		d butter pecan ice cream in a		Chaplain, Marketing/Admissions		
		all sat outside to eat their ice		Service Manager, Medical Reco	us, Plant	
		esident #67 did not appear to ng her ice cream cone.		Operation, Quality of Life, or Environmental Services to 5 diff	erent	
	-	ney started to walk back to		staff members daily x 2 weeks, t		
	the facility as it was n	-		staff members 3 times a week fo		
		e other 2 residents were in		weeks, then 1 staff member week		
		activity assistant and 2		2 week. If an employee did not s	•	
		ning them). She stated that		100% on post-test, then employed		
		to gasp for air and she		immediately re-educated and po		
		ded something to drink and		re-administered. Results of the		
		yes. The Activities Assistant		post-tests will be reported to the	Quality	
		get her a bottle of water		Assurance Performance Improve		

Facility ID: 923268

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		MEDICAID SERVICES	(X2) MULTI		ON		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, í	6		· · ·	MPLETED
		245225	B. WING				С
	ROVIDER OR SUPPLIER	345225	B. WING		SS, CITY, STATE, ZIP CODE		04/26/2017
NAME OF FI	ROVIDER OR SUFFLIER			1602 E FRANKL			
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL		CHAPEL HILL			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRE ICH CORRECTIVE ACTION SH SS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 224	Continued From page which took approxima	e 18 ately 5 minutes. She stated	F 2:		ommittee weekly by the	Director	
	when she came out of was opening her mou able to speak and set She stated the intern and the 911 operator	of the store Resident #67 uth, gasping for air, was not emed to be less responsive. volunteer was calling 911		of Nursing of continu At that tim QAPI com frequency	g to determine the furth led education or revisione, based on evaluation mittee will determine a v the staff questionnaire le. A Quality Assurance	er need in of plan. in, the at what e will need	
	facility to try and get the 911 operator told laying down and they wheelchair back. She	the information. She stated them to try and get her were able to lay her stated EMS arrived and		Performar be held we Medical D of Nursing	nce Improvement meet eekly times 4 weeks wi Director, Administrator, I g, Social Services Direc	ing will ith the Director ctor,	
	they placed a tube down her throat out a piece of waffle cone. A nursin from the facility arrived about 5 to 1 after she had called the facility and from red hall came (didn ' t know he stated that Resident #67 seemed fi	cone. A nursing assistant ed about 5 to 10 minutes he facility and then a nurse lidn ' t know her name). She		Admission a Nursing Director, t with the co	irector, Quality of Life D ns Coordinator, a Charg Assistant and the Mair to ensure continued cor orrective action plan ar	ge Nurse, ntenance mpliance nd for	
SI nu st er An re 4/ fir to ou cr th	She stated that she h nurse know that she	ad not let Resident #67 ' s was taking her out. She ot have any training in		Quality As Improvem weeks the recommen	commendations as indi- ssurance/Performance nent will be held weekly en monthly for 2 months indations and further fol	r times 4 s for low up	
	revealed she was the 4/5/17. She stated th fine all day. She state	17 at 1:30 pm with Nurse #3 e nurse for Resident #67 on hat the resident had been ed that she went to find her		regarding	the above stated plan.		
	out that activities had cream. She stated the that they were taking	oon medications and found taken her out to get ice at they didn ' t even tell her her out. She stated that laborate on who "everyone"					
	was) knew that Resid						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345225	B. WING				_ 26/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			602 E FRANKLIN STREET HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 224	4:32 pm revealed tha facility from her lunch facility staff member ( stopped her and told unresponsive down the shop. She stated she medical information a staff. She stated Resput in the ambulance the medical information full code, to EMS. She aware of any further i the facility after the in An interview on 4/21/ activities intern / volut accompanied Resider ice cream shop. She finished their ice creat the residents back to #67 started gasping for Activity Assistant wen something to drink. W #67 seemed to be ge 911. She stated the re breathing. She stated volunteering at the fac and that she did atter orientation. She stated any training at the fac response. A follow-up interview the Assistant Activity	it Manager #1. t Manager #1 on 4/20/17 at t she was returning to the break on 4/5/17 and a (could not remember who) her that Resident #67 was he street at the ice cream e obtained Resident #67 's ind brought it to the EMS sident # 67 had already been by that time. She provided on, including that she was a he stated that she was not nterventions or follow-up by cident. 17 at 1:00 pm with the neer revealed that she had nt #67 on the outing to the stated that everyone had m and they were walking the facility when Resident or air. She stated that the it to get Resident #67 /hile she was gone Resident tting worse and she called esident did not stop d that she had been cility since January 2017	F	224			
		training on the Heimlich ergency medical training.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345225	B. WING				26/2017
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			602 E FRANKLIN STREET HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page	20	F 2	224			
	the Activity Assistant is volunteers provided be events as obtained in An interview on 4/21/ Development Coordin activity staff are not the technique or how to re emergencies because clinical capacity. She attend the facility gen does not include any such as the Heimlich An interview on 4/21/ Administrator reveale aware of the incident involving Resident #6 discussed Resident # the next day in the more	17 at 2:00 pm with the Staff nator revealed that the rained in the Heimlich espond in medical e they don ' t work in a stated that volunteers do eral orientation, but this medical emergency training					
	informed of the imme provided a credible al pm. The allegation of On 4/5/17 Resident # activity assistant and began gasping for air obtain water approxin Resident # 67 with tw called 911. EMS arriv 67, applied O2 and be transported Resident was admitted to hosp	n, the administrator was diate jeopardy. The facility llegation on 4/23/17 at 2:00 f compliance indicated: # 67 went on outing with two interns, resident # 67 , activity assistant went to nately 100 feet away, leaving to activity interns, one intern ved, suctioned Resident # agged resident, and # 67 to Hospital. Resident					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 06/08/2017 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345225	B. WING		_		C 26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	APEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 2751			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	<ul> <li>4/5/17 no other concernent with a sudden changer potential to be affected practice. Residents with ave been reviewed the Development Coordin changes have been it follow up completed.</li> <li>Activity assistant was Development Coordin identifying an emerger recognizing an emerger recognizing an emerger maybe characterized breathing, respiratory change in muscle ton calling 911 immediater resident.</li> <li>The facility Administration Managers, Nursing Staff Development Coordin Staff Development Coordin Coordination of the subject o</li></ul>	y the DON, ADON, on erns identified. All residents a in condition have the d by this alleged deficient with a change in condition by the DON, ADON, Staff hator to ensure that any dentified and appropriate educated by the Staff hator on 4/22/17 on ency situation which included lency situation episode that by apnea, difficulty distress, color change, e, choking or gagging, ely and staying with the ator, DON, ADON, Unit upervisor, MDS Coordinator, bordinator, Director of Dining ffice Manager, Social ntral Supply, Chaplain, a Director, Rehab Services al Records Staff were onal Nurse Consultant on s and procedures regarding s. 1) Call 911 if initial e such action is necessary facility pending location of The above training was e in order to facilitate on on policies, procedures	F 224				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION     (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A BUILDING     (X3) DATE SURVEY COMPLETED       NAME OF PROVIDER OF SUPPLIER     345225     STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN STREET CHAPEL HILL, NC 27514       INAME OF PROVIDER OF SUPPLIER     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     IN PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)     IN PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)     IN PREFIX TAG     F 224       F 224     Continued From page 22 Once the facility Administrator, DON, ADON, Unit Mangers, Nursing Supervisors, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Central Supply, Chaplain, Marketing/Admissions, RSM, and medical records were educated on the above policies and procedures and processes they were then assigned to re-educate, Nursing staff, nursing assistants, Dietary Staff, Activities, Maintenance and House Keeping staff which started on 4/22/17. No employee will be allowed to work until education is provided. This education will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until education is provided.		MENT OF HEALTH AN						FORM	): 06/08/2017 APPROVED ). 0938-0391
345225     B. WING	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /				(X3) DATE COMP	SURVEY LETED
Idea to the second sec			345225	B. WING					
SIGNATURE HEALTHCARE OF CHAPEL HILL       CHAPEL HILL, NC 27514         Image: Colspan="2">(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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED To THE APPROPRIATE DEFICIENCY)       (ACH DEFICIENCY)         F 224       Continued From page 22 Once the facility Administrator, DON, ADON, Unit Mangers, Nursing Supervisors, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services, Director, Central Supply, Chaplain, Marketing/Admissions, RSM, and medical records were educated on the above policies and procedures and processes they were then assigned to re-educate, Nursing staff, nursing assistants, Dietary Staff, Activities, Maintenance and House Keeping staff which started on 4/22/17. No employee will be allowed to work until education is provided. This education will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until education is provided.       CHAPEL HILL, NC 27514	NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP	CODE		
PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLET DATE         F 224       Continued From page 22 Once the facility Administrator, DON, ADON, Unit Mangers, Nursing Supervisors, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services, Central Supply, Chaplain, Marketing/Admissions, RSM, and medical records were educated on the above policies and procedures and processes they were then assigned to re-educate, Nursing staff, nursing assistants, Dietary Staff, Activities, Maintenance and House Keeping staff which started on 4/22/17. No employee will be allowed to work until education is provided. This education will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until education is provided.       No	SIGNATU	RE HEALTHCARE OF CH	APEL HILL						
Once the facility Administrator, DON, ADON, Unit Mangers, Nursing Supervisors, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Central Supply, Chaplain, Marketing/Admissions, RSM, and medical records were educated on the above policies and procedures and processes they were then assigned to re-educate, Nursing staff, nursing assistants, Dietary Staff, Activities, Maintenance and House Keeping staff which started on 4/22/17. No employee will be allowed to work until education is provided. This education will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until education is provided.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD B		COMPLETION
The credible allegation was verified on 4/23/17 at 5:02 PM. The Activity Assistant was interviewed on 4/23/17 at 4:16 PM and was able to describe the education she received. Assessments of the residents who attended the activity, as well as those who had not attended the activity were reviewed. Communication forms (SBAR) were created for every resident that was assessed. The change of condition policy was reviewed and it was noted life threatening events were defined. In-service topics included elder outings and emergency events. Sign-in sheets were reviewed. Random staff in the nursing home including a unit secretary, licensed nurse, nurse aide/activity assistant were interviewed between 4:32 PM and 4:56 PM to confirm they had received in-services. The Staff Development Coordinator was interviewed to confirm there was a system to train all staff prior to reporting to duty. The immediate jeopardy was removed on 4/22/17.	F 224	Once the facility Admi Mangers, Nursing Su SDC, Director of Dinir manager, Social Serv Supply, Chaplain, Ma and medical records of policies and procedur then assigned to re-en nursing assistants, Di Maintenance and Hou started on 4/22/17. No to work until education education will be inclu process for all newly fine education will be inclu process for all newly fine education is provided The credible allegation 5:02 PM. The Activity on 4/23/17 at 4:16 PM the education she recor residents who attended those who had not attr reviewed. Communic created for every resid The change of conditi it was noted life threat In-service topics inclu emergency events. S reviewed. Random st including a unit secret aide/activity assistant 4:32 PM and 4:56 PM received in-services. Coordinator was inter a system to train all st The immediate jeopat	inistrator, DON, ADON, Unit pervisors, MDS coordinator, ng Services, Business office vices Director, Central rketing/Admissions, RSM, were educated on the above res and processes they were ducate, Nursing staff, ietary Staff, Activities, use Keeping staff which o employee will be allowed n is provided. This uded in the orientation hired staff members. No e will be allowed to work until on was verified on 4/23/17 at y Assistant was interviewed <i>A</i> and was able to describe seived. Assessments of the ed the activity, as well as tended the activity were cation forms (SBAR) were dent that was assessed. ion policy was reviewed and tening events were defined. uded elder outings and Sign-in sheets were taff in the nursing home tary, licensed nurse, nurse were interviewed between to confirm they had The Staff Development viewed to confirm there was taff prior to reporting to duty.	F 2	'24				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345225	B. WING				C /26/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 224	10:28 PM when Resid unattended through th The resident had bee exit-seeking behavior guard (a small transm resident's wrist or ank alarm when it comes door). The door alarm turned off the alarm fr 200 Hall Nursing Stat without identifying the been activated. Imme removed on 4/22/17 f The facility remained scope and severity of harm with the potentia harm that is not imme facility to complete stat corrective action to en procedures are put in door alarm when it is The findings included Resident #166 was in 3/6/17. The Hospital 3/6/17 indicated the ro diagnosis of a small ri left sided mass along membranous cover of mild mass effect on th intracranial or brain m diagnoses of seizures The resident was disc	dy began on 4/10/17 at dent #166 exited the building ne front door of the facility. n identified as having and was wearing a wander nitting device placed on a de, which would trigger an in close proximity to an exit n sounded, but a staff nurse om a remote location (the ion) using a reset button e reason why the alarm had ediate jeopardy was for F224. out of compliance at a lower D (isolated with no actual al for more than minimal ediate jeopardy), for the aff training and to monitor its nsure appropriate to place for responding to a activated. the hospital from 2/23/17 - Discharge Summary of esident had a discharge ight sided mass and large the tentorium (a r horizontal partition) with a ne dorsal midbrain (an nass). He had a secondary s.	F	224			
	and admitted to the fa						

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	-	ID HUMAN SERVICES				FORM	/ APPROVED	
	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING .			LETED	
		345225	B. WING				C 26/2017	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			1602 E FRANKLIN STREET			
					CHAPEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 224	Continued From page	a 24		224				
1 227		uscle weakness, cognitive		224	*			
	communication defici							
		#166's admission Minimum						
		ssment dated 3/13/17 had intact cognitive skills for						
	daily decision making	. No wandering behaviors						
		vas reported within the last sion. The resident required						
	extensive assistance	for all of his Activities of						
	Daily Living (ADLs), v independent for eatin	vith the exception of being g.						
	A review of the reside	ent's Care Area Assessment						
		ed 3/14/17 revealed the						
		v of seizures and altered his hospitalization. No						
	wandering behaviors	were noted.						
	On 3/29/17, a							
		I-Appearance-Review ion Form indicated the						
		e in condition. The SBAR						
		had a positive urinalysis for						
	on 3/25/17. The resid	on, with symptoms first noted dent's mental status						
		nere was an increase in						
	confusion or disorient	tation at that time.						
		nent Risk Evaluation was						
	completed. At that tir determined to be at ri							
		#166's medical record						
		s telephone order was use a wander guard for the						
		acement and function every						
		resident's whereabouts						
	throughout the facility	every 2 nours.						

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING	·			
						С	
		345225	B. WING		04	4/26/2017	
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP COD	E		
				1602 E FRANKLIN STREET			
SIGNATU	RE HEALTHCARE OF CH	HAPEL HILL		CHAPEL HILL, NC 27514			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION	
F 224	Continued From page 25		F 22	4			
	Further review of the resident's medical record included an SBAR Communication Form dated						
	4/2/17 and written by Nurse #4. The SBAR form						
	reported Resident #166 had become combative and was attempting elopement. Nursing notes on						
		is change started on 3/30/17					
	U U	e. The resident's Mental					
		ted the resident had an					
		or disorientation; memory					
		toms or signs of delirium.					
		ted to be uncooperative with					
		ad tried to exit the facility					
		eelchair with no shoes on.					
	follows:	e on the SBAR read as					
		ombative this AM (morning)					
		( <b>C</b> )					
		arted swinging at staff ut was incontinent at the					
	<u> </u>	bers were able to transfer					
		air and get him to the					
		AM care and put clothes on.					
		eelchair resident took his					
		off and proceeded to front					
		directed back inside facility					
		ing at staff but able to get					
		om front door. Resident then					
		door and proceeded to go					
		ied to redirect him telling him					
	-	and he said he hadn't seen					
	-	e was leaving now to go out.					
	-	o be barefoot at that time					
		pit at staff. Resident was					
		ed with 3 staff members					
		needed) given while staff sat					
		cation began to work and					
		et and sleepy. Once asleep					
		ents and wander guard					

Facility ID: 923268

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345225	B. WING				C 26/2017	
NAME OF PI	ROVIDER OR SUPPLIER	L		s	STREET ADDRESS, CITY, STATE, ZIP CODE			
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			1602 E FRANKLIN STREET CHAPEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 224	Continued From page	26	F	224				
	the care plan had bee include an area of foo resident was at risk foo by exit seeking behav cognitive deficits. Inter plan included: Use at alert staff of exit seek Check audible monitor functioning per policy PM-7:00 AM sitter (no Further review of the included an Interdisci at 2:43 PM, which rea reviewed by IDT (Inter Elopement/Wandering due to current medica deficits tends to spea and therefore has the good results at this tin guard at this time." A review of Resident included an SBAR Co 4/11/17. The SBAR for the resident's condition noting he had increas	erventions listed on the care udible monitoring system to ing behavior (dated 4/3/17); oring system for proper (dated 4/3/17); and, 11:00 ot dated). resident's medical record plinary Note dated 4/10/17 ad: "The resident is being erdisciplinary) Team for g at this time as the resident al status and cognitive k of leaving this place now e wander guard in place with me. Continue with wander #166's medical record ommunication Form dated orm reported a change in on occurred on 4/10/17, sed agitation, confusion and						
	started on 4/10/17; th had occurred before; last episode was impl guard. Resident #160 reported increased co memory loss; and oth delirium. The Nursing read as follows:	R reported the condition e condition/symptom/sign and the treatment for the lementation of a wander 6's Mental Status Evaluation onfusion or disorientation; her symptoms or signs of Narrative for the SBAR increased agitation and						

Facility ID: 923268

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		O. 0938-039 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED	
					С		
		345225	B. WING			/26/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO	DE		
				1602 E FRANKLIN STREET			
SIGNATU	RE HEALTHCARE OF CH			CHAPEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 224	Continued From page		F 22	4			
		efused hour of sleep care.					
		ncoherent speech and was					
		tions. Resident scattered floor and then propelled					
		m. He apparently eloped					
		rance. One of the staff					
		to her car at about 10:30 PM					
		esident trying to cross					
		heelchair. She brought the					
		building and informed this					
		nspired. Resident had					
	-	ankle intact. Wander guard ere asked to keep a close					
	eye on the resident.	•					
		d and informed of resident's					
		e gave an order for 0.5 mg					
	(milligrams) Ativan po						
		(one dose). Resident					
		5 mg po ordered. Resident					
		n and he took it. Resident's					
		fied of the proceedings and ion would be here. The					
	-	owed up. Family called at					
		m, resident was observed					
		ng the hallway towards the					
		tried to escape through the					
		ought back before he could					
	-	did set off the alarm though.					
		resident if he was tired and					
		ed. Resident stated he was The nurse assisted the					
		e stayed in bed the whole					
		ked on every hour while in					
	bed. Will continue to	-					
	Further review of Res	sident #166's care plan					
						1	
		en notation on the care plan					

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	S FOR MEDICARE & OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	MPLETED
						С
		345225	B. WING		0	4/26/2017
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP COD	)E	
0.01.47.1			1	602 E FRANKLIN STREET		
SIGNATU	RE HEALTHCARE OF CH			CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 224	1.0		F 224			
	An interview was conducted on 4/20/17 at 4:15 PM with the Assistant Director of Maintenance. The Director of Maintenance was not available for an interview. The Assistant Director stated all exit doors had a key pad adjacent to the door. If the correct code was entered on the key pad, the door would open without activating the door alarm. If the correct code was not entered on the key pad and the release bar on the exit door was pushed, the door alarm would be activated. If the locked exit door's release bar was pushed for 15 seconds, the door would open. He reported the main entrance door was the only exit with a wander guard protection. If a resident with a wander guard came within 2 feet or so of the door, it would lock down. If the door would alarm. If a resident with a wander guard pushed on the front exit door for 15 seconds, it would unlock and continue to alarm until a code was entered into the key pad adjacent to the door.					
	The Assistant Director main entrance (front el locked at 9:00 PM to period of time, whether wander guard, the fro when the door release release bar was press would unlock to allow inquiry, the Assistant been no problems wit 5 years he had worked An observation was of 4:25 PM through 4:39 Maintenance Assistant	r of Maintenance stated the exit door) of the facility was 5:00 AM daily. During that er or not a resident had a int exit door would alarm e bar was pressed. If the sed for 15 seconds, the door someone to exit. Upon Director reported there had th the door alarms during the				

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	OF DEFICIENCIES					10. 0938-039	
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		· · ·	TE SURVEY MPLETED	
			A. BUILDING	3	с		
		345225	B. WING				
		545225				4/26/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	'E		
SIGNATU	RE HEALTHCARE OF C	HAPEL HILL		1602 E FRANKLIN STREET			
	1			CHAPEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 224	Continued From pag	e 20	F 22	24			
1 22 1	· · · · · · · · · · · · · · · · ·		F 22	24			
		itiated the door to lock as it the doorway. When asked					
	•	nsible to respond to a door					
		ing, the Assistant stated,					
		d this was particularly					
		cause there was less staffing					
	on those shifts.						
	An observation was	conducted of Resident #166					
	on 4/20/17 at 5:00 P	M. The resident was lying on					
	his bed resting. He	was dressed and					
	well-groomed. The re	esident was noted to have a					
	wander guard around	d his ankle.					
	An interview was cor	nducted on 4/21/17 at 7:38					
	AM with Nurse #1 wl	ho worked the evening of					
	4/10/17 at the time F	Resident #166 exited the					
	facility. The nurse st	tated the resident had anxiety					
		on the shift and she had					
		ssistant (NA) to keep an eye					
		80-10:00 PM that evening,					
		o check on the resident. He					
		ng around and pulling on					
		she again told the NA to					
	1 · ·	eye on him. The nurse					
		e 200 Hall nursing station for a new resident when she					
		ont door alarm go off. She					
	-	nd the time the next shift of					
		plained that if a staff member					
		ty put in the code and					
		bar too soon, the alarm would					
	-	ated she could turn off the					
	facility's front door al	arm from the nursing station,					
	-	entifying the cause of the					
		nued to do her work. The					
	nurse recalled "less	than 30 minutes later," she					
		he resident down the hall in					
		NA told the nurse he was					

Facility ID: 923268

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345225	B. WING				C 26/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 224	outside and was about Name]. She asked the guard on and he did. figured out he had pure enough to make it opper reported as confused by the nursing station resident propel himset tried to open that doorstaff reached him before open the exit door. Re- tired at that point and bed. When asked how was activated each midel. 9:00 PM; the nurse st further inquiry, she ind activated more than of have to either reset the Station or enter the co- further inquiry, the nur- had a wander guard of was working. When a supposed to do when nurse stated they were the door because the going out the facility's An interview was compared the only way putting in a code at the A follow-up interview fat at 8:15 AM with Nurse nurse pointed out the	to cross the road [Street he NA if he had a wander The nurse stated they shed on the door long en. The resident was at that time and he was set b. The nurse observed the eff down the Rehab hall. He r and it alarmed; however, ore he was able to actually esident #166 stated he was the nurse assisted him to w often the front door alarm ight after being locked at tated "pretty often." Upon dicated the alarm was once a night, and she would he alarm from the Nursing ode at the door. Upon rse reiterated the resident on and the alarm on the door asked what staff was a door alarm sounded, the re supposed to go and check y need to check on who is a door. ducted on 4/21/17 at 8:10 of Nursing (DON) upon her ated the door alarms could the Nursing Station. She r to silence the alarm was by ne door itself.	F	224			

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-					FORM	APPROVED 0. 0938-0391	
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED	
	345225	B. WING				C 26/2017	
ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
			1	1602 E FRANKLIN STREET			
RE HEALTHCARE OF CH	IAPEL HILL		C	CHAPEL HILL, NC 27514			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
Continued From page	9 31	F	224				
at 9:20 AM with the A Maintenance. Upon inquiry, the Ass about the incident wh building on 4/10/17. I Maintenance Director for review. The came only video (no audio). Director confirmed tha without wearing a war the door bar would so inquiry as to how the stated someone woul the door. When aske located at the 200 Ha silence an alarm, the "That would be news An observation was c AM. Accompanied by Maintenance Assistar guard to activate the a door. A second surve Nursing Station obser (identified by Nurse # was silenced. Howeve building at that time s whether or not the ala guest entry or by pusi Nursing Station. A se on 4/21/17 at 9:30 AM surveyor, the Assistar again used a wander on the main entrance located at the 200 Ha	ssistant Director of istant stated he had heard en Resident #166 exited the He reported the had gotten the camera feed era surveillance included When asked, the Assistant at after 9:00 PM (with or nder guard), any push on bund the alarm. Upon alarm would be silenced, he d need to enter the code at d about the reset button II Nursing Station used to Assistant Director stated, to me."						
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER RE HEALTHCARE OF CH SUMMARY ST, (EACH DEFICIENC) REGULATORY OR I Continued From page A follow-up interview at 9:20 AM with the A Maintenance. Upon inquiry, the Ass about the incident wh building on 4/10/17. I Maintenance Director for review. The came only video (no audio). Director confirmed tha without wearing a war the door bar would sc inquiry as to how the stated someone woul the door. When aske located at the 200 Ha silence an alarm, the "That would be news An observation was c AM. Accompanied by Maintenance Assistant guard to activate the a door. A second surver Nursing Station obset (identified by Nurse # was silenced. However building at that time s whether or not the ala guest entry or by pus Nursing Station. A sec on 4/21/17 at 9:30 AM surveyor, the Assistant again used a wander on the main entrance located at the 200 Ha surveyor, the Assistant again used a wander on the main entrance located at the 200 Ha when the reset buttor	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345225         ROVIDER OR SUPPLIER         RE HEALTHCARE OF CHAPEL HILL         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 31         A follow-up interview was conducted on 4/21/17 at 9:20 AM with the Assistant Director of	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.       (X2) MUL A. BUILD         345225       B. WING         ROVIDER OR SUPPLIER       B. WING         ROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFICE         Continued From page 31       F         A follow-up interview was conducted on 4/21/17 at 9:20 AM with the Assistant Director of Maintenance.       F         Upon inquiry, the Assistant stated he had heard about the incident when Resident #166 exited the building on 4/10/17. He reported the Maintenance Director had gotten the camera feed for review. The camera surveillance included only video (no audio). When asked, the Assistant Director confirmed that after 9:00 PM (with or without wearing a wander guard), any push on the door bar would sound the alarm. Upon inquiry as to how the alarm would be silenced, he stated someone would need to enter the code at the door. When asked about the reset button located at the 200 Hall Nursing Station used to silence an alarm, the Assistant Director stated, "That would be news to me."         An observation was conducted on 4/21/17 at 9:27 AM. Accompanied by one surveyor, the Maintenance Assistant Director used a wander guard to activate the alarm on the main entrance door. A second survey located at the 200 Hall Nursing Station observed when the reset button (identified by Nurse #1) was pushed, the alarm was silenced. However, someone entered the building at that time so it was unclear as to whether or not the alarm was silenced by the guest entry or by pushing the button at the N	S FOR MEDICARE & MEDICAID SERVICES         SF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER:       (X2) MULTIPLI A BUILDING.         345225       B. WING         ROVIDER OR SUPPLIER REMEALTHCARE OF CHAPEL HILL       ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX A Gollow-up interview was conducted on 4/21/17 at 9:20 AM with the Assistant Director of Maintenance.       ID Upon inquiry, the Assistant stated he had heard about the incident when Resident #166 exited the building on 4/10/17. He reported the Maintenance Director had gotten the camera feed for review. The camera surveillance included only video (no audio). When asked, the Assistant Director confirmed that after 9:00 PM (with or without wearing a wander guard), any push on the door bar would sound the alarm. Upon inquiry as to how the alarm would be silenced, he stated somene would need to enter the code at the door. When asked about the reset button located at the 200 Hall Nursing Station used to silence an alarm, the Assistant Director stated, "That would be news to me."         An observation was conducted on 4/21/17 at 9:27 AM. Accompanied by one surveyor, the Maintenance Assistant Director used a wander guard to activate the alarm on the main entrance door. A second surveyor located at the 200 Hall Nursing Station observed when the reset button (identified by Nurse #1) was pushed, the alarm was silenced. However, someone entered the building at that time so it was unclear as to whether on the dalarm was silenced by the guest entry or by pushing the button at the Nursing Station. A second observation was made on 4/21/17 at 9:30 AM. Accompanied by a surveyor, the Assistant Director of Malintenance again used a wander guard to activate the ala	S FOR MEDICARE & MEDICAID SERVICES         0° DEFICIENTIONES       (x1) PROVIDERSUPPLICECLIA IDENTIFICATION NUMBER:       (x2) MULTIPLE CONSTRUCTION A BUILDING         345225       B. WING         COMDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, 2P CODE         1602 E FRANKLIN STREET CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC DEMTEYING INFORMATION)       PROVIDERS INAN OF CORRECTION (EACH ODERICENCY MUST BE PRECEDED BY FULL REGULATORY OR USC DEMTEYING INFORMATION)         Continued From page 31       F 224         A follow-up interview was conducted on 4/21/17 at 9:20 AM with the Assistant Director of Maintenance.       F 224         Upon Inquiry, the Assistant Director of Maintenance.       F 224         Vibour Wibout Weating a wander guard), any push on the door bar would be alerned, he stated someone would need to enter the code at the door. Who the alarm would be silenced, he stated someone would need to enter the code at the door. Who the alarm on the main entrance door. A second surveyor, the Maintenance Austistant Director stated. "That would be news to me."         An observation was conducted on 4/21/17 at 9:27 AM. Accompanied by one surveyor, the Maintenance Austistant Director stated. "That would be alerned the alarm vas silenced. However, someone entered the building at that time so it was unclear as to whether or not the alarm was unclear as to whethether exto button was bushed, the alarm	MENT OF HEALTH AND HUMAN SERVICES OMB NC SFOR MEDICARE & MEDICALD SERVICES OMB NC CORRECTION A BUILUING 345225 CONDER OR SUPPLIER CE HEALTHCARE OF CHAPEL HILL STREET ADDRESS. CITY, STATE, ZP CODE 1522 FRANKLIN STREET CHAPEL HILL, NC 27514 CONTRECT OR SUPPLIER RE HEALTHCARE OF CHAPEL HILL SUMMARY STATEMENT OF DEPICIENCIES (ACC) DEPICIENCY MUST BE PRECEDED BY YULL REGULATORY OR LSC DENTFYING INFORMATION REGULATORY OR LSC DENTFYING INFORMATION Continued From page 31 A follow-up interview was conducted on 4/21/17 at 9.20 AM with the Assistant Director of Maintenance. Upon inquiry, the Assistant Stated he had heard about the incident when Resident #166 exited the building on 4/10/17. He reported the Maintenance. Upon inquiry as to how the alarm would be silenced, he stated someone would need the enter the code at the door Jav would sound the enter the code at the door. When asked, about the reset button located at the 200 Hall Nursing Station used to stated someone would need the need the 200 Hall Nursing Station observed when the reset button located at the 200 Hall Nursing Station used to stated someone would exit the assign to the anima need dor. A second surveyor, for Assign to the Assign the ham mance dor. A second surveyor located at the 200 Hall Nursing Station observed when the reset button located at the 200 Hall Nursing Station observed when the reset button located at the 30.4 Max enclear as to whether or not the alarm was silenced by the guest entry of by pushing the button at the Nursing Station. A second surveyor located at the 200 Hall Nursing Station observed when the reset button on the main entrance door. A second surveyor located at the 200 Hall Nursing Station observed when the reset button whether or not the alarm was bilenced by the guest entry of by pushing the button at the Nursing Station. A second surveyor located at the 200 Hall Nursing Station observed the alarm was silenced button asputed, the a	

Facility ID: 923268

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	S FOR MEDICARE &				OMB NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>,</i>	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345225	B. WING		C 04/26/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETI	
F 224	Continued From page 32 stated at that time, "She must have cut it off."		F 224			
On 4/21/17 at 9:32 AM, the Assistant Maintenance Director and Unit Manager #1 were interviewed in regards to the button used to deactivate the door alarm. The Unit Manager stated she had worked at the facility for 4 years and did not know about the button. The Assistant Director of Maintenance stated, "That's not good to have."						
	was conducted with h as the nursing assists outside of the building worked from 7:00 AM NA #1 recalled hearin evening (the sound th beeps during the first of the door alarm). S 100 Hall at the time. minutes after the alar front door to specifica off the alarm. She st her car. No one was door, so she went ou reported seeing a ma sidewalk, just past th [Street Name]. The h was Resident #166 s the building. When a would have been out time the alarm sound him back in), she stat inquiry about the long	AM, a telephone interview NA #1. NA #1 was identified ant who found the resident g. The NA reported she 1 to 11:00 PM on 4/10/17. Ing the loud alarm that nat occurs past the warning a 15 seconds upon activation whe was in the back of the The NA stated within 1-2 rm sounding, she went to the ally put in the code and turn ated she was not going to around the main entrance tside to look around. She in in a wheelchair on the e Rehab awning facing NA stated she discovered it o she brought him back into usked how long the resident of the building (between the ed and when she brought ted, "1-2 minutes." Upon ger time frame noted by the mera surveillance), the NA				

Facility ID: 923268

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COMF	
		345225	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 224	4 Continued From page 33		F	224	4		
	was conducted with the worked with the Reside 4/1/17 and 4/2/17. No #166 had tried to exit time, he did not have there were people in the redirected. He then the activated the door allow staff were able to stop door. However, base nurse stated she wen resident's Elopement the family and Nurse reported the resident antianxiety medication periods of agitation. It initiated at that time. how she could deactive stated, "The only way to (enter the code and	AM, a telephone interview the Nurse #4. Nurse #4 had dent #166 on 1st shift on urse #4 recalled Resident from the front door. At that a wander guard. However, the lobby and he was ried to exit near Rehab and trm there. Nurse #4 stated to him from going out the d on what she had seen, the t ahead and updated the Evaluation, and also called Practitioner (NP). The NP already had an order for an in to be used as needed for Use of a wander guard was When the nurse was asked wate the door alarm, she I know is to go to the door d) deactivate the alarm. the was trying to exit the					
	Director and the Corp camera surveillance v 4/10/17 was viewed of Assistant Maintenance date on the camera si correct, the time stam needed to be added t correct time from the surveillance video fro corrected times) rever At 10:25 PM (correct was observed as he p	on 4/21/17 at 1:26 PM. The e Director reported while the urveillance monitor was op was off and 32 minutes o the time stamp to get the surveillance. The camera m 4/10/17 (with the					

Facility ID: 923268

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345225	B. WING				26/2017	
	ROVIDER OR SUPPLIER	IAPEL HILL		160	REET ADDRESS, CITY, STATE, ZIP CODE D2 E FRANKLIN STREET IAPEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 224	Assistant Director of a larm would have go Resident #166 was wheelchair in front of At 10:27 PM (correct observed as he proce hallway. At 10:27 PM (correct observed as he open went through first doo get outside of the fac At 10:32 PM (correct (identified as NA #1 th Consultant) opened the of the facility's front e observed with a purs- jacket tied around he phone. Initially upon was observed to be u phone. She was out brief periods of time. At 10:36 PM (correct man came to the from the building. At 10:36 PM (correct observed as she cam pushing the resident On 4/21/17 at 1:45 Pf the Assistant Director camera surveillance a were being discussed conducted with the D interview, the DON st facility for 12 years at button at the Nursing	Maintenance stated the ne off at that time. observed as he sat in his the door for 1-2 minutes. cted time), the resident was eeded back down the facility cted time), Resident #166 ont entrance door. cted time), the resident was ed the front exit door and or, then the second door to ility. cted time), a staff member by the Corporate Nurse both doors and stood outside ntrance door. The NA was e over her shoulder, a light r waist, and holding her cell exiting the building, the NA using and/or viewing a cell of view of the camera for cted time), an unidentified at entrance door and entered cted time), NA #1 was he back in the building, in his wheelchair. M, the facility's DON joined of Maintenance as the and timeline from 4/10/17	F2	224				

Facility ID: 923268

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 06/08/2017 RM APPROVED NO. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345225	B. WING			c	C )4/26/2017	
NAME OF P	ROVIDER OR SUPPLIER	•	•	STF	REET ADDRESS, CITY, STATE, ZIP CODE			
SIGNATU	RE HEALTHCARE OF CH			160	2 E FRANKLIN STREET			
SIGNATO				СН	APEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 224	DON if the reset buttor Station worked to sile "Yes it did." When the actually deactivated to Director of Maintenary deactivate the alarm inquiry, the DON state "Never, ever" be used expectation would be investigate why a door An observation was re as NA #1 identified the when he was found of time, the Assistant Di measured how far the door entrance where how far the resident we was found. Measure resident had traveled entrance of the facility reported to be facing front of the facility at the Measurements revea feet from the curb adj A telephone interview at 11:47 AM with NA nursing assistant ass #166 at the time he e evening of 4/10/17. U recalled about the even reported she knew th front door of the facility. When asked that evening, NA #2 st	ked in the presence of the on at the 200 Hall Nursing ence the alarm. He stated, e DON asked him if it he alarm, the Assistant nee confirmed the button did when it was tested. Upon ed the reset button should d. She reported her for the staff to immediately or alarm was activated. made on 4/22/17 at 9:52 AM re location of Resident #166 putside on 4/10/17. At that rector of Maintenance e resident was from the front he exited the facility, and was from the street when he ments determined the 108 feet from the front y. The resident was a 5-lane street directly in the time he was found. led Resident #166 was 109	F	224				

Facility ID: 923268

If continuation sheet Page 36 of 125
						O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	E SURVEY IPLETED	
			A. BUILDIN	G		с	
		345225	B. WING		04/26/2017		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
010114711			1602 E FRANKLIN STREET				
SIGNATU	RE HEALTHCARE OF CH			CHAPEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
F 224	Continued From page	o 36	F 2	24			
1 224		oor alarm only went off for a	F 2	24			
	few seconds at a time that evening (not minutes).						
	On 4/21/17 at 4:25 P	M, the Administrator was					
		diate jeopardy. The facility					
	provided a credible a compliance indicated	llegation. The allegation of :					
	Credible Allegation F	224					
	On 4/10/17 at 2156 (	9:56 PM), Resident #166					
		e the facility on the sidewalk					
	near the rehab side of	-					
		loor alarm had sounded as					
		the facility. Nurse #1 heard out did not attempt to identify					
		m, and silenced the alarm					
		n at the nurses' station.					
		nded pending investigation					
		assessment was completed					
		4/10/17 with no injury					
		ian and responsible party f Nurse #1] on 4/10/2017.					
	-	laced on every one hour					
	monitoring by the cha	arge nurse.					
	On 4/5/17 Resident #	67 went on outing with					
		two interns, Resident #67					
		r, activity assistant went to					
		nately 100 feet away, leaving erns, intern called 911,					
		errived, suctioned Resident					
	• • •	bagged due to agonal					
	breathing and Reside	ent #67 was transported to					
		Resident #67 chart and					
	care plan was review						
	-	r Signature Care Consultant quality of care and quality of					
		no other concerns identified.					

Facility ID: 923268

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345225	B. WING				C 26/2017
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUR	RE HEALTHCARE OF CH			16	602 E FRANKLIN STREET		
SIGNATOR				С	HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page	37	F	224			
	B. All residents have	he potential to be affected					
		ce. A head count was					
		at 12:00 am for the entire					
	residents were affected	nurse to ensure no other					
		I residents were accounted					
		17, 8 resident wander					
	guards were checked						
		rge nurse and the central					
		found to be in place and No other potential areas of					
	neglect were identified	-					
		potential to be affected by Situation with Resident					
	•	h Activity Director on 4/6/17,					
		sing. Change in condition					
		reatening events was					
		vity assistant on 4/22/17 by					
	4/21/2017 Staff Devel	t Coordinator. Starting on					
	ADON's, Regional Nu	•					
	Regional team will rev	view policy and procedure					
	• •	ing events, to include an					
		characterized by apnea, spiratory distress, color					
	change, change in mu						
	• •	mergency protocols with					
	priority of who to call	first, call 911 immediately.					
	-	residing in the facility were					
		s and symptoms of distress sing, Staff Development					
		Nurse and/or the Signature					
	-	/22/17, for any possible					
		nedical assistance. No					
	residents were identif emergency services.	ied with the need for					
	chiergency services.						

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 06/08/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY
		345225	B. WING			C / <b>26/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				1602 E FRANKLIN STREET		
SIGNATU	RE HEALTHCARE OF CH			CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 224	C. The Staff Develop Worker educated the MDS Coordinators, D Office Manager, Pay Central Supply, Mark Service Manager, Me Operations Director, Environmental Servic 4/11/17 and 4/13/17 r policy, and respondin alarms to ensure resi regarding the abuse/r administered to the a managers. Once the Director of Nursing, A , Minimum Data Set ( Development Coordin Business office mana Assistant, Social Sen Supply, Marketing/Ac Manager, Medical Re Quality of Life, and E educated and receive and procedure post-tr educate nursing, nurs maintenance, house abuse/neglect policy responding immediat resident safety. All s regarding the abuse/r education. Staff will t the education is recei has been obtained or did not score 100% o was immediately re-e re-administered. This stakeholders obtainet	ment Coordinator and Social Administrator, DON, ADON, Dietary Manager, Business roll Administrative Assistant, eting/Admissions, Rehab edical Records, Plant Quality of Life Director, and ces Director starting on regarding the abuse/neglect of immediately to door dent safety. A post-test neglect policy was bove stated department facility Administrator, Assistant Director of Nursing Coordinators, Staff nator, Dietary Manager, orger, Payroll/Administrative vices Director, Central Imissions, Rehab Service ecords, Plant Operation, nvironmental Services were ed 100% on the abuse policy est, they were assigned to sing assistants, dietary, aceping staff regarding the	F 23	24		

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						O. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · /	E SURVEY IPLETED	
			A. BOILDING			С	
		345225	B. WING		04	04/26/2017	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		1 0		
				1602 E FRANKLIN STREET			
SIGNATU	RE HEALTHCARE OF CI	HAPEL HILL		CHAPEL HILL, NC 27514			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLETION	
F 224	Continued From pag	e 39	F 224	L .			
	DON, ADON, Staff D	evelopment Coordinator or					
	Administrator.						
	The Staff Developme	ent Coordinator and Social					
		Administrator, DON, ADON,					
		Dietary Manager, Business					
		roll Administrative Assistant,					
		keting/Admissions, Rehab					
		edical Records, Plant					
		Quality of Life Director, and ces Director starting on					
		e abuse/neglect policy, and					
		reatening situations. A					
		ne abuse/neglect policy was					
	administered to the a	above stated department					
		facility Administrator, DON,					
		ators, Staff Development					
		Manager, Business office					
		ministrative Assistant, Social					
	Services Director, Ce	is, Rehab Service Manager,					
	U U	ant Operation, Quality of Life,					
		Services were educated and					
	received 100% on th						
	procedure post-test,	they were assigned to					
		sing assistants, dietary,					
		keeping staff regarding the					
	abuse/neglect policy						
		tely to life threatening events e that may be characterized					
	-	reathing, respiratory distress,					
		e in muscle tone, choking or					
		emergency protocols with					
	priority of who to call	first, call 911 immediately.					
		e a post-test regarding the					
		and procedure education.					
	Staff will not be allow						
		d and a score of 100% has e posttest. If stakeholder did					

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		ND HUMAN SERVICES			FORM AP OMB NO. 09		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SUR COMPLETE		
		345225	B. WING			C 04/26/2017	
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
GNATU	RE HEALTHCARE OF CH	HAPEL HILL		1602 E FRANKLIN STREET			
				CHAPEL HILL, NC 27514	0000000		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE CC	(X5) DMPLETIC DATE	
F 224	Continued From page	e 40	F 224	4			
		ost-test, then stakeholder	F 224	*			
		educated and post-test					
	-	s process continued until all					
		d a 100% score on post-test.					
		eviewed for compliance by					
		Consultant, Regional Team,					
	Administrator.	evelopment Coordinator or					
	Auministrator.						
	Facility alleged IJ rer	noval 4/22/2017					
		on was verified on 4/23/17 at					
	5:02 PM. The Activit	y Assistant was interviewed					
		M and was able to describe					
		ceived. Assessments of the					
		ed the activity, as well as					
		ttended the activity were cation forms (SBAR) were					
		ident that was assessed.					
		se policy was reviewed.					
		uded neglect definitions and					
		sheets and post education					
		Random staff in the nursing					
		t secretary, licensed nurse,					
		sistant were interviewed d 4:56 PM to confirm they					
		ces. The Staff Development					
		rviewed to confirm there was					
	a system to train all s	staff prior to reporting to duty.					
	The immediate jeopa 4/22/17.	ardy was removed on					
F 241	483.10(a)(1) DIGNIT	Y AND RESPECT OF	F 24	1	5/3	1/17	
SS=D	INDIVIDUALITY						
	(a)(1) A facility must	treat and care for each					
		and in an environment that					
		ce or enhancement of his or					
		ognizing each resident's					
	individuality. The faci	llity must protect and					

Facility ID: 923268

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 06/08/2017 RM APPROVED IO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345225	B. WING			C 04/26/2017		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				1	602 E FRANKLIN STREET			
SIGNATU	RE HEALTHCARE OF CH			c	CHAPEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 241	Continued From page	o 41		241				
1 241			F.	241				
	promote the rights of							
		Γ is not met as evidenced						
	by:	·····			5044			
		iew, observations and / failed to respond to a			F241:	od		
	resident's request for				A. Resident #97 was placed on the b pan on 4/20/17 at 10:45pm. The resid			
		nity for 1 of 8 resident's			urinated, was cleaned, changed into l			
		s of Daily Living (resident			pajamas and repositioned in bed.			
	#97).				B. All residents have the potential to	be		
					affected by the alleged deficient pract			
	Findings Included:				An interview was completed with resid			
	i indinge meldedi				with a BIMS (Brief Interview for Menta			
	Resident #97 was ad	mitted on 7/8/16 with the			Status) Assessment score of 8 or abo			
	current diagnoses of	heart failure, diabetes and			by the Social Services Director,			
	hypertension.				Administrator, or Chaplain, Director o			
					Nursing, Assistant Director of Nursing			
		um Data Set (MDS) dated			regarding receiving assistance for toil	-		
		was moderately cognitively			in a timely manner this was complete	•		
	impaired. The resider	•			5/19/17. Corrective actions to be take			
	assistance with bed r	-			for any issues identified with receiving	9		
	-	, eating, toilet use and			toileting in a timely manner.	aina		
		e resident got intermittent			C. Education was completed for Nurs	•		
		had urinary continence and			Staff by Staff Development Coordinat			
	was frequently incont				Director Nursing, Assistant Director o Nursing, Unit Coordinator or Regiona			
	The resident had car	e plans last updated 3/8/17			Nurse by 5/31/17 regarding the provis			
		Living and refusal of care.			of toileting in a timely manner to main			
					dignity for residents.			
	On observation and i	nterview with Resident #97			D. The Social Services Director,			
		20/17 at 10:17 PM. The			Administrator, Chaplain, Director of			
		n her wheelchair in her room.			Nursing, Assistant Director of Nursing	],		
		hat she had been waiting to			Central Supply, Medical Records,			
	use the bedpan for a	n hour. She stated she			Business Office Manager, Assistant			
	asked staff before 9:0	00 PM to get her to the			Business Office Manager, Admission	s		
		ut was still waiting. She			Coordinator or Rehabilitation Service			
	stated she normally u				Manager will complete interviews of 5			
		ation, the resident's face			residents daily 5 days per week x 4 w			
		dent's eyes were puffy with			3 days per week x 4 weeks and once			
	tears forming. The re	sident was moving around in			weekly x 4 weeks with a BIMS score	of 8		

Facility ID: 923268

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMP	LETED
					0	2
		345225	B. WING			26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
SIGNATU	RE HEALTHCARE OF CH	HAPEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE
F 241	Continued From page	e 42	E 24	11		
F 241	her wheelchair as if s resident still had her On 4/20/17 at 10:28 waiting in the wheelc assistance. On 4/20/17 at 10:45 transferred from the v the assistance of NA When NA #9 went to bathroom the resider hurry, I have to go." the bedpan and urina cleaned, changed int repositioned in bed. NA #6 was interviewe She stated Resident toilet but mostly used resident always need with the lift and she v stated she always ha her with the resident. that evening, the resi get to bed and she to to be a while because see and a new admit her. She stated the re bedpan before gettin Nursing Assistant #8 at 11:12 PM. She state	she was uncomfortable. The day clothes on. PM, the resident was still hair in her room for staff PM, the resident was wheelchair to her bed with #6 and NA #9 via the lift. get the bedpan out of the nt started to yell, "hurry, The resident was placed on ated. The resident was to her pajamas and ed on 4/20/17 at 11:12 PM. #97 sometimes used the d the bedpan. She stated the led assistance from 2 people was rarely incontinent. She ad to find someone to help . She stated that at 8:30 PM ident told her she wanted to old the resident it was going e she had other people to and then would get back to esident always used the	F 24	or above to ensure they re assistance in a timely mar their dignity. Findings of th interviews will be discusse Services Director with the Assurance Performance Ir (QAPI) Committee monthly for recommendations and up as indicated.	ner to preserve e above stated d by the Social Quality nprovement y for 3 months,	
	4/22/17 at 12:41 PM.	member was interviewed on The resident's family he resident told him that she				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				M APPROVE 0. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345225	B. WING		04	C 4/26/2017
	ROVIDER OR SUPPLIER	IAPEL HILL	10	IREET ADDRESS, CITY, STATE, ZIP CODE 502 E FRANKLIN STREET HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 241 F 278 SS=D	told him that it happer 4/21/17 and she had the bed pan and then the staff to take her o resident had an accid staff could not get her Resident #97 was int 12:41 PM. She stated night on 4/21/17. On had used her call bell that the staff never ca stated the staff never ca stated the staff were her feel mad. The administrator wa 6:22 PM. He stated th take care of the resid manner. 483.20(g)-(j) ASSESS ACCURACY/COORE (g) Accuracy of Asses must accurately reflect (h) Coordination A registered nurse mi each assessment wit participation of health (i) Certification (1) A registered nurse the assessment is co (2) Each individual with	ometimes for them to He stated the resident had ned again on the evening of to wait a long time to use had to wait a long time for ff the bed pan. He stated the lent in the past because the r the bedpan in time. erviewed again on 4/22/17 at d that she had to wait last Thursday night, 4/20/17, she l to call before 9:00 PM and ame to assist her. She ignoring her and that made s interviewed on 4/22/17 at hat he would expect staff to ents' needs in a timely SMENT DINATION/CERTIFIED ssments. The assessment ct the resident's status. ust conduct or coordinate h the appropriate a professionals.	F 241			5/31/17

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/08/201 FORM APPROVE OMB NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345225	B. WING		C 04/26/2017
	ROVIDER OR SUPPLIER	IAPEL HILL		STREET ADDRESS, CITY, STATE, ZI 1602 E FRANKLIN STREET	P CODE
				CHAPEL HILL, NC 27514	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 278	Continued From page that portion of the as		F 2	78	
	(j) Penalty for Falsific (1) Under Medicare a who willfully and know	nd Medicaid, an individual			
	()	l and false statement in a is subject to a civil money nan \$1,000 for each			
	(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.				
	material and false sta	nent does not constitute a atement. ¯ is not met as evidenced			
	Based on record rev facility failed to code to accurately reflect t of 2 residents that we catheters (Resident # of 6 residents review	ing Resident Review		F278: A. The Minimum Data S (MDS Coordinator)) com modification to the MDS resident #117 related to indwelling catheter on 4/ modification to the MDS completed by the MDS ( Resident #221 to removi that indicated the reside physician prescribed we	apleted a assessment for the use of an 22/17. A assessment was Coordinator for e the check mark nt was on a
	Findings included:			on 4/20/17. A modification assessment was complete	on to the MDS eted by the MDS
	the diagnoses of mus urinary retention.	vas admitted on 3/3/16 with scle weakness, diabetes and are plan in place created ling urinary catheter.		Coordinator on 4/20/17 t that occurred on 3/28/17 A modification was comp #111 s MDS assessme the MDS Coordinator to	for Resident #4. bleted to Resident nt on 4/22/17 by

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TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) I	DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	;		COMPLETED
						С
		345225	B. WING			04/26/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ē	
SIGNATU	RE HEALTHCARE OF CH			1602 E FRANKLIN STREET		
		<i></i>		CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 278	Continued From page	e 45	F 27	8		
				an indwelling catheter. A mod	ification was	
		ted 2/23/17 stated that the		completed to the MDS assess		
	resident had a chroni	c urinary catheter.		MDS Coordinator on 4/22/17		
	Physician's orders da	ted 3/13/17 revealed the		#49 to correctly code the PAS status.	KK IEVEI 2	
	-	or urinary catheter care		B. All residents have the pote	ntial to be	
		e urinary catheter bag to be		affected by the alleged deficie		
	changed once a mon			The MDS Coordinator and the		
	Ū			MDS Consultant completed a		
		erly Minimal Data Set (MDS)		MDS assessments by 5/17/17		
	dated 4/3/17 revealed			residents requiring the use of		
	moderately cognitive	• • •		catheters, residents with weig		
	incontinence was not catheter was not chee	<b>.</b>		the last 6 months, residents w experienced a fall in the last 6		
	assessment.			and residents who have a PAS		
		erved on 4/22/17 at 2:43		status to ensure they were co		
		l an indwelling urinary		on the most recent comprehe		
	catheter in place.			assessment. Corrective action		
		interviewed on 4/22/17 at		completed as indicated by the Coordinator.	MDS	
	4:30 PM. She stated			C. Education was provided to	the MDS	
		heter. She stated that she		Coordinator on 4/24/17 by the		
		lling urinary catheter on the		MDS Consultant regarding the	-	
		ated she would make a		of correct coding of MDS asse		
	correction to the MDS	3.		D. The Regional MDS Consu Director of Nursing will comple		
	The Administrator wa	s interviewed stated on		of 10 Resident s MDS asses		
	4/22/17 at 6:22 PM. H	le stated he would expect		monthly for 3 months to ensur		
	that the MDS was con	rrect and coded to the		coding. The MDS Coordinator	will present	
	resident's condition.			findings of the above stated a		
	0 Desident #004			Quality Assurance Performant		
		s admitted on 12/6/16 with nsion and a past cerebral		Improvement Committee (QA for 3 months for recommenda		
	vascular accident.	noion and a past cerebial		further follow-up as indicated.	uono anu	
		2/23/17 stated the resident				
		was 98 pounds. The resident				
	was on a regular diet	with fortified foods and				
	supplements.					

Facility ID: 923268

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &				FOF	ED: 06/08/2017 RM APPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
	345225	B. WING		04	C 4/26/2017
NAME OF PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATURE HEALTHCARE OF C			1602 E FRANKLIN STREET		
SIGNATURE REALTIOARE OF C			CHAPEL HILL, NC 27514		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
<ul> <li>3/17/17 revealed the of weight loss in the more weight loss in the more weight loss in the a physician prescriber. The resident had a construction of the MDS nurse was 2:57 PM. She stated hospice and had a d MDS was completed K of the MDS. The reside weight loss. The MD code section K. She end of the MDS state completed and accurshould have been constructed by the section K was not coded that section of the Kas not code that section of the MDS and not sig However, there was data entry error. She section but typically MDS and update the The Administrator wa 4/22/17 at 6:22 PM.</li> </ul>	nificant change MDS dated e resident had a 5% or more last month, or loss of 10% or the last 6 months and was on ed weight loss regimen. care plan last updated on al decline and hospice care. a interviewed on 4/20/17 at d the resident was put on ecline so a significant change d. The dietitian coded section esident was not on a l weight loss regimen. Int did have a significant S nurse stated she did not stated she only signed the ing that her section was rate. She stated the resident oded as having a 5% weight as not on a physician ss regimen. She also stated ever signed by whomever	F 278			

Facility ID: 923268

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 APPROVED
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345225	B. WING			C 04/26/2017	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	e 47	F	278			
	facility on 5/12/2014 v	originally admitted to the with cumulative diagnoses tes and seizure disorder.					
	Medical record review experienced a fall to t	v revealed Resident #4 the floor on 3/28/17.					
	assessment dated 4/2						
		017 at 3:12 PM with the MDS correct code on the MDS					
		017 at 4:24 PM with the d his expectation was the					
	,	admitted to the facility on of second s					
	Resident #111 reveale catheter care every sl bag monthly, secure to	2017 physician orders for ed orders to provide urinary hift, change urinary catheter urinary catheter with leg change urinary catheter as					
		sion MDS, dated 4/6/17, for ed that her urinary catheter MDS.					
	A review of the care p Resident #111 reveale						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345225	B. WING _				C 26/2017	
NAME OF P	ROVIDER OR SUPPLIER		•		REET ADDRESS, CITY, STATE, ZIP CODE			
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			602 E FRANKLIN STREET HAPEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 278	complications related bladder elimination. An observation of Res 9:20 am revealed she catheter. An interview with the 9:38 am revealed that urinary catheter. She the catheter as an ap comprehensive asses 5) Resident #49 was 11/7/15 and her diagr and end stage renal of A review of the PASR form dated 9/22/14 re was determined to be expiration date was in A review of the annual dated 10/7/16 for Res MDS was not coded find An interview with the 4/22/17 at 8:47 am re had been a PASRR le admitted to the facility An interview with the 9:34 am revealed tha 10/7/16 for Resident a correctly for PASRR I 483.24, 483.25(k)(I) F	to indwelling catheter for sident #111 on 4/22/17 at a had an indwelling urinary MDS nurse on 4/22/17 at t Resident #111 had a stated she missed coding pliance on her admission asment dated 4/6/17. admitted to the facility on noses included depression disease. R determination notification evealed that Resident #49 a PASRR level 2. No dentified. Al comprehensive MDS sident #49 revealed that the for PASRR level 2. Social Services Director on vealed that Resident #49 evel 2 since she was 7. MDS nurse on 4/22/17 at t the annual MDS dated #49 had not been coded evel 2. PROVIDE CARE/SERVICES		278	DEFICIENCY		5/31/17	
SS=J	FOR HIGHEST WELI	L BEING						

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 06/08/2017 MAPPROVED O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED C
		345225	B. WING		04	
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	483.24 Quality of life Quality of life is a fun applies to all care and residents. Each resid facility must provide t services to attain or r practicable physical, well-being, consisten comprehensive asses 483.25 Quality of care Quality of care is a fun applies to all treatment facility residents. Base assessment of a resid that residents received accordance with profi- practice, the comprehi- care plan, and the residents consistent with profess the comprehensive p and the residents' good (I) Dialysis. The facility residents who requires services, consistent w of practice, the compre- care plan, and the residents' good (I) Dialysis. The facility residents who requires services, consistent w of practice, the comp care plan, and the residents' good (I) Dialysis. The facility residents who requires services, consistent w of practice, the comp care plan, and the residents' preferences. This REQUIREMENT by:	damental principle that d services provided to facility dent must receive and the he necessary care and maintain the highest mental, and psychosocial t with the resident's asment and plan of care. e ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered sidents' choices, including following: t. ure that pain management is who require such services, esional standards of practice, erson-centered care plan, als and preferences. ity must ensure that e dialysis receive such with professional standards rehensive person-centered sidents' goals and is not met as evidenced iew, staff and paramedic staff left a resident in	F 309	F309: A. On 4/5/17 Resident # 67 wer outing with activity assistant and		

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	06/08/2017 APPROVED 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		345225	B. WING		C 04/2	6/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• •	
				1602 E FRANKLIN STREET		
SIGNATUR	RE HEALTHCARE OF CH			CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	Continued From page	<u>a</u> 50	F 30	19		
F 309	gasping for air (Resid Immediate jeopardy b Resident #67 was our outing to a local ice c air after eating an ice home staff left the res not initiate emergency immediately. The imm removed on 4/22/17 v acceptable credible a facility will remain out and severity level of D potential for more tha immediate jeopardy) systems put into plac Findings Included: Resident #67 was ad 9/12/12 and her diagr torticollis (a chronic n disorder causing the the left, right, upward dysphagia and postur	ency medical services for a resident g for air (Resident #67). liate jeopardy began on 4/5/17 when ent #67 was out of the facility on an activity to a local ice cream shop, was gasping for er eating an ice cream cone, and nursing staff left the resident unattended and did iate emergency medical services liately. The immediate jeopardy was ed on 4/22/17 when the facility provided an able credible allegation of compliance. The will remain out of compliance at a scope everity level of D (not actual harm with the ial for more than minimal harm that is not liate jeopardy) to ensure monitoring ns put into place are effective.		<ul> <li>interns, resident # 67 began gas air, activity assistant went to obt approximately 100 feet away, le Resident # 67 with two activity in one intern called 911. Emergen Medical Service (EMS) arrived, Resident # 67, applied oxygen a bagged resident, and transporte Resident # 67 to Hospital. Resi admitted to hospital.</li> <li>B. All residents on the outing we assessed for any change in con the Director of Nursing (DON), A Director of Nursing (ADON), on other concerns identified. All re with a sudden change in conditi the potential to be affected by th deficient practice. Residents wi change in condition have been by the DON, ADON, Staff Devel Coordinator to ensure that any of have been identified and approp follow up completed.</li> <li>Activity assistant was educated Staff Development Coordinator on identifying an emergency situ which included recognizing an e situation episode that maybe characterized by apnea, difficult breathing, respiratory distress, o change, change in muscle tone,</li> </ul>	tain water aving interns, incy suctioned and ed dent was ere dition by Assistant 4/5/17 no esidents on have his alleged th a reviewed lopment changes priate by the on 4/22/17 uation emergency	
	was active and at risk evidenced by refusal	4/17 revealed Resident #67 for behavior problems as to follow Medical Doctor		or gagging, calling 911 immedia staying with the resident.	itely and	
	dysphagia due to neu diet texture downgrad	her (NP) orders related to Iralgia. Resident #67 refused de and a swallow study. The nt #67 would have fewer		C. The facility Administrator, DC Unit Managers, Nursing Superv Minimum Data Set Coordinator Staff Development Coordinator	isor, (MDS),	

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		MEDICAID SERVICES				B NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		DATE SURVEY COMPLETED
		0.45005				С
		345225	B. WING			04/26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page	9 51	F 30	99		
F 309	<ul> <li>episodes of choking/a behavior occurring lesi included report to phy behavioral status. Ant provide for the reside Dietitian (RD) and Sp needed.</li> <li>An entry in the nursin revealed Resident #6 while taking her medi- in vanilla pudding. Co cardiopulmonary resu- initiated. She was abl again. An order was r x-ray which came back A telephone interview the ST that treated Re- had last treated her in week. She stated that of choking.</li> <li>An entry in the nursin Resident #67 was ser University of North Carolina (UN outing at an ice crean aspiration.</li> <li>A review of the emerge (EMS) patient care re</li> </ul>	aspiration as evidenced by as than weekly. Interventions visician changes in ticipate care needs and nt. Refer to Registered eech Therapist (ST) as g notes dated 1/27/17 7 had an episode of choking cations which were crushed de blue was called and iscitation (CPR) was e to start breathing normally received to obtain a chest ck negative for aspiration. To n 4/21/17 at 9:45 am with esident #67 revealed she n late January for about a t Resident #67 had a history g notes on 4/5/17 revealed nt by ambulance to IC) hospital from an activity in shop due to potential	F 30	Director of Dining Ser Office Manager, Soci Central Supply, Chap Marketing/Admission Services Manager (R Records Staff were e Regional Nurse Cons the policies and proce threatening events. 1 assessment indicates necessary and 2) Nor facility pending locati- event. The above tra face to face in order to discussion and quest procedures and proce administrative manage work until education i Once the facility Adm ADON, Unit Mangers Supervisors, MDS co Director of Dining Ser office manager, Socia Central Supply, Chap Marketing/Admission records were educate policies and procedur they were then assign Nursing staff, nursing Staff, Activities, Main Housekeeping staff w 4/22/17. No employed	ial Services Director, blain, is Director, Rehab RSM), and Medical educated by the sultant on 4/22/17 on edures regarding life ) Call 911 if initial is such action is tify physician and on of life threatening aining was performed to facilitate tion on policies, esses. Department gers can t return to is provided. hinistrator, DON, is, Nursing bordinator, SDC, rvices, Business al Services Director, blain, is, RSM, and medical ed on the above res and processes ned to re-educate, g assistants, Dietary tenance and which started on ie will be allowed to	
	ice cream shop at 2:4 EMS was dispatched Rescue (FR) arrived of and obtained history of (the facility Activity As	d that they arrived at local 5 pm. The report stated that for cardiac arrest. The Fire on scene prior to ambulance of the event from bystanders sistant and intern volunteer). ') had just gotten ice cream		work until education i education will be inclu orientation process for members. No newly be allowed to work un provided.	uded in the or all newly hired staff hired employee will	

Facility ID: 923268

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IES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. (X3) DATE S	URVEY
N	IDENTIFICATION NUMBER:	A. BUILDING			ETED
	345225	B. WING			6/2017
SUPPLIER				04/2	0/2017
CARE OF CH	IAPEL HILL		CHAPEL HILL, NC 27514		
CH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	ILD BE	(X5) COMPLETIO DATE
bup from her rs stated sho on of breath lmonary res by bystander e and found re only to pa ued CPR. At on 10 liters of aturation lev level of resp er than this" rs knew very ent of patient w non-verbal a er breathing ly slow with e. She had kin appeare ts administed ted as place ns assisted ation of 5 m us administr ers (cc) of no tal emergen nterview wa 6/17 at 10:4	r care facility when her e became apneic (temporary ing) and unresponsive. uscitation (CPR) was rs at that time. FR arrived at the patient breathing but inful stimuli and t that time FR placed of oxygen and status post rel was 90%. Patients onsiveness was not known, per bystanders. Per FR y little about resident. In by Paramedic revealed vas sitting in her wheelchair. and responsive to painful y was shallow and a respiration rate (RR) of 8 strong radial pulses present d pale and waxy. ered to patient were ement on 10 liters of oxygen, via bag valve mask, illigrams (mg) of albuterol, ration of 300 cubic ormal saline and transport to cy department.	F 30	9 D. A Quality Assurance (QA) meet be held weekly beginning on 5/4/17 weekly for 4 weeks, then monthly t months for recommendations and f follow up regarding the above state At that time based upon evaluation Committee will determine at what frequency any ongoing audits will r continue. The Administrator has th oversight to ensure an effective pla place to meet resident wellbeing ar ensure quality of care and quality of being delivered as well as an effect plan to identify facility concerns and implement a plan of correction to in all staff of the facility. Corporate Administrative oversight of the Qua Assurance meeting will be complet the Special Projects Administrator, Regional Vice President of Operati	7, then imes 2 further ed plan. the QA need to ne in is in nd of life is tive d ivolve ality ed by the ons, or	
	SUPPLIER SUPPLIER ICARE OF CH SUMMARY ST ACH DEFICIENC GULATORY OR Dup from here is stated shi on of breath Ilmonary res by bystander e and found ve only to pa ued CPR. At on 10 liters of aturation lev level of resp er than this" rs knew very ient of patient w non-verbal a ler breathing Ily slow with te. She had skin appeare nos assisted ration of 5 m ous administre ons assisted ration on 5 m ous administre on 5 m ous administre on 5 m on 5 m o	CIES       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         SUPPLIER         ACARE OF CHAPEL HILL         SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION)         Add From page 52         Dup from her care facility when her Pres stated she became apneic (temporary on of breathing) and unresponsive.         Ilmonary resuscitation (CPR) was oy bystanders at that time. FR arrived at e and found the patient breathing but we only to painful stimuli and ued CPR. At that time FR placed on 10 liters of oxygen and status post iaturation level was 90%. Patients level of responsiveness was not known, er than this" per bystanders. Per FR ers knew very little about resident. Inon-verbal and responsive to painful ler breathing was shallow and Ily slow with a respiration rate (RR) of 8 te. She had strong radial pulses present skin appeared pale and waxy. Its administered to patient were thed as placement on 10 liters of oxygen, ons assisted via bag valve mask, ration of 5 milligrams (mg) of albuterol, ous administration of 300 cubic ers (cc) of normal saline and transport to ital emergency department.         interview was conducted with Paramedic 26/17 at 10:40 am. She confirmed that responded to the call on 4/5/17 at the ice arlor for Resident #67. She stated that	CIES ON       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPI A. BUILDING         345225       B. WING	IDENTIFICATION NUMBER:       A. BUILDING         SUPPLIER       345225         ICARE OF CHAPEL HILL       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES       ID         SUMMARY STATEMENT OF DEFICIENCIES       ID         GLAFE OF CHAPEL HILL       ID         SUMMARY STATEMENT OF DEFICIENCIES       ID         GULATORY OR LSC IDENTIFYING INFORMATION)       ID         d From page 52       F 309         D. A Quality Assurance (QA) meel       be held weekly beginning on 5/4/17         months for recommendations and 1       follow up regarding the above state         At that time FR paced       Continue.         on 10 liters of oxygen and status post       At that time based upon evaluation         continue. The Administrator has th oversight to ensure quality of care and quality of care and quality of care and quality of palae to meeting will be completing the about resident.         non-verbal and responsive to painful ler breathing was shallow and       ID section to in all staff of the facility. Corporate Administrator, Regional Vice President weekly to the Quality of care and quality or being delivered as well as an effect palae to correction to in all staff of the facility. Corporate Administrator, Regional Vice President weekly times 2.         ued CPR. At that time PR placed on the weeklothair.       Sumarce meeting will be complet the special Projects Administrator, Regional Vice President weeklow is assurance meeting will be comp	DES N       (X1) PROVIDERISUPPLENCIA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE 5         SUPPLER       345225       STREET ADDRESS, CITY, STATE, ZIP CODE         SUPPLER       STREET ADDRESS, CITY, STATE, ZIP CODE       1602 E FRANKLIN STREET         CARE OF CHAPEL HILL       STREET ADDRESS, CITY, STATE, ZIP CODE       1602 E FRANKLIN STREET         SUMMAY STATEMENT OF DEFICIENCES       p.       PROVIDER'S PLAN OF CORRECTION SHOLD BE         CARE OF CHAPEL HILL       PROVIDER'S PLAN OF CORRECTION SHOLD BE         GARD OF DEFICIENCES       p.       PROVIDER'S PLAN OF CORRECTION SHOLD BE         GARD OF DEFICIENCES       PACH OF CORRECTIVA ATTACE       DEFICIENCY         d From page 52       F 309       D. A Quality Assurance (QA) meeting will be held weekly bor and unresponsive.       DEFICIENCY         Imonary resuscitation (CPR) was by bystanders at that time. FR arrived at a and found the patient breathing but we only to painful stimuli and ued CPR. At that time FR placed on 10 liters of oxygen and status post aturation level was 90%. Patients level of responsiveness was not known, er rhan this" per bystanders. PEF FR rs knew very little abour steadent wellobing and ensure quality of care and quality of life is being delivered as well as an effective plan is in place to meet resident wellbeing and implement a plan of correction to involve all staff of the facility. Corporate Administrator, the Regional Vice President of Departions, or member of Regional Staff weekly times 4 weeks, then monthly times 2.         weeks, then monthly times 2.

Facility ID: 923268

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII			(X3) DATE	
		345225	B. WING _				C <b>26/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	ambulance trip to the she did not observe th and that it was not ind #67 was breathing, no and did not require CL not observe that the r not perform any suction She stated that she we facility staff members did not seem to know condition and they we from the facility to brin stated that it was 5 to from the facility arrive A review of the hospit 4/5/17 for Resident #67 unresponsive in the e that Resident #67 wa 4/5/17 with her friends suddenly became unr bystander CRP - unkn pulse. When EMS arr was bagged for 3-4 m A review of the hospit 4/8/17 for Resident #6 septic shock seconda (UTI). An interview on 4/20// Activity Director revea working at the facility when she returned to that the Activity Assist taken Resident #67 o shop on 4/5/17. She s statements of the inci	hospital. She stated that he resident receiving CPR dicated because Resident of well, but was breathing PR. She stated that she did esident was choking and did oning or treatment for that. Vas concerned that the that were with Resident #67 anything about her health ere trying to get someone ing her medical records. She 10 minutes before anyone d with her medical records. The revealed she presented mergency room. It stated is at an ice cream parlor on is from her facility when she responsive. She received hown if she ever lost a ived, she had a RR of 5 and inutes. al discharge summary dated 67 revealed a diagnosis of irry to a urinary tract infection 17 at 10:30 am with the	F	309			

Facility ID: 923268

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 06/08/2017 RM APPROVED IO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345225	B. WING		0	C 4/26/2017
NAME OF PR	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
				1602 E FRANKLIN STREET		
SIGNATU	RE HEALTHCARE OF CH			CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 309	out of the facility for a a list of residents that She stated that a nur- did not always accom and that it depended were going on. A review of the "Off-F dated August, 2007; n provided by the Activi revealed procedure # more members of nur- accompany the activi field trips." An interview on 4/20/ Assistant Activity Dire on the outing with Re stated that she had c on 4/5/17 and decide the ice cream shop. S volunteer interns that students at a local co Resident #67 ordered waffle cone and they cream. She stated Re have any trouble eati When they finished th the facility as it was n (Resident #67 and the wheelchairs and the a volunteers were push Resident #67 started asked her if she need	ally when residents are taken an activity she would provide a were going to the DON. se or nursing assistant (NA) apany them on the outings on the type of outing they Premise Activities" policy revision date January 2009 ity Director on 4/20/17 3 stated "At least one or rsing services will ty director / coordinator on 17 at 10:45 am with the ector revealed she had been isident # 67 on 4/5/17. She ome in to work at 1:00 pm d to take a few residents to She was accompanied by 2 were recreational therapy illege. She stated that d butter pecan ice cream in a all sat outside to eat their ice esident #67 did not appear to ng her ice cream cone. hey started to walk back to	F 3			
	which took approximation	o get her a bottle of water ately 5 minutes. She stated				
	when she came out o	of the store Resident #67				

Facility ID: 923268

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	
		345225	B. WING				_ 26/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	was opening her mou able to speak and see She stated the intern and the 911 operator information about Res facility to try and get t the 911 operator told laying down and they wheelchair back. She they placed a tube do out a piece of waffle of from the facility arrive after she had called th from red hall came (d stated that Resident # She stated that she h nurse know that she h stated that she did no emergency health pro An interview on 4/20/ revealed she was the 4/5/17. She stated th fine all day. She stated to provide her afterno out that activities had cream. She stated that that they were taking "everyone "(did not el was) knew that Resid swallowing and had o past. An interview with the	th, gasping for air, was not emed to be less responsive. volunteer was calling 911 asked for medical sident #67. She called the he information. She stated them to try and get her were able to lay her estated EMS arrived and own her throat and sucked cone. A nursing assistant d about 5 to 10 minutes he facility and then a nurse idn ' t know her name). She #67 seemed fine all day. ad not let Resident #67 ' s was taking her out. She thave any training in ocedures. 17 at 1:30 pm with Nurse #3 nurse for Resident #67 on at the resident had been ed that she went to find her on medications and found taken her out to get ice at they didn ' t even tell her her out. She stated that aborate on who "everyone" ent #67 had trouble hoked once or twice in the DON on 4/20/17 at 4:20 pm s not in the facility on 4/5/17 the details of what ent #67 that day. She	F	309			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 06/08/2017 APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345225	B. WING _				C 26/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SIGNATU	RE HEALTHCARE OF CH			16	602 E FRANKLIN STREET		
				C	HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 309	4:32 pm revealed that facility from her lunch facility staff member ( stopped her and told l unresponsive down the shop. She stated she medical information a staff. She stated Res put in the ambulance the medical information full code, to EMS. She aware of any further in the facility after the in- An interview on 4/21/1 activities intern / volur accompanied Resider ice cream shop. She finished their ice creat the residents back to #67 started gasping for Activity Assistant wen something to drink. W #67 seemed to be get 911. She stated the re- breathing. She stated volunteering at the fac and that she did atten orientation. She stated any training at the fac response. A follow-up interview of the Assistant Activity I had not received any maneuver or any eme	Manager #1 on 4/20/17 at a she was returning to the break on 4/5/17 and a could not remember who) her that Resident #67 was he street at the ice cream a obtained Resident #67 's ind brought it to the EMS ident # 67 had already been by that time. She provided on, including that she was a e stated that she was not herventions or follow-up by cident. 17 at 1:00 pm with the heter revealed that she had ht #67 on the outing to the stated that everyone had m and they were walking the facility when Resident or air. She stated that the t to get Resident #67 'hile she was gone Resident ting worse and she called esident did not stop I that she had been cility since January 2017 d the facility general d that she did not receive ility on emergency medical on 4/21/17 at 2:30 pm with Director revealed that she training on the Heimlich ergency medical training.	F3	.09			
	the Activity Assistant a	and the activities intern					

Facility ID: 923268

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
		345225	B. WING				C / <b>26/2017</b>		
NAME OF P	ROVIDER OR SUPPLIER	L	<b>I</b>		STREET ADDRESS, CITY, STATE, ZIP CODE	• -			
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 27514					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ЗE	(X5) COMPLETION DATE		
F 309	volunteers provided b events as obtained in An interview on 4/21/ Development Coordir activity staff are not tr technique or how to re emergencies because clinical capacity. She attend the facility gen does not include any such as the Heimlich An interview on 4/21/ Administrator reveale aware of the incident involving Resident #6 discussed Resident # the next day in the me that this was an isolat additional investigation On 4/21/17 at 4:25 pr informed of the imme provided a credible al pm. The allegation of On 4/5/17 Resident # activity assistant and began gasping for air obtain water approxin Resident # 67 with tw called 911. EMS arriv 67, applied O2 and ba transported Resident was admitted to hosp	by the DON confirmed the their interviews. 17 at 2:00 pm with the Staff hator revealed that the rained in the Heimlich espond in medical e they don't work in a stated that volunteers do eral orientation, but this medical emergency training maneuverer. 17 at 3:45 pm with the d that he was somewhat that occurred on 4/5/17 i7. He stated that they had 67's swallowing difficulty orning meeting. He stated ted incident and that no on was completed. m, the administrator was diate jeopardy. The facility llegation on 4/23/17 at 2:00 f compliance indicated: 67 went on outing with two interns, resident # 67 , activity assistant went to nately 100 feet away, leaving to activity interns, one intern ved, suctioned Resident # agged resident, and # 67 to Hospital. Resident	F	309					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/08/2017 APPROVED D. 0938-0391
STATEMENT OF DEFI AND PLAN OF CORRE	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		SURVEY LETED
		345225	B. WING					C 26/2017
NAME OF PROVIDE	R OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE			
	ALTHCARE OF CH				1602 E FRANKLIN STREET			
SIGNATURE HE	ALTHCARE OF CH				CHAPEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE		(X5) COMPLETION DATE
4/5/1 with poter pract have Deve chan follow Activ Deve ident recog mayb breat chan callir resid The Mana Staff Serv Serv Serv Mark Mana educ 4/22/ life th perfo discu and p	a sudden change ntial to be affecte tice. Residents w e been reviewed b elopment Coordin ages have been ic w up completed. vity assistant was elopment Coordin tifying an emerge gnizing an emerge gnizing an emerge gnizing an emerge be characterized thing, respiratory age in muscle tone ong 911 immediate lent. facility Administra agers, Nursing Su i Development Co- cices, Business O- ices Director, Cen keting/Admissions ager, and Medica cated by the Regio /17 on the policies hreatening events ssment indicates 2) Notify MD and hreatening event. ormed face to face ussion and questi processes. Depai agers can ' t retur ided.	e 58 erns identified. All residents e in condition have the d by this alleged deficient vith a change in condition by the DON, ADON, Staff lator to ensure that any dentified and appropriate educated by the Staff lator on 4/22/17 on ncy situation which included ency situation episode that by apnea, difficulty distress, color change, e, choking or gagging, ly and staying with the tor, DON, ADON, Unit upervisor, MDS Coordinator, bordinator, Director of Dining ffice Manager, Social ntral Supply, Chaplain, b Director, Rehab Services l Records Staff were onal Nurse Consultant on s and procedures regarding s. 1) Call 911 if initial such action is necessary facility pending location of The above training was e in order to facilitate on on policies, procedures rtment administrative in to work until education is nistrator, DON, ADON, Unit	F	309				

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M					FORM	D: 06/08/2017 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
	345225	B. WING				C /26/2017
NAME OF PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATURE HEALTHCARE OF CH	APEL HILL			1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
SDC, Director of Dinin manager, Social Servi Supply, Chaplain, Mar and medical records w policies and procedure then assigned to re-ee nursing assistants, Die Maintenance and Hou started on 4/22/17. No to work until education education will be inclu process for all newly h newly hired employee education is provided. The credible allegation 5:02 PM. The Activity on 4/23/17 at 4:16 PM the education she recor residents who attende those who had not atter reviewed. Communic created for every reside The change of conditivi it was noted life threat In-service topics inclue emergency events. S reviewed. Random st including a unit secret aide/activity assistant 4:32 PM and 4:56 PM received in-services. Coordinator was interva	bervisors, MDS coordinator, ng Services, Business office ices Director, Central rketing/Admissions, RSM, vere educated on the above es and processes they were ducate, Nursing staff, etary Staff, Activities, use Keeping staff which o employee will be allowed in is provided. This ided in the orientation nired staff members. No will be allowed to work until in was verified on 4/23/17 at Assistant was interviewed I and was able to describe eived. Assessments of the ed the activity, as well as ended the activity were ation forms (SBAR) were dent that was assessed. on policy was reviewed and tening events were defined. ded elder outings and ign-in sheets were atif in the nursing home ary, licensed nurse, nurse were interviewed between	F	309			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION		PLETED
		345225	B. WING				C /26/2017
NAME OF PI	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUR	RE HEALTHCARE OF CH			1	602 E FRANKLIN STREET		
OIGNAIO				C	HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From page	e 60	F	312			
F 312 SS=D		RE PROVIDED FOR		312			5/31/17
	activities of daily living services to maintain of personal and oral hyo This REQUIREMENT by: Based on record revi- and resident interview provide a shower, tra- bed, and toileting ass reviewed for activities (Resident #36, Resid Findings included: 1.)Resident #36 was 2/19/12 and had the f stenosis, anemia and The resident had a ca- updated 3/12/17 for A goal stated the reside care and be clean, gr Resident's choice thru Interventions included assistance/supervisio for all ADLs. Resident #36's Minim 3/30/17 revealed the	is not met as evidenced iew, observation and staff vs, the facility failed to nsfer from wheelchair to sistance to 2 of 8 residents s of daily living (ADL) ent #97). admitted to the facility following diagnoses of spinal I hypertension. are plan in place last ADLs self-care deficit. The ent would participate with roomed and dressed by the ough next review.			F312: A. The Director of Nursing completed interviews for resident #24 and #36 on 5/19/17, regarding the alleged deficient practice of providing care needs includ showers and toileting needs being met and addressed appropriately. Residen #97 no longer resides in the facility. B. Residents with Brief Interview Men Status (BIMS) 8 or > were interviewed the Social Services Director, Director o Nursing (DON), Assistant Director of Nursing (ADON), Unit Coordinator, Administrator, MDS Coordinator, Staff Development Coordinator, Dietary Manager, Business Office Manager, Central Supply, Admissions Director, Rehabilitation Service Manager and Chaplain to assure their care needs (toileting and showers) are being met. This was completed by 5/19/17). Any concerns identified were addressed. A residents with BIMs of 7 or < were assessed to assure that their care need are being met as outlined per the	t tal by f	
	bathing. The MDS sp frequently incontinent	ndent on staff assistance for becified the resident was t of bowel and bladder.			residents care plan by the Director of Nursing, Assistant Director of Nursing, Unit Coordinator, or Signature Care Consultant. Any findings were forward		
	Review of Resident #	36's shower schedule			to the DON to ensure corrective actions	5	

Event ID: HXZN11

Facility ID: 923268

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		MEDICAID SERVICES				1	<u>IO. 0938-03</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	1 Y	TE SURVEY MPLETED
				_			С
		345225	B. WING			0	4/26/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH			16	602 E FRANKLIN STREET		
SIGNATO	RE HEALTHCARE OF C			С	HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 312	Continued From page	e 61	F ?	312			
	revealed the resident			512	are completed.		
	Wednesday and Satu						
		nt's Activities of Daily Living			C. Nursing staff (Licensed Nurses and	t	
		nower assignment sheets			Certified Nursing Assistants) will be in		
	revealed the resident			serviced and re-educated regarding			
-	any kind of bath on S	aturday 4/15/17.			Activities of Daily Living care and corre	ect	
					documentation. Education will be		
		in the resident's medical			completed by 5/31/17 by the Staff		
		the resident got a shower or			Development Coordinator (SDC), Dire		
	bath of any kind on S	aturday 4/15/17.			of Nursing, or Regional Nurse Consult		
	Number Assistant (N)	A) #F was interviewed on			to address the importance of and polic		
		A) #5 was interviewed on She stated that they were			expectations of meeting residents care needs to include bathing/showers,	;	
		Saturday 4/15/17 and she			incontinent care and any other reasona	ahle	
		e stated that none of the			care needs the resident may have.	abic	
		a shower on Saturday on			Secondly, the Administrator, DON, AD	ON.	
		She had teamed up with the			Unit Coordinator, Licensed Nurse will	,	
		baths done with all other			review daily staffing sheet to ensure		
	residents because the	ere wasn't enough staff. She			sufficient staffing is scheduled to meet	the	
	stated she worked 16	b hours that day.			care needs of each resident.		
		erviewed on 4/22/17 at 1:49			D. Care delivery audits will be complet		
		ally wanted a shower last			for bathing/showers, and incontinent c	are;	
	-	ne resident stated it didn't			audits will be conducted 5 per day x 4	_	
	nappen because the	re was not enough staff.			weeks, 3 per day x 4 weeks, then once weekly x 4 weeks. Any deficit in care		
	Nurse #5 was intervie	ewed on 4/22/17 at 11:36			delivery will be reported to DON, ADO		
		she worked last Saturday			Regional Nurse Consultant and		
		4/16/17 and the Nursing			reeducation provided to assure		
		t staffed. She stated the			understanding and importance of		
	nursing assistants go	t to everyone to provide care			providing good quality care in a timely		
	the best they could. S				manner. Results of audits or trends		
	-	showers were missed, but			identified will be addressed by the Qua	-	
		nat did not get completed.			Assurance Committee (QAPI) committ		
		e really short staffed on the			for 3 months as they arise and the plan	n	
		call nurse never came in.			will be revised to ensure continued		
		is interviewed on 4/22/17 at			compliance. The QAPI committee	20	
		hat he would expect for staff			consists of the Administrator, DON, SE	JC,	
	for take care of the re	esidents' needs.			Minimum Data Coordinator (MDS),		1

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/2017 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345225	B. WING				C / <b>26/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUR	RE HEALTHCARE OF CH			16	602 E FRANKLIN STREET		
GIGINATO				С	HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From page	e 62	F	312			
	current diagnoses of hypertension. The resident's MDS of was moderately cogn required extensive as transfers, locomotion and personal hygiene continence and was f bowel. The resident had care for Activities of Daily I that the resident required 2 person with toilet us dependence for trans Resident #97 was sitt room on 4/20/17 at 10 that she had been wa had been waiting an staff before 9:00 PM and bed but was still always used the bedy resident appeared to and was moving arou she was uncomfortab day clothes on.	requently incontinent of e plans last updated 3/8/17 Living. Interventions included ired extensive assistance of se, bed mobility, and total fers. ting in her wheel chair in her 0:17 PM. The resident stated atting to use the bedpan and hour. She stated she asked to get her to the bathroom waiting. She stated she ban or bathroom. The be holding back from crying and in her wheelchair as if ole. The resident still had her			Admissions Coordinator, Medical Director of Social Services, Quality of Director, Chaplain, and Environmenta Service Director.	Life	
	On 4/20/17 at 10:45 F	hair in her room for staff. PM, the resident was vheelchair to her bed with					
	the assistance of 2 st lift. When the nursing the bedpan out of the started to scream "hu	aff members via mechanical assistant (NA) went to get bathroom the resident urry, hurry, I have to go". The on the bedpan and urinated.					

Facility ID: 923268

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		IO. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	CON	<b>IPLETED</b>
						С
		345225	B. WING			4/26/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
SIGNATU	RE HEALTHCARE OF CI	HAPEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 312	Continued From pag	e 63	F 31	2		
1 512		aned, changed into her	FJI	2		
	pajamas and repositi					
	NA #6 was interviewe	ed on 4/20/17 at 11:12 PM.				
	She stated the reside	ent always needed				
		ople with the lift for transfers				
		d she was rarely incontinent. ys had to find someone to				
	•	dent. She stated that tonight				
	-	ent told her she wanted to				
	•	old the resident it was going				
		e she had other people to				
		ack to her. She stated the bedpan before getting to the				
	bed.	bedpan before getting to the				
	-	y member was interviewed				
		PM. The resident's family				
		he resident told him that she cometimes for them to				
		He stated the resident had				
		ened again last night and she				
		ne to use the bed pan and				
		ng time for the staff to take				
	-	n. He stated he knew they				
		nd the resident has had an because they could not get				
	her the bedpan in tim					
		erviewed again on 4/22/17 at				
		d that she had to wait last				
	night and on 4/21/17 too. She added on Thursday night, 4/20/17, she had used her call bell to call	-				
	•	that the staff never came.				
		were ignoring her and that				
	made her feel mad.					
	The administrator wa	as interviewed stated on				
	The automistrator Wa		1	1		1

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	URVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLE	
					c	
		345225	B. WING		04/2	6/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUI	RE HEALTHCARE OF CH	APEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 312	Continued From page	9 64	F 312	2		
		are of the residents' needs.				
F 323 SS=J	483.25(d)(1)(2)(n)(1)- HAZARDS/SUPERVI	(3) FREE OF ACCIDENT SION/DEVICES	F 323	3	5	5/31/17
	(d) Accidents. The facility must ensu	(d) Accidents. The facility must ensure that -				
	(1) The resident envir from accident hazards	onment remains as free s as is possible; and				
		eives adequate supervision es to prevent accidents.				
	appropriate alternative bed rail. If a bed or simust ensure correct in	ails, including but not limited				
	(1) Assess the reside from bed rails prior to	nt for risk of entrapment installation.				
		nd benefits of bed rails with nt representative and obtain or to installation.				
	This REQUIREMENT	ed's dimensions are sident's size and weight. i is not met as evidenced				
	medical record review the cause of the front and failed to intervene exit-seeking behavior	exited the building for 1 of 1 sident #166) identified to be		F323: A. Resident # 166 was noted by st be outside on the sidewalk by the ri- side of the building on 4/10/2017. Resident # 166 was assisted back facility by the Certified Nursing Ass on 4/10/2017 at approximately 10:0	ehab to the istant	

Event ID: HXZN11

Facility ID: 923268

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	S	COMPLETED
			5.14/110		С
		345225	B. WING		04/26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SIGNATU	RE HEALTHCARE OF CH	HAPEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 27514	
		TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE
F 323	Continued From page	e 65	F 32	23	
	maintain the receptad		_	and placed at the nurses statior	n for
		entially flammable items in		closer monitoring at approximatel	
	the designated reside	ent smoking area. This had		PM. The Charge Nurse assisted	
		ct 6 of 6 residents that were		resident to bed. The Charge Nurs	
	currently identified as	s smokers.		changed the bed linens and provi	
				incontinent care for the resident.	-
	1 Immediate ieonard	ly began on 4/10/17 at 10:28		nurse performed an assessment resident #166 during care, no nev	
		166 exited the building		were noted at this time. The Res	
		the front door of the facility.		responsible party and physician v	
	-	en identified as having		notified of incident by the charge	
		r and was wearing a wander		4/10/17. Resident #166 was mor	
		nitting device placed on a		every hour for the rest of the nigh	t by the
		kle, which would trigger an		charge nurse.	
		in close proximity to an exit m sounded when Resident		A review of the resident smoking	area was
		facility's front door, but a staff		completed by the Administrator a	
		alarm from a remote location		Maintenance Supervisor on 5/19/	
		g Station) using a reset		receptacle for cigarette butts was	
		ying the reason why the		replaced with a red can that appr	
		vated and without intervening		opens and closes. A larger sign v	
		nt. A credible allegation of		placed on the receptacle to speci	-
		oted. Immediate jeopardy 2/17 at 7:23 PM for F323.		was to be utilized only for cigaret	
				resident smoking area by the	
	The facility remains of	out of compliance at a lower		Maintenance Director on 5/19/17	The fire
	scope and severity of	f E (pattern with no actual		blanket was removed, cleaned, a	nd
		ial for more than minimal		replaced by the Maintenance Dire	ector on
		ediate jeopardy), for the		5/19/17.	
		taff training and to monitor its		P A boad count of the entire for	ility was
	corrective action to e	into place for residents at		B. A head count of the entire fact conducted on 4/11/2017 at 12:00	-
	risk for elopement and procedures for responding			by the charge nurses. All residen	-
		it is activated. The facility		accounted for and were safe. On	
		liance to complete corrective		4/11/2017 all exits were checked	by the
		e maintainence of the		plant operations assistant. All ex	
		uishing cigarettes in the		were found to be functioning prop	-
	smoking area.			4/11/17, all resident wanderguard	
				checked for placement and functi	oning by

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345225	B. WING				C 26/2017
NAME OF PF	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUR	RE HEALTHCARE OF CH			16	602 E FRANKLIN STREET		
JONATON				С	HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 323	Continued From page	9 66	F	323			
	Findings included:			020	the Charge Nurses and Central Suppl Clerk and all were properly functioning	j.	
	3/6/17. The Hospital 3/6/17 indicated the r diagnosis of a brain n	the hospital from 2/23/17 - Discharge Summary of esident had a discharge nass. He had a secondary			All residents were reassessed for risk elopement on 4/12/2017 by Assistant Director of Nursing, and Director of Nursing (DON). No new residents we	re	
	diagnosis of seizures The resident was disc	charged from the hospital			identified as being at risk for elopement Care plans and care cards were review and updated as indicated for the 8		
	and admitted to the factor cumulative diagnoses	•			residents identified as being at risk for elopement on 4/21/2017 by Social Services Director, or Staff Developme		
	communication defici	t. ent's medical record included			Coordinator (SDC). The binders whic identify residents who are at risk for elopement were reviewed by the	h	
	a Nursing Admission	Assessment completed on lent included an Elopement			Administrator and Social Services Dire to ensure that they were updated and		
	independently mobile	h indicated the resident was , had the ability to exit the mined to not be at risk for			place at each nurse□s station and at t receptionist□s desk on 4/13/2017, all were found to be in place and correct.		
		#166 was assessed to be			4/21/2017, Plant Operations Assistant contacted an outside vendor for service	ce to	
		#166's admission Minimum ssment dated 3/13/17			dismantle the reset button located at t red hall nursing station. The service of for dismantling the reset button will be	all	
	revealed the resident daily decision making	had intact cognitive skills for . No wandering behaviors			part of the plan of correction. In the meantime, the reset button at red hall		
	month prior to admiss extensive assistance	vas reported within the last sion. The resident required for all of his Activities of vith the exception of being			nursing station was covered and a sig was placed informing staff Do Not Use Button on 4/22/2107 at 1145 am, by S Development Coordinator and Plant	9	
	independent for eatin				Operations Assistant.		
	(CAA) Summary date resident had a history	ent's Care Area Assessment d 3/14/17 revealed the of seizures and altered his hospitalization. No were noted.			6 residents who are identified as resid who smoke have the potential to be affected by the alleged deficient practi A review of the resident smoking area completed by the Administrator and	ce.	
					Maintenance Supervisor on 5/19/17. 1	he	

Event ID: HXZN11

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						NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	DATE SURVEY
			A. BOILDING	J		С
		345225	B. WING			04/26/2017
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO	DE	0.120.2011
				1602 E FRANKLIN STREET		
SIGNATU	RE HEALTHCARE OF CH	1APEL HILL		CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 323	Continued From page	<u>- 67</u>	F 32	23		
. 020	On 3/29/17, a		1 52	receptacle for cigarette butt	5 W26	
	,	d-Appearance-Review		replaced with a red can that		
		ion Form indicated the		opens and closes. A larger		
		e in condition. The SBAR		placed on the receptacle to		
		had a positive urinalysis for		was to be utilized only for ci		
		on, with symptoms first noted		Another trash can was place		
	on 3/25/17. The resid			resident smoking area by th		
		here was an increase in		Maintenance Director on 5/		
	confusion or disorient			blanket was removed, clean		
				replaced by the Maintenanc		
	On 4/1/17, an Elopen	nent Risk Evaluation was		5/19/17.		
		#4. At that time, the resident				
		e at risk for elopement.		C. Education on elopement	policy	
				including how to respond to		
	A review of Resident	#166's medical record		complete head counts, chec		
		s telephone order was		wanderguard for function ar		
		use a wander guard for the		functioning of doors, and im		
		acement and function every		of care plans related to trigg		
		resident's whereabouts		including elopement risk as		
	throughout the facility			was initiated to all staff on d		
		2		4/21/2017 and will continue	-	
	A review of the reside	ent's medical record included		staff working next shift by A		
	an SBAR Communica	ation Form dated 4/2/17 and		Director of Nursing, Staff De		
	written by Nurse #4.	The SBAR form reported		Coordinator, Quality of Life		
		ecome combative and was		(QOL), Minimum Data Set		
	attempting elopemen	t. Nursing notes on the form		(MDS), Social Services Dire	ctor, Social	
	indicated this change	started on 3/30/17 and had		Services Assistant, Chaplair	n, Customer	
	gotten worse. The re	esident's Mental Status		Experience Director, Dietary		
	Evaluation noted the	resident had an increase in		Manager, Admissions Direc	tor, Plant	
		tation; memory loss; and		Operations Director, Plant C		
		gns of delirium. Additional		Assistant, or Business Offic		
		sident was more confused		The Administrator and Direc		
		e he was or why. The		trained these educators on t		
		be uncooperative with staff		cover for the education on 4		
	and care and had trie	-		Education and return demor		
		elchair with no shoes on.		use of Accutech transmitter		
	-	e on the SBAR read as		check function of wander gu	•	
	follows:			staff competency of wander		
	Resident became co	ombative this AM (morning)		function and battery checks	was initiated	

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		ND HUMAN SERVICES MEDICAID SERVICES					M APPROVE 0. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				E SURVEY IPLETED
		345225	B. WING			04	C I/26/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				16	02 E FRANKLIN STREET		
SIGNATU	RE HEALTHCARE OF C	HAPEL HILL		CI	HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 323	Continued From pag	e 68		323			
1 020				523	an 4/22/2017 by the Plant Oneration		
		arted swinging at staff			on 4/22/2017 by the Plant Operation Director, Plant Operations Assistant		
		ut was incontinent at the bers were able to transfer			Central Supply Clerk/Certified Nursi		
		air and get him to the			Assistant, SDC, or Regional Nurse		
		AM care and put clothes on.			Consultant for licensed nurses and	nurse	
	-	eelchair resident took his			aides. A post-test will be given to st		
		< off and proceeded to front			received the education in which a p		
	door to leave and re	directed back inside facility			score of 100% must be obtained. If	staff	
	÷	ing at staff but able to get			did not receive a score of 100% on		
	-	om front door. Resident then			the staff member will be re-educate		
		door and proceeded to go			the spot and a new post-test will be		
		ied to redirect him telling him			Staff that were not working on 4/22/		
		and he said he hadn't seen			will be educated on the elopement p		
	-	e was leaving now to go out. to be barefoot at that time			and procedure, care plan and use of Accutech by Administrator, Director		
		pit at staff. Resident was			Nursing, Staff Development Coordir		
		bed with 3 staff members			Quality of Life Director, Social Servi		
		needed) given while staff sat			Director, Social Services Assistant,		
		ication began to work and			Dietary Services Manager, Chaplair	۱,	
		et and sleepy. Once asleep			Customer Experience Director,	,	
		vents and wander guard			Admissions Director, Plant Operation	ns	
	placed on resident's	leg."			Director, Plant Operations Assistant	, or	
					Business Office Manager prior to ta	king	
		#166's care plan revealed			their assignment upon return to wor		
	•	en updated on 4/3/17 to			post-test will be given in which a pa	-	
		cus which indicated the			score of 100% must be obtained. If		
		for elopement as evidenced			was not obtained the staff member	WIII DE	
		viors and attributed to			re-educated and a post test will be	or	
		terventions listed on the care audible monitoring system to			reissued. The Administrator, DON, Signature Care Consultant or region		
	· ·	king behavior (dated 4/3/17);			team will review the Post Tests give		
		oring system for proper			weekly for any noted concerns. Any		
		y (dated 4/3/17); and, 11:00			concerns will be addressed immedia		
	PM-7:00 AM sitter (n				Staff who are As Needed, on the Fa	•	
					Medical Leave Act or on leave will r	-	
	Further review of the	e resident's medical record			allowed to return to work until they h	nave	
	included an Interdisc	iplinary Note dated 4/10/17			received Elopement training, the po		
		ad: "The resident is being			is administered and 100% score ob	tained.	
	reviewed by IDT (Int	erdisciplinary) Team for			If employee did not score 100% on		

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F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		ATE SURVEY
					С
	345225	B. WING			04/26/2017
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
			1602 E FRANKLIN STREET		
E REALTHCARE OF CH			CHAPEL HILL, NC 27514		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
Continued From page	<u>&gt; 69</u>	E 33	22		
		F J2		will bo	
	•		-		
	•				
-				•	
•			education is provided, po	st-test	
A review of Resident	#166's medical record		administered and 100% s	core obtained.	
-	-				
•					
•					
delirium.			including that care plans	should reflect	
			nursing assessments. As	sistant Directors	
0	e for the SBAR read as		-		
	•				
			Education was completed	d by the Staff	
			-	-	
	-		-	-	
	-				
				-	
-	-				
	Name of practitioner		cigarette butts. Staff were		
	CORRECTION COVIDER OR SUPPLIER E HEALTHCARE OF CH SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page Elopement/Wandering due to current medica deficits tends to spea and therefore has the good results at this tim guard at this time." A review of Resident included an SBAR Co 4/11/17. The SBAR f the resident's condition noting he had increase elopement. The SBA started on 4/10/17; th had occurred before; last episode was impl guard. Resident #166 reported increased co memory loss; and oth delirium. The Nursing Narrative follows: "Resident noted with in unable to follow direcc his belongings on the himself out of the roo through the main entr members was going f when she noted the ro [Street Name] on a w resident back to the b writer of what had tra working well. Staff w eye on the resident.	CORRECTION IDENTIFICATION NUMBER: 345225 COVIDER OR SUPPLIER TE HEALTHCARE OF CHAPEL HILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 69 Elopement/Wandering at this time as the resident due to current medical status and cognitive deficits tends to speak of leaving this place now and therefore has the wander guard in place with good results at this time. Continue with wander guard at this time. Continue with wander guard at this time. The SBAR form reported a change in the resident's condition occurred on 4/10/17, noting he had increased agitation, confusion and elopement. The SBAR form reported the condition started on 4/10/17; the condition/symptom/sign had occurred before; and the treatment for the last episode was implementation of a wander guard. Resident #166's Mental Status Evaluation reported increased confusion or disorientation; memory loss; and other symptoms or signs of delirium. The Nursing Narrative for the SBAR read as follows: "Resident noted with increased agitation and confusion and even refused hour of sleep care. Resident noted with incoherent speech and was unable to follow directions. Resident scattered himself out of the room. He apparently eloped through the main entrance. One of the staff members was going to her car at about 10:30 PM when she noted the resident trying to cross [Street Name] on a wheelchair. She brought the resident back to the building and informed this writer of what had transpired. Resident had wander guard to left ankle intact. Wander guard working well. Staff were asked to keep a close eye on the resident. [Name of practitioner	CORRECTION       IDENTIFICATION NUMBER:       A BUILDIN         345225       B. WING	CORRECTION         IDENTIFICATION NUMBER:         A BUILDING           345225         B. WING           COVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIF           E HEALTHCARE OF CHAPEL HILL         STREET ADDRESS, CITY, STATE, ZIF           Continued FOR CHAPEL HILL         SUMMARY STATEMENT OF DEFICIENCIES           (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION)         PREFIX           Continued From page 69         F 323           Elopement/Wandering at this time as the resident due to current medical status and cognitive good results at this time. Continue with wander guard at this time.         F 323           Post-test, then employee immediately re-educated education is provided, po administered. This pro continue until employee ( administered. This pro continue until employee ( admin	CORRECTION         IDENTIFICATION NUMBER:         A BUILDING         C           345225         IN WING         ISTREET ADDRESS, CITY, STATE, ZIP CODE           CONDER OR SUPPLIER         ISTREET ADDRESS, CITY, STATE, ZIP CODE         ISTREET ADDRESS, CITY, STATE, ZIP CODE           E HEALTHCARE OF CHAPEL HILL         ISTREET ADDRESS, CITY, STATE, ZIP CODE         ISTREET ADDRESS, CITY, STATE, ZIP CODE           Continued From page 69         ISTREET ADDRESS, CITY, STATE, ZIP CODE         ISTREET ADDRESS, CITY, STATE, ZIP CODE           Continued From page 69         F 323         post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test. No newly hired employee will be allowed to work until education is provided, post-test in employee will be immediately re-educated and post-test re-administered and 100% score on post-test. No newly hired employee will be immediately re-educated and post-test re-administered and 100% score on post-test. No newly hired employee will be immediately re-educated and post-test re-administered and 100% score on post-test. No newly hired employee will be immediately re-educated and post-test re-administered. This process will continue until employee will be immediately re-educated and 100% score on post-test. Assistant Directors of Nursing, and MDS Coordinators were reducated of the Administrator and Director of Nursing on 42/12/17 on completion of care plans on admission, quarterly, and with changes of condition, including that care plans on admission, quarterly, and with changes of condition, including that care plans on admission, quarterly, and with changes of condition, including that care plans on admission,

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		10. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	MPLETED
						С
		345225	B. WING		0	4/26/2017
NAME OF P	ROVIDER OR SUPPLIER	·	·	STREET ADDRESS, CITY, STATE, ZIP	CODE	
CICNATU	RE HEALTHCARE OF CH			1602 E FRANKLIN STREET		
SIGNATU	RE REALINGARE OF G			CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 323	Continued From page	e 70	F 32	23		
		e gave an order for 0.5 mg		regarding ensuring that the	e fire blanket is	
		or IM (intramuscularly) x 1		clean and available for use		
		t already had Ativan 0.5 mg		trash can has been placed		
		t offered the medication and		smoking area for other tra		
		s family called and notified of		D. Beginning 04/22/2017	•	
		said that the companion		be completed each shift by		
		companion never showed		Nurse for wander guard fu	•	
		11:10 pm. At 11:15 pm,		identified residents. Begin		
		ed propelling himself along		the Plant Operations Direc		
		he rehab hall. Resident tried		Operations Assistant will o		
		e rehab hall but was brought exit the building. He did set		doors in the facility daily for functioning and place on the function of the function of the function of the function of the facility of the facility daily for		
		This nurse asked the		function checks will be che	-	
		ed and was ready to go to		days a week for two week		
		I he was ready to go to bed.		times a week for 3 weeks		
		ne resident to bed and he		Administrator, Director of I	-	
		ole shift. Resident checked		Assistant Director of Nursi	-	
	on every hour while in	n bed. Will continue to		Development Coordinator,	Business	
	monitor."			Office Assistant, Human R		
				Director, Dietary Services	-	
		sident #166's care plan		Quality of Life Director, Ad		
		en notation on the care plan		Director, Chaplain, Environ		
	read: "4/11/17 Reside	ent walked to parking area."		Services Director, Social S		
	An interview was een	ducted on 4/20/17 at 4:15		Director, Business Office I	-	
		ducted on 4/20/17 at 4:15 t Director of Maintenance.		Operations Director or Soc Assistant. Beginning 4/21		
		enance was not available for		Operations Director or Pla		
		sistant Director stated all exit		Assistant Department or th		
		adjacent to the door. If the		Nurse will check functionir		
		ered on the key pad, the		wanderguards on all ident	•	
		out activating the door		daily for two weeks. A Co		
	alarm. If the correct of	code was not entered on the		(Elopement Drill) was com	pleted on	
		ase bar on the exit door was		4/13/17 by the Maintenand		
		m would be activated. If the		will continue to be comple	-	
		ease bar was pushed for 15		Maintenance Director, Adr		
		ould open. He reported the		Director of Nursing, or Sta		
		vas the only exit with a		Coordinator as follows: 1 o	•	
		tion. If a resident with a		alternating shifts for one w		
	wander guard came v	within 2 feet or so of the		times/week on each shift f	or one week; 2	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY IPLETED
		345225	B. WING			С
	ROVIDER OR SUPPLIER	040220		STREET ADDRESS, CITY, STATE, ZIP CC		4/26/2017
	CONDER OR SUFFLIER			1602 E FRANKLIN STREET	DE	
BIGNATUR	RE HEALTHCARE OF CI	HAPEL HILL		CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE TE APPROPRIATE	(X5) COMPLETIC DATE
F 323	Continued From pag	e 71	F 32	3		
F 323	door, it would lock do open (as when a visi alarm. If a resident w on the front exit door unlock and continue entered into the key The Assistant Director main entrance (front locked at 9:00 PM to period of time, wheth wander guard, the fro when the door releas release bar was pres would unlock to allow inquiry, the Assistant been no problems wi 5 years he had worke An observation was of 4:25 PM through 4:30 Maintenance Assista 8 facility doors were working order. The r tested with use of an The wander guard in was brought close to who would be respon alarm if it was alarmi "everyone." He note important at night be on those shifts.	wwn. If the door was already tor goes out), the door would vith a wander guard pushed for 15 seconds, it would to alarm until a code was pad adjacent to the door. or of Maintenance stated the exit door) of the facility was 5:00 AM daily. During that er or not a resident had a ont exit door would alarm se bar was pressed. If the used for 15 seconds, the door v someone to exit. Upon Director reported there had th the door alarms during the	F 32.	times/week on each shift for time/week on each shift for times/month on each shift for time/month on each shift for time/month on each shift for time/month on each shift ea A Quality Assurance meetin weekly beginning on 5/4/17, for 4 weeks, then monthly x further follow up regarding the stated plan. At that time base evaluation the QA Committee determine at what frequency audits will need to continue. Administrator has the oversit an effective plan is in place resident wellbeing and ensu- care and quality of life is bei as well as an effective plan facility concerns and implem correction to involve all staff Corporate Administrative ov Quality Assurance meeting completed by the Special Pr Administrator, the Regional of Operations, or member of staff weekly times 4 weeks to month. The Maintenance Director of Maintenance Director will cor rounds of the resident smok 5 times per week x 2 weeks week for 2 weeks, then oncor times 2 week to ensure that	4 weeks; 2 or 4 weeks; 1 4 weeks; 1 ch quarter. g will be held then weekly 2 months for he above and upon the above and upon the will y any ongoing The to meet re quality of ng delivered to identify to dentify the facility. ersight of the will be rojects Vice President f Regional then times 2 r Assistant omplete ing area daily , 3 times per te per week	
	his bed resting. He v	esident was noted to have a		receptacle is in place and fu the lid closed appropriately, ensuring that the red recept being utilized for cigarette b	as well as acle is only	

Facility ID: 923268

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUT	TIPI F	CONSTRUCTION	(X3) DATE	D. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· /	PLETED
				_			С
		345225	B. WING				26/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				16	602 E FRANKLIN STREET		
SIGNATU	RE HEALTHCARE OF CH			С	HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETIO DATE
F 323	Continued From page	e 72	É F	323			
		cility's Administrator. Upon		020	other trash items. Findings of the round	ds	
		ator reported he was aware			will be reported to the Administrator to		
		e building the previous			ensure corrective action is completed		
		ator stated the resident had			immediately for identified concerns.		
	a lot going on and wa	is very anxious. The			Findings of the rounds will be discusse	ed	
	Administration stated	, "It was an isolated			by the Maintenance Director with the		
	incident." He reporte	d the resident had a sitter			QAPI Committee monthly for 3 months	s to	
		ed in and was not present at			ensure continued compliance and for		
		When asked what was done			recommendations and further follow-up	o as	
	-	the Administrator stated the			indicated.		
		el was the first issue to be					
		reported the facility staff had					
		n him more often. He stated					
		ed down quite a bit since.					
	-	exit of the building was 's morning meeting. When					
	asked if anything else						
		s, the Administrator stated					
		his was an isolated incident.					
		ducted on 4/20/17 at 6:05					
		Director of Nursing (DON).					
		arding the incident on					
		nt #166 exited the building					
		N stated that based on					
		the resident went to the					
		d pushed on it, the alarm					
		ne back up the hallway, and came back to the door					
	-	he stated the alarm had not					
		le so it did continue to alarm.					
		at shortly after the alarm					
	-	Assistant (NA) went out the					
		, and then saw the resident					
		how many minutes had					
		en Resident #166 went					
	outside and when he						
							1
	reported she would h	eed to check on the time					

Facility ID: 923268

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	S FOR MEDICARE &				OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	JUNILUTUN	IDENTIFICATION NUMBER.	A. BUILDING	j	
					C
		345225	B. WING	· · · · · · · · · · · · · · · · · · ·	04/26/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE
SIGNATU	RE HEALTHCARE OF CI			1602 E FRANKLIN STREET	
SIGNATO				CHAPEL HILL, NC 27514	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETI IE APPROPRIATE DATE
F 323	Continued From pag	e 73	F 32	3	
1 020			F 32	3	
	of the incident, she s	tated, "Of Sorts."			
		nducted on 4/21/17 at 7:38			
		no worked the evening of			
		Resident #166 exited the			
		ated the resident had anxiety			
	-	on the shift and she had			
		an eye on him. At about			
		evening, she recalled going to			
		t. He was in his room rolling			
		n "stuff." At that point, she			
		lease keep a close eye on			
		ed she was at the 200 Hall			
		an admission for a new			
		eard the facility's front door			
		ated that was around the			
	time the next shift of	staff came in and explained			
	that if a staff member	r coming into the facility put			
	in the code and push	ed on the door bar too soon,			
	the alarm would sour	nd. Nurse #1 stated she			
	could turn off the faci	ility's front door alarm from			
	the nursing station, s	o she did without identifying			
	the cause of the alar	m and she continued to do			
	her work. The nurse	recalled "less than 30			
	minutes later," she sa	aw NA #1 pushing the			
		II in his wheelchair. NA #1			
		s outside and was about to			
		et Name]. She asked the NA			
		uard on and he did. The			
		ured out he had pushed on			
		n to make it open. The			
	-	d as confused at that time			
		his wheelchair by the			
		pervision. The nurse			
		t propel himself down the			
		to open that exit door and it			
		taff reached him before he open the exit door. Resident			

Facility ID: 923268

If continuation sheet Page 74 of 125

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345225	B. WING				C 26/2017
NAME OF P	ROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
SIGNATU	RE HEALTHCARE OF CH	APEL HILL			1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	nurse assisted him to often the front door al night after being locke stated "pretty often." indicated the alarm w a night, and she woul alarm from the Nursin at the door. Upon fur reiterated the residen and the alarm on the asked what staff was door alarm sounded, supposed to go and c need to check on who door. An interview was com AM with the DON upo stated the door alarm at the Nursing Station the alarm was by putt itself. A follow-up interview at 8:15 AM with Nurse nurse pointed out the used to deactivate the the 200 Hall Nursing Station at 9:20 AM with the A Maintenance. Upon inquiry, the Ass about the incident wh building on 4/10/17. I Maintenance Director for review. The came only video (no audio).	bed. When asked how arm was activated each ed at 9:00 PM; the nurse Upon further inquiry, she as activated more than once d have to either reset the ng Station or enter the code ther inquiry, the nurse t had a wander guard on door was working. When supposed to do when a the nurse stated they were theck the door because they o is going out the facility's ducted on 4/21/17 at 8:10 on her request. The DON s could not be deactivated be completed at the door was conducted on 4/21/17 e #1. Upon request, the location of the reset button e facility's front door alarm at Station. was conducted on 4/21/17 sistant Director of istant stated he had heard en Resident #166 exited the	F	32:	3		

Facility ID: 923268

If continuation sheet Page 75 of 125

		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 06/08/2017 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345225	B. WING		_		C 26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
SIGNATU	RE HEALTHCARE OF CH	APEL HILL		1602 E FRANKLIN STREE CHAPEL HILL, NC 275			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER" (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	without wearing a wait the door bar would so inquiry as to how the stated someone would the door. When aske located at the 200 Ha silence an alarm, the "That would be news An observation was c AM. Accompanied by Maintenance Assistar guard to activate the a door. A second surve Nursing Station obser (identified by Nurse # was silenced. Howeve building at that time s whether or not the ala guest entry or by push Nursing Station. A se on 4/21/17 at 9:30 AM surveyor, the Assistar again used a wander on the main entrance located at the 200 Ha when the reset buttom stopped. The Assistar stated at that time, "S On 4/21/17 at 9:32 AM Maintenance Director interviewed in regards deactivate the door al stated she had worke and did not know abo	nder guard), any push on ound the alarm. Upon alarm would be silenced, he d need to enter the code at d about the reset button II Nursing Station used to Assistant Director stated, to me." onducted on 4/21/17 at 9:27 v one surveyor, the at Director used a wander alarm on the main entrance eyor located at the 200 Hall ved when the reset button 1) was pushed, the alarm er, someone entered the o it was unclear as to orm was silenced by the hing the button at the econd observation was made A. Accompanied by a nt Director of Maintenance guard to activate the alarm door. A second surveyor II Nursing Station observed was pushed, the alarm th Director of Maintenance he must have cut it off."	F 32				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345225	B. WING				_ 26/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	, <u> </u>	
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	On 4/21/17 at 10:45 Å was conducted with N as the nursing assista outside of the building 4/10/17, she worked f NA #1 recalled hearin evening (the sound th beeps during the first of the door alarm). S 100 Hall at the time. minutes after the alar front door to specifica off the alarm. She sta her car. No one was door, so she went out reported seeing a ma sidewalk, just past the [Street Name.]. The I was Resident #166 so the building. When a would have been out time the alarm sound him back in), she stat inquiry about the long facility (based on carr stated she, "didn't kno she responded to the seconds." On 4/21/17 at 11:24 Å was conducted with th worked with the Resid 4/1/17 and 4/2/17. Ni #166 had tried to exit time, he did not have there were people in redirected. He then to activated the door alar	AM, a telephone interview IA #1. NA #1 was identified ant who found the resident g. NA #1 reported on from 7:00 AM to 11:00 PM. Ig the loud alarm that hat occurs past the warning 15 seconds upon activation he was in the back of the The NA stated within 1-2 m sounding, she went to the illy put in the code and turn ated she was not going to around the main entrance iside to look around. She n in a wheelchair on the e Rehab awning facing NA stated she discovered it o she brought him back into sked how long the resident of the building (between the ed and when she brought ed, "1-2 minutes." Upon er time frame noted by the hera surveillance), the NA bw about that" and stated loud door alarm "in a couple AM, a telephone interview he Nurse #4. Nurse #4 had dent #166 on 1st shift on urse #4 recalled Resident from the front door. At that a wander guard. However,	F	323			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/2017 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345225	B. WING				C / <b>26/2017</b>
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
SIGNATUR	RE HEALTHCARE OF CH			160	02 E FRANKLIN STREET		
OIGHAIOI				СН	IAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	nurse stated she wen resident's Elopement the family and Nurse reported the resident antianxiety medication periods of agitation. received to initiate the During the interview, she could deactivate stated, "The only way to (enter the code and That's how we knew H door." Accompanied by the Director and the Corp camera surveillance v 4/10/17 was viewed of Assistant Maintenance date on the camera s correct, the time starm needed to be added t correct time from the surveillance video fro corrected times) reve At 10:25 PM (correct was observed as he p door. Upon viewing t Assistant Director of I alarm would have gor Resident #166 was wheelchair in front of At 10:27 PM (correct observed as he proce	d on what she had seen, the t ahead and updated the Evaluation, and also called Practitioner (NP). The NP already had an order for an in to be used as needed for A telephone order was e use of wander guard. the nurse was asked how a door alarm. Nurse #4 I know is to go to the door d) deactivate the alarm. he was trying to exit the Assistant Maintenance borate Nurse Consultant, the video from evening of on 4/21/17 at 1:26 PM. The e Director reported while the urveillance monitor was po was off and 32 minutes o the time stamp to get the surveillance. The camera m 4/10/17 (with the aled the following: ted time), Resident #166 pushed on the front entrance his portion of the video, the Maintenance stated the	F	323			
	re-approached the fro	ted time), Resident #166 ont entrance door. ted time), the resident was					

Facility ID: 923268

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/2017 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COME	E SURVEY PLETED
		345225	B. WING				C / <b>26/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH			16	02 E FRANKLIN STREET		
SIGNATO				CI	HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	observed as he open went through first doo get outside of the fac At 10:32 PM (correc (identified as NA #1 b Consultant) opened b of the facility's front e observed with a purse jacket tied around he phone. Initially upon was observed to be u phone. She was out brief periods of time. At 10:36 PM (correc man came to the from the building. At 10:36 PM (correc observed as she cam pushing the resident On 4/21/17 at 1:45 Pf the Assistant Director camera surveillance a were being discussed conducted with the D interview, the DON st facility for 12 years an button at the Nursing alarm. At that time, ti Maintenance was as DON if the reset butto Station worked to sile "Yes it did." When th actually deactivated t Director of Maintenar deactivate the alarm inquiry, the DON stat "Never, ever" be used	ed the front exit door and or, then the second door to lity. Sted time), a staff member by the Corporate Nurse both doors and stood outside ntrance door. The NA was e over her shoulder, a light r waist, and holding her cell exiting the building, the NA using and/or viewing a cell of view of the camera for sted time), an unidentified t entrance door and entered teted time), NA #1 was he back in the building, in his wheelchair. M, the facility's DON joined of Maintenance as the and timeline from 4/10/17 d. An interview was ON at that time. During the tated she had worked at the holdid not know there was Station to disarm the door he Assistant Director of ked in the presence of the on at the 200 Hall Nursing ence the alarm. He stated, e DON asked him if it he alarm, the Assistant for confirmed the button did when it was tested. Upon ed the reset button should	F	323			

Facility ID: 923268

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SIATEMENT OF DERIGENCES AND PLAN OF CORRECTION       (M) PROVIDER SUPPLIER DENTIFICATION NUMBER:       (M) PROVIDER SUPPLIER 345225       (M) PROVIDER CONSTRUCTION A BUILDING       (M) CONSTRUCTION (CONSTRUCTION (CONSTRUCTION (CONSTRUCTION CONSTRUCTION (CONSTRUCTION) (CONSTRUCTION) (CONSTRUCTION (CONSTRUCTION) (CONSTR			ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
345225         0.0426/2017           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, GITV, STATE, ZP CODE           SIGNATURE HEALTHCARE OF CHAPEL HILL         STREET ADDRESS, GITV, STATE, ZP CODE           (PA) ID         SUMMARY STATEMENT OF DEFICIENCES         STREET ADDRESS, GITV, STATE, ZP CODE           (PA) ID         SUMMARY STATEMENT OF DEFICIENCES         STREET ADDRESS, GITV, STATE, ZP CODE           (PA) ID         SUMMARY STATEMENT OF DEFICIENCES         DEFICIENCES         CODE           (PA) ID         SUMMARY STATEMENT OF DEFICIENCES         PERCENCE         CONSENT OF DEFICIENCES         DEFICIENCES         DEFICIENCES         DEFICIENCES         CODE           TO STATE ADDRESS STATEMENT OF DEFICIENCES         PERCENCE         CONSENT FERE TOWERS FOR TOWERS            <	STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ECONSTRUCTION	(X3) DATE COMP	SURVEY LETED
180RATURE HEALTHCARE OF CHAPEL HILL     1802 E FRANKLIN STREET CHAPEL HILL NC 27914       PMETPX TAG     SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFX TAG     PROVIDER'S PLANOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFX TAG     PROVIDER'S PLANOF CORRECTION (EACH ODRECTIVE ACTION BY DEFICIENCY)     COMPLETION DEFICIENCY)     COMPLETION (EACH ODRECTIVE ACTION BY DEFICIENCY)     COMPLETION DEFICIENCY)       F 323     Continued From page 79 investigate why a door alarm was activated.     F 323     F 323       An observation was made on 4/22/17 at 9.52 AM as NA #1 identified the location of Resident #166 when he was found outside on 4/10/17. A that time, the Assistant Director of Maintenance measured how far the resident was from the front door entrance where he exited the facility, and how far the resident was from the street when he was found. Measurements determined the resident had traveled 108 feet from the front entrance of the Eacility. The testident was reported to be facing a 5-lane street directly in from the curb adjacent to the street.       A telephone interview was conducted on 4/22/17 at 11.47 AM with NA #2. NA #2 was the 2 nd shift nursing assistant assigned to care for Resident #166 at the time he exited the facility on the evening of 4/10/17. Upon inquiry as to what she recorded about the evening of 4/10/17, the NA reported she hume the resident kept going to the front door of the facility, NH & NA reported she hume the resident kept going to the front door of the facility. The NA reported she hume the resident kept going to the front door of the facility. The NA reported she hume the resident kept going to the facili			345225	B. WING				-
SHAPEL HILL       CHAPEL HILL         (M) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH EDRESS PLAN OF CORRECTION BIL RECOLLATIONY OR LSC IDENTIFYING INFORMATION)       ID PREFIX PREFIX TAG       PROVIDENTIFY PROVIDENTIFY IND INFORMATION)       D PREFIX PREFIX       PROVIDENTIFY PROVIDENTIFY IND INFORMATION)       D PREFIX PREFIX       PROVIDENTIFY PROVIDENTIFY IND INFORMATION)       D PREFIX       PROVIDENTIFY IND INFORMATION)       D PROVIDENTIFY IND INFORMATION       D PROVIDENTIFY IND INFORMATION       D PROVIDENTIFY IND INFORMATION)       D PROVIDENTIFY IND INFORMATION       D PROVIDENTIFY IND INFORMATION INFORMATION       D PROVIDENTIFY INTERTIFY INTER	NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PREPX Tx3     Cach DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)     PREFX Tx3     CEACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F 323     Continued From page 79 investigate why a door alarm was activated.     F 323       An observation was made on 4/22/17 at 9:52 AM as NA #1 identified the location of Resident #166 when he was found outside on 4/10/17. At that time, the Assistant Director of Maintenance measured how far the resident was from the front door entrance where he exited the facility, and how far the resident was from the street directly in front of the facility. The resident #466 was 109 feet from the curb adjacent to the street.       A telephone interview was conducted on 4/22/17 at 11:47 AM with NA #2. NA #2 was the 2nd shift nursing assistant assigned to care for Resident #166 at the time he exited the facility on the evening of 4/10/17. Upon inquiny as to what she reported to be facility. Journ inquiny as to what she record abs knew the resident kept going to the front door of the facility. Journ inquiny as to what she record abs knew the resident kept going to the froit door of the facility. They shars how we knew he was going to the door." Upon inquiny, the NA resident de door alarm went off that evening 0.42 stated, "Yes, that's how we knew he was going to the door." Upon inquiny, the NA resident de door alarm only went off for a few seconds at a time that evening (not minutes).	SIGNATUR	RE HEALTHCARE OF CH	IAPEL HILL					
investigate why a door alarm was activated. An observation was made on 4/22/17 at 9:52 AM as NA #1 identified the location of Resident #166 when he was found outside on 4/10/17. At that time, the Assistant Director of Maintenance measured how far the resident was from the front door entrance where he exited the facility, and how far the resident was from the street when he was found. Measurements determined the resident had traveled 108 feet from the front entrance of the facility. The resident was reported to be facing a 5-lane street directly in front of the facility. The resident was reported to be facing a 5-lane street directly in front of the facility. The resident was reported to be facing a 5-lane street directly in front of the facility. The resident was reported to be facing a 5-lane street directly in front of the facility. The resident was reported to be facing a 5-lane street directly in front of the resident was flow as 109 feet from the curb adjacent to the street. A telephone interview was conducted on 4/22/17 at 11:47 AM with NA#2. NA #2 was the 2nd shift nursing assistant assigned to care for Resident #166 at the time he exited the facility on the evening of 4/10/17. Upon inquiry as to what she recalled about the evening of 4/10/17, the NA reported she knew the resident kept going to the front door of the facility. However, she did not know Resident #166 actually got out of the facility. When asked if the door alarm onel yeen of ffor a few seconds at a time that evening (not minutes). On 4/21/17 at 2:32 PM, the Administrator was	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
informed of the immediate jeopardy. The facility provided a credible allegation on 4/22/17 at 4:05 PM. The allegation of compliance indicated: Credible Allegation for F323	F 323	investigate why a door An observation was m as NA #1 identified the when he was found of time, the Assistant Dia measured how far the door entrance where how far the resident we was found. Measurer resident had traveled entrance of the facility reported to be facing front of the facility at the Measurements reveal feet from the curb adj A telephone interview at 11:47 AM with NA a nursing assistant assi #166 at the time he ex- evening of 4/10/17. Ur recalled about the ever front door of the facilitik know Resident #166 a facility. When asked that evening, NA #2 s knew he was going to the NA recalled the do few seconds at a time On 4/21/17 at 2:32 PP informed of the imme provided a credible al PM. The allegation or	and an arr was activated. nade on 4/22/17 at 9:52 AM e location of Resident #166 utside on 4/10/17. At that rector of Maintenance e resident was from the front he exited the facility, and was from the street when he ments determined the 108 feet from the front /. The resident was a 5-lane street directly in the time he was found. led Resident #166 was 109 acent to the street. Twas conducted on 4/22/17 #2. NA #2 was the 2nd shift igned to care for Resident xited the facility on the Jpon inquiry as to what she ening of 4/10/17, the NA e resident kept going to the ty. However, she did not actually got out of the if the door alarm went off tated, "Yes, that's how we the door." Upon inquiry, por alarm only went off for a e that evening (not minutes). M, the Administrator was diate jeopardy. The facility legation on 4/22/17 at 4:05 f compliance indicated:	F	323			

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	S FOR MEDICARE &					O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	· · ·	E SURVEY
	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING	i	001	
			D 14/11/0			С
		345225	B. WING			4/26/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
SIGNATUR	RE HEALTHCARE OF C			1602 E FRANKLIN STREET		
olonaloi				CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 323	Continued From pag	o 80	Гаа	2		
F 323			F 32	3		
		as noted by staff to be				
		alk by the rehab side of the				
	building on 4/10/201					
		assisted back to the facility				
	-	ing Assistant on 4/10/2017 at				
		PM. and placed at the				
	nurses' station for clo	•				
		PM. The Charge Nurse				
		to bed. The Charge Nurse				
	÷	ens and provided incontinent				
		The nurse performed an				
		lent #166 during care, no				
	new injuries were no					
	-	ble party and physician were				
	-	y the charge nurse on				
		166 was monitored every				
		ne night by the charge nurse.				
	B. A head count of t	he entire facility was				
	conducted on 4/11/2	017 at 12:00 midnight by the				
	charge nurses. All re	sidents were accounted for				
	and were safe. On 4	/11/2017 all exits were				
	checked by the plant	operations assistant. All				
	exit doors were found	d to be functioning properly.				
	On 4/11/17, all reside	ent wander guards were				
		ent and functioning by the				
	÷	Central Supply Clerk and all				
		oning. All residents were				
		of elopement on 4/12//2017				
		of Nursing, and Director of				
	-	sidents were identified as				
		ement. Care plans and care				
		and updated as indicated for				
		ified as being at risk for				
	-	017 by Social Services				
		velopment Coordinator. The				
	binders which identif	y residents who are at risk				1
		eviewed by the Administrator				

Facility ID: 923268

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TATE					0(0) =	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY
			A. BUILDING	3		0
		345225	B. WING			C
		545225		STREET ADDRESS, CITY, STATE, ZIP COD		4/26/2017
NAME OF PP	OVIDER OR SUPPLIER				E	
SIGNATUR	E HEALTHCARE OF CH	IAPEL HILL		1602 E FRANKLIN STREET		
				CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From page	e 81	F 32	23		
1 020			F 32			
		place at each nurse's station st's desk on 4/13/2017, all				
		lace and correct. On				
	•	erations Assistant contacted				
		service to dismantle the				
	reset button located a	at the red hall nursing				
		call for dismantling the reset				
	button will be a part of	of the plan of correction. In				
	the meantime, the rea	set button at red hall nursing				
		and a sign was placed				
		ot Use Button" on 4/22/2107				
	-	Development Coordinator				
	and Plant Operations	Assistant.				
	-	pement policy including how				
	-	arms, complete head counts,				
		for function and placement,				
	•	and implementation of care				
	plans related to trigge					
	-	sments, was initiated to all				
	-	2017 and will continue prior				
	Director of Nursing, S	ext shift by Administrator,				
		of Life Director, Social				
		ocial Services Assistant,				
		Experience Director, Dietary				
		dmissions Director, Plant				
	0	Plant Operations Assistant,				
		anager. The Administrator				
	and Director of Nursi	ng trained these educators				
		ver for the education on				
		and return demonstration on				
		smitter (device to check				
	function of wander gu					
		er guard function and battery				
		on 4/22/2017 by the Plant				
	Operations Director,	Plant Operations Assistant,				
1		/Certified Nursing Assistant,				

Facility ID: 923268

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		MEDICAID SERVICES					<u>NO. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		TRUCTION	· · · ·	TE SURVEY MPLETED
			A. BUILDIN	IG			
		345335	B. WING				С
		345225	B. WING				4/26/2017
NAME OF PF	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUR	RE HEALTHCARE OF CH	IAPEL HILL			FRANKLIN STREET		
				CHAPE	EL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 323	Continued From page	<u>- 82</u>	F 3	23			
1 020			ГЭ	23			
		es. A post-test will be given the education in which a					
		% must be obtained. If staff					
		re of 100% on test the staff					
		ucated on the spot and a					
		given. Staff that were not					
		7 will be educated on the					
	-	I procedure, care plan and					
		by Administrator, Director of					
		opment Coordinator, Quality					
	•	al Services Director, Social					
		lietary Services Manager,					
	Chaplain, Customer I						
		Plant Operations Director,					
		istant, or Business Office					
	-	ng their assignment upon					
	return to work. A pos	sttest will be given in which a					
	passing score of 100	% must be obtained. If					
	100% was not obtain	ed the staff member will be					
	re-educated and a po	ost test will be reissued. The					
	Administrator, DON,	or Signature Care					
	Consultant or regiona	al team will review the Post					
		l immediacy removed and					
	then weekly for any n	-					
		essed immediately. Staff					
		on the Family Medical Leave					
		ot be allowed to return to					
		lopement training, the					
	post-test is administe						
		e did not score 100% on					
		yee will be immediately					
	-	t-test re-administered. This until employee obtains a					
	100% score on post-f						
		wed to work until education					
		administered and 100%					
		ployee did not score 100%					
	on post-test, then em						

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STATEMENT		MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	· · ·	PLETED
						С
		345225	B. WING		04	4/26/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				1602 E FRANKLIN STREET		
SIGNATU	RE HEALTHCARE OF CH			CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 323	Continued From page	e 83	F 32	23		
. 020	-	until employee obtains a	1 52	23		
		test. Assistant Directors of				
	-	oordinators were reeducated				
		and Director of Nursing on				
	4/21/2017 on comple					
	admission, quarterly,	and with changes of				
	condition, including th	hat care plans should reflect				
		S. Assistant Directors of				
	-	oordinators were reeducated				
		and Director of Nursing on				
	4/21/2017 on comple	•				
	admission, quarterly,	-				
		hat care plans should reflect B. Beginning 04/22/2017 daily				
		ted each shift for wander				
	-	all identified residents.				
		, the Plant Operations				
		Operations Assistant will				
	check the exit doors	in the facility daily for correct				
	functioning and place	e on their log until immediacy				
		tion checks will continue to				
		ays a week for two weeks,				
	then three times a we	-				
		or of Nursing, Assistant				
	Director of Nursing, S	-				
		s Office Assistant, Human				
		Dietary Services Manager, or, Admissions Director,				
		ntal Services Director, Social				
		usiness Office Manager,				
		ector or Social Services				
		4/21/2017, the Plant				
		or Plant Operations Assistant				
		ng will check functioning of				
	-	l identified residents daily for				
		Green Drill (Elopement Drill)				
	-	13/17 by the Maintenance				
		tinue to be completed by the r, Administrator, Director of				

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STATUSENCY DEPOSITION     (XI) PROVIDERSUPPLENCIAL INDETINICATION NAMESE:     (XI) MEDIATION NAMESE: <th></th> <th></th> <th>ND HUMAN SERVICES MEDICAID SERVICES</th> <th></th> <th></th> <th>F</th> <th>NTED: 06/08/2017 ORM APPROVED 3 NO. 0938-0391</th>			ND HUMAN SERVICES MEDICAID SERVICES			F	NTED: 06/08/2017 ORM APPROVED 3 NO. 0938-0391
345225         8. WHO         04/26/2017           NAME OF PROVIDER OF SUPPLIER         STREET ADDRESSOT STREET         CONTINUES IN CONTRACTOR CO	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,		(X3)	DATE SURVEY COMPLETED
1982 FRANKLIN STREET CHAFEL HILL, NC. 2754       CAPL PRETX TAG     SUMMARY STATEMENT OF DEPICIENCIES INCOMESTIGATION OF CORRECTION RECOL DEPICIENCY MUST BE PRECEDED BY FULL TAG     DIME       F 323     Continued From page 84 Nursing, or Staff Development Coordinator as follows: 1 daily on alternating shifts for one week; 2 times/week on each shift for 4 weeks; 1 time/week on each shift for 4 weeks; 1 time/month on each shift for 4 weeks; 1 times/meak on the Nursing to the stress and nursing assistants). Maintenance, and Dietary Departments were interviewed. Staff were able to describe the education received on resident topement, how to respond when the door alarm was activated, and how to verify a resident's wanter guad was in working order. Care Plans and Care Guides of a resident sample determined to be at risk for elopement weer ereviewed and able able at risk for elopement weer ereviewed			345225	B. WING			-
SIGNATURE HEALTHCARE OF CHAPEL HILL       CHAPEL HILL, NC 27314         (M)10 HEERIK TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH EDERCINEY MAST & PERCEED BY ILL REGULATORY ON USC DENTIFYING INFORMATION)       ID PRETIX REGULATORY CONSCIENT IN THE APPROPRIATE DECROSS REFERENCEI TO THE APPROPRIATE DECROSS REFERENCEI TO THE APPROPRIATE DECROSS AREFERENCEI TO	NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STAT	E, ZIP CODE	
Charle Hill, NC 27814           PRETX TAG         SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY MUST BEPRECEDED BY FULL TAG         Different TAG         Providers PLAN of CORRECTION (EACH CORRECTION ON SHOULD BE CROSS-REFERENCE) TO HE APPROPRIATE DEPICIENCY)         Own (EACH CORRECTION (EACH CORRECTION DEPICIENCY)           F 323         Continued From page 84 Nursing, of Staff Development Coordinator as follows: 1 daily on alternating shifts for one week; 3 times/week on each shift for one week; 1 times/week on each shift for a weeks; 1 times/month on each shift for 4 weeks; 1 times/week on each for the Wires in which a post test will be given and a score of 100% must be obtained.         Facility alleged J removal on 4/22/2017 The credible allegation was verified on 4/22/17 at 7:04 PM. On 4/22/17 times/month the door alarm was activated, and how to verify a resident sidentified as being at risk for elopement was in place at each Nursing Station (which					1602 E FRANKLIN STREET		
instring TAG       IEACH CORRECISATION OR LSC IDENTIFYING INFORMATION)       PRETX TAG       IEACH CORRECISE AT THE APPROPRIATE       CONSISTER       Consistence of the APPROPRIATE       CONSISTER       Consistence of the APPROPRIATE       CONSISTER       CONSISTER <thconsister< th="">       CONSISTER       CONS</thconsister<>	SIGNATU	RE HEALTHCARE OF CF			CHAPEL HILL, NC 27514		
Nursing, or Staff Development Coordinator as follows: 1 daily on alternating shifts for one week; 3 times/week on each shift for one week; 2 times/week on each shift for 4 weeks; 1 time/month on each shift for 4 weeks; 1 time/month on each shift for 4 weeks; 1 time/month on each shift are quarter. Regional Care Consultant Staff are providing oversight to the audits three times a week beginning 4/21/2017. The elopement policy and procedure, missing resident, care plans and Accutech will be in serviced in orientation for all new hires in which a post test will be given and a score of 100% must be obtained. Facility alleged JJ removal on 4/22/2017 The credible allegation was verified on 4/22/17 at 7.04 PM. On 4/22/17 from 6:36 PM through 7:04 PM, staff members from the Nursing (both nurses and nursing assistants), Maintenance, and Dietary Departments were interviewed. Staff were able to describe the education received on resident elopement, how to respond when the door alarm was activated, and how to verify a resident's wander guard was in working order. Care Plans and Care Guides of a resident sample determined to be at risk for elopement were reviewed and each noted to have been updated. A Binder containing information on the resident identified as being at risk for elopement were reviewed and each noted to have been updated. A Binder containing information on the residents identified as being at risk for elopement were reviewed and each noted to have been updated. A Binder containing information on the resident identified as being at risk for elopement were reviewed and each noted to have been updated. A Binder containing information on the residents identified as being at risk for elopement were reviewed and each noted to have been updated. A Binder containing information on the resident identified as being at risk for elopement were reviewed and each noted to have been updated. A Binder containing information on the resident identified as being at risk for elopement were reviewed and each noted to have been u	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECT CROSS-REFERENC	IVE ACTION SHOULD BE ED TO THE APPROPRIATE	COMPLETION
letters, "DO NOT USE (RESET) BUTTON." The	F 323	Nursing, or Staff Deve follows: 1 daily on alt 3 times/week on each times/week on each time/week on each st times/month on each st time/month on each st tare Consultant Staff the audits three times 4/21/2017. The elope missing resident, card in serviced in orientat a post test will be give must be obtained. Facility alleged IJ rem The credible allegation 7:04 PM. On 4/22/17 PM, staff members fr and nursing assistant Dietary Departments were able to describe resident elopement, h door alarm was active resident's wander gue Care Plans and Care sample determined to were reviewed and each was in place at each Reception's Desk. Th the 200 Hall Nursing the front door alarm) 6:54 PM to have been	elopment Coordinator as ternating shifts for one week; 2 shift for one week; 2 shift for one week; 1 hift for 4 weeks; 2 shift for 4 weeks; 1 shift each quarter. Regional f are providing oversight to a week beginning ement policy and procedure, e plans and Accutech will be tion for all new hires in which en and a score of 100% hoval on 4/22/2017 on was verified on 4/22/17 at 7 from 6:36 PM through 7:04 om the Nursing (both nurses ts), Maintenance, and were interviewed. Staff e the education received on now to respond when the ated, and how to verify a ard was in working order. • Guides of a resident o be at risk for elopement ach noted to have been ontaining information on the s being at risk for elopement Nursing Station and at the he reset button located at Station (which deactivated was observed on 4/22/17 at n taped over with a large	F 3			
	l						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345225	B. WING				26/2017
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUR	RE HEALTHCARE OF CH	IAPEL HILL			602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL P REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	area for residents on revealed the smoking contained courtyard. I designated for resider red receptacle with th handwritten note on ti stated "cigarette butts approximately half ful butts and paper trash pack, and foam cups) receptacle available f smoking area. A fire to attached to a wall in ti be covered in a birds An observation on 4/7 designated smoking a the receptacle for exti open and contained of trash items. There wa available for trash not bird was observed fly built on the fire blanket was noted that there nest. An interview with the 4:00 pm revealed tha any trash in the recep- cigarette butts. He sta there was not a trash	the designated smoking 4/18/2017 at 2:30 pm area was outside in a The section of the courtyard ints to smoke contained a e lid open; there was a he lid of the receptacle that s only". The receptacle was I and contained cigarette items (empty cigarette b. There was no other or trash noted in the blanket was in a container he courtyard; it was noted to nest. 18/17 at 3:55 pm of the area for residents revealed inguishing cigarettes was cigarette butts and paper as no other receptacle ted in the smoking area. A ing out of the nest that was et; upon closer observation it were 5 eggs in the birds administrator on 4/18/17 at t there should not have been otacle designated for ated he was not aware that can in the smoking area or as covered in a birds nest.	F	323			
F 332	corrected. 483.45(f)(1) FREE OI	F MEDICATION ERROR	F	332			6/5/17

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 06/08/2017 // APPROVED ). 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		345225	B. WING				C 26/2017
NAME OF P	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				10	602 E FRANKLIN STREET		
SIGNATU	RE HEALTHCARE OF CH			С	HAPEL HILL, NC 27514		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION DATE
F 332	Continued From page	286	F	332			
SS=D				002			
55-D	RATES OF 5% OR M	ORE					
	(f) Medication Errors. that its-	The facility must ensure					
	(1) Medication error ra	ates are not 5 percent or					
		is not met as evidenced					
		ns, record review, and staff			F332:		
		failed to have a medication					
	error rate less than 59						
	medication errors out	-			A. An assessment was completed by t	he	
		ion error rate of 7.1%, for 2			Unit Manager on 4/20/17 for Resident		
	of 4 residents				to ensure his gastrostomy tube was		
	(Resident #86 and Re	esident #14) observed			patent following the administration of		
	during medication pas	SS.			powdered medication. The gastrostom	У	
	The findings included	:			tube was found to be patent and functioning properly. A competency for gastrostomy tube medication	r	
	1) A review of the faci	ility ' s Policy and			administration was completed by the S	taff	
		"Medication Administration			Development Coordinator for Nurse #2		
	Enteral Tubes" (Dated	,			ensure understanding of the requireme		
	following procedural s				to dissolve powered medications in wa	ter	
	-	lications for administration.			prior to administration through a		
		rush guidelines before			gastrostomy tube, and the requirement		
	-	sh tablets into a fine powder			that a water flush must occur between		
	and dissolve	rel of water or other			each medication. Nurse # 3 received		
		ml of water or other			re-education regarding administration of nasal spray as ordered.	וו	
	appropriate liquid.	psule contents into at least 5			B. All other residents with gastrostomy	,	
	ml of water or other a				tubes and receiving medication via nas		
					spray have the potential to be affected		
	On 4/20/17 at 9:10 At	M, Nurse #2 was observed			the alleged deficient practice. No othe	-	
		tions from the medication			concerns were identified.		
		to Resident #86 via a			C. Licensed Nurses received		
		eeding tube put directly into			re-education by the Staff Development		
	the stomach). The m				Coordinator for safe and effective		
		ed the following: one - 500			administration of medication per facility	1	

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		MEDICAID SERVICES	(X2) MI II TIP	LE CONSTRUCTION		IO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:		)	. ,	IPLETED
						С
		345225	B. WING	······	0,	4/26/2017
NAME OF PR	ROVIDER OR SUPPLIER	•	· 1	STREET ADDRESS, CITY, STATE, ZI	P CODE	
				1602 E FRANKLIN STREET		
SIGNATUR	RE HEALTHCARE OF CH			CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 332	Continued From page	e 87	F 33	2		
		rmin tablet (an antidiabetic	1 00	policy regarding adminis	tration of	
	agent); one - 5 mg lis			medication through a ga		
		lication); one capsule of		include the requirement	•	
		ilus (a probiotic); 10 milliliters		powered medication in w		
	(ml) of 0.2 mg/ml glyc	copyrrolate (a medication		administration through th	-	
		tions); a multi-dose eye drop		tube, and that a water flu		
		al tears (an eye drop used		between each medicatio		
		es); and, one - 1.5 mg		License Nurses also rec		
	Transderm-Scop tran			re-education regarding s		
		he prevention of nausea		administration of medica	-	
		<ol> <li>Nurse #2 was observed netformin and lisinopril</li> </ol>		nasal spray per order. F		
		d placed each of the crushed		completed by the Staff D Coordinator for licensed	-	
		parate medication cup. She		5/31/17. This education		
		llus acidophilus capsule and		provided upon hire and a		
		of the capsule into a 3rd		D. The Staff Developme	-	
		water was added to the		Assistant Director of Nur		
	medication cups to di	issolve the powdered		Nurse, and Director of N	ursing will	
	medications.			complete gastrostomy tu		
				administration audit whe		
		M, Nurse #2 was observed		administered via enteral		
		edications to Resident #86 '		administration of nasal s		
		hecked the resident 's tube		This will be executed on		
		trostomy tube placement. ge to the tubing and instilled		including weekends for 4 per week x 2 weeks, the		
		e tube to flush the tubing.		Nurse per week x 2 weeks, the		
		dry white powder (one of the		compliance. Any issues		
		been crushed but not		identified will be address		
		om one of the medication		Assurance Performance		
	-	, and then poured 5 ml water		committee as they arise	-	
		repeated this process with		be revise to ensure cont	inued compliance.	
		hat had been crushed into a				
	-	1 5 ml of water. The nurse				
		ppyrrolate liquid into the				
		it with 5 ml of water. Next,				
	-	dry contents of the opened				
	capsule from the last	of the three medication				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345225	B. WING				C / <b>26/2017</b>
NAME OF P	ROVIDER OR SUPPLIER		•				
SIGNATU	RE HEALTHCARE OF CH	APEL HILL			1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE					(X5) COMPLETION DATE	
F 332	been administered. medications and wate down the tube very sl approximately <sup>3</sup> / <sup>4</sup> " long tubing, approximately connection. The pink plugging the tube. Af floated back up into th two additional 5-10 m the substance and pro- the tubing. The nurse the capsule (the prob stopped the tube from s stomach. The nurse time she had run into medications instilled s Nurse #2 also reported just been replaced the #86 was observed as and the transdermal p skin. An interview was con AM with Nurse #2. U the procedures she for administration via a g usual procedures she medications via a tub procedures she used facility ' s recommend A follow-up interview at 12:16 PM with Nurse shown the facility's po- indicating crushed me contents should be di prior to administration reported she had bee	The dry powdered er were noted to be draining owly and a pink substance g was observed within the 2" down from the syringe substance appeared to be ter 1-2 minutes, the plug he syringe. Nurse #2 used I flushes to try and dissolve omote the flow back down e reported the contents from iotic) was the "plug" that h draining into the resident ' e stated this was the first the situation where the so slowly through the tubing. ed this resident ' s tube had e previous week. Resident the eye drops were instilled batch was applied to her ducted on 4/20/17 at 11:55 pon inquiry, Nurse #2 stated ollowed for medication astrostomy tube were the e used for administering the e. The nurse reported the were in accordance with the led procedures. was conducted on 4/20/17 se #2. The nurse was	F	33:	2		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345225	B. WING				C 26/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SIGNATU	RE HEALTHCARE OF CH	IAPEL 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 332	via a tube, and was to observed during med Manager #1 joined th the Unit Manager rep crushed meds (and ca be dissolved in a sma administration via a tu when the nurse pource medication into a syri then 5 ml of water, the medication on top of to inquiry, the Unit Mana practice would not pro- the individual medicat An interview was con PM with the facility ' s presence of the Corpo Inquiry was made as on medication admini intent of the instructio and Nurse Consultan or contents of a capso in a small amount of v	bld to follow the procedures pass. At that time, Unit e discussion. When asked, orted she had understood apsule contents) needed to all amount of water prior to ube. The practice observed ed a dry powdered nge attached to the tubing, en another dry powdered that was discussed. Upon ager acknowledge this ovide a water flush between tions. ducted on 4/20/17 at 12:30 b Director of Nursing in the orate Nurse Consultant. to the morning in-servicing istration via tube and the ons provided. Both the DON t stated the crushed meds ule needed to be dissolved water prior to pouring the yringe and, a water flush	F	332	2		
	-	rders dated March 23, 2017 7 for Fluticasone Propionate te (drug used to treat					
	pass on 4/20/17 at 9:	#3 during the medication 26 AM revealed Resident #4 ticasone Propionate 2 (two)					

Facility ID: 923268

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/08/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345225	B. WING		C 04/26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SIGNATU	RE HEALTHCARE OF CH			1602 E FRANKLIN STREET	
SIGNATO				CHAPEL HILL, NC 27514	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 332	Continued From page nasal sprays in the le		F 332		
F 333 SS=E	Interview on 04/20/20 #3 revealed she thoug Fluticasone Propiona that the order was for Propionate in each no Interview on 04/22/20 Administrator reveale be administered as pu 483.45(f)(2) RESIDER SIGNIFICANT MED E 483.45(f) Medication The facility must ensu (f)(2) Residents are fr medication errors. This REQUIREMENT by: Based on consultation record reviews, and s interviews, the facility antibiotic and antifung after the medications Infectious Disease co the resident 's physic sampled residents (R unnecessary medicat The findings included Resident #134 was an 1/31/17 from the hosp diagnoses included o	<ul> <li>a 17 at 9:43 AM with Nurse ght that she had sprayed to into both nostrils but knew 1 spray of Fluticasone botril.</li> <li>b 17 at 4:19 PM with the d he expected medications rescribed.</li> <li>b 17 S FREE OF ERRORS</li> <li>c and significant</li> <li>c is not met as evidenced on report reviews, facility taff and physician failed to administer an gal medication for 14 days were recommended by an insultant and approved by cian. This occurred for 1 of 6 esident #134) reviewed for ions.</li> <li>c dmitted to the facility on</li> </ul>	F 333	<ul> <li>F333:</li> <li>A. The Physician for Resident #134 w notified of the medication error on 3/29/17. An order was received to stat the medication and continue as previor ordered. Medication administration wa initiated 3/29/17.</li> <li>B. Residents who required consultation from outside physicians have the potent to be affected by the alleged deficient practice. Orders and consultation report for Residents who have had consultating from outside physicians for the last 6 months were reviewed by the Director Nursing, Unit Coordinator, Licensed Nurse or Nurse Consultant on 4/25/17</li> </ul>	rt usly s n ntial orts on of

Event ID: HXZN11

Facility ID: 923268

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,	)	· · ·	MPLETED	
						С	
		345225	B. WING			4/26/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
CICNATU				1602 E FRANKLIN STREET			
SIGNATOR	RE HEALTHCARE OF CH			CHAPEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 333	Continued From page	a 01	F 33	2			
1 000			F 33		up and initiation		
	of small bones formin			ensure appropriate follow of medication as ordered.			
	A review of Resident	#134 ' s admission Minimum		concerns were identified.			
	Data Set (MDS) asse			C. Education will be com	pleted by		
		had moderately impaired		5/31/17 by the Staff Deve			
		ly decision making. The		Coordinator, Director of N	•		
		ensive assistance for all of		Director of Nursing or Nur			
		Living (ADLs), with the		for licensed nurses regard			
		supervision only for eating		orders and consultation re			
		f the unit. Section N of the		return of the resident to the			
		licated the resident received of the 7 days during the look		following a consultation. E included ensuring orders			
	back period.	of the 7 days during the look		appropriately transmitted			
	back period.			and medications were init	• •		
	A review of the reside	ent ' s Care Plan dated		ordered. Residents who r			
		following area of focus:		consultation will be discus	•		
		complications related to the		clinical meeting by the Int	•		
	use of intravenous flu	iids or intravenous		Team (Director of Nursing	g, Unit		
	medications.			Managers, Social Service			
				Dietary Director, Wound			
		#134 's medical record		Quality of Life Director, an	• •		
		on report from an Infectious		ensure appropriate follow			
		ted 3/15/17. The Report of		of medication as ordered.			
		d Resident #134 was seen oral osteomyelitis. At that		D. The Director of Nursin Director of Nursing Unit C			
	time, the Infectious D			development Coordinator			
		ng the intravenous antibiotic		Consultant will complete a			
		biotics, including 100		physician consultation rep			
		cycline (an antibiotic) to be		resident⊡s, 5 times a wee			
	given by mouth twice			weeks, then 3 times per v	veek for 2		
		ingal agent) to be given by		weeks, then weekly for 2			
	mouth once daily.			medications have been in	-		
		11 M 1 00/7		to physician s orders and			
	A review of the reside			through consultation. Find	-		
	Medication Administra			reported to the Director or ensure immediate correct			
		750 mg vancomycin (an ) administered once daily		concerns. Unit Managers			
				findings of the above stat			
	was discontinued on 3/15/17. Further review of the March 2017 revealed doxycycline and			interings of the above stat			

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		PLETED
		345225	B. WING _				C /26/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1	
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333	Continued From page	<u> </u>	F3	133			
	fluconazole were not PM.	initiated until 3/29/17 at 9:00		,00	Improvement Committee (QAPI) mon for recommendations and further follow-up as indicated.	thly	
	A review of Resident revealed the resident on 3/16/17. The phys read, in part:						
	"He was recently seen in infectious disease clinic for vertebral osteomyelitis. MRI was obtained which showed improvement. Antibiotic IV vancomycin is discontinued, he was started on doxycycline 100 mg twice a day and fluconazole 400 mg daily"						
	a notation was made which read, in part: "Resident approache form dated 3/15/17. physician ordered hir medications were set Writer attempted to c (MD Name) but was						
	PM revealed a return consulting physician	note dated 3/29/17 at 8:30 call was received from the from the ID clinic. The note ibiotics were to be started months.					
	ID clinic revealed the 4/10/17. The Report following notation: "F doxy (doxycycline) ar fluconazole) for 2 wks	consultation report from the resident was seen on of Consultation included the Facility did not administer nd Diflucan (brand name for s (weeks) after last visit as e. Rectified." The ID clinic					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/2017 M APPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345225	B. WING				C /26/2017
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUR	RE HEALTHCARE OF CH			1	1602 E FRANKLIN STREET		
CICILATO				0	CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333	doxycycline and fluco ordered. An interview was com PM with the facility 's Nursing (DON). Upon s medical record, the the March 2017 MAR and fluconazole were evening of 3/29/17. U an investigation had b error report complete Consultant DON report check. A telephone interview at 4:22 PM with Reside was also the facility 's the interview, the phy initialed the 3/15/17 II 3/16/17) to show she physician also recaller medications and state be started. "When co orders." The MD stat expected the nurses of as prescribed. When been harm caused fo starting the oral antibi so she could not say	ducted on 4/22/17 at 4:10 consultant Director of n review of Resident #134 ' Consultant DON confirmed indicated the doxycycline not initiated until the Joon inquiry as to whether been done or a medication d for this situation, the orted she would need to was conducted on 4/22/17 dent #134 ' s physician (who s Medical Director). During sician recalled she had D consult report (initialed on had reviewed it. The ed inquiring about the oral ed she was told these would onsults come in, I verify the ted she would have to carry out the new orders asked if there may have r this resident by the delay in iotics, the physician stated there was harm. She had been monitored and did	F	333			
	A telephone interview at 4:41 PM with a pha facility 's contracted p pharmacy technician	was conducted on 4/22/17 armacy technician from the oharmacy. Upon inquiry, the reported doxycycline and h sent out one time only (on					

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	MENT OF HEALTH AN S FOR MEDICARE &	MEDICAID SERVICES				M APPROVE 0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
		345225	B. WING		04	4/26/2017
NAME OF PF	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUR	RE HEALTHCARE OF CH	HAPEL HILL		1602 E FRANKLIN STREET		
				CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 333	Continued From page	e 94	F 33	3		
		#134 during the month of				
	observation of the fac medications was con PM. At that time, it w supply of medications doxycycline 100 caps doxycycline; 6 - 100 - 150 mg fluconazole available for review to any) of the medicatio	ducted on 4/22/17 at 4:47 vas revealed the emergency s included 6 - 100 mg sules, 10 - 100 mg mg fluconazole tablets and 7 tablets. No record was o determine how many (or if ns administered to Resident facility ' s emergency supply				
	PM with the interim E the DON reported an resident would be red was administered, ev from the emergency interim DON indicate to follow the facility ' returned to the facility consultation. She rej should be brought ba resident, and the new reviewed by the physic approved an order, the write that order (either Verbal Order) and the system to initiate any medications. 483.35(a)(1)-(4) SUF	ducted on 4/22/17 at 4:51 OON. During the interview, y medication given to the corded on the MAR when it y and the medication came supply. Upon inquiry, the d she would expect nurses s process when a resident y after having an outside ported a consult report teck to the facility with the y orders would need to be sician. If the physician the nurse was expected to er via a Telephone Order or en put it into the computer y changes in the resident ' s	F 353	3		5/31/17
SS=D	STAFF PER CARE F 483.35 Nursing Servi					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE	ECONSTRUCTION	(X3) DATE	
AND FLAN OF	CORRECTION	IDENTIFICATION NOWBER.	A. BUILDI	NG _			C
		345225	B. WING				26/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	APEL HILL		CHAPEL HILL, NC 27514			
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page	95	F	353			
	The facility must have the appropriate comp provide nursing and m resident safety and at practicable physical, m well-being of each res resident assessments and considering the m diagnoses of the facili accordance with the f at §483.70(e). [As linked to Facility A be implemented begin (Phase 2)] (a) Sufficient Staff. (a)(1) The facility mus sufficient numbers of of personnel on a 24- nursing care to all res resident care plans: (i) Except when waive this section, licensed (ii) Other nursing pers limited to nurse aides (a)(2) Except when w this section, the facilit nurse to serve as a ch duty. (a)(3) The facility mus nurses have the spec sets necessary to car	e sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care umber, acuity and ity's resident population in acility assessment required assessment, §483.70(e), will ming November 28, 2017 at provide services by each of the following types hour basis to provide idents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not					

Facility ID: 923268

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/08/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345225	B. WING		C 04/26/2017
NAME OF P	ROVIDER OR SUPPLIER	l	s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL		602 E FRANKLIN STREET CHAPEL HILL, NC 27514	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 353	Continued From page described in the plan		F 353		
	assessing, evaluating resident care plans at needs. This REQUIREMENT by: Based on record revi interviews and observe provide sufficient nurs of Daily Living (ADLs reviewed for ADLs (R Resident #97). Findings included: The staffing schedule hours worked for Blue Saturday 4/15/17: 3 NA scheduled for B PM. 2 NAs called out 1 NA scheduled for B PM. 2 NAs called out 1 NA scheduled for B Both NA came in late Sunday 4/16/17: 3 NAs scheduled on B 3:00 PM. 2 NAs called 1 NA scheduled on B 7:00 pm and 1 NA sci 8:00 PM. 1 NA scheduled for B 11:00 PM. 4 NAs called	esident #36, Resident #24, es and Nurse Aides' (NA) e hall is as follows: lue hall 7:00 AM to 11:00 for Blue hall. ne entire facility from 11:00 lue Hall 1:00 AM to 7:30 AM. for 3rd shift for blue hall. Blue hall from 7:00 AM to d out for Blue hall. lue hall from 3:00 PM to heduled from 3:00 PM to		F353: A. Interview was completed by 5/19/ the Director of Nursing (DON) for resi #24, and #36 regarding the alleged deficient practice of lack of sufficient staffing and the residents care needs met through staff education and suffic staffing; resident # 97 no longer resid the facility. The nursing schedule is b reviewed daily by the Administrator (ADM), Director of Nursing (DON), Assistant Director of Nursing (ADON) Unit Coordinator (UC) to assure that a staffing levels are appropriate to mee resident care needs. The Administrat DON, or Unit Coordinator, will daily determine the number of staff needed the 24 hour period based on facility census and resident acuity. B. All residents with Brief Interview Mental Status (BIMS) 8 or > were interviewed to assure their care need being met, this was completed on 5/1 by the Admission Coordinator, Social Service Director, Quality of Life Direc Chaplain, Assistant Director of Nursir Director of Nursing, Unit Coordinator, Rehabilitation Service Manager or Nu Consultant. Any concerns identified to be addressed. All residents with BIM or < were assessed to assure that the	dent are sient es in eing , daily t tor, l for s are 9/17 tor, ig, irse will s 7

Facility ID: 923268

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 APPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		PLETED
		345225	B. WING				C 26/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE		
CICNATUR				16	602 E FRANKLIN STREET		
SIGNATUR	RE HEALTHCARE OF CH			С	HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page	e 97	E:	353			
	7:00 AM.				care needs are being met as outlined p	her	
					the residents care plan by the DON,		
	1.) Resident #36 had	the following diagnoses of			ADON, UC, or Nurse Consultant This		
	spinal stenosis, anen	nia and hypertension.			was completed by 5/19/17 Any finding		
		num Data Set dated 3/30/17			were forwarded to the DON. Correctiv	е	
		was moderately cognitively nt required total dependence			actions were completed as indicated.		
	for bathing.				C. Education to be completed by 5/31.	/17	
					by the Staff Development Coordinator		
	The resident had a ca				(SDC), DON, or Regional Nurse to		
	updated 3/12/17 for A				include nursing staff (Licensed Nurses	6	
	• •	Social Worker of all alert ts revealed that resident #36			and Certified Nursing Assistant) to		
		d. The resident was residing			address the importance of and policy expectations of meeting residents care		
	on blue hall.				needs to include bathing/showers,		
					incontinent care and any other reasona	able	
	Review of #36's show	ver days revealed the			care needs the resident may have.		
		ys were scheduled for			Secondly, the Administrator, DON, AD	ON,	
	Wednesday and Satu				Unit Coordinator, Licensed Nurse will		
		nt's Activities of Daily Living			review daily staffing sheet to ensure	41	
		nower assignment sheets			sufficient staffing is scheduled to meet care needs of each resident.	tne	
	any kind of bath on S				care needs of each resident.		
					D. Care delivery audits will be comple		
		that revealed the resident			for bathing/showers, and incontinent ca		
	got a shower or bath 4/15/17.	of any kind on Saturday			audits will be conducted 5 residents pe day x 4 weeks, 3 per day x 4 weeks, th		
		was interviewed on 4/20/17			once weekly x 4 weeks. Any deficit in		
		ted she worked from 3:00			care delivery or trends identified will be	9	
		then 11:00 PM and 7:00 PM			addressed by the Quality Assurance		
	over the weekend. SI	he worked last Saturday and			Performance Improvement committee		
		5 - 16, 2017). She came in			(QAPI) as they arise and the plan will b		
	•	e stated they were short			revised to ensure continued compliance	e.	
		n Saturday and Sunday. She			The QAPI committee consists of the	-1-	
	-	om 3:00 PM to 7:00 PM they			Administrator, DON, SDC, Minimum D		
		A) for the entire building and 00 PM they only had 2 NAs			Set Coordinator, Admissions Coordina Medical Director, Director of Social	ω,	
	for the whole building				Services, Quality of Life Director,		
		utting extra people on the			Chaplain, and Environmental Services		

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G		TE SURVEY MPLETED
			A. BUILDING	J		С
		345225	B. WING		0	4/26/2017
NAME OF P	ROVIDER OR SUPPLIER	<b>A</b>		STREET ADDRESS, CITY, STATE, ZIP COD		
				1602 E FRANKLIN STREET		
SIGNATU	RE HEALTHCARE OF C			CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 353	Continued From pag	e 98	F 35	53		
1 000		ot actually here. She stated	F JC			
		s up that had to get up for				
	-	is, but many residents had to				
	just eat in their beds					
	Nursing Assistant #5 was interviewed on 4/22/17 at 12:02 AM. She stated that they were really					
short staffed on Saturday 4/15/17 and she worked first shift. She stated that none of the residents were given a shower on Saturday on						
	-	amed up with the other NAs				
		e with all other residents				
		t enough staff. She stated				
	she worked 16 hours	s that day.				
	The resident was inte	erviewed on 4/22/17 at 1:49				
		ally wanted a shower last				
		le stated he really wanted a				
		l it didn't happen because				
	there was not enoug					
		ewed on 4/22/17 at 11:36				
		she worked last Saturday				
	-	4/16/17 and the Nursing				
		t staffed. She stated the ot to everyone to provide care				
	the best they could.	•				
	-	showers were missed, but				
		nat did not get completed.				
	She stated they were	e really short staffed on the				
		call nurse never came in.				
		as interviewed on 4/22/17 at				
		hat he would expect for staff esidents' needs. He stated				
		Easter holiday weekend was				
		short staffed with Nursing				
		d they had multiple staff				
	members that called					
		the staffing was usually				
	alright minus this pas					1

Facility ID: 923268

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	-					FORM	APPROVED
			(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,				LETED
			-				C
		345225	B. WING			04/	26/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN STREET		
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			CHAPEL HILL, NC 27514		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 353	Continued From page	99	F	353	3		
	2) Resident #24 was	admitted to the facility on					
	failure, Hemiplegia, a	nd multiple falls.					
	Resident #24's Minim	um Data Set dated 4/2/17					
	intact and required to	tal dependence for bathing.					
	The resident had a ca	are plan in place last					
	updated 4/7/17 for Ac	tivities of Daily Living Deficit					
	due to left sided hemi						
	any kind of bath on S	aturday 4/15/17.					
		ICARE & MEDICAID SERVICES         S       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         345225         PPLIER         ARE OF CHAPEL HILL         UMMARY STATEMENT OF DEFICIENCIES IDEFICIENCY MUST BE PRECEDED BY FULL .ATORY OR LSC IDENTIFYING INFORMATION)         From page 99         # #24 was admitted to the facility on with the current diagnosis of heart hiplegia, and multiple falls.         EXAMPLE INDEX         ARE of CHAPEL HILL         From page 99         # #24 was admitted to the facility on with the current diagnosis of heart hiplegia, and multiple falls.         EXAMPLE INDEX         At #24 was admitted to the facility on with the current diagnosis of heart hiplegia, and multiple falls.         EXAMPLE INDEX         At #24 was admitted to the facility on with the current diagnosis of heart hiplegia, and multiple falls.         At #24 was admitted to the facility on with the current diagnosis of Daily Living and the shower assignment sheets e resident's Activities of Daily Living and the shower assignment sheets e resident did not receive a shower or bath on Saturday 4/15/17.         PA was interviewed on 4/21/17 at 4:13 ated on Saturday that she was to get a shower in the afternoon. The that they didn't have enough staff to her to the shower. She stated she told was ok not getting a shower since she tidn't have enough					
	Resident #24 was inte	erviewed on 4/21/17 at 4:13					
		-					
	-	-					
	the NA she was ok no	ot getting a shower since she					
	-	-					
	Wednesday and Satu						
	NA #7 was interviewe	ad on 4/22/17 10:05 AM Sha					
	She stated that when	the resident's room was					
	-						
	reflect this change bu	t they all knew that it was					
	Wednesday and Satu						
	I NULSE #0 Was IIILEIVIE	$\frac{1}{2}$					

Facility ID: 923268

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345225	B. WING				_ 26/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			602 E FRANKLIN STREET SHAPEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 353	AM. She stated that s 4/15/17 and Sunday 4 Assistants were short nursing assistants go could. She stated that showers were missed that did not get compli- really short staffed on nurse never came in. NA # 5 was interview She stated the reside Saturdays. She stated staffed on Saturday at a shower but got was resident was able to h offered to give the res- resident stated "they shower because I kno- today". She stated sh- resident refusing a sh- of the residents were on blue hall. She had NAs to get bed baths because there wasn't she worked 16 hours The administrator wat 4/22/17 at 6:22 PM. H for staff for take care stated the staffing over weekend was rough at of Nursing Assistants staff members that care weekend. He stated t alright minus this pas 3.) Resident #97 was	she worked last Saturday 4/16/17 and the Nursing staffed. She stated the t to everyone the best they t she suspected that some d, but was not told of any leted. She stated they were a the blue hall and the on call ed on 4/22/17at 12:02 AM. Int got showers on d that they were really short ind resident #24 did not get hed up in the bathroom. The help some. She stated she sident a shower after but the don't have to give me a bw you all are short staffed he counted that as the iower. She stated that none given a shower on Saturday teamed up with the other done with all other residents a enough staff. She stated that day. s interviewed stated on he stated he would expect of the residents' needs. He er the Easter holiday and they were short staffed . He stated they had multiple alled out over Easter he staffing was usually	F	353				

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If continuation sheet Page 101 of 125

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345225	B. WING				26/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	hypertension. The resident's MDS of was moderately cogn required extensive as transfers, locomotion, and personal hygiene intermittent catheteriz continence and was f bowel. The resident had care for Activities of Daily I Resident #97 was up room on 4/20/17 at 10 that she had been wa had been waiting an I staff before 9:00 PM f and bed but was still always used the bedp observation, the reside back from crying and wheelchair as if she v resident still had her of On 4/20/17 at 10:45 F transferred from the v the assistance of 2 st When the NA went to bathroom the residen	lated 3/3/17 revealed she itively intact. The resident sistance with bed mobility, dressing, eating, toilet use a. The resident got ration. She had urinary requently incontinent of a plans last updated 3/8/17 Living and refusal of care. to her wheel chair in her 0:17 PM. The resident stated iting to use the bedpan and hour. She stated she asked to get her to the bathroom waiting. She stated she ban or bathroom. On lent's voice was whiney and ent appeared to be holding was moving around in her vas uncomfortable. The day clothes on. PM, the resident was still hair in her room for staff. PM, the resident was vheelchair to her bed with aff members via the lift. get the bedpan out of the t started to scream "hurry, the resident was place on ted. The resident was	F	353			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		PLE CONSTRUCTION	(X3) DATE COMP	
		345225	B. WING				_ 26/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	NA #6 was interviewe She stated the reside but mostly used the b resident always need with the lift and she w stated she always had her with the resident. 8:30 PM, the resident to bed and she told th a while because she a new admit and then stated the resident alw getting to the bed. Nursing Assistant #8 at 11:12 PM. She state putting extra people of not actually here. She been terrible for 3 mo The resident's family on 4/22/17 at 12:41 P member stated that th had to wait an hour se answer the call bell. H told him that it happen had to wait a long tim then had to wait a long tim then stated the stated accident in the past b her the bedpan in tim The resident was inte 12:41 PM. She stated night on 4/21/17 too. 4/20/17, she had use 9:00 PM and that the	ed on 4/20/17 at 11:12 PM. Int sometimes used the toilet redpan. She stated the ed assistance from 2 people vas rarely incontinent. She d to find someone to help She stated that tonight at t told her she wanted to get he resident it was going to be had other people to see and n would get back to her. She ways the bedpan before was interviewed on 4/20/17 the d the administration was on the schedule that were the stated that staffing had in ths. member were interviewed PM. The resident's family he resident told him that she ometimes for them to the stated the resident had ned again last night and she to use the bed pan and ig time for the staff to take . He stated he knew they it the resident has had an ecause they could not get	F	35	3		

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345225	B. WING				C 26/2017
NAME OF P	ROVIDER OR SUPPLIER		•	Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	APEL HILL			1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page	9 103	F	353	3		
F 371 SS=F	<ul> <li>4/22/17 at 6:22 PM. Hexpect staff to take car He stated the staffing weekend was rough a of Nursing Assistants staff members that car weekend. He stated the alright minus this pass 483.60(i)(1)-(3) FOOD STORE/PREPARE/SI</li> <li>(i)(1) - Procure food fr considered satisfactor authorities.</li> <li>(i) This may include for from local producers, and local laws or regulation of the state of the stat</li></ul>	he staffing was usually t weekend. D PROCURE, ERVE - SANITARY rom sources approved or ry by federal, state or local bod items obtained directly subject to applicable State llations. s not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents is not procured by the facility. distribute and serve food in essional standards for food lents by family and other e and sanitary storage,	F	371			6/5/17

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 06/08/2017 APPROVED ). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		LETED
		345225	B. WING			C 04/26/2017	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
0.01.47.1				10	602 E FRANKLIN STREET		
SIGNATU	RE HEALTHCARE OF CH			С	CHAPEL HILL, NC 27514		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG	х	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 371		9 104	F	371			
	by: Based on observation	ns and staff interviews the			F371:		
		e cookware and service					
		dried and in good repair;			A. The steam table pans were thoroug	hlv	
		alls and ceiling tiles were			cleaned and allowed to air dry by the	iny in a	
		air; and food was labeled,			dietary staff member on 4/18/17. Meal		
		ealed packages. This had			trays were reviewed by the Dietary		
	the potential to impac	t 83 of the 85 residents that			Manager 4/18/17. Those identified with	I	
	resided in the facility.				exposed metal edges were discarded.		
					The remaining meal trays were thoroug	jhly	
	Findings Included:				cleaned and allowed to air dry prior to returning them to service. New meal tra	ays	
		kitchen on 4/18/17 at 10:50			were ordered to replace those that wer		
	am with the Dietary M	lanager identified:			discarded. Ceiling tiles were reviewed	зу	
					the Maintenance Director and		
		ble pans were on a storage r wet with food particles.			Maintenance Assistant on 4/25/17. The that needed replacement were replace		
		i wet with lood particles.			The others were cleaned to remove for		
	· 25 of 25 meal tr	ays were on a storage cart			particles. The identified section of wall	, a	
		with food particles, pieces of			under the hood system with damage a	nd	
	tape and exposed me	tal edges.			peeling paint repairs and repainting wil	be	
					completed by the Maintenance Assista	nt	
		ad stains and food			on 4/24/17. The hood vents and light		
	substances on them.				covers under the hood system were		
	A postion (com	ovimately 15" long and 10"			thoroughly cleaned by the Chef on	or	
		oximately 15" long and 12" er the hood system was			4/18/17. The table that holds the steam was thoroughly cleaned by the dietary	ler	
	-	paint. The hood vents and			staff member on 4/18/17. The seal of t	he	
		hood system had a coating			ice machine bin door was cleaned	iic ii	
	of grease and dust on				thoroughly by the Dietary Manager on		
					4/18/17. The storage bin that containe	d	
	The table that he	ld the steamer was covered			gelatin mix that was stained and		
	with rusty colored wat	ter that contained food			contained food particles was washed a	nd	
	particles.				air dried by the Chef. The metal cart		
					containing cans of food was cleaned		
		ick substance on the seal of			thoroughly by dietary staff member on		
	the ice machine bin d	oor.			4/18/17. The opened bags of diced har		
	· A storage bin th	at contained packages of			chicken pieces, veggie burgers that we not labeled or dated and the open case		

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						10. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			7. 00120110			С
		345225	B. WING		0	4/26/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	CODE	
SIGNATU	RE HEALTHCARE OF CI			1602 E FRANKLIN STREET		
GIGINATO				CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE
F 371	Continued From page	e 105	F 37	71		
		ed and contained food		succotash that was not in s	sealed	
	0	rt containing cans of food		containers were discarded		
	had a layer of dust a	nd food particles on it.		Manager on 4/18/17.	-	
				B. An inspection of the kite		
		ezer contained opened bags		completed by the Dietary N 4/18/17 and any other issu		
		n pieces and veggie burgers I or dated. An open case of		were addressed by the Die		
		se of succotash were not in		on 4/18/17.	ally Manager	
	sealed containers an			C. Education will be comp	pleted by the	
				Dietary Manager with Dieta		
		/17 at 12:43 pm with the		4/23/17 regarding maintain		
		ealed she expected the		environment in the kitchen		
		be clean and air dried on		requirements of F371. Rou	•	
		ney were put away. She trays with exposed metal		schedules were developed Manager and reviewed with	• •	
		laced and the adhesive tape		by 4/23/17. Routine Main	•	
		She expected the meal trays		in the kitchen were develop		
		ved to air dry. She stated that		Administrator on 5/17/17 a	nd reviewed	
		tiles should be replaced and		with Maintenance Staff. Ro		
		clean and without food		maintenance rounds will be		
	-	the wall under the vent		monthly by the Plant Opera	-	
		paired and the hood vents uld be cleaned routinely.		or Plant Operations Assista staff will document mainter		
		the staff saw something dirty		repair on the Maintenance		
		d clean it immediately. She		review by the Plant Ops Di		
		ood products should be		repairs arise.		
				D. The Dietary Manager w		
		Administrator on 4/22/17 at		daily review of the daily cle	•	
		expected all open food		as well as weekly rounds b		
		ed, labeled and dated. He tchen equipment, walls and		Manager, Assistant Dietary Regional Dietary Manager		
		nd in good repair. He stated		Administrator. This review		
		n good repair, clean and		documented on the daily cl		
	allowed to air dry.			schedule for four weeks, th		
				two months. A Review of r	nonthly	
				maintenance rounds by Pla		
				Manager or Plant Operatio		
				be documented monthly x	3 months. All	

Event ID: HXZN11

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/08/2017 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345225	B. WING		C 04/26/2017
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, Z	•
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 27514	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 371 F 372 SS=C	PROPERLY (i)(4)- Dispose of garl This REQUIREMENT by: Based on observatio	E GARBAGE & REFUSE page and refuse properly. is not met as evidenced n and staff interviews the	F 3	data will be summarized the facility QAPI meeting months by the Dietary M Operations Manager. A trends identified will be a QAPI committee as they plan will be revised to en compliance. The QAPI of consists of the Administ MDS Coordinator, Admin Coordinator, Medical Di Social Services, Quality Chaplain, and Environm 72	g monthly x 3 Manager and Plant Any issues or addressed by the y arise and the nsure continued committee trator, DON, SDC, issions frector, Director of of Life Director, hental Services. 5/31/17
	<ul> <li>2) closed and maintaid umpster free of trash</li> <li>Findings included:</li> <li>An observation of the Dietary Manager on 4 the door of 1 dumpster trash was hanging ou plastic gloves, a tube and snack wrappers of ground around the du</li> <li>An interview with the at 12:43 pm revealed</li> </ul>	e dumpster area with the 4/18/17 at 11:15 am revealed er was open and a bag of it of the door. Cardboard, of toothpaste, soda bottles were noted to be on the		<ul> <li>A. No specific residents this cite. The dumpster by the Dietary Manager of the concern. The bag placed inside the dumps around the dumpster wa and debris.</li> <li>B. All residents have th affected by the alleged of The dumpster door was Dietary Manager upon in concern. The bag of tras inside the dumpster and the dumpster was cleared debris.</li> <li>C. Education was provi Maintenance Director, S Coordinator, or Director</li> </ul>	door was closed upon identification g of trash was ster and the area as cleared of trash e potential to be deficient practice. closed by the dentification of the sh was placed d the area around ed of trash and ided by the Staff Development

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPR OMB NO. 0938	8-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	1
		345225	B. WING		C 04/26/201	7
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BIGNATUI	RE HEALTHCARE OF CH	IAPEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPL	
F 372	Continued From page	e 107	F 372	facility staff to include nursing staff.	, dietary	
	2:05 pm revealed his	Administrator on 4/22/17 at expectation was that the be clean and the dumpster		staff, and housekeeping staff, rega the requirement to keep the dumps door closed and keep the area arou dumpster clear of trash and debris. will be completed by 5/31/17. D. The Maintenance Director or Maintenance Assistant will complet rounds 2 times daily for 2 weeks, 3 weekly for 2 weeks, then weekly fo weeks to ensure the dumpster door remains closed and that the area a the dumpster is clear of trash and of Findings of the rounds will be forwa the Administrator to ensure correcti actions immediately upon identifica any concern. Findings of the round be discussed by the Maintenance I with the Quality Assurance Perform Improvement team (QAPI) monthly months for recommendations and f follow-up as indicated.	ter und the This times r 2 r round debris. arded to ive tion of s will Director hance for 3	
F 431 SS=E	LABEL/STORE DRU		F 431		5/31/1	7
	them under an agree §483.70(g) of this par	ment described in t. The facility may permit to administer drugs if State under the general				
	that assure the accur dispensing, and admi	cility must provide ces (including procedures ate acquiring, receiving, inistering of all drugs and ne needs of each resident.				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE SURV COMPLETED	
		345225	B. WING				C 26/2017
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			602 E FRANKLIN STREET HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From page	e 108	F 4	131			
		ion. The facility must services of a licensed					
	disposition of all cont	tem of records of receipt and rolled drugs in sufficient curate reconciliation; and					
	(3) Determines that d that an account of all maintained and perio						
		s used in the facility must be e with currently accepted s, and include the y and cautionary					
	the facility must store locked compartments	h State and Federal laws, all drugs and biologicals in s under proper temperature only authorized personnel to					
	permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when t package drug distribu quantity stored is min be readily detected.	provide separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to the facility uses single unit ution systems in which the imal and a missing dose can					

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/20 MAPPROVE 0. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345225	B. WING			04	C // <b>26/2017</b>
NAME OF PF	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUF	RE HEALTHCARE OF CH	IAPEL HILL			2 E FRANKLIN STREET APEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIOI DATE
F 431	Continued From page	e 109	E 4	431			
		ons and staff interviews, the			F431:		
		iscard expired medications			A. The Tuberculin PPD injectable		
	• •	hortened expiration dates in			medication that had an opened date	of	
		ms (Red Hall medication			1/21/17 was discarded on 4/19/17 b		
		medication carts (Blue Hall			Nurse Consultant. The Lantus Insuli		
		all front cart); and, 2) Failed			an opened date of 3/9/17 was discal	rded	
	to store medications	in accordance with the			on 4/19/17 by the Charge Nurse. Th	е	
		nmendations in 1 of 2			Budesonide Inhalation Suspension f	or	
		ed Hall medication room)			Resident #43 that was found to be o	•	
		tion carts (Red Hall front			and not dated to indicate when it had	d	
	cart).				been opened was discarded by the		
	1 a Accompanied by	the facility 's Corporate			Charge Nurse on 4/19/17. The Budesonide Inhalation Suspension f	or	
		observation was made on			Resident #28 that was found to be o		
		f the Red Hall medication			and not dated to indicate when it has	•	
		on revealed an open, vial of			been opened was discarded by the		
		table medication (used for			Manager on 4/19/17. The Niacin 500		
	skin test in the diagno	osis of tuberculosis) was			tablets (stock medication) that were	found	
	stored in the refrigera	ator. A hand-written date			to be expired were discarded by the	Nurse	
		he outside of the box and on			Consultant on 4/19/17. The Prednise		
		ate the Tuberculin PPD			Acetate 1% ophthalmic solution that		
		ed on 1/21/17. A pharmacy			found to be stored inappropriately w		
		ed on the vial read, "Discard the expiration date of 30			discarded by the Corporate Nurse o		
	days."	ine expiration date of 30			4/19/17. The Dorzolamide-timolol ey drops that were inappropriately store		
	uuyo.				the refrigerator were discarded by the		
	The manufacturer 's	product information			Nurse Consultant on 4/19/17.		
	indicated opened vial	-			B. All residents have the potential to	o be	
	-	should be discarded after			affected by the alleged deficient practice		
	30 days.				An audit of medication carts was au		
					by the nurse consultant on 4/19/17 a	•	
		ducted on 4/19/17 at 2:35			concerns identified were immediatel	у	
	PM with the facility 's				corrected.		
		quiry, the Nurse Consultant			C. Education will be completed by th		
		culin PPD medication was			staff development coordinator by 5/3		
	expired.				regarding F431 and the policy for lal		
I							
	An interview was can	ducted on 4/20/17 at 5:15			and storage of drugs and biologicals licensed nursing staff. A review was		

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AID SERVICES	(X2) MULT			O. 0938-0391
	. ,	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
345225	B. WING		04	C 1/26/2017
		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
1111		1602 E FRANKLIN STREET		
		CHAPEL HILL, NC 27514		
BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	ON SHOULD BE	(X5) COMPLETION DATE
be storage concerns atted, "That was de on 4/19/17 at 3:15 edication cart. The ened vial of Lantus tion cart was expired. led for use by n note on the insulin n was opened on t information use), Lantus insulin frigeration or at room vs. Physician Orders t order for Lantus ts injected skin) once daily every n provided by Medication R) indicated the Lantus insulin 11 culated expiration with Unit Manager #1 ng the interview, the d Lantus insulin 28 days after opening. on 4/20/17 at 5:15 istrator. During the reported he had been	F 4	medication rooms on 4/20/11 Director of Nursing, Assistan Nursing, or Unit Coordinator Nurse or Nurse Consultant to no other expired medications available for usage, that mul were appropriately labeled a to when they were opened, a medications were stored app based upon manufacturer D. The Director of Nursing, A Director of Nursing, Unit Coo Licensed Nurse or Nurse Co complete an audit 3 times a weeks, then 2 times weekly then once weekly for 2 week medication rooms and medic ensure medications are labe appropriately, that medicatio expired and available for use stored according to manufac guidelines. Corrective action completed immediately upor of a concern. Findings of the audit will be discussed by the Nursing with the Quality Ass Performance Improvement C (QAPI) monthly for 6 months continued compliance and for	at Director of c, Licensed o ensure that s were ti-dose vials and dated as and that propriately s guidelines. htified. Assistant prodinator, ponsultant will week for 2 for 2 weeks, s of cation carts to eled ons are not e, and are cturer □ s a will be n identification e above stated e Director of urance committee s to ensure or	
	345225         HILL         T OF DEFICIENCIES         BE PRECEDED BY FULL         ITIFYING INFORMATION)         reported he had been         on storage concerns         ated, "That was         de on 4/19/17 at 3:15         edication cart. The         ened vial of Lantus         tion cart was expired.         led for use by         n note on the insulin         n was opened on         et information         use), Lantus insulin         effigeration or at room         y.         Physician Orders         t order for Lantus         its injected         skin) once daily every         n provided by         Medication         R) indicated the         Lantus insulin 11         culated expiration         with Unit Manager #1         ing the interview, the         d Lantus insulin         28 days after opening.         on 4/20/17 at 5:15         nistrator. During the         reported he had been         on storage concerns	HILL       ID         HILL       ID         PRECEDED BY FULL       PREFIX         ITIFYING INFORMATION)       PREFIX         Tag       F 4         reported he had been       F 4         on storage concerns       ated, "That was         de on 4/19/17 at 3:15       edication cart. The         ened vial of Lantus       tion cart was expired.         led for use by       n note on the insulin         n was opened on       et information         et information       euse), Lantus insulin         effigeration or at room       r/s.         Physician Orders       t order for Lantus         its injected       skin) once daily every         n provided by       Wedication         R) indicated the       Lantus insulin 11         culated expiration       with Unit Manager #1         ing the interview, the       Lantus insulin 28 days after opening.         on 4/20/17 at 5:15       nistrator. During the         reported he had been       end been	IILL       STREET ADDRESS, CITY, STATE, ZIP CO.         IILL       ID         TOF DEFICIENCIES       ID         BE PRECEDED BY FULL       PREFIX         TREED ADDRESS, CITY, STATE, ZIP CO.       (EACH CORRECTIVE ACTINE         BE PRECEDED BY FULL       PREFIX         TREED ADDRESS, CITY, STATE, ZIP CO.       (EACH CORRECTIVE ACTINE         Department       PREFIX         TAG       PROVIDER'S PLAN OF CO.         Department       (EACH CORRECTIVE ACTINE         On storage concerns       TAG         ated, "That was       F 431         medication rooms on 4/20/1       Director of Nursing, Assistar         Nursing, or Unit Coordinator       Nurse or Nurse Consultant to no other expired medication available for usage, that muluwere appropriately labeled at to when they were opened, at medications were stored apple based upon manufacture and to the insulin on note on the insulin         n note on the insulin       No other concerns were ider         n use), Lantus insulin       Weeks, then 2 times weekly then once weekly for 2 week         physician Orders       Weeks, then 2 times weekly         t order for Lantus       Stored according to manufacture appropriately, that medicatic expired and available for usage stored according to manufacture and the indicated expiration         Physician Orders       Crecorective action         t or	HILL     STREET ADDRESS. CITY, STATE, ZIP CODE       HILL     ID       TO DEFICIENCIES     ID       PRECEDED BY FULL     ID       THEYING INFORMATION)     ID       PRECEDED BY FULL     ID       PRECEDED BY FULL     ID       THEYING INFORMATION)     PRECIDENCES       Preported he had been     ID       on storage concerns     ID       ated, "That was     F 431       Medication cart. The     medication rooms on 4/20/17 by the       Din cotor septored     Director of Nursing, Assistant Director of       Nurse or Nurse Consultant to ensure that no other expired medications were appropriately labeled and dated as to when they were opened, and that       medication cart. The     medications were stored appropriately based upon manufacturer: s guidelines.       No other concerns were identified.     D. The Director of Nursing, Assistant       Director of Nursing, Mit Coordinator, Licensed Nurse or Nurse Consultant will complete an audit 3 times a week for 2       weeks, then 2 times weekly for 2 weeks, of medication rooms and medication carts to ensure medications are labeled appropriately, that medications are not expired and available for use, and are stored according to manufacturer: s guidelines. Corrective action will be completed immediately upon identification of a concern. Findings of the above stated audit will be discussed by the Director of Nursing with the Quality Assurance Performance Improvement Committee (QAPI) monthy for 6 months to ensure continued compliance and for recommendations and

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		ND HUMAN SERVICES MEDICAID SERVICES				FOI	ED: 06/08/2017 RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345225	B. WING			0	C 4/26/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SIGNATU	RE HEALTHCARE OF CH			160	2 E FRANKLIN STREET		
				СН	APEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 431	Continued From page	e 111	F 4	.31			
	identified on 4/19/17. unacceptable."	He stated, "That was					
	observation was made the Blue Hall back me observation revealed budesonide inhalation corticosteroid medica a nebulizer) labeled f in a drawer of the me the carton of the bud suspension indicated dispensed from the p carton included one of envelope lying in the inhalation suspension carton. Upon review, on the box of the bud suspension included read, in part: "Once t use the vials within 2	a carton of 0.5 mg / 2 ml n suspension (a tition to be inhaled via use of or Resident #43 was stored edication cart. Labeling on esonide inhalation the medication was harmacy on 3/28/17. The opened and empty foil box on top of 1 vial of n lying on the bottom of the the manufacturer labeling					
	revealed there was a budesonide 0.5 mg /	#43 's Physician Orders current order for 2 ml inhalation suspension al via nebulizer twice daily.					
	on 4/19/17 at 3:20 PM	ducted with Unit Manager #1 M. During the interview, the d she did not know when d been opened.					
	PM with the facility ' s interview, the Admini	ducted on 4/20/17 at 5:15 s Administrator. During the strator reported he had been redication storage concerns					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 06/08/2017 RM APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345225	B. WING			04	C 4/26/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH			1	602 E FRANKLIN STREET		
CICILATO				C	CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	unacceptable." 1.d. Accompanied by observation was mad the Blue Hall front me observation revealed budesonide inhalation corticosteroid medica a nebulizer) labeled fr in a drawer of the me the carton of the bude suspension indicated dispensed from the p carton included one of containing 3 vials of i second opened foil en inhalation suspension manufacturer labeling budesonide inhalation storage instructions w foil envelope is opened weeks." Neither of th were dated to indicate A review of Resident revealed there was a budesonide 0.5 mg / to be given as one via An interview was con	He stated, "That was Unit Manager #1, an le on 4/19/17 at 3:05 PM of edication cart. The a carton of 0.5 mg / 2 ml n suspension (a tion to be inhaled via use of or Resident #28 was stored dication cart. Labeling on esonide inhalation the medication was harmacy on 4/3/17. The opened foil envelope nhalation suspension; and, a nvelope containing 2 vials of n. Upon review, the g on the box of the n suspension included which read, in part: "Once the ed, use the vials within 2 he opened foil envelopes e when they were opened. #28 ' s Physician Orders	F	431			
	the foil envelopes had An interview was con PM with the facility 's interview, the Adminis	ed she did not know when d been opened. ducted on 4/20/17 at 5:15 s Administrator. During the strator reported he had been edication storage concerns					

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	-	ID HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _		COMP	PLETED
		345225	B. WING				C 26/2017
NAME OF P	ROVIDER OR SUPPLIER	010110		5	STREET ADDRESS, CITY, STATE, ZIP CODE	04/	20/2017
					1602 E FRANKLIN STREET		
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL			CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 431	identified on 4/19/17. unacceptable." 1.e. Accompanied by	He stated, "That was the facility ' s Corporate	F 4	431			
	4/19/17 at 2:30 PM of room. The observation stock bottle of 500 mi (a vitamin B supplement with the other stock m	ration date stamped on the					
	PM with the facility ' s Consultant. Upon inc	ducted on 4/19/17 at 2:35 Corporate Nurse quiry, the Nurse Consultant ottle of 500 mg Niacin					
	PM with the facility ' s interview, the Adminis made aware of the m	ducted on 4/20/17 at 5:15 Administrator. During the strator reported he had been edication storage concerns He stated, "That was					
	Nurse Consultant, an 4/19/17 at 2:45 PM of medication cart. The opened bottle of pred ophthalmic suspension medication) was stored drawer of the medication were labeled for use I dispensed from the pl (opened on 3/26/17). storage instructions p	observation revealed an nisolone acetate 1% on eye drops (a steroid ed lying down on its side in a tion cart. The eye drops by Resident #76 and					

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
	345225	B. WING		04/26/2017
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	CODE
SIGNATURE HEALTHCARE OF	CHAPEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 27514	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
<ul> <li>revealed the reside order for prednisole suspension eye drainstilled into the rig</li> <li>An interview was of PM with the facility Consultant. Upon reported the prednisole with the manufacture of the prednisole with the manufacture of the facility interview, the Adminade aware of the identified on 4/19/1 unacceptable."</li> <li>2.b. Accompanied Nurse Consultant, 4/19/17 at 2:30 PW room. The observation bottle of dorzolamic combination eye miglaucoma) was stored to be 42 observation. The experimentation of the instructions specific indicated the eye of 200-250C (680-77).</li> </ul>	50F). Int #76 's physician orders ent had a current medication one acetate 1% ophthalmic ops to be given as one drop ht eye three times a day. Inducted on 4/19/17 at 2:50 's Corporate Nurse inquiry, the Nurse Consultant isolone acetate eye drops tored upright in accordance rer 's instructions. Inducted on 4/20/17 at 5:15 's Administrator. During the inistrator reported he had been medication storage concerns 7. He stated, "That was by the facility 's Corporate an observation was made on I of the Red Hall medication ation revealed an unopened de-timolol eye drops (a edication used to treat red in the refrigerator. The medication room refrigerator to F at the time of the eye drops were labeled for use d dispensed from the pharmacy anufacturer 's storage ed in the package insert roops should be stored at	F 4	31	

Facility ID: 923268

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 06/08/2017 // APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE COMF	SURVEY PLETED
		345225	B. WING		C 04/26/2017	
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUI	RE HEALTHCARE OF CH	IAPEL HILL		E FRANKLIN STREET APEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 431 F 441 SS=E	order for dorzolamide given as one drop ins times a day. An interview was con PM with the facility 's Consultant. Upon inc reported she would n pharmacy to see if the used. The Consultan medications to be sto manufacturer 's instri- An interview was con PM with the facility 's interview, the Adminis made aware of the m identified on 4/19/17. unacceptable." 483.80(a)(1)(2)(4)(e)( PREVENT SPREAD, (a) Infection prevention The facility must esta and control program (a minimum, the follow (1) A system for preve investigating, and cor communicable diseas volunteers, visitors, a providing services un arrangement based u conducted according	had a current medication timelol eye drops to be tilled into each eye two ducted on 4/19/17 at 2:35 a Corporate Nurse puiry, the Nurse Consultant eed to check with the e medication could still be t stated she would expect red in accordance with the uctions. ducted on 4/20/17 at 5:15 a Administrator. During the strator reported he had been edication storage concerns He stated, "That was f) INFECTION CONTROL, LINENS on and control program. blish an infection prevention (IPCP) that must include, at ving elements: enting, identifying, reporting, ntrolling infections and ses for all residents, staff, nd other individuals der a contractual pon the facility assessment to §483.70(e) and following ndards (facility assessment	F 431			5/31/17

Facility ID: 923268

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345225	B. WING				C 26/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
SIGNATU	RE HEALTHCARE OF CH	APEL HILL		1602 E FRANKLIN STREET CHAPEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page	9 116	F	441	1		
		, policies, and procedures h must include, but are not					
	possible communicab	lance designed to identify le diseases or infections ad to other persons in the					
		n possible incidents of e or infections should be					
	. ,	smission-based precautions ent spread of infections;					
	(iv) When and how iso resident; including bu	blation should be used for a t not limited to:					
	involved, and (B) A requirement tha	ation of the isolation, nfectious agent or organism t the isolation should be the ple for the resident under the					
	must prohibit employed disease or infected ske	s under which the facility ees with a communicable kin lesions from direct or their food, if direct ne disease; and					
	(vi) The hand hygiene by staff involved in dir	e procedures to be followed rect resident contact.					
	(4) A system for recor under the facility's IPC	ding incidents identified CP and the corrective					

Facility ID: 923268

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/08/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345225	B. WING		C 04/26/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SIGNATUR	RE HEALTHCARE OF CH			1602 E FRANKLIN STREET	
JONATO				CHAPEL HILL, NC 27514	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 441	Continued From page	e 117	F 44	1	
	actions taken by the f				
	,	,			
	(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.				
	(f) Annual review. Th annual review of its If program, as necessa	-			
	by:	is not met as evidenced		F441	
		nent surveillance of a room		A. On 3/15/17 rooms 110 and 111 v	vere
		ns and residents after the		inspected and there was no noted b	
		s, and failed to prevent the		bug activity during this inspection.	
		additional resident rooms		bugs were addressed for residents	
	-	esidents reviewed for pest		#48, #67, #173 through skin evaluat	tions
	and resident #25).	resident #48, resident #173		and there is no further indication or observation of active bed bugs.	
	Findings included:			B. All residents have the potential to affected by this alleged deficient pra	
	The facility's bed bug	policy dated 8/2015 stated		An inspection on 5/18/17 by the pes	
		t of bed bugs included staff		management company revealed no	
		on, recordkeeping and		bugs.	
		of resident's symptoms,			
	treatment of infestation			C. Education was provided to Licen	
	treatment effectivene			Nursing and Certified Nursing Assis	tants
		y also specified that the ent the actions taken for the		by Staff Development Coordinator, Director of Nursing, and Plant Opera	ations
	•	staff training on eradication		Manager regarding surveillance of s	
		lity wide plan to monitor and		members that come in contact with	
	respond to future infe			residents that are found to have bed	d bug.
	-			Maintaining documentation of surve	0
	-	11/24/16 stated that a		that is completed on other residents	
		giving care to Resident #48		monitor for future bed bugs. The po	-
		ne bed bugs on the resident.		and procedure for pest control (bed	bug).
		t took some specimens on her staff member to confirm		D. The pest management company	( will
	tape and asked alloll				VVIII

Facility ID: 923268

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/2017 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345225	B. WING _				C /26/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SIGNATU	RE HEALTHCARE OF CH			16	602 E FRANKLIN STREET		
		<i></i>		С	HAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	advised that the resid and that a skin check Another nursing note Resident #67 who wa #48, was also moved bugs were found in R residents were showe gown. A nursing note dated	pervisor was called and lent be moved to room 110B		141	audit and document surveillance of ro 110, 111 periodically and other rooms within the facility monthly x 6 months. issues or trends identified will be addressed by the Quality Assurance Committee (QAPI) as they arise and t plan will be revised to ensure continue compliance. The QAPI committee consists of the Administrator, DON, S MDS Coordinator, Admissions Coordinator, Medical Director, Director Social Services, Quality of Life Director Chaplain, and Environmental Service	Any he ed DC, or of or,	
	of itching. The reside checks and mattress further treatments or There was no other d about the surveillance	ptoms of bites or complaints nt agreed with daily skin checks. There were no orders at this time. locumentation provided e of staff members that Residents #67 and #48 on			This will be completed by 5/31/17.		
		/17 stated that pest control gs were present in the its # 67 and # 48 had					
	Administration Recor	ber, 2016 Medication d (MAR) revealed Resident on isolation until 11/25/16.					
	bed bug from 11/25/1 mattress checks were through 11/30/16. A note from pest cont	MAR revealed that aced on contact isolation for 6 through 11/28/16 and e completed from 11/25/16 arol dated 11/26/16 revealed oted during inspection of					

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	· ,				LETED
						'	C
		345225	B. WING			04/	26/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUI	RE HEALTHCARE OF CH	IAPEL HILL			602 E FRANKLIN STREET CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441	Bed begs were noted activity was present of the wheelchair. The a room was inspected a taken out of service u 110, 112, and 113 we and inspected but no A 24 hours follow up a 11/27/16 stated that in noted in room 111 on Rooms 112, 114, 110 bed beg activity was a was completed for roo found on the second a A staff in-service date was educated on faci There was no docum was completed for oth implemented to monit infestations from 11/2 The infection control on 4/21/17 at 2:08 PM problems with bed bu and January. She sta 111A was affected that resided in this room w different rooms, giver control was called. Th member had brought residents were assess skin checks were pre-	idents #67 and #48 resided. during treatment. Bed bug only in room 111 bed A and action needed stated that the and serviced and should be until further notice. Rooms re also treated for bed bugs bed bugs were noted. from pest control dated no bed bug activity was follow up after treatment. were also inspected and no found. A follow up treatment om 111 and no activity was follow up. ed 11/30/16 revealed staff lity's bed bug policy. entation of surveillance that her residents or a plan tor for future bed bug 27/16 to 12/9/16. (IC) nurse was interviewed <i>A</i> . She stated the facility had togs in November, December ted in November, 2016, bed	F	441			
	nurse explained anoth happened in Decemb	her issue with bed bug issue					

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 06/08/2017 RM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345225	B. WING			C 04/26/2017	
NAME OF P	ROVIDER OR SUPPLIER	·		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH			160	2 E FRANKLIN STREET		
SIGNATO				CH	APEL HILL, NC 27514		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 441	ROVIDER OR SUPPLIER RE HEALTHCARE OF CHAPEL HILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	441			

Facility ID: 923268

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	FORM APPROVED OMB NO. 0938-0391							
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDIN			COMPLETED		
		345225	B. WING			C 04/26/2017		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
SIGNATU	RE HEALTHCARE OF CH	IAPEL 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 441	Continued From page 121 medical office too. He stated that he would always spray the adjoining rooms too. He stated the pest control staff had the facility bag up everything in the resident's room, wash everything at the hottest temperature as possible and then separate and clean everything before the resident was let back in the room. The resident's wheelchair were to be cleaned using an alcohol based solution. They were not sure how the bed bugs were coming in but thought family was bringing them in. The Infection control nurse was interviewed on 4/22/17 at 5:07 PM. She stated the facility did surveillance of bed bugs for the entire facility via the nurses but didn't know where they documented it for the first and second time they had incidents of bed bugs. The Infection control nurse was interviewed on 4/22/17 at 1:52 PM. She stated there was no other paperwork she had on what was done		F	441				
	surveillance for bed b months, the nurses w the checks for the blu bed bugs were found. The administrator was 4/22/17 at 6:22 PM. H	She didn't know where the ugs was for the missing ere supposed to be doing e hall, which was where the s interviewed stated on de stated he would expect called to make sure the bed						
	bed bugs were noted 110 and they recomm taken out of service. A nursing note dated	ated 12/20/16 stated that during inspection in room lended that the room be 12/22/16 stated Resident n room #110 to room #114						

Facility ID: 923268

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/2017 M APPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345225	B. WING				C / <b>26/2017</b>
NAME OF PF	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH				1602 E FRANKLIN STREET		
	-			(	CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	Continued From page	e 122	F.	441			
	due to bed bug proble precautions.	ems and placed on isolation					
	report dated 12/2016 and check list of 17 it This included that blo residents body and m (no date). The health (12/22/16), employee (12/20/16), pest contr cleaning rooms and c affected resident and disinfected and bagg (12/20/16) per CDC g and body audit was p resident (12/20/16), a treated (12/22/16), fa performed weekly for months (per skin sche The MAR for Resider resided in room #110	rol was contacted for other surfaces (12/21/16), roommate's clothes were ed per pest control guideline and pest control performed on affected affected residents were cility wide skin sweeps were 1 month and monthly for 3 edule.) nt #173, who originally					
	12/29/16 and was ge checks from 12/22/16	C C					
	room 110 was inspect bugs. Rooms 111,113 inspected and no bec note also stated that bed bugs were on the	ated 12/23/16 stated that sted and treated for bed 3,114, 119 were also d bug activity was found. The during the inspection that e wheelchair of room 110 so completed on the exterior					
		nentation of other resident's cked for bug surveillance 0 or the facility for					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345225	B. WING				C 26/2017
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF CH	IAPEL 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)			PROVIDER'S PLAN OF CORRECTION           FIX         (EACH CORRECTIVE ACTION SHOULD BE           G         CROSS-REFERENCED TO THE APPROPRIATE           DEFICIENCY)         DEFICIENCY			(X5) COMPLETION DATE
F 441	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	441			

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		ID HUMAN SERVICES				FORM	APPROVED	
					CONSTRUCTION		0.0938-0391	
STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION					(X3) DATE SURVEY COMPLETED			
			A. BUILDI	ING _		с		
		345225	B. WING			04/26/2017		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				10	602 E FRANKLIN STREET			
SIGNATU	RE HEALTHCARE OF CH	IAPEL HILL		с	HAPEL HILL, NC 27514			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
TAG	REGULATORY OR		TAG		DEFICIENCY)			
F 441	Continued From page	e 124	F	441				
	An insect/bed bug ski	in check was completed on						
		nts on 100 hall on the 11:00						
		00 AM - 3:00 PM shift and						
		shift and 7:00 AM - 11:00						
	PM shift and no bed b	bugs were noted.						

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