### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Signature Healthcare of Chapel Hill  
**Street Address, City, State, Zip Code:** 1602 E Franklin Street, Chapel Hill, NC 27514

**Provider's Plan of Correction:**  
(Each corrective action should be cross-referenced to the appropriate deficiency)

#### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Initial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
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<td>A paper follow up was conducted on 10/20/2020 and the facility is back into compliance effective 10/12/2020. The Directed Plan of Correction which included the Root Cause Analysis were reviewed.</td>
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</tbody>
</table>

**Laboratory Director's or Provider/Supplier Representative's Signature:** Electronically Signed  
**Title:**  
**Date:** 10/21/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.