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

PRINTED: 10/21/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF CHAPEL HILL  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SIGNATURE HEALTHCARE OF CHAPEL HILL  (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  R-C 10/20/2021  STREET ADDRESS, CITY, STATE, ZIP CODE  1602 E FRANKLIN STREET  CHAPEL HILL, NC 27514  (EACH CORRECTION SHOULD BE PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF CHAPEL HILL  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  1602 E FRANKLIN STREET  CHAPEL HILL, NC 27514  ID PROVIDER'S PLAN OF CORRECTION (X5)  COMPLET (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE			345225	B. WING				
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE					STREET ADDRESS, CITY, STATE, ZIP CODE  1602 E FRANKLIN STREET			
	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACCROSS-REFERENCED TO	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
F 000  A paper follow-up was conducted on 10-20-21 and the facility is back into compliance effective 10-5-21. Event ID C8Q312	F 000	A paper follow-up wand the facility is bad	as conducted on 10-20-21 ck into compliance effective	FC	100			

**Electronically Signed** 

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE