STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345225	A. BUILDING ______ B. WING ______	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/08/24 through 04/11/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #503V11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/08/24 through 04/11/23. Event ID# 503V11. The following intakes were investigated NC00210823, NC00211388, NC00214583, and NC00213746. 9 of 9 complaint allegations did not resulted in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 553		5/5/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/01/2024

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.

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F 553	Continued From page 1 right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with the resident, Responsible Party (RP), and staff, the facility failed to facilitate the inclusion of a cognitively intact resident and her RP in the care planning process for 1 of 1 resident reviewed for the care planning process (Resident #71). The findings included: Resident #71 was admitted to the facility on 6/9/23. The medical record indicated Resident #71's family member was her RP. A review of Resident #71's care plan dated 6/9/23 revealed it was last revised on 3/20/24 at 5:21 pm. Review of the care conference note dated 12/14/23 indicated a care plan meeting was held regarding Resident #71. The attendees listed were the Minimum Data Set (MDS) Nurse and the Social Services Director (SSD).	F 553	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F.553 Corrective action the resident found to have been affected by the deficient practice: Resident #71 still resides in the facility. On 4/10/24, the Social Worker sent an invitation letter to the resident for a care plan meeting scheduled for 4/25/24 at 2:15 pm. The resident and her daughter opted to have a meeting on 5/2/24 at 3:00 pm. Corrective action for other residents having the potential to be affected by the same deficient practice: On 4/10/24, the Social Worker reviewed	

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F 553 Continued From page 2

The care conference note dated 3/7/24 indicated a care plan meeting was held regarding Resident #71. The attendees listed were the MDS Nurse, SSD, and Unit Manager #1.

The record did not reveal evidence that Resident #71 or her RP had been invited to or involved in the care planning and review process.

Review of the quarterly MDS dated 3/13/24 revealed Resident #71 was cognitively intact.

During an interview on 4/8/24 at 10:33 am, Resident #71 revealed nobody had talked with her about her care plan.

During a follow-up interview on 4/10/24 at 7:19 pm, Resident #71 stated her RP may know more about the care plan meeting. Resident #71 explained she could not get out of bed and wondered how the facility could include her during the care plan meetings. She stated nobody offered other ways for her to attend the meetings.

During a telephone interview on 4/10/24 at 4:49 pm, Resident #71's RP revealed she had not received any invitation to a care plan meeting this year. She stated could not remember the exact date, but last year she had been called and invited to a care plan meeting after Resident #71 was admitted to the facility. She explained she had not received any further invitations.

During an interview on 4/09/24 at 2:36 pm, the SSD revealed Resident #71, or the RP did not attend the care plan meetings on 12/14/23 and 3/7/24. She stated she usually talked to the residents and invited them to care plan meetings

F 553

the care plan calendar from 2/01/ 2024 to 4/30/2024 for any resident/responsible party, not in attendance for the care plan, they were provided the opportunity via letter/phone to participate in a make-up care plan conference. The review was completed on 4/12/24 and invitation letters were sent as needed. Any requests for changes to the meeting date and time will be communicated, rescheduled, and documented as needed. Residents have a choice to request a care plan meeting whenever they wish, and this will be reiterated to the residents during the resident council meeting scheduled for 5/7/24.
Systemic changes made to ensure that the deficient practice will not recur:

On 4/25/24, the Administrator initiated education for the Social Worker, Assistant Social Worker, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Minimum Data Set (MDS) nurses on ensuring that residents and/or their representatives are invited to the care plan meetings. Education was completed on 4/26/24. Any new hires will be educated as indicated above by the Administrator and/or DON during orientation. Any Social Worker, Assistant Social Worker, DON, ADON, and MDS nurses not educated as indicated, will be provided education before the start of their next shift, and not be allowed to work until their education is completed.
The Administrator implemented a monthly process for validation to include a calendar, an invitation letter, and an

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F 553 Continued From page 3

and called to invite the representatives. The SSD could not recall the reason Resident #71, or the RP were unable to attend. She could not recall if any reasonable adjustments were made to accommodate Resident #71's or her RP's schedule. She stated it was either they did not want to attend, or she did not get an answer in time. She stated they could conduct the care plan meeting in the resident's room or in her office depending on the resident's preference. The SSD stated the invitation, the reason for the resident's or RP's absence and any attempts to work with them to facilitate their attendance were not documented in the medical records.

During an interview on 4/10/24 at 1:57 PM, the MDS Nurse stated she created the list of residents that were due for care plan meetings and gave them to the SSD. The SSD sent letters to the representatives or verbally invited the residents to their care plan meetings. The MDS Nurse stated all refusals were documented in their care plan. She checked Resident #71's care plan and revealed there were no refusals documented in the resident's care plan. She stated she was not aware of the reason for Resident #71's or the RP's absence during the care plan meetings on 12/14/23 and 3/7/24.

During an interview on 4/10/24 at 9:40 am, the Director of Nursing stated the care plan meetings were held quarterly, annually, and as needed. She stated the residents, and their RP should be encouraged to always attend and participate in their care plan.

During an interview on 1/24/24 at 1:42 PM, the Administrator stated he expected all the residents to be involved in their care. Any contact with the

F 553

observation tool on 4/26/24 to be utilized by the Social Worker, Assistant Social Worker, and MDS nurses to ensure all residents/responsible parties are allowed to participate in the care plan conference.
Plans to monitor its performance to make sure that solutions are sustained:
The Social Service Director/Designee will provide the tools to the Quality Assurance (QA) committee weekly for 4 weeks, then monthly for 3 months until compliance is maintained. The Administrator and/or the DON will review the observation tool weekly for 4 weeks and then monthly until compliance is maintained.
Any areas of non-compliance will be reported by the Administrator and/or DON to the QA Committee quarterly or as needed for further action and adjustments to the plan to ensure compliance.
Date of Compliance: 5/5/24

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F 553	Continued From page 4 resident or RP regarding their care should be documented.	F 553		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews with resident and staff, the facility failed to assess if a cognitively impaired resident could self-administer eye drops kept at the bedside for 1 of 1 resident reviewed for self-administration (Resident #6). The findings included: Resident #6 was admitted to the facility on 8/20/15. Her diagnoses included glaucoma (increased pressure within the eyeball causing gradual loss of vision), and dry eyes syndrome. Review of the physician order dated 7/15/20 revealed Resident #6 was to receive one drop of latanoprost 0.005%, a prescription eye drop, in each eye each night between the hours of 7:00 pm to 11:00 pm to treat glaucoma. Another order on 3/14/24 revealed Resident #6 was to receive two drops of artificial tears, an over-the-counter eye drop, for dry eyes four times a day at 8:00 am, 12:00 noon, 4:00 pm and 8:00 pm. There was no physician order for Resident #6 to self-administer medications. Review of Resident #6's annual Minimum Data Set dated 2/25/24 revealed she had impaired	F 554	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F. 554 D Corrective action the resident found to have been affected by the deficient practice: Resident #6 still resides in the facility. On 4/25/24, the resident was assessed by the DON and found not to have the ability to self-administer medications as ordered. The resident's medications will only be administered by a licensed nurse and/or a qualified medication aide as ordered by the physician. The licensed nurse and/or qualified medication aide will administer all medications per policy. The nurse was immediately educated on 4/23/24 by the Director of Nursing on medication administration/self-administration.	5/5/24

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F 554	Continued From page 5 vision and was cognitively intact. Review of Resident #6's medical records revealed no assessment was completed to determine if the resident could administer medications independently to herself. Resident #6's care plan revised on 3/15/24 revealed potential for impaired vision related to glaucoma. Interventions included assessing the effect of vision loss on resident's functional status, assuring floor was free of glare, liquids, or foreign objects, and always keeping the call light within reach. The resident's care plan did not include medication self-administration. Review of the April 2024 Medication Administration Record for the period of 4/1/24 through 4/9/24 revealed the latanoprost eyedrops were initialed by Nurse #1 to indicate it was administered on 4/7/24 between 7:00 pm to 11:00 pm. The artificial tears were initialed by Nurse #1 on 4/7/24 at 8:00 pm and Medication Aide #1 on 4/8/24 at 8:00 am and 12:00 noon to indicate it was administered at those dates and times. During the initial observation on 4/8/24 at 11:33 am, Resident #6 had a vial of artificial tears eye drop and a vial of latanoprost 0.0005% eye drop on her bedside table. Resident #6 stated she administered both eye drops to herself. She stated she used the eye drops for her dry eyes two times a day in the morning and at night. She stated she used her glaucoma eyedrops at night only. During a follow up interview by Medication Aide #1 and the surveyor on 4/8/24 at 3:32 pm, Resident # 6 stated the evening nurse (Nurse #1)	F 554	Corrective action for other residents having the potential to be affected by the same deficient practice: On 4/25/24, the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Staff Development Coordinator (SDC) initiated a review of all in-house residents' medication administration orders for self-administration. The review was completed on 4/26/24 and established that all residents' medications are administered by the licensed nurse and/or qualified medication aide. For any resident(s) deemed able to self-administer medication(s), an order will be obtained from the physician and the care plan updated as needed by the interdisciplinary team (IDT) team that includes the DON, ADON, SDC, MDS nurses, Social Worker and, the Unit Managers. Systemic changes made to ensure that the deficient practice will not recur: On 4/8/24, the SDC, DON, and ADON initiated education to all licensed nurses and all qualified medication aides on medication administration to ensure all medications are administered per policy including any orders regarding self-administration. Education will be completed by 4/25/24. Any newly hired licensed nurses and medication aides will be educated as indicated above by the SDC and/or DON during orientation. Any licensed nurses and medication aides not educated as indicated, will not be allowed to work until they are educated. The Administrator and the DON	

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F 554 Continued From page 6

left both eye drops with her on 4/7/24 and gave her instructions. She stated she used both eye drops the night of 4/7/24 and used only the artificial tears the morning of 4/8/24.

During an interview and observation on 4/8/24 at 3:33 pm, Medication Aide #1 stated Resident #6 was not supposed to have eye drops at bedside. She stated the resident did not have an order to self-administer medications. Medication Aide #1 was observed to take both eye drops and proceeded to lock them in her medication cart.

The evening nurse was not in the facility during the survey and was unavailable for telephone interview.

During an interview on 4/9/24 1:09 pm, the interim Unit Manager for the Blue Hall explained the facility's medication self-administration process. She stated the if a resident was requesting to self-administer medications, the nurses completed the Self-Administration Assessment form. This was filed under the Clinical Observation tab in the resident's medical record. The interim Unit Manager stated the doctor or the physician's assistant was notified if the resident was assessed they were capable of medication self-administration. The provider had to order that a resident could self- administer medications. The medications had to be in a locked box so only the resident could access the medications. The resident's new order for self-administration was discussed during the clinical morning meeting. The Minimum Data Set Nurse or the nurse who received the order updated the resident's care plan to address self-administration of medications.

F 554

implemented an observation tool on 4/25/24 to be utilized by the SDC, ADON, Unit Managers, and Manager on Duty to observe for any medications left at beside. The tool will be utilized daily for 5 days a week for 4 weeks, then 2 times weekly for 4 weeks, and then weekly for 3 months until compliance is maintained.
Plans to monitor its performance to make sure that solutions are sustained:

The Administrator and the DON will review the observation tool weekly for 12 weeks and then monthly until compliance is maintained.
Any areas of non-compliance will be reported by the Administrator and/or DON to the QA Committee quarterly or as needed for further action to ensure compliance.

Date of Compliance: 5/5/24

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F 554	Continued From page 7 During an interview on 4/10/24 at 9:34 am, the Director of Nursing stated the evening nurse was an agency nurse. She stated the agency nurses got checked off with medication administration before they were assigned a cart. She stated Resident #6 was not assessed for medication self-administration. The agency nurse must have left those eye drops on the resident's bedside by accident.	F 554		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account,	F 567		5/5/24

F 567

Continued From page 8

interest-bearing account, or petty cash fund.
(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident interview and staff interviews, the facility failed to allow a resident the right to manage personal funds for 1 of 3 sampled residents reviewed for personal funds. (Resident #40)

The findings included:

Resident # 40 was admitted to the facility on 10/27/23 with diagnoses that included contracture to the right knee and type 2 diabetes.

A review of the Admission Minimum Data Set assessment dated 11/2/23 revealed Resident #40 was cognitively intact.

An interview was conducted with Resident #40 on 4/6/24 at 9:50 am and she revealed the Business Office Manager had changed the banking location of where her social security check was to be deposited from her private banking account to the facility's account. Resident #40 added the Business Office Manger did this without her permission.

F 567

Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.
F.567
Corrective action the resident found to have been affected by the deficient practice:
Resident #40 still resides in the facility. On 4/26/24, the Business Office Manager spoke with the resident to give her an option to manage her funds. The resident stated that she would call the Social Security Administration when she gets a moment, however, did sign the Resident Fund Management authorization form giving the center permission to continue direct deposit, transfer resident liability, and maintain an account on her behalf giving her access to her Personal needs

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F 567	Continued From page 9 An interview was conducted with the Business Office Manager on 4/9/24 at 2:30 pm and she confirmed that she applied for the facility to become Resident #40's representative payee so that her money would come directly to the facility and did not get Resident #40's written permission. She further revealed that she did not offer Resident #40 the opportunity to manage her own funds because she thought the money needed to come to the facility directly because it was owed to the facility. The Business Office Manager also revealed that she did not keep a copy of the representative payee application and did not recall the physician deeming Resident #40 as cognitively impaired or unable to manage her personal funds. An interview was conducted with the facility Administrator on 4/11/23 at 12:20 pm and he indicated that alert and oriented residents should be given the opportunity to manage their personal funds. An interview was conducted with the facility Administrator on 4/11/23 at 12:20 pm and he indicated that alert and oriented residents should be given the opportunity to manage their personal funds	F 567	allowance and the ability to manage her personal needs funds on 4/25/2024. Corrective action for other residents having the potential to be affected by the same deficient practice: On 4/25/24, the Business Office Manager reviewed all residents for whom the facility manages funds for or is the organizational representative payee and established that they all have supporting documentation and that the residents and/or their representatives signed the appropriate authorization forms. For any residents who apply for Medicaid and who have patient liability, they will be given an option to manage their funds. Systemic changes made to ensure that the deficient practice will not recur: On 4/25/24, the Regional Business Office Consultant educated the Business Office Manager and the Assistant Business Office Manager on the management of resident funds by giving residents an option to manage their funds. The education was completed on 4/25/24. Any newly hired Business Office Manager and Assistant Business Office Manager will be educated as indicated above by the Administrator and/or the Regional Business Office Consultant during orientation. The Administrator and the Business Office Manager will review all Medicaid/Medicaid pending residents weekly and give them an option of managing their funds if deemed to have patient liability payment. The Administrator implemented a tool to be utilized by the Business Office	

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F 567	Continued From page 10	F 567	Manager to monitor for any residents who are Medicaid/Medicaid pending to be given the option to manage their funds if capable. This tool is only for residents with patient liability payments due. The tool will be utilized weekly for 4 weeks, then monthly for 3 months until compliance is maintained. Plans to monitor its performance to make sure that solutions are sustained: The Administrator or designee will review the observation tool weekly for 4 weeks and then monthly until compliance is maintained. Any areas of non-compliance will be reported by the Administrator and/or DON to the QA Committee quarterly or as needed for further action to ensure compliance. Date of Compliance: 5/5/24	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.	F 607		5/5/24

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SIGNATURE HEALTHCARE OF CHAPEL HILL	1602 E FRANKLIN STREET CHAPEL HILL, NC 27514

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F 607	Continued From page 11 §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, law enforcement interview and staff interviews, the facility failed to report an allegation of abuse to law enforcement and adult protective services (Resident #242) and failed to report an allegation of misappropriation of resident property to adult protective services (Resident #66). In addition, the facility policy failed to include procedures for reporting allegations of abuse/misappropriation of resident property to adult protective services. This was for 2 of 3 residents reviewed abuse/misappropriation of resident property. The findings included: A review of the facility's policy titled, "Abuse, Neglect, and Misappropriation of Property" dated and revised 9/15/23 indicated every stakeholder shall immediately report any allegation of abuse, injury of unknown origin, or suspicion of a crime to the facility Administrator or designee as assigned by the facility administrator in his/her	F 607	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F.607 Corrective action the resident found to have been affected by the deficient practice: Resident #66 still resides in the facility. On 4/26/24, the Administrator and the DON called and reported the allegation made by resident #66 to the Orange County APS. The call was not answered but a voicemail message was left for the Social Worker. The social worker with Adult Protective Services (APS) did return a call to the Administrator and DON. The report was made complete, and a letter will be	

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absence. The policy also indicated that any abuse allegation must be reported to the State within 2 hours from the time the allegation was received and any reasonable suspicion of a crime with serious bodily injury must be reported to the State and Police. Additionally, the policy stated any allegation of neglect, exploitation, mistreatment, or misappropriation resulting in serious bodily injury must be reported to the State Regulatory Agency and Police within 2 hours.

1. Resident #242 was admitted to the facility on 9/21/23.

A review of the facility's 24-Hour Initial Report dated 11/13/23 indicated there was an allegation of staff to resident abuse made by Resident #242. The report indicated that Resident #242 said she was pushed down into her bed but did not name a perpetrator at that time. The incident occurred on 11/12/23 but was not reported to the facility staff until 11/13/23 and did not result in serious bodily injury. The facility reported the allegation to the state agency within 2 hours. The initial report indicated law enforcement was not notified.

A review of the Investigation Report dated 11/20/23 indicated law enforcement and adult protective services (APS) was not notified.

An interview was conducted with the Administrator on 4/11/24 at 2:45 pm and he indicated that he thought he had reported this incident to law enforcement, but he did not report the incident to APS. The Administrator did not explain why he did not report the allegation of abuse to APS.

F 607

sent. Allegation was already reported to law enforcement and a report/incident number 2311724 was obtained.
Resident #242 was discharged from the facility on 11/14/23. On 5/3/2024, the Administrator called local law enforcement as well as APS and reported the allegation. The police report/event number is 2404670. APS Social Worker will send a letter as soon as they finish documenting the allegation.
Corrective action for other residents having the potential to be affected by the same deficient practice:
On 4/30/24, the Administrator reviewed the allegations from 2/1/2024 to 4/30/24 to ensure that they were reported to the appropriate authorities. Any allegations that had not been reported, the Administrator ensured all were reported to law enforcement and APS by 5/3/24. A grievance log/checklist will be utilized for any residents that have the potential to be affected.
Systemic changes made to ensure that the deficient practice will not recur:

On 4/25/24, the Regional Vice President of Operations educated the Administrator on the abuse policy with an emphasis on reporting to law enforcement and APS. The Administrator educated Department heads on the abuse reporting requirements per policy. The education was completed on 4/26/24. Any new hires will be educated as indicated above by the Administrator and/or DON during orientation. Anyone not educated as indicated, will not be allowed to work until

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F 607	Continued From page 13 A telephone interview was conducted on 4/11/24 at 9:26 am with the local law enforcement's community safety specialist. He indicated there was no record that the facility or facility administrator had reported this incident to law enforcement. 2. Resident #66 was admitted to the facility on 10/19/21. A review of the facility's 24-Hour Initial Report dated 11/13/23 revealed there was an allegation of misappropriation of resident funds made by Resident #66. The report further revealed that Resident #66 reported that his bank card was stolen but no perpetrator was noted. The report indicated that law enforcement had been notified but APS was not notified. A review of the Investigation Report dated 11/17/23 indicated law enforcement and adult protective services (APS) was not notified. An interview was conducted with the Administrator on 4/11/24 at 2:45pm and he indicated that he did report this incident to law enforcement and the ombudsman but did not report it to APS. The Administrator did not explain why he did not report the allegation of misappropriation of resident funds to APS.	F 607	their education has been completed. The Administrator and/or the DON will review the event checklist weekly for 4 weeks, then the regional nurse will review it monthly for 3 months until substantial compliance is achieved. Plans to monitor its performance to make sure that solutions are sustained: Any areas of non-compliance will be reported by the Regional Nurse Consultant, Administrator, and/or DON to the QA Committee monthly for 3 months, then as needed for further action to ensure compliance. Date of Compliance: 5/5/24	
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:	F 687		5/5/24

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(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and
(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews, the facility failed to arrange podiatry services and/or provide toenail care for 1of 1 resident reviewed for foot care (Resident #70).

Findings Included:

Resident #70 was admitted to the facility on 8/15/23. His diagnoses included left hemiplegia (weakness on one side) and hemiparesis (paralysis on one side) following a stroke.
Review of the facility's skin alert form indicated Mr. Downey's nails were trimmed on 12/5/23, 12/19/23 and 12/29/23.

A review of Resident #70's quarterly Minimum Data Set dated 2/18/24 revealed he was cognitively intact and had an impairment on one side of his body. He was assessed as requiring supervision or touch assistance for showers. He was independent in performing personal hygiene and in putting on and taking off his footwear.

Resident #70's care plan dated 3/11/24 revealed a risk for self-care deficit or decline due to his medical conditions. Interventions included encouraging him to participate in activities of daily living, allowing him to do as much as possible and assisting him as needed.

F 687

Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.
F.687
Corrective action the resident found to have been affected by the deficient practice:
Resident #70 still resides in the facility. On 4/24/24, the Social Worker was able to successfully bring forward the podiatry scheduled visit to 5/2/24. Resident #70 is on the list to be seen on 5/2/24.
Corrective action for other residents having the potential to be affected by the same deficient practice:
On 4/11/24, the Social Worker reviewed the list obtained from nursing for the residents that needed podiatry services.
All residents listed were scheduled for a podiatry visit on 5/2/24. All residents were assessed to determine if they needed podiatry services before 5/2/2024 to include new admissions.

F 687 Continued From page 15

During the initial assessment on 4/8/24 at 10:53 am, Resident #70 stated nobody cut his toenails and he was needing an ingrown nail pulled out. He had reported this two months ago to Unit Manager #1, but nothing was done. The resident's toenails were observed to be long and extending over the tip of his toes. They were thick and grayish in color. His toenails on both of his big toes were curling downwards. No redness or inflammation were observed. He denied any pain in his toes during the survey.

Unit Manager #1 no longer worked at the facility and attempts to interview her were unsuccessful.

During an interview on 4/9/24 at 12:52 pm, Nurse Aide (NA) #2 stated she had been assisting Resident #70 with his showers and personal hygiene. She stated she cut residents' nails after their shower or as needed. She stated she tried cutting the resident's toenails before, but they were too thick. NA #2 stated she did not have the tools to do it. She stated there was a list for the podiatrist in the nurses' station and she would add the resident's name on the list.

During an interview on 4/9/24 at 2:24 pm, the Social Services Director (SSD) stated she scheduled the residents' podiatry appointments. The podiatrist came to the facility every three months. She stated she referred residents to the podiatrist if they were diabetic or if the provider informed her of a resident's need for the service. The nursing staff also provided her with the names of residents that needed their nails cut by the podiatrist. The SSD was unable to provide a date when the resident was last seen by podiatry. She offered to check and schedule Resident #70

F 687

Systemic changes made to ensure that the deficient practice will not recur:
On 4/18/24, the SDC, DON, and ADON initiated education for nurse aides and licensed nurses for ADL care with an emphasis on toenail care and reporting to nursing management when not able to provide the care so that the facility can refer them to podiatry. The education was completed on 4/26/24. Any new hires will be educated as indicated above by the SDC, DON, and/or ADON during orientation. Any nurse aide or licensed nurse not educated as indicated, will be provided education before the start of their next shift, and not be allowed to work until their education is completed.
The Administrator and DON implemented an observation tool on 4/26/24 to be used by nurses and nurse managers to be used for any resident that is identified to need podiatry services. The tool will be shared with the Social Worker weekly to set up podiatry services as needed. The tool will be utilized weekly for a month, then monthly for 3 months until compliance is maintained.
Plans to monitor its performance to make sure that solutions are sustained:

The Administrator and the DON will review the observation tool weekly for 4 weeks and then monthly until compliance is maintained.
Any areas of non-compliance will be reported by the Administrator and/or DON to the QA Committee quarterly or as needed for further action to ensure compliance.

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F 687	Continued From page 16 for podiatry service. During an interview on 4/10/24 at 8:54 am, the Director of Nursing (DON) stated Resident #70 did not verbalize any complaints to her. The staff usually cut the residents' nails after shower. She stated Resident #70 was getting showers so they should have been trimming his nails. She provided the resident's shower logs and added three skin care alert forms that were filled out by the nurse aides. The forms indicated the resident's nails were trimmed on 12/5/23, 12/19/23 and 12/29/23. The DON stated that was all the forms she found. During an interview on 4/11/24 at 11:22 am, the Administrator stated it was his expectation that the residents' nails well groomed. If staff were unable to cut a resident's nails or if the resident was diabetic, the resident should be referred to the podiatrist or sent to a specialist as needed.	F 687	Date of Compliance: 5/5/24	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that	F 867		5/5/24

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F 867	Continued From page 17 are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;	F 867		

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F 867	Continued From page 18	F 867		

Continued From page 18

(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

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F 867	Continued From page 19 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented effective procedures and monitor the interventions that the committee put into place following a recertification and complaint investigation survey on 04/11/24, the complaint investigation survey on 11/3/23 and the complaint investigation survey on 6/23/22. This was for one deficiency in the area of Resident Self-Administer Medication (554) recited on the current recertification and complaint investigation survey on 4/11/24. The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included. This citation is cross referenced to:	F 867	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F.867 Corrective action the resident found to have been affected by the deficient practice: Resident #6 still resides in the facility, and this references F554. On 4/25/24, the resident was assessed by the DON and found not to have the ability to self-administer medications as ordered. The resident's medications will only be administered by a licensed nurse and/or a	

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F 554: Based on observations, record review, interviews with resident and staff, the facility failed to assess if a cognitively impaired resident could self-administer eye drops kept at the bedside for 1 of 1 resident reviewed for self-administration (Resident #6).

During a the complaint investigation survey of 11/03/23, the facility failed to assess the ability of residents to self-administer medication.

During a the complaint investigation survey of 06/23/22, the facility failed to assess the ability of a resident to self-administer medications left at bedside.

An interview was conducted with the Administrator on 04/11/24 at 4:30pm, during which he indicated that his expectations for Quality Assurance were for the facility to conduct an on-going Quality Assurance/Performance Improvement program to systematically monitor, evaluate and improve quality and appropriateness of resident care. Areas of concern were identified through meetings, grievances, observations during rounding, care plan meetings, etc. The QAPI committee was composed of but not limited to the Administrator, Director of Nursing, Medical Director, Consultant Pharmacist, Registered Dietician, Medical Records Director, and Infection Control Preventionist. The Administrator explained the committee met quarterly and/or as needed. Any identified areas of non-compliance were corrected and monitored until compliance was maintained.

F 867

qualified medication aide as ordered by the physician. The licensed nurse and/or qualified medication aide will administer all medications per policy.
Corrective action for other residents having the potential to be affected by the same deficient practice:
On 4/25/24, the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Staff Development Coordinator (SDC) initiated a review of all residents' medication administration orders for self-administration. The review was completed on 4/26/24 and established that all residents' medications are administered by the licensed nurse and/or qualified medication aide. For any resident(s) deemed able to self-administer medication(s), an order will be obtained from the physician and the care plan updated as needed by the IDT team that includes the DON, ADON, SDC, MDS nurses, Social Worker and, the Unit Managers. Education will be provided to all licensed nurses and all qualified medication aides on medication administration to ensure all medications are administered per policy including any orders regarding self-administration.
Systemic changes made to ensure that the deficient practice will not recur:

On 4/25/24, the Regional Vice President of Operations educated the Administrator on QAPI policy and expectations. On 4/25/Administrator educated all department heads on the QAPI policy. Any new hires will be educated as indicated above by the Administrator

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F 867	Continued From page 21	F 867	and/or DON during orientation. Anyone not educated as indicated, will not be allowed to work until they are educated. Plans to monitor its performance to make sure that solutions are sustained: The Administrator will conduct QAPI meetings and/or as needed to review any areas of non-compliance. The VPO and/or Regional Nurse will attend the QAPI meeting in person or virtually until the VPO and/or Regional Nurse determine 100% compliance. The facility will conduct ad hoc meetings weekly for 4 weeks and monthly for 3 months until compliance is maintained. The Administrator and the DON will report any areas of non-compliance to the Regional Vice President of Operations and the Senior Clinical Consultant. Any areas of non-compliance will also be reported by the Administrator and/or DON to the facility governing body as needed for further action to ensure compliance. Date of Compliance: 5/5/24	
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;	F 887		5/5/24

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	345225	A. BUILDING ______ B. WING ______	C 04/11/2024

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

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F 887	Continued From page 22 (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks	F 887		

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F 887	Continued From page 23 associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review, residents and staff interviews, the facility failed to follow the current Centers for Disease Control (CDC) recommendations for coronavirus disease 2019 (COVID-19) vaccination for 5 of 5 residents reviewed for COVID-19 vaccination (Resident #53, Resident #4, Resident #43, Resident #6, and Resident #46). The findings included: The facility's infection control vaccination program revised on 9/17/23 stated "The company intends to and will follow all governing regulations and strives to follow all official COVID-19 recommendations for the health and welfare of our residents and stakeholders." The CDC COVID-19 vaccine recommendations for long term care residents updated on 2/7/24 stated "Everyone aged 5 years and older, including people who live and work in Long-term Care (LTC) settings, get 1 updated COVID-19 vaccine ...People aged 65 years and older who received 1 dose of any updated 2023-2024 COVID-19 vaccine (Pfizer-BioNTech, Moderna or Novavax) should receive 1 additional dose of an updated COVID-19 vaccine at least 4 months after the previous updated dose ... People who are moderately or severely immunocompromised	F 887	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F.887 Corrective action the resident found to have been affected by the deficient practice: Residents #6, #43, #53, #46, and #4 still reside in the facility. On 4/25/24 all five residents were educated/informed on the CDC recommendations for COVID-19 vaccination using the Vaccine Information Statement (VIS). Corrective action for other residents having the potential to be affected by the same deficient practice: On 4/10/24, the Staff Development Coordinator (SDC) initiated the review education using the Vaccine Information Statement for all residents regarding their COVID-19 vaccination. The review and education were completed on 4/25/24. New admissions are educated on COVID-19 upon admission.	

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F 887	Continued From page 24 can get additional updated COVID-19 vaccine doses ... People who live in LTC settings must give consent or agree to getting a COVID-19 vaccine." Review of the facility's vaccine information sheet (VIS) from the CDC dated 10/19/23 revealed the current recommendations for 2023-2024 COVID-19 vaccines. The recommendations on the VIS were consistent with the CDC recommendations. a. Resident #53 was admitted to the facility on 3/11/20. Review of the annual Minimum Data Set (MDS) dated 2/20/24 revealed Resident #53 was cognitively intact. Review of Resident #53's medical record revealed no information about the resident being offered the 2023-2024 COVID-19 vaccine or receiving education related to the vaccine. During the interview on 4/10/24 at 2:39 pm, Resident #53 stated she did not recall anybody coming to discuss the 2023-2024 COVID-19 Vaccine and get consent. b. Resident #4 was admitted to the facility on 10/7/23. Review of the quarterly Minimum Data Set (MDS) dated 2/20/24 revealed Resident #4 was cognitively intact. Review of Resident #4's medical record revealed no information about the resident being offered the 2023-2024 COVID-19 vaccine or receiving	F 887	Systemic changes made to ensure that the deficient practice will not recur: On 4/22/24, the Administrator educated the SDC, DON, and ADON on Center for Disease Control (CDC) COVID-19 vaccination recommendations Any newly hired SDC, DON, and ADON will be educated as indicated above by the Administrator during orientation. Anyone not educated as indicated, will not be allowed to work until they are educated. Plans to monitor its performance to make sure that solutions are sustained: The Administrator and the DON implemented an observation tool on 4/25/24 to be utilized by the SDC and ADON. The tool will be utilized daily for 7 days, then 3 times weekly for 4 weeks and then weekly for 3 months until compliance is maintained. The Administrator and the DON will review the observation tool weekly for 4 weeks and then monthly until compliance is maintained. Any areas of non-compliance will be reported by the Administrator and/or DON to the QA Committee quarterly or as needed for further action to ensure compliance. Date of Compliance: 5/5/24	

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F 887	Continued From page 25	F 887		

education related to the vaccine.

During the interview on 4/10/24 at 2:33 pm, Resident #4 stated nobody told her about a new vaccine. She stated, "I want one."

c. Resident #43 was admitted to the facility on 3/11/21.

Review of the quarterly Minimum Data Set (MDS) dated 2/23/24 revealed Resident #43 was cognitively intact.

Review of Resident #43's medical record revealed no information about the resident being offered the 2023-2024 COVID-19 vaccine or receiving education related to the vaccine.

During an interview on 4/10/23 at 2:13 pm, Resident #43 stated nobody came since fall to talk to him about the new COVID-19 vaccine and would like to have it.

d. Resident #6 was admitted to the facility on 8/20/15.

Review of the annual Minimum Data Set (MDS) dated 2/15/24 revealed Resident #6 was cognitively intact.

Review of Resident #6's medical record revealed no information about the resident being offered the 2023-2024 COVID-19 vaccine or receiving education related to the vaccine.

During an interview on 4/10/24 at 2:42 pm, Resident #6 stated she heard about the new vaccine that came out last year, but nobody ever came to talk to her about it. She stated she would

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F 887		F 887		

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like to have it.

e. Resident #46 was admitted to the facility on 11/30/20.

Review of the annual Minimum Data Set (MDS) dated 3/5/24 revealed Resident #46 was cognitively intact.

Review of Resident #46's medical record revealed no information about the resident being offered the 2023-2024 COVID-19 vaccine or receiving education related to the vaccine.

During an interview on 4/10/24 at 7:18 pm, Resident #46 shook his head when asked if any staff updated him on the new 2023-2024 COVID-19 vaccine that was released last fall.

During an interview on 4/10/24 at 9:15 am, the Director of Nursing revealed she was the Infection Preventionist for the facility and she was responsible for the vaccination process. She stated she was aware of the new 2023-2024 COVID vaccine and had been vaccinating residents who wanted it. She stated the facility's COVID-19 vaccination consent was in the residents' admission packets.

During a follow up interview on 4/11/24 at 10:00 am, the DON stated she believed the residents were offered the new vaccine but after she checked, there were no documents in the residents' medical records related to the new 2023-2024 COVID-19 vaccine. All five residents were not offered or educated on the new vaccine.

During the interview on 4/11/24 at 11:17 am, the Administrator stated the residents were offered

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F 887	Continued From page 27 immunizations on admission. He stated he was not aware of the new vaccination and that corporate office did not send the CDC updates.	F 887		