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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to consistently assess the thrill and bruit of Resident ' s #58 shunt as ordered. The facility failed to correctly transcribe the order to assess the thrill and bruit each shift every day. This was evident in 1 of 1 resident reviewed for dialysis. Findings included: Resident #58 was admitted to the facility on 10/25/05 with cumulative diagnoses which included chronic kidney disease requiring hemodialysis three times a week on Monday, Wednesday and Friday (MWF). Record review of the quarterly Minimum Data Set dated 4/16/16 revealed the resident was alert and oriented. Review of the care plan dated 9/2/15 and revised 4/15/16 revealed interventions to monitor the shunt site for thrill and auscultation for the bruit every shift. The bruit is the swishing and swooshing audible sound of the shunt. The thrill was the pulsation of the shunt. The thrill and the bruit assessment can assist in the determination of a blocked shunt or whether there was adequate blood flow. Review of Resident #58 ' s April 2016 and May 2016 monthly physician orders revealed orders to check the right arm for a bruit and thrill every shift. The scheduled frequency to check the thrill and bruit was 7 AM-7 PM shift and 7 PM - 7 AM shift.	F 281	F281 1. The orders for Resident #58 were changed by the Director of Nursing (DON) on 5/18/16 to assess the bruit/thrill each shift with hours of administration being set to 7A-7P and 7P-7A on a frequency to be done daily on each shift 2. The action taken for those residents having the potential to be affected by this alleged deficient practice was to audit all other dialysis resident's orders to ensure the accuracy of their orders and the proper transcription of their orders. This was completed by the DON on 5/20/16. 3. The measures put into place to ensure that the alleged deficient practice will not reoccur is the Staff Development Coordinator (SDC) has re-educated licensed staff on transcription of orders for assessing the shunt site for thrill and bruit each shift every day as ordered on the Medication Administration Record. This was completed by 6/13/16. The SDC will also cover this education with all new hires and rehires during their initial orientation class before they are allowed to work on the unit. The DON, Assisted Director of Nursing (ADON) or SDC will audit telephone orders for accurate transcription during our Clinical White Board Meetings Monday through Friday.	6/13/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2016

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.

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 1 Review of the Medication Administration Record (MAR) revealed documentation that indicated the bruit and thrill were documented as performed only on dialysis days. There was no written entries that indicated the thrill and bruit assessment was performed on 4/1/16-4/3/16, 4/5/16,4/7/16, 4/9-10/16,4/12/16, 4/14/16, 4/16-17/16, 4/19/16, 4/21/16, 4/23/16-4/24/16, 4/26/16, 4/29/16 ,4/30/16, 5/2/16, 5/3/16, 5/5/16, 5/7/16, 5/9/16, 5/10/16, 5/12/16, 5/14/16, 5/16/16 and 5/17/16. Attempts to interview Resident #58 were unsuccessful. Interview on 05/19/2016 at 5:59 PM with Nurse #10 revealed the thrill and bruit was to be checked every day on every shift. Nurse #10 indicated the nurses generally worked 12 hour shifts. Interview on 05/19/2016 at 6 PM with Unit Manager #2 stated that the staff only needed to check the thrill and bruit on MWF which were the days of dialysis. Interview on 05/20/2016 at 7:40 AM with Nurse #11(who worked 4/ 3/16 and 4/28/16 during the 7 PM-7AM shift and 5/1/16 during the 11 PM-7 AM) stated sometimes information was entered into the computer and the information goes away. Nurse #11 stated " Not sure if I performed the assessment of the thrill and bruit. I think I did. " Interview on 05/20/2016 at 8:05 AM with Nurse #12 who stated any resident with a shunt for dialysis should be assessed for the bruit and thrill. Nurse #12 revealed that the nurses should then document the assessment on the MAR.	F 281	4. The DON or ADON will audit dialysis residents for documentation of consistently assessing the thrill and bruit shunt site as ordered and correctly transcribing the order to assess the thrill and bruit each shift every day. This audit will occur weekly for one month, then twice monthly for one month and then in the future they will monitor on a monthly basis for three months. The results of these audits will be brought to the monthly Quality Assurance Performance Improvement (QAPI) Committee meetings to ensure we have evaluated the effectiveness of our corrective action. The Administrator and Director of Nursing will be responsible for ensuring this process is followed. Any concerns will be corrected immediately.	

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 2	F 281		

Interview on 05/20/2016 at 8:10 AM with Nurse #14 (who worked 4/2/16 and 5/14/16 during the 7 PM to 7 AM shift) indicated there may have been computer issues. Nurse #14 stated " I did check the thrill and bruit. " Record review revealed she was unable to validate that the assessment had been performed.

Interview on 05/20/2016 at 8:12 AM with Nurse #15 (who worked 5/15/16 during the hours of 11 PM-7 AM) revealed " I do not remember checking " the thrill and bruit. " We (referring to the staff nurses) do not check the bruit and thrill except on dialysis days. "

A second interview on 05/20/2016 at 11:10 AM with Nurse #10 (who worked during the 7 AM-7 PM shift on 4/2/16, 4/3/16, 4/7/16,4/12/16,4/16/16, 4/17/16, 4/21/16, 4/26/16, 5/1/16, 5/5/16, 5/6/16, 5/14/16, and 5/15/16) revealed she checked the bruit and thrill each day she worked. An inquiry was made about the lack of written data on the MAR. Nurse #10 indicated someone transcribed the incorrect order into the computer to check the thrill and bruit on dialysis days only. Further interview with Nurse #10 who stated she did not know who transcribed the order in the computer for MWF checks only.

Nurse #16 who worked during the 7 AM -7 PM shift on 4/5/16 ,4/9/16, 4/14/16, 4/19/16, 4/23/16, 4/24/16 4/28/16, 5/3/16. 5/7/16, 5/8/16, 5/12/16, and 5/17/16 were not available for interview.

Nurse #17 who worked the 7 PM-7 AM shift on 4/5/16, 4/9/16, 4/10/16, 4/12/16, 4/14/16,4/16/16, 4/17/16, 4/19/16 ,4/23/16, 4/24/16, 4/26/16, 5/3/16, 5/7/16, 5/8/16, 5/10/16 and 5/17/16 was not available for interview.

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 3 Interview on 5/20/16 at 2:10 pm with the Director of Nurses and corporate representative was conducted and indicated Nurse #18 keyed into the computer for the thrill and bruit be checked MWF on dialysis day instead of each shift every day. The DON stated her she expected the nurse to follow the physician orders and document on the MAR or in the nurses notes that the brit and thrill were assessed. There were unsuccessful attempts to interview Nurse #18 who transcribed the order incorrectly.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to assist a dependent resident with eating breakfast. This was evident 1 of 1 resident observed during the breakfast meal. (Resident #84) Findings included: Resident #84 was admitted to the facility on 7/13/15 with cumulative diagnoses which included dementia. Review of the quarterly Minimum Data Set dated 4/13/16 revealed the resident had impaired	F 282	F282 1. The corrective action taken for Resident #84 was to change to having her meals in the dining room effective 5/20/16. If for some reason she declines going to the dining room her wishes will be honored. Otherwise she will be escorted to the dining room for all meals. 2. The corrective action accomplished for those residents having the potential to be affected by the alleged deficient practice was to audit all current residents' meal ticket for accuracy to determine the amount, if any, of assistance they require.	6/13/16

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 ___	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 4 cognition and required 1 staff assistance for tray set up, supervision, oversight, encouragement and/or cueing at mealtime to ensure food intake. Review of the care plan dated 5/13/16 revealed a problem of activity of daily living (eating) deficit. One of the approaches included the assist of 1 staff for completion of the task. Record review revealed the resident was on a regular diet. Continuous observation revealed: On 05/19/2016 at 08:25 AM Resident #84 was asleep in bed with the breakfast tray on the bedside table untouched or set-up. The privacy curtain was pulled between the A and B bed. There was no staff present. On 05/19/2016 at 08:40 AM Resident #84 remained asleep. The breakfast tray was still untouched or set-up. The privacy curtain remained pulled between the A and B bed. There was still no staff present. On 05/19/2016 at 08:45 AM Resident #84 was in bed, not asleep but appeared drowsy. The breakfast food tray still was untouched. The privacy curtain remained pulled between the A and B bed. There was no staff present. Observation and interview on 05/19/2016 at 9 AM with Resident #84 revealed the resident loved coffee and wanted coffee to drink. Her breakfast tray was still untouched. The privacy curtain was still pulled between the A and B bed. On 05/19/2016 at 09:15 AM there was no change from the above observations.	F 282	For any in-house resident or future resident needing assistance with their tray they are, or will be, placed in the Colored Napkin Program. The Colored Napkin Program is where we utilize a colored napkin on a resident's tray which identifies them as a dependent resident needing assistance with their meal. Residents who do not require assistance have a white napkin on their tray. 3. The measures taken to ensure that the deficient practice will not reoccur were for the SDC to educate or re-educate all staff members in the nursing, dietary, housekeeping, rehabilitation, administration, maintenance, social services and human resources departments who possibly may be involved in passing resident trays to the Colored Napkin Program. This training will be completed by 6/13/16. Any new hires or rehires will be educated on this process by the SDC during their initial orientation class prior to working the floor. 4. The department heads will be used to monitor meal trays for timeliness of set up and assistance offered to the resident. We will monitor 5 residents weekly for each meal for 1 month, then 5 residents twice monthly for each meal for one month, then 10 residents monthly for each meal for one month. The Administrator will be responsible for ensuring the monitoring is completed. The results of the audits will then be submitted at the monthly QAPI Committee meeting for review of the effectiveness of our corrective action. Any concerns identified will be corrected immediately.	

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5 By 05/19/2016 at 9:18 AM a staff inquiry to Nursing Assistant #12 (NA) was made about the status of this resident eating breakfast. NA #12 asked the resident was she ready to eat and the response was yes. NA #12 obtained coffee for the resident and she began to drink the coffee. NA #12 partially set up the food tray in front of the resident to eat and left the room. Resident #84 attempted to drink her milk which had not been opened. Butter nor jelly was placed on the toasted bread. Nor did NA #12 ask the resident if she wanted butter or jelly. On 05/19/2016 at 09:35 A.M. Resident #84 was not able to eat independently. MDS nurse #1 came into the resident's room at 09: 37 AM and encouraged the resident to eat. MDS nurse #1 stated this resident needed cueing and encouragement to eat then left the room picking up breakfast trays from other resident rooms. Interview on 05/19/16 at 09:40 AM with NA# 12 revealed resident was usually a set-up only and was not sure who delivered the tray to the room. NA #12 stated Resident #84 was not as alert as usual today (referring to 05/19/16). An inquiry was made about why the resident tray was not fully set up and why she left the resident unsupervised and not being cued to eat especially not being as alert as usual. NA #12 did not respond. Interview on 05/19/16 at 09:45 AM with Nurse #18 indicated the resident was assisted with her breakfast and consumed 75%. Further interview with Nurse #18 revealed Resident #84 was agitated and did not sleep throughout the early	F 282		

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 6 hours of 05/19/2016. Interview on 05/19/2016 at 11:37AM with the Director of Nurses indicated she expected staff to stay with the resident, assist with eating until the meal was completed. Observation on 05/19/2016 12:19:28 PM revealed Resident #84 was alert and in the dining room being set-up to eat, supervised with cueing. The resident was able to feed herself.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff and resident interviews the facility failed to use 2 (two) staff to reposition Resident #20 in bed resulting in a fall to the floor. As a result of the fall Resident #20 sustained a head injury, bruises to the left arm and left sided pain. The staff continued to transfer the resident out of bed without the benefit of 2 staff members or the use of the hydraulic lift. This was evident in 1 of 4 residents reviewed for accidents. The findings included: Resident #20 was originally admitted to the facility	F 323	F323 1. The corrective action taken for Resident #20 was to send her to the emergency room for evaluation of her head injury when the fall occurred. We also have reviewed and updated her Care Plan and Care Card to reflect she requires a 2 person assist for bed mobility. The Certified Nursing Assistant, C.N.A., “NA #4,” that was caring for Resident #20 on 5/6/16, was re-educated on proper bed positioning for her residents and that the draw sheet is not to be used for turning	6/13/16

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 323

Continued From page 7

on 3/8/15 and had diagnoses which included bilateral amputation (above the right knee and below the left knee) due to peripheral vascular disease.

Review of the care plan updated 4/13/15 revealed in part to roll resident slowly when turning resident and staff to provide only the amount of assistance or supervision to meet Resident #20 needs for activity of daily living.

Review of the " Fall Risk Evaluation " form dated 4/21/16 revealed Resident #20 ' s score was 13. According to the form a resident who scored 10 or higher would be at risk for falls.

Review of the 1/13/16 annual Minimum Data Set (MDS) assessment and the quarterly MDS dated 4/16/16 revealed Resident #20 was alert and oriented and required extensive assistance of 2 (two) persons for bed mobility (while turning side to side) and transfers.

Review of the progress notes dated 5/7/16 at 12:31 AM revealed a late written entry by Nurse #5 which indicated NA #4 (assigned to care for Resident #20 on 5/6/16 informed Nurse #5 that a fall occurred (referring to the 5/6/16 fall). This written entry revealed Nurse #5 and NA #4 observed Resident #20 on the floor beside the bed positioned on her right side. Resident #20 was transferred back to bed. Swelling to the right side of her forehead, bruising to the outer aspect of her left arm and complaints of right stump discomfort were noted. Nurse #5 applied an ice pack to the forehead and the right stump. Further record review revealed Resident #20 initially refused to be transferred to the hospital for an evaluation. On 5/6/16 at 8:45 AM Resident #20

F 323

residents.
2. For residents having the potential to be affected by this alleged deficient practice we have audited all current residents' Care Plans and Care Cards to ensure they are accurately coded to match the needs of the resident.
3. The measures and actions we have put in place to ensure this does not happen again is we have had the SDC provide education to clinical staff on bed mobility, turning & positioning of our residents. Included in this education was the proper utilization of a draw sheet when repositioning a resident in bed. The draw sheet is to be used for bed mobility of a resident, not for turning a resident. This training was completed 6/13/16. Any new clinical hires or rehires will go through this training process during their orientation prior to working on the floor.
4. Our plan to monitor this process will be for the DON or ADON to audit 5 residents weekly to ensure that the appropriate numbers of staff are being utilized for one month, then we will monitor 5 residents twice monthly for one month and then we will monitor 5 residents monthly for one month. The DON will then bring the results of these audits and submit them for review at the monthly QAPI Committee meeting to ensure our corrective actions have been achieved and are sustained. Any issues or concern will be addressed immediately.

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8	F 323		

was transferred via emergency services to the hospital.

Review of the hospital records dated 5/6/2016 revealed in part a discharge diagnosis of a head injury.

Review of the " Nursing Assessment " form (authored by Nurse #4) dated 5/6/16 (utilized by the facility for an incident investigation) revealed NA #4 stated that she turned the resident to her left side when Resident #20 placed her right stump over her left stump and fell to the floor.

A review of the 24-Hour initial Report dated 5/6/2016 and the 5-Working Day Report dated 5/9/2016 submitted to the Health Care Personnel Registry revealed in part:

- Resident #20 placed one stump over the other stump she started to slide off the bed.
- NA #4 then pulled the draw sheet toward her so that Resident #20 would not be on the edge of the bed.
- The pull of the draw sheet caused Resident #20 ' s fall onto the floor.

Interview on 05/18/2016 at 3:26 PM with Nursing Assistant (NA) #2 revealed 1 person was needed to transfer Resident #20 out of bed and move her about in bed before the fall.

Interview on 05/18/2016 at 3:33 PM with MDS Nurse #1 revealed Resident #20 required 2 staff persons to assist with bed mobility and transfers.

An interview was conducted with NA #3 on 05/18/2016 at 3:58 PM revealed he was familiar

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9	F 323		

with Resident #20 ' s needs since her admission and she will tell you want she wants. NA #3 stated " I turn her and transfer her out of bed with just myself after explaining to her what I want her to do. " An inquiry was made about how he was aware of the resident needs and he responded that the facility had a care guide.

Interview via the phone on 05/19/2016 at 3:06 PM with Nurse #5 (nurse on duty when resident fell)revealed she was passing medications around 6 AM when NA #4 came out of the room and stated Resident #20 had fallen to the floor. Nurse #5 stated when she assessed her, Resident #20 was on the floor positioned on her left side. Resident #20 ' s vital signs were taken and an ice pack was applied to her forehead. Continued interview with Nurse #5 indicated Resident #20 initially refused to be transferred to the hospital. Nurse #5 stated Resident #20 was " very upset she had fallen. " An inquiry was made about how many staff members were required to turn the resident in bed and Nurse #5 stated she was unsure whether 1 or 2 people were required to move Resident #20 about in bed before the fall. Nurse #5 indicated Resident #20 needed 2 staff after the 5/6/16 fall.

Attempts to interview NA #4 (who was involved in the fall incident) were unsuccessful.

Further review of the care plan revealed an update of interventions dated 5/6/16 to include a scoop mattress, the use of 2 (two) staff with bed mobility and transfers. On 5/11/16 the use of the hydraulic lift was added.

Record review of the NA care guide (undated) revealed updated instructions after the fall to roll

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10	F 323		

resident slowly while in bed, the use of the scoop mattress, the use of 2 (two) staff for all bed mobility/transfers and the use of the hydraulic lift for transfers.

Interview on 05/19/2016 at 10:24 AM with Resident #20 revealed NA #4 was caring for her alone and did not ask her to turn. Resident #20 stated she had a draw sheet placed under her. Further interview revealed NA #4 pulled the draw sheet causing her to fall off the bed landing on her left side. Resident #20 stated her left lower arm and side were still sore because of the way she landed on the floor. Additionally, Resident #20 stated before my fall only 1 aide (referring to NA #2) could transfer or moved her about in bed. The interview continued with Resident #20, who stated NA #2 would tell " me what to do and I do. They (referring to NA #2 are able to move and care for me by themselves. " During this interview Resident #20 was observed with bruises on the left lower arm.

Interview on 05/19/2016 at 8:25 AM with the Staff Development Coordinator (SDC) revealed in-service training was held on 5/6/16 after the fall regarding the use of 2 person assistance for bed mobility and transfers. Record review of the attendance sheets revealed NA #3 and NA #2 attended the training.

Interview on 05/19/2016 at 10:39AM with Nurse #6 revealed Resident #20 as of the 5/6/16 fall) required the use of a hydraulic lift or two people to move the resident in bed or to transfer out of bed. Nurse #6 stated she never knew Resident #20 required 2 people until after the fall occurred.

Observation of Resident #20 ' s transfer out of the

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 bed into the wheelchair on 05/19/2016 at 10:49 AM was conducted. NA #5 was present in the room and NA #2 lifted Resident #20 without the benefit of the hydraulic lift or NA #5 physically assisting with the transfer. Interview on 05/19/2016 at 11:03AM with Unit Manager #1 (UM) revealed Resident #20 should be transferred with a mechanical lift. Interview on 05/19/2016 at 11:10 AM with NA #2 revealed he transferred Resident #20 by himself because she does not like the lift. NA #2 stated " I do not think it fits her correctly. " When an inquiry was made about whether he notified the nurse about the resident's preference or improper fit of the lift NA #2 responded that he did but could not remember what nurse or when he reported. Further interview revealed he indicated "I always transfer her by myself because that is what she wanted. " UM #1 joined the conversation and indicated she was not aware of the resident ' s preference or issues with the use of the lift. An interview was conducted on 05/19/2016 at 11:26 AM with the Director of Nurses (DON) and the SDC. The DON stated the expectation for staff were to follow the instructions written on the NA care guide and report any issues about the use of the hydraulic lift to the nurse.	F 323		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper	F 364		6/27/16

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 12 temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to provide palatable foods to 1 of 1 resident during the breakfast meal. Resident #84. Findings included: Resident #84 was admitted to the facility on 7/13/15 with cumulative diagnoses which included dementia. Review of the quarterly Minimum Data Set dated 4/13/16 revealed the resident had impaired cognition and required 1 staff assistance for tray set up, supervision, oversight, encouragement and/or cueing at mealtime to ensure food intake. Review of the care plan dated 5/13/16 revealed a problem of activity of daily living (eating) deficit. One of the approaches included the assist of 1 staff for completion of the task. Record review revealed the resident was on a regular diet. Interview on 05/20/2016 at 1:40 PM with the dietary manager revealed the front blue cart with Resident # ' s food tray was delivered to the unit at 07:40 AM on 5/19/16. Observation on 05/19/2016 at 08:25 AM revealed Resident #84 was asleep in bed with the breakfast tray on the bedside table untouched or set-up. By 05/19/2016 at 9:18 AM Nursing Assistant #12(NA) partially set up the food tray for the resident to eat without the benefit of reheating or obtaining another food tray. The cooked oatmeal served in a bowl had gelled. A dry film developed on the top of the cooked oatmeal. The scrambled eggs looked dry and had formed into round balls. NA #12 indicated that since the food	F 364	F364 1. The corrective action taken for Resident #84 was to change her to be served her meals in the dining room effective 5/20/16. If for some reason she declines going to the dining room her wishes will be honored. Otherwise she will be escorted to the dining room for all meals. 2. The corrective action accomplished for those residents having the potential to be affected by the alleged deficient practice was to have all current residents audited for their meal ticket accuracy of the assistance required and to update the Colored Napkin Program for any dependent resident needing assistance with their meal. To ensure the food is palatable, if the resident has not begun eating their meal within 10 minutes of delivery, we will offer to reheat their food. If they do not want the food or are not capable of eating at the time, the tray will be removed and a new meal offered when they want to eat or when they become capable of eating, i.e., after waking up from taking a nap. 3. The measures taken to ensure that the deficient practice will not reoccur were for the SDC to re-educate all staff members involved in the process of passing meal trays to include timely delivery of meals, set up and assistance as needed. The training also included the utilization of the	

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 13 plate felt warm on the bottom the food would also be warm. After an inquiry about the time the food tray arrived on the unit and the consistency of the eggs and cooked oatmeal, NA #12 reheated the food. Interview on 05/19/2016 at 11:37AM with the Director of Nurses indicated she expected staff to reheat food or obtain another food tray from the kitchen.	F 364	Colored Napkin Program. This training will be completed by 6/13/16. Any new hires or rehires will be educated on this process by the SDC during their initial orientation class prior to working the floor. 4. The department heads will be used to monitor timely delivery of meal trays to ensure food palatability as well as timeliness of set up and assistance offered to the resident. We will monitor 5 residents weekly for each meal for 1 month, then 5 residents twice monthly for each meal for one month, then 10 residents monthly for each meal for one month. The Administrator will be responsible for ensuring the monitoring is completed. The results of the audits will then be submitted at the monthly QAPI Committee meeting for review of the effectiveness of our corrective action plan. Any concerns identified will be corrected immediately.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		6/13/16

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 14 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interview the facility failed to follow established procedures to provide for an accurate accounting of all controlled substances on 4 of 4 medication carts and one of one medication refrigerators. (Rehabilitation hall medication cart, back blue hall medications cart, front red hall medication cart, front blue hall medication cart and the red hall medication refrigerator). Findings included: The facility ' s policy and procedures for controlled medication and drug diversion policy (no date) stated " A controlled medication accountability record is prepared when receiving or checking in a scheduled II, III, IV or V Medication. At each shift change or when key are	F 431	F431 1. The corrective action taken for ensuring an accurate accounting of all controlled substances were to combine the notebooks that contain the count sheet logs of controlled drugs for the red hall medication refrigerator with the front red hall medication cart. As well the DON performed an audit of all narcotics in the medication carts and medication room refrigerator to ensure all narcotic count sheets were accurate and that the narcotics sheets signature of the two nurses who performed the audit/count. This was completed on 5/20/16. 2. The corrective action we took to ensure	

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 15 rendered a physical inventory of all controlled medications is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record. " 1 a. An observation was made of the facility ' s locked Red Medication room on 5/18/16 at 2:54 PM. A locked refrigerator was observed in this medications room. Observations inside this refrigerator revealed a control substance of Ativan was stored inside. The controlled substance accountability log for the medication refrigerator in the Red Hallway Medication room was reviewed from 12/29/15 through 5/19/16. The log reflected there were no narcotics being stored in the refrigerator from 1/7/16 through 03/18/16. The narcotics order sheet revealed that a controlled substance was delivered on 3/18/16. The narcotics log revealed the medication was completely missing signatures and narcotics counts for the following dates 1/5/16, 3/19/16 through 4/5/16, 4/9/16 through 4/21/16, 4/23/16, 4/24/16 through 5/2/16, and 5/12/16 through 5/16/16. There were missing 10 dual signatures for the following dates of 12/29/15, 1/1/16, 3/19/16, 4/5/16, 4/7/16, 4/8/16, 4/9/16, 5/3/16, 5/10/16, and 5/12/16. There were 5 missing narcotic counts for the documented dates of 4/7/16 (AM and PM shifts), 4/9/16 (AM and PM shifts), 5/7/16 (PM shift), 5/12/16 (AM shift), and 5/18/16 (PM shift). Nurse #3 was interviewed on 5/18/16 at 2:54 PM. He stated controlled substances are counted every shift change for the cabinets and for the refrigerator in the red hall medication room. Nurse #4 was interviewed on 5/18/16 at 3:51 PM. She stated she did the narcotic count this morning. She stated there was one narcotic stored in the red hall ' s medication refrigerator and it was Ativan. She stated the unit manager	F 431	all controlled substances are accounted for accurately was to audit all medications carts to ensure the narcotic count sheets were correct and that each count had the appropriate signatures. This was completed on 5/20/16. 3.The measures taken to ensure that this situation will not reoccur was for the SDC to provide education to all licensed staff on the correct procedure for counting and documenting the number of narcotics at every shift change. The education of this documentation included the requirement of dual signatures with each count as well as a numerical value to include the number of current narcotic cards on each cart. The documentation for the count and the required two nurses' signatures verifying the narcotics in the red hall medication refrigerator will in the future be part of the front red hall Controlled Substance Notebook. This was completed on 6/13/16. 4. The plan for monitoring for compliance will be to have the DON to audit each medication carts' Controlled Substance Notebook for the presence of signatures and counts once a week for the first month, then monitor the Controlled Substance Notebooks every other week of one month and then in the future monitor the Controlled Substance Notebooks once per month for three months. As well the consultant pharmacist will perform a random controlled substance notebook audit on one medication cart per month to include change of shift count, dual signatures and proper storage. The Administrator will be	

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 16 also signed off that the medication was counted. The unit manager #1 was interviewed on 5/18/16 at 3:54 PM. The refrigerator should be checked every day and the narcotics were counted every day. 1b. Review of the Rehabilitation Hall Medication cart ' s narcotics log from 12/30/15 through 5/19/16, revealed there were narcotics stored on this cart with 20 missing narcotics counts on the Controlled Substance Accountability count sheet for AM and/or PM shifts and 5 missing dual nurses signatures from the narcotic controlled substance counts for AM and/or PM shifts. 1c. Observations on 5/20/16 at 9:37 AM of the facility ' s back blue hall medication cart revealed narcotics were stored in this medication cart. Review of the back blue hall medication cart ' s Controlled Substance Accountability count sheet from 3/2/16 through 5/19/16, revealed there were 54 dates of missing narcotic counts for AM and/or PM shifts and 23 missing dual nurse signatures for AM, PM or both shifts. 1d. Review of the front blue hall medication cart ' s Controlled Substance Accountability Sheet from 1/1/16 through 5/19/16 revealed there were narcotics stored on this cart. There were 2 dates of missing narcotic counts from AM, PM or both shifts and 6 missing dual nurse signatures for AM and/or PM shifts. There were no record of the controlled substance accountability sheets from 1/31/16 through 3/5/16. 1e. Observations on 5/17/6 at 7:35 AM of the facility ' s front red hall medication cart revealed narcotics were stored in this medication cart. Review of the front red hall medication cart ' s controlled substance log from 12/16/15 through 5/19/16. There were 5 missing narcotic counts and 3 missing dual nurses ' signatures. The entire narcotic ' s sheets from 1/19/16 through	F 431	responsible for ensuring the monitoring is completed. The results of the DON's and Consultant Pharmacist's audits will then be submitted at the monthly QAPI Committee meeting for review of the effectiveness of our corrective action plan. Any concerns identified will be corrected immediately.	

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 17 4/22/16 was missing. Nurse #2 was interviewed on 5/17/16 at 11:21 AM. She stated the controlled medications are reconciled and counted every shift. The Director of Nursing (DON) was interviewed on 5/19/16 at 2:26 PM. She stated the narcotics in the medication machine was only counted by pharmacy. The oncoming nurse and the off going nurse count the medication cart ' s controlled substances. The narcotics stored in the red hall ' s refrigerator were counted by the oncoming nurse and off going nurse at shift change. The Corporate Pharmacy Consultant and DON were interviewed on 5/20/16 at 11:27 AM. The pharmacy consultant stated she was unaware of any discrepancies reports from the narcotics count sheets in the last 6 months. The DON stated she expected for the number of individual narcotics on the medication carts to be counted and recorded in the controlled substance accountability sheet with the nurse ' s signature who counted them. This was to be completed at every shift change. The Director of Nursing (DON) was interviewed on 5/20/16 at 1:44 PM. She stated she could not find the controlled substance sheets from 01/19/16 to 04/22/16 for Front Red hall medication cart. The DON further stated she was also unable to find the controlled substance sheets for the month of February 2016 the front blue hall medication cart The Pharmacist Consultant was interviewed on 5/20/16 at 2:11 PM. She stated each month she performed random medication checks, controlled substances checks, and medication room checks. She also performed controlled substances quarterly reviews. She stated the last quarterly review for controlled substances was completed on February 4, 2016 and she did not	F 431		

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 ______	05/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 18 remember any issues with diversion of narcotics. The pharmacist stated the only issue on their last quarterly review was a couple of as needed doses of narcotics that were signed out on the control sheet, but were not documented on Medication Administration Record as administered. She stated the facility should be doing the narcotic counts every shift change and they should be documenting any discrepancies on the narcotics sheet. The pharmacy consultant further stated the nurse has to count, reconcile and have 2 signatures of nurses on the narcotics count. She stated she had not been aware of any narcotic discrepancies or any issues with the controlled substance counts.	F 431		