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 06/01/2018

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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) on 2 out of 5 residents (Residents #59 and #41) reviewed for unnecessary medications and 1 out of 1 resident (Resident #29) reviewed for dialysis. Findings include: A. Resident #59 was admitted to the facility on 11/11/16 with diagnoses that include encephalopathy, unspecified dementia, major depressive disorder, spinal instabilities. A review of Resident #59's most recent MDS was coded as a quarterly assessment and was dated for 4/27/18. The resident was coded as cognitively impaired. Resident #59's active diagnoses were coded as Non-Alzheimer's dementia, feeding difficulties, and muscle weakness. Resident #59 was coded as receiving antipsychotic medications for 7 out of 7 days, antianxiety medications for 1 out of 7 days, antidepressant medications for 7 out of 7 days, and a diuretic for 7 out of 7 days. No diagnoses for edema, anxiety, or depression were coded on the MDS. A review of Resident #59's medical record revealed a physician's order dated 3/15/18 that stated the resident was to start on Klonopin 0.25mg twice daily for a diagnosis of anxiety.	F 641	F641 1. What lead to the deficient practice was the MDS Coordinator failing to review documentation thoroughly and appropriately to code MDS correctly/accurately and facility failed to randomly audit MDS coding process to ensure compliance in reflecting the resident's status on MDS. The facility failed to accurately code the MDS reviewed for Resident #59 and #41 reviewed for unnecessary medications and Resident #29 reviewed for dialysis. MDS Coordinator modified and re-submitted MDS for Residents #59, #41 and #29. MDS Coordinator immediately educated regarding expectations for accurately coding MDS upon identification of errors. 2. All residents have the potential to be affected by this alleged deficient practice. The MDS Coordinator/designees and Regional MDS Consultant will complete a review of assessments for residents that have the diagnosis of Anxiety, depression, paranoid schizophrenia, edema, ESRD by June 27, 2018. Modifications will be completed as indicated by MDS Coordinator. 3. Education provided to MDS Coordinators on 6/1/2018 and 6/4/2018 on capturing appropriate diagnosis for MDS	6/27/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/15/2018

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F 641	Continued From page 1 A review of Resident #59's medical record revealed a physician's order dated 2/16/18 for Furosemide 20mg daily for a diagnosis of edema. A review of Resident #59's medical record revealed a physician's order dated 11/11/16 for Escitalopram 10mg daily for depression. B. Resident #41 was admitted to the facility on 4/9/18 with diagnoses of multiple sclerosis, muscle weakness, other reduced mobility, unsteadiness on feet, mild cognitive impairment, dysphagia, and hidradenitis suppurativa. A review of Resident #41's most recent MDS was coded as an admission assessment and was dated 4/16/18. The resident was coded as cognitively alert. Resident #41's active diagnoses were coded as hyperlipidemia, multiple sclerosis, and seizure disorder. The resident's MDS revealed the resident had an antipsychotic medication 7 out of 7 days look back, an antidepressant medication 7 out of 7 days, and an opioid 2 out of 7 days. The MDS did not have a diagnosis of depression or paranoid schizophrenia coded. A review of Resident #41's medical record revealed a facility physician note that stated the resident has a history of multiple sclerosis, paranoid schizophrenia, menorrhagia, and depression. A review of Resident #41's medical record revealed the resident had a physician's order dated 4/9/18 for Aripiprazole 5mg daily for	F 641	coding. The Regional MDS Consultant or designee will complete an audit of 3 resident□s MDS Assessments weekly x 8 weeks to ensure accurate coding; then 2 resident□s MDS Assessments weekly x 4 weeks: then 1 monthly resident□s MDS Assessments thereafter. Education will be provided as indicated. All data will be summarized and presented to the facility QAPI meeting monthly x 3 months by the MDS Coordinator. Any issues or trends identified will be addressed by the QAPI Committee as they arise and the plan will be revised to ensure continued compliance. 4. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. 5. Corrective action will be completed by June 27, 2018.	

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F 641	Continued From page 2	F 641		

mood stabilization.

A review of Resident #41's medical record revealed the resident had a physician's order dated 4/9/18 for Sertraline 100mg daily for depression.

C. Resident # 29 was admitted to the facility on 1/23/18 with diagnoses that include end stage renal disease, cellulitis, mild cognitive impairment, and chronic obstructive pulmonary disease.

Resident #29's most recent MDS was coded as a quarterly assessment and dated 4/10/18.

The resident was coded as not having any cognitive impairments. Resident #29's MDS coded her active diagnoses as hypertension, diabetes mellitus, depression, and chronic pain. Under Resident #29's special treatments, oxygen and dialysis were coded as in use. No diagnosis of end stage renal disease was coded on the MDS.

An interview was conducted on 6/1/18 at 11:50am with the MDS coordinator. She reported the MDS diagnoses should reflect the treatments and medications the resident has. She reported that Resident #59 should have the diagnoses of anxiety, edema, and depression coded on the MDS. She stated Resident #41's MDS should have had depression and paranoid schizophrenia coded as active diagnoses. The MDS coordinator reported end stage renal disease should have been coded on Resident #29's MDS.
An interview with the Administrator was conducted on 6/1/18 at 1:00pm. She reported it is her expectation that the diagnoses coded on the MDS should include all active diagnoses that the resident is being treated for in the facility.

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F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove food in 1 out of 2 nourishment rooms (200 unit) that was past the use by date. Findings include: An observation was made on 6/1/18 at 10:00am of the nourishment room on the 200 unit. In the cabinet next to the refrigerator it was revealed that there were 4 containers of Thickened orange juice that expired on 4/11/18 and 2 containers of Med Plus NSA vanilla supplement that expired on 3/26/18. An interview was conducted on 6/1/18 at 10:15am with the Administrator. She reported that	F 812	F812 1. What lead to the deficient practice was the facility failed to monitor all areas of food storage consistently for expiration dates and facility failed to monitor systems for removing foods prior to use by date to meet food safety requirements. The facility failed to remove food in nourishments rooms that was past the use by date. The food items were immediately discarded and immediate monitoring tools implemented. The foods identified were sealed and not in use. No negative impact. Immediate education provided to dietary staff regarding expectation to remove foods past the use	6/15/18

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F 812	Continued From page 4 dietary monitors the nourishment rooms and removes any expired products daily. She reported it is her expectation that all food be checked daily for expiration and expired products be removed immediately. The administrator disposed of the expired items following the interview.	F 812	by date. 2. Dietary staff educated on expectations of monitoring foods past the use by date and daily monitoring expectations. Education completed on June 1, 2018. 3. Nourishments rooms are inspected daily for foods past the use by date. Nourishment room audits will be conducted daily x 4 weeks: once weekly x 4 weeks; then weekly thereafter. All data will be summarized and presented to the facility QAPI meeting monthly x 3 months by the Dietary Director. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. 4. The Dietary Director and Administrator/DNS is responsible for implementing and maintaining the acceptable plan of correction. 5. Corrective action completed by June 15, 2018.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to	F 865		6/27/18

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F 865	Continued From page 5 the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain procedures and monitor the interventions that the committee put into place on March 26, 2017. This was for recited deficiency, which was originally cited in minimum data set (MDS) F278 for accuracy of assessment on a Recertification and complaint survey on March 26, 2018 and again on June 1, 2018, at F641 during the Recertification and complaint investigation for MDS accuracy of assessment. The second deficiency was in the area of F371 (Kitchen.) on March 26, 2018. This deficiency was cited again on 06/01/2016 on a Recertification and complaint survey F812 (kitchen). The continued failure of the facility during three surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. Finding included: This tag was cross-referred to: F 278 March 26, 2017, Based on record review and staff interviews the facility failed to code the minimum data set (MDS) to accurately reflect the residents condition for 2 of 2 residents that were reviewed for urinary catheters (Resident #117 and Resident #111), 1 of 6 residents reviewed for	F 865	F865 1. What lead to the deficient practice and failed QI was the QAPI committee failed to sustain an effective QA monitoring program to avoid ongoing issues regarding MDS coding to ensure accurate reflection of resident status: QAPI committee also failed to ensure appropriate monitoring system in place for foods past the use by date in food storage areas to ensure food safety requirements were being met. The QAPI committee failed to sustain routine auditing to identify deficient practices in MDS coding and monitoring foods past the use by date. Residents in the facility have the potential to be affected by the alleged deficient practice. The facility□s Quality Assessment and Assurance committee failed to maintain procedures and monitor the interventions that the committee put in place on June 1, 2016, March 26, 2017, March 26, 2018, June 1, 2018.The Quality Assurance Performance Improvement (QAPI) team notified Medical Director on June 1, 2018 and held a discussion with the QAPI team regarding the findings of the survey. An Ad Hoc QAPI team meeting was held on June 4, 2018	

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F 865	Continued From page 6 accidents (Resident #4) of 1 resident reviewed for Hospice (Resident #221) and 1 of 1 resident reviewed for Preadmission Screening Resident Review (PASRR) (Resident #49). During the recertifcation and complaint survey on June 1, 2018 the facility failed to accurately code the MDS (Minimum Data Set) on 2 out of 5 residents (Residents #59 and #41) reviewed for unnecessary medications and 1 out of 1 resident (Resident #29) reviewed for dialysis. (F641) F 371 on March 26, 2017, Based on observations and staff interviews the facility failed to ensure cookware and service ware were clean, air dried and in good repair; kitchen equipment, walls and ceiling tiles were clean and in good repair; and food was labeled, dated and stored in sealed packages. This had the potential to impact 83 of the 85 residents that resided in the facility. During the recertification and complaint survey on June 1, 2018, the facility failed to remove food in 1 out of 2 nourishment rooms (200 unit) that was past the use by date. During an interview with the Administrator on 6/1/2018 at 12:42PM she indicated that it is her expectation is that all nourishments are labeled and dated appropriately: no expired nourishments. It is also expected that MDS are to be coded correctly.	F 865	regarding the plan of correction and the involvement of the QAPI team to ensure the identified concerns are corrected and maintained in compliance. 2. Residents in the facility have the potential to be affected by the alleged deficient practice. 3. The Quality Assurance Performance Improvement Committee will ensure that MDS diagnosis coding is accurate and there are no foods past the use by date in food storage areas. MDS diagnosis coding education completed by 6/4/18. Foods past the use by date education were completed by 6/1/2018. 4. The QAPI Committee will review results of MDS Coding accuracy audits and Foods past the used by date audits during the monthly meetings. Audits will be completed on 3 resident□s MDS Assessments weekly x 8 weeks to ensure accurate coding; then 2 resident□s Assessments weekly x 4 weeks: the 1 monthly resident Assessment monthly thereafter. Nourishments rooms are inspected daily for foods past the use by date. Nourishment room audits will be conducted daily x 4 weeks: once weekly x 4 weeks; then weekly thereafter. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. 5. The Administrator and DNS is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 27, 2018. Corporate office representative will review	

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F 865	Continued From page 7	F 865	Performance Improvement Plans monthly x 3 months: then quarterly thereafter to ensure QAPI committee is effective.	