| 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 06/14/2017 |

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

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| F 167 SS=C | 483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE<br><br>(g)(10) The resident has the right to-<br><br>(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and<br><br>(g)(11) The facility must--<br><br>(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.<br><br>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and<br><br>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.<br><br>(iv) The facility shall not make available identifying information about complainants or residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interview the facility failed the post plans of corrections for the statement of deficiencies for 2 of the 3 days of the survey.<br>Findings included:<br><br>Observation on 06/12/2017 at 11:00 AM revealed the survey results were posted in the front lobby | F 167 | F167:<br>1. No Residents or Family Members had requested to see the plan of correction for the last annual survey. The Administrator immediately upon identification that the Plan of Correction was not in the survey findings binder, copied the Plan of correction and placed it in the binder on | 6/29/17 |

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

Electronically Signed | 06/26/2017

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| F 167 | Continued From page 1<br>near the receptionist desk in a white colored binder. Record review of the survey book revealed on May 9, 2017 through May 11, 2017, a complaint survey was conducted. On April 8, 2017 through April 26, 2017, a recertification and complaint survey was conducted. These statements of deficiencies were posted but plans of correction for these surveys were not posted.<br><br>Observation and records review on 06/13/2017 at 5:26 PM of the survey results continued to reveal plans of correction for the surveys conducted April 8, 2017 through April 26, 2017 and May 9, 2017 through May 11, 2017 were not posted.<br><br>Interview on 06/13/2017 at 5:54 PM with the administrator revealed she printed the wrong form that did not include the plan of correction. | F 167 | 6/13/17.<br>2. Residents in the facility had the potential to be affected, as well as family members of residents, by the alleged deficient practice. No residents or family members requested to see the plan of correction for the recent annual survey.<br>3. The Survey findings binder will continue to be maintained in the front lobby of the facility near the reception desk. Education was provided to the Administrator and Director of Nursing on 6/13/17 by the Nurse Consultant, regarding the requirement of posting survey results and based on the updated regulation dated 3/8/17. The Administrator will review the survey findings binder weekly for 4 weeks to ensure the appropriate information remains in place as required.<br>4. Findings of the review of the survey binder will be discussed by the Administrator with the QAPI team monthly for 3 months for recommendations and further follow-up as indicated.<br>5. Compliance date: 6/29/17 | |
| F 241 SS=D | 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record reviews, video | F 241 | F241: | 6/29/17 |

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| F 241 | Continued From page 2<br>review, family member, ombudsman and staff interviews the facility failed to provide activities of daily living (incontinence care) to a dependent resident in a dignified manner by placing a white object over the face and the failure to talk to the resident when tasks were performed. This was evident in 1 of 3 residents reviewed for activities of daily living. (Resident #6)<br>Findings included:<br><br>Resident #6 was admitted to the facility on 9/6/2011 with a diagnosis of traumatic brain injury, quadriplegia with jerky movements and contractures to both hands and wrists.<br>A review of a quarterly Minimum Data Set (MDS) assessment dated 4/1/2017 revealed Resident #6 was unable to speak with highly impaired vision, severely impaired cognition, did not reject care, and did not exhibit any behaviors during this assessment period. The MDS also coded Resident #6 as totally dependent on staff for bed mobility, personal hygiene and was incontinent of bowel and bladder.<br>Review of the care plan last revised 4/4/17 included:<br>A problem with communication as exhibited by (AEB) being non-verbal related to anoxia anoxic brain injury and aphasia. The interventions to address this problem included using brief, simple consistent words, clues and statements to promote dignity and conversing with the resident while care was provided.<br>A problem for the risk for developing skin breakdown. The intervention was to address incontinence care after each incontinence episode.<br><br>1a. Review of the zoomed recorded video by a family member revealed Nursing Assistant (NA) | F 241 | 1. The Director of Nursing completed a physical assessment of Resident # 6 on 6/14/17 to ensure that there was no change in condition following the provision of perineal care by the nursing assistant. No change in physical or mental condition was observed.<br><br>2. Resident Interviews were conducted with residents with a BIMS (Brief Interview of Mental Status) score of 8 or above who require assistance with perineal care to ensure care was being provided in a manner to promote dignity by Director of Nursing, Assistant Director of Nursing, Licensed Nurses, Department Managers and Assistants. Resident observations were conducted for residents with a BIMS score of 7 or below to ensure perineal care was being provided in a manner to promote dignity, this will be completed by Director of Nursing, Assistant Director of Nursing and Licensed Nurses.<br>Corrective actions to be taken for any issues identified. This will be completed by 6/29/17.<br><br>3. Perineal care competencies were initiated by Director of Nursing, Assistant Director of Nursing, Nurse Consultant and Licensed Nurses regarding providing perineal care in a manner that promotes resident dignity. This will be completed by 6/29/17.<br><br>4. Resident Interviews for BIM score of 8 and above will be completed by Director of Nursing, Assistant Director of Nursing, Licensed Nurses, Department Managers | |

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| F 241 | Continued From page 3<br>#2 (who was identified as the recorded NA by the facility). This video revealed Resident #6 coughed and a white colored object was placed on the resident's face by NA #2. It was noted that NA #2 repositioned Resident #6 in an undignified manner and did not engage in talking with Resident #6 when care was provided.<br><br>Interview on 6/13/17 at 10:45 AM with a family member and ombudsman was made. The family member stated on 5/7/17 at 2 PM a video camera stored in a picture frame was placed in Resident #6's room and was removed on 5/9/17 at 2 PM. The family member stated his perception of the video indicated that during care a male NA "flipped" him over when moving him, treated him roughly, picked his body up with his feet and placed a pillow over his mouth. Further interview with the family member revealed the facility agreed with him that two people were needed to care for him but only one person was in the video. Continued interview with the family member revealed on 5/10/17 at approximately 10:30 AM he met with the Administrator regarding the on line filing of a police report due to the concerns he viewed on the video camera. Interview via the phone on 6/19/17 at 2:30 PM with the criminal investigator regarding the video revealed the case would be closed and no criminal charges would occur.<br>Record review revealed the facility conducted an investigation of the recorded video on 5/10/17. Review of the written statement by the NA #2 indicated "when working with _____ (name of Resident #6) there are occasions where he coughs and kicks. "As he coughs I occasionally have to keep his cough off my (me) by blocking his mouth-not obstructing breathing of course-just adequate to keep cough off me with a pillow case | F 241 | and Assistants. Resident observations for BIM score of 7 and below will be completed by Director of Nursing (DON), Assistant Director of Nursing (ADON), Licensed Nurses, for 3 residents daily, 5x week for 2 weeks including weekends and varying shifts, then 3 residents, 3x weekly x 10 weeks to ensure dignity is provided during the provision of perineal care. Findings of interviews and observations will be discussed by the Director of Nursing with the Quality Assurance Improvement Committee monthly for 3 months for recommendations and further follow-up as indicated.<br><br>Compliance Date: 6/29/17 | |

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| F 241 | Continued From page 4<br>cover resting on his chest a few inches from his mouth."<br><br>Several attempts during the survey to contact NA #2 were unsuccessful.<br><br>Interview on 06/14/2017 at 1:13 PM with the Administrator and Director of Nurses (DON) was held. The DON believed it was a pillow and not a pillow case that was placed over the resident's face. The DON and administrator indicated placing anything over the resident's face was unacceptable and expected all residents to be treated with dignity.<br><br>1b. Observation on 6/12/17 at 12:35 PM of care performed by Nursing Assistant (NA) #1 and witnessed by Nurse #1 was done. NA #1 was providing care and didn't let the resident know what she was doing and going to do.<br>Interview on 6/12/17 at 1:31 PM with the Corporate Representative, Director of Nurses (DON), NA #1 and Nurse #1 was held. NA #1 indicated she routinely had NA #3 assist her when caring for the resident but she was not available and had told the resident that she would be in to provide care to the resident prior to the observation of care (NA #1 did not provide a specific time when she had spoken with the resident).<br><br>Interview on 06/14/2017 at 1:13 PM with the Administrator and Director of Nurses (DON) was held. Both indicated they expected all residents to be treated with dignity. | F 241 | | |
| F 520 SS=D | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS | F 520 | | 6/29/17 |

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| F 520 | Continued From page 5<br><br>(g) Quality assessment and assurance.<br><br>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee;<br><br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br><br>(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 the compliance of such committee with the requirements of this section.<br><br>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for | F 520 | | |

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| F 520 | Continued From page 6<br>sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>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 May 2017. This was for F 241 recited deficiency, which was originally cited in dignity and respect (F241) during a Recertification and Complaint Survey on April 26, 2017. This deficiency was cited again on June 14, 2017 on a Follow Up and Complaint Survey. The continued failure of the facility during two surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program.<br><br>This tag is cross referenced to<br>Findings included:<br><br>F-241: Based on observations, record review, video review, family member, ombudsman and staff interviews the facility failed to provide activities of daily living (incontinence care) to a dependent resident in a dignified manner by placing a white object over the face and failure to talk to the resident when task were performed. This was evident in 1 of 3 resident for activities of daily living (Resident # 6).<br><br>During the recertification and complaint survey on April 26, 2017 the facility was cited for dignity and Respect (F 241). Based on record review, observation and interviews, the facility failed to respond to a resident's request for toileting which compromised the dignity for 1 of 8 residents reviewed for activities of Daily living (resident #97). | F 520 | F520:<br>1. Residents in the facility have the potential to be affected by the alleged deficient practice. The Quality Assurance Performance Improvement (QAPI) team met with the Medical Director on 6/15/17 regarding the findings of the follow-up survey and the re-citing of F241 – dignity. Discussion was held with the QAPI team regarding the plan of correction and the involvement of the QAPI team to ensure the identified concern is corrected and maintained in compliance.<br><br>2. Residents in the facility have the potential to be affected by the alleged deficient practice.<br><br>3. The Quality Assurance Performance Improvement Committee will ensure that Resident Interviews were conducted with residents with a BIMS (Brief Interview of Mental Status) score of 8 or above who require assistance with perineal care to ensure care was being provided in a manner to promote dignity by Director of Nursing, Assistant Director of Nursing, Licensed Nurses, Department Managers and Assistants. Resident observations were conducted for residents with a BIMS score of 7 or below to ensure perineal care was being provided in a manner to promote dignity, this will be completed by Director of Nursing, Assistant Director of Nursing and Licensed Nurses.<br>Corrective actions to be taken for any | |

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| F 520 | Continued From page 7<br><br>During an interview on June 14, 2017 at 3:00 PM with the Administrator, she indicated that her expectations was for the highest quality of care to be given to each resident with Dignity and Respect. Also care guides are to be followed with the required staff present to provide care at all times. Administrator expected all residents to be treated with dignity. | F 520 | issues identified. This will be completed by 6/29/17. Perineal care competencies were initiated by Director of Nursing, Assistant Director of Nursing, Nurse Consultant and Licensed Nurses regarding providing perineal care in a manner that promotes resident dignity. This will be completed by 6/29/17.<br><br>4. The QAPI Committee will review the resident interviews, resident observations, and competency evaluations to ensure appropriate completion monthly for 3 months, for recommendations and further follow-up as indicated.<br>a. Compliance date: 6/29/17 | |