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 05/02/2019

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 A recertification survey was conducted on 5-2-19. No deficiencies in emergency preparedness were found during the survey.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey conducted on 5-2-19. Event ID #HJ4R11.	F 000		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking,	F 676		5/30/19

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

Electronically Signed | 05/21/2019

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 05/02/2019

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 676	Continued From page 1 §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record reviews the facility delayed Resident #37 participation into the restorative program. This was evident in 1 of 1 resident in a planned restorative program. The findings included: Resident #37 was admitted to the facility on 8/30/18 with numerous diagnoses which included vascular dementia difficulty in walking and unspecified osteoarthritis. Review of the Quarterly Minimum Data Set dated 2/19/19 revealed the resident was coded as impaired cognition, balance unsteady and used a walker and wheelchair for locomotion. Unable to interview Resident #37 due to impaired cognition. Record review revealed Resident # 37 participated in skilled rehabilitation and physical therapy discharge summary notes dated 3/15/19 indicated a referral for restorative care. Review of the Restorative referral form revealed Resident #37 was originally referred to the	F 676	F676 1. The facility delayed Resident #37 participation into the restorative program. Resident #37 was referred back to rehab for further evaluation on 5/2/19 to ensure no decline in ADLs. Per therapy evaluation, Resident #37 has maintained the appropriate level of care with no decline. Restorative Nurse, Restorative Aides and Rehab staff were re-educated on the process of therapy discharge to restorative services. 2. All residents have the potential to be affected by this alleged deficient practice. In-house audited completed on 5/17/19 on therapy discharges with restorative referrals from 3/1/19-5/17/19. Corrective actions completed as deemed necessary. 3. Education provided to Restorative Nurse, Restorative Aides, and Rehab Manager on 5/1/19, 5/7/19, and 5/16/19 as it relates to the initiation of restorative services upon discharge from therapy. The Administrator and/or the Director of Nursing will complete an audit of resident discharges from therapy to the restorative program weekly x 8 weeks 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 _____	C 05/02/2019

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 676	Continued From page 2 Restorative program on 3/16/19. The treatment goals for restorative included the resident would maintain current level of range of motion (ROM) of the bilateral upper and lower extremities, maintain current level of bed mobility and maintain current ability to ambulate (no distance was included in the goals. The treatment program for restorative included active range of motion (AROM) to bilateral lower extremities and to ambulate 15 minutes a day from 150 feet to 175 feet seven (7) days a week. Further review of the referral form revealed another date of 4/10/19 was written in a different handwriting. Reviewed the documentation of Resident#37's restorative care on the Restorative Service Delivery Record (RSDR) revealed restorative services started on 4/11/19 but Resident #37 did not receive or was offered restorative services on the weekends of 4/13, 4/14, 4/21, 4/22, 4/27 and 4/28/19. Interview on 5/1/19 at approximately 9:30 AM with Restorative Assistant (RA) #1 revealed she had not received the referral until 4/10/19 and was instructed by the Director of Rehabilitation (DOR) to enter on the referral form the date she obtained the referral. RA #1 could not remember who provided her with the restorative referral. RA #1 indicated RA #1 and RA #2 work every other weekend and the nursing assistants (NA) do not perform restorative therapy. Review of the "Point of Care ADL (Activity of Daily Living)" documentation by the NA revealed no documentation of range of motion during bathing or during the shifts nor ambulation with the resident by the NA. There were written entries of Resident #37's locomotion off the unit via a	F 676	referrals made to restorative are initiated timely, weekly x 4 weeks, then monthly thereafter to include Restorative Aide documentation. Education will be provided as indicated. All data will be summarized and presented to the facility QAPI meeting weekly x 3 months, then monthly x 3 months by the Administrator or DON. 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 are responsible for implementing and maintaining the acceptable plan of correction. 5. Corrective action will be completed by May 30, 2019.	

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 05/02/2019

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 676	Continued From page 3	F 676		

wheelchair (WH).
Interview on 05/01/19 at 10:38 AM with the DOR stated she was recently hired at the facility and started working on improving the restorative program. The DOR stated the process that " I used was when a resident was discharge from physical therapy and the recommendation for restorative I would submit the referral to the Director of Nurse (DON) who in turn forwarded the information to the restorative team to begin maintenance therapy." Further interview with the DOR indicated a group decision from staff was to bring restorative referrals to the morning stand up meeting and give to the DON. The DOR stated she realized in general and specifically Resident # 37 who had a referral and plans for restorative services that were not being communicated to the restorative team. DOR stated the facility was still working on trying to address the restorative program and she instructed RA #1 to place the date of 4/10/19 when she received the restorative referral. Continued interview with the DOR stated she was unaware of concerns about restorative being discussed in a Quality Assurance Committee or Quality Assessment and Performance Improvement committee nor the development of an action plan.

Interview on 5/01/19 at 1:28 PM with the Administrator and DON was held. The corporate representative joined the discussion then left the interview. The administrator revealed the facility had 2 restorative assistants (RA #1 and RA #2) .The Administrator stated Nurse #1 was the interim Restorative Coordinator since the previous DON no longer worked at the facility. Additionally, the facility met with the Rehab team, Restorative team, other disciplines and the previous DON. We discussed how the resident

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 05/02/2019

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 676	Continued From page 4	F 676		

would transition from skilled therapy to restorative therapy. The practice of the facility was to have the DOR submit the restorative referral to the DON and also train the RA. The DON would provide the referral to the RA to begin the restorative services. During the interview the Administrator submitted a one page "Restorative Plan" with dates of 3/4/19 and 3/7/19. The plan included to audit for missed documentation of restorative services, therapy training for staff and have restorative case load notebooks be reviewed weekly during Medicare meetings. The Administrator was unable to provide supportive documentation of the initial plan and continued plan to avoid any delay in the Restorative program. Later during the interview the Administrator provided an In-service sheet of dates 3/7/19, 3/12/19, and 3/14/19 and 3/21/19. It is unclear whether each of the signed signatures attended each dated signature. During the interview the Administrator stated the previous DON no longer worked for the facility as of 4/19/19 and the current DON started 4/22/19. The Administrator indicated she had not been able to locate other supportive documents of the plan since the previous DON no longer worked at the facility.

The previous DON was unable to be interviewed during the survey.

The interim Restorative Coordinator was not available to be interviewed.

Interview on 05/02/19 at 2:02 PM with the Administrator and DON was held. The Administrator's expectation was resident's to receive restorative services as appropriate.

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 05/02/2019

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 761	Continued From page 5	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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 observation and staff interviews the facility failed to date medications when opened in 2 of 2 medication carts reviewed. (Front red and Rehab Unit). The findings included: Observation on 04/29/2019 at 4:32 PM of the Front Red medication cart and interview with Nurse #2 revealed medications were opened and	F 761	F761 1. The facility failed to date medications when opened in 2 of 2 medication carts reviewed. No negative impact to residents. Education provided immediately regarding the expectation regarding dating medications once opened. All undated medications were removed, replaced, and dated properly on medication carts by	5/30/19

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 05/02/2019

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 761	Continued From page 6 undated: " Altalube ophthalmic ointment " Systane ophthalmic gel " 2 bottles of Fluticasone 50 micrograms (mcg) nasal spray " House stock of Sodium Bicarbonate 650 milligrams tablets " 2- tubes of Diclofenac Sodium topical gel 1% Nurse #2 stated medications should be initialed and dated when opened. B Observation on 04/29/2019 at 4:45 PM of the Rehab unit medication cart revealed medications were opened and undated: " House stock Omeprazole 20 milligrams (mg) Delayed Release bottle was opened and undated. " Sodium Chloride 100 mg tablets bottle was opened but not dated. Interview on 05/02/19 at 1:47 PM with the Administrator and Director of Nurses (DON) was held. The DON stated she expected staff to date all medications when opened.	F 761	5/3/19. 2. Nursing staff were educated on the expectations of dating medications once opened. Education was provided on 5/2/19, 5/3/19, 5/7/19, 5/8/19, and 5/9/19. Additional education provided to the nursing staff on 5/7/19 and 5/9/19 as it relates to dating medications once opened by the pharmacy. In-house audit completed by pharmacy on 5/13/19. 3. Daily audits of the medication carts will be completed by the DON and/or Unit Managers to ensure medications are dated once opened. Medication cart audits will be performed daily x 4 weeks, once weekly x 4 weeks, and then weekly thereafter. All data will be summarized and presented to the facility QAPI meeting weekly x 3 months by the DON or Unit Managers. 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 DON and Unit Managers are responsible for implementing and maintaining the acceptable plan of correction. 5. Corrective action will be completed by May 30, 2019.	