STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF CHAPEL HILL	1602 E FRANKLIN STREET , CHAPEL HILL, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 06/16/25 through 06/19/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SC1B11.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/16/25 through 06/19/25. Event ID # SC1B11. The following intakes were investigated: NC00229527, NC00227968, NC00225216, NC00224861, NC00224248, NC00223968, NC00222440, NC00221326, NC00220478, NC00219795, NC00219445, NC00217560, NC00231159, NC00229025, NC00222318, NC00223506, and NC00223194. 4 of the 49 complaint allegations resulted in deficiency.	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F0584	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F 584 Corrective action for the residents found to have been affected by the deficient practice: Resident #76 still resides in the facility. On 6/19/2025, the floor and furniture in Resident #76's room were immediately cleaned by the Housekeeping Manager and is free from drainage from enteral feeding. Resident# 31 still resides in the facility and on 6/19/2025, a new bed control was immediately installed by the Maintenance Director to replace the one without outer covering for control wires.	07/05/2025

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 reverse for further 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.

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

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F0584 SS = D	Continued from page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to ensure the furniture and floors were maintained in a clean state, free from drainage from an enteral feeding (Resident #76) and the insulated outer covering of the bed control wires was intact (Resident #31) for 2 of 6 rooms on 1 of 2 halls observed for a safe, clean and homelike environment. Findings included: 1. An initial observation completed on 6/16/25 at 11:28 AM revealed a large brown semi-solid puddle of dried fluid trailing towards the windows on the left side of Resident #76's bed. The floor was sticky underfoot as well. In addition, there was a brown dried substance on the casing of the bedside television monitor that spanned the width of the lower lip with drip marks dried on the controls.	F0584	Continued from page 1 Corrective action for other residents having the potential to be affected by the same deficient practice: On 06/19/2025, the Maintenance Director and the Assistant Maintenance Director audited 100% of all residents' bed controls to ensure no exposed wires were present and no beds were found to have exposed wires. B. On 6/19/2025 and 6/20/2025, the Housekeeping Manager and the District Manager inspected all residents' room floors and furniture to ensure none were soiled and/or dirty. Any rooms found to be soiled and with any spills were immediately cleaned by the housekeeping team. The Maintenance Director, the Assistant Maintenance Director and the Housekeeping Manager were educated on ensuring resident furniture and floors were maintained in a clean state. Systemic Changes made to ensure that the deficient practice will not recur: On 06/19/2025, the Administrator and the Assistant Administrator initiated education for the housekeeping and maintenance staff on maintaining a safe, clean and homelike environment to ensure resident furniture and floors are kept in a clean state. Education was completed on 6/25/25. Any new hires will be educated as indicated above by the Administrator or the Assistant Administrator and the Housekeeping District Manager during orientation. Any maintenance and housekeeping staff who are not educated as indicated will not be allowed to work until their education is completed. Plans to monitor its performance to make sure that solutions are sustained: On 6/19/25, the Administrator introduced a bed control/remote observation tool to be utilized by the Maintenance Director and the Assistant. The tool will be used 3 times a week for 2 weeks, then 1 time a week for two weeks and monthly for 3 months until compliance is maintained. The Administrator, the Assistant Administrator and the DON will review the observation tool weekly for 4 weeks and then monthly until compliance is maintained. Any areas of non-compliance will be reported by the Administrator, the Assistant Administrator and/or DON to the QAA Committee quarterly or as needed for further action to ensure compliance. The Administrator also introduced a furniture and floor observation tool on 6/19/25 to be utilized by the Housekeeping Manager and/or the District Manager. The tool will be used daily for 1 week, then 3 times a week for two weeks, then weekly for 3 months until	

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F0584 SS = D	Continued from page 2 Additional observations of Resident #76's room on 6/18/25 at 8:30 AM and on 6/19/25 at 1:06 PM continued to reveal the brown substance remained on the bedside television monitor and the equipment as it had from the initial observation on 6/16/25. An interview was conducted with Housekeeper #1 on 6/19/25 at 1:40 PM who was responsible for cleaning the hall where Resident #76. She stated the process of cleaning a resident's room included emptying trash, sweeping the floor and mopping the floor. She stated she wiped down the dresser, nightstand, and overbed table as well. She indicated housekeeping was not allowed to clean up bodily fluids but was able to clean up spills such as water, juices, or food items. She stated the last time she cleaned Resident #76's room was on 6/18/25. The Director of Housekeeping was interviewed on 6/19/25 at 1:46 PM, and he stated this past Monday 6/16/25 he had to do an extra scrub of Resident #76's floor because a puddle of tube feed was left to dry over the weekend. He stated the puddle was underneath the wheel of the pole the tube feeding hung from and ran out towards the window. He stated he had to "soak and really scrape" to get the spill up. After being shown the brown substance on Resident #76's television monitor, he stated he wasn't aware tube feeding had leaked onto the television as well, but he would have it cleaned up. The Director of Housekeeping indicated housekeeping worked seven days on weekdays from 7:00 AM to 4:00 PM, but on the weekends housekeeping left at 2:00 PM. The Director stated tube feeding spills were difficult to clean up once they were dried, and it would be helpful if staff wiped up the spill while it was still wet once they noted one happened. On 6/19/25 at 1:55 PM the Administrator toured the resident rooms with this writer in the hall where Resident #76 resided and stated housekeeping would clean the room that day. 2. On 6/18/25 at 1:02 PM an observation was made of the bed control that operated Resident #31's bed wrapped around the left upper bar of the resident's bed and resting on the pillow. The outer insulation casing over the wiring was stripped away leaving three individual wires exposed, a red wire, a white wire, and a black wire. Resident #31 was lying in bed at the time of the	F0584	Continued from page 2 compliance is maintained. Any areas of non-compliance will be reported by the Administrator, the Assistant Administrator and/or DON to the QAA Committee quarterly or as needed for further recommendations to ensure compliance. The Administrator, the Assistant Administrator and the District Manager will utilize the presented tools to randomly check the beds, furniture and floors weekly for four weeks and then monthly three months to ensure compliance is maintained. Any findings of concern will be reported by the Administrator to the QAA Committee quarterly or as needed for further recommendations to ensure compliance. Date of Compliance: 7/5/2025	

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F0584 SS = D	Continued from page 3 observation. An interview was conducted with the Maintenance Director in conjunction with the Administrator on 6/19/25 at 11:02 AM. The Maintenance Director stated bed controls were checked monthly to make sure they were working. The Maintenance Director further stated if the staff noted a problem with bed controls they would notify maintenance for repairs. The Administrator provided documentation from the maintenance logbook that indicated the bed controls were inspected by maintenance on 5/2/25 and to make sure the bed control operated the bed correctly, checked for any cracked or frayed wires, and ensured bed control wires were not wrapped around rails. The Administrator further indicated Resident #31's bed was a rental and would be replaced. The Administrator provided a copy of quality improvement projects for the rooms of the facility that included plans for repairs, painting, and maintenance.	F0584		
F0761 SS = E	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:	F0761	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F 761 Corrective action the resident found to have been affected by the deficient practice. On 6/17/2025, the Unit Managers, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) immediately removed and disposed of all drugs and biologicals that were expired and/or open and undated from all medication carts, storage refrigerators and medication rooms. On 6/18/25 and 6/19/25, the DON and ADON, ensured all medication carts, storage refrigerators and medication rooms were free of expired and open and undated drugs and biologicals Corrective action for other residents having the potential to be affected by the same deficient practice: On 6/18/25 and 6/19/25, the Director of Nursing and the Assistant Director of Nursing audited all medication carts, medication rooms, and storage refrigerators to ensure no more expired and open and undated drugs and biologicals were present. The audit was for all	07/05/2025

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F0761 SS = E	Continued from page 4 Based on observations and staff interviews the facility failed to (1) remove expired medication and date open medication for 1 of 2 medication storage refrigerators reviewed (Blue Hall), and (2) failed to date open medications for 1 of 2 medication carts reviewed (Red Hall). The findings included: 1. During an observation of the Blue Hall medication storage refrigerator with Unit Manager #1 on 6/17/25 at 11:23 am the following was observed. Unit Manager #1 confirmed all findings before the removal of the identified items. - One glargine (long-acting) insulin injector pen was observed to be open with approximately 180 units of the 300 units of insulin remaining. There was no open date noted on the insulin pen. The manufacturer's recommendation for the storage of insulin glargine was to discard unused insulin 28 days after first use. - One vial of tuberculin purified protein derivative (used in the diagnosis of tuberculosis) was observed to be open with approximately one third of the medication remaining. The vial had an open date of 5/05/25. The medication box noted to discard open product after thirty (30) days. An interview was conducted with Unit Manager #1 on 6/17/25 at 11:30 am who revealed all medications were to be dated when opened by the nurse that opened the medication. Unit Manager #1 further reported that all nurses were responsible for checking medications for expiration dates when they were used and the medication should have been removed from the medication storage refrigerator when expired. During an interview on 6/18/25 at 12:44 pm with the Director of Nursing (DON) she revealed that all nurses were responsible for dating medications when they were opened. The DON stated Unit Manager #1 was responsible for ensuring the medication storage refrigerator was monitored for expired medications. 2. During an observation of the Red Hall medication	F0761	Continued from page 4 residents and no residents were found to have expired or open and undated drugs and biologicals. This was completed on 6/19/25. Education was conducted for all licensed nurses and medication aides labeling and storing drugs and biologicals. Systemic Changes made to ensure that the deficient practice will not recur: On 6/19/25, the DON and the Staff Development Coordinator (SDC) initiated education for all licensed nurses and medication aides on labeling and storing drugs and biologicals per company policy. The education was completed on 6/30/25. Any new hires will be trained as indicated above by the SDC and/or DON during orientation. Any licensed nurses and medication aides who have not received educated as indicated will not be allowed to work until their education is completed. Plans to monitor its performance to make sure that solutions are sustained: On 6/20/25, Clinical Consultant and the DON introduced an observation tool for labeling and storing of drugs and biologicals to be utilized by Unit Managers and charge nurses. The tool will be used weekly for 4 weeks and then monthly for 3 months until compliance is maintained. The DON and ADON will perform random audits of all medication carts, storage refrigerators and medication rooms weekly for 4 weeks, then monthly for 3 months to ensure continued compliance. Reports of any non-compliance will be presented to the QAA committee monthly and/or as needed by the Administrator or Director of Nursing for further recommendations to ensure compliance is maintained. Date of Compliance: 7/5/25	

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F0761 SS = E	Continued from page 5 cart with Medication Aide (MA) #2 on 6/17/25 at 1:35 pm the following was observed. MA #2 and Unit Manager #2 confirmed all findings before the removal of the identified items. -One glargine (long-acting) insulin injector pen was observed open with approximately 140 units of the 300 units insulin remaining. There was no open date noted on the insulin injector pen. The manufacturer's recommendations for glargine insulin injector pen was to discard the unused insulin 28 days after first use. - One insulin lispro (rapid-acting) injector pen was observed open with approximately 220 units of the 300 units of insulin remaining. There was no open date noted on the insulin injector pen. The manufacturer's recommendations for insulin lispro injector pen was to discard the unused insulin after 28 days of opening. - One fluticasone furoate, umeclidinium and vilanterol 100 micrograms (mcg)/62.5 mcg/25 mcg inhalation powder (medication used to treat chronic obstructive pulmonary disease (COPD) and asthma) was observed open with no open date noted. The manufacturer's recommendations for the fluticasone furoate, umeclidinium and vilanterol inhalation powder was to discard after 6 weeks of opening. - One fluticasone propionate and salmeterol 500 mcg/50 mcg inhalation powder (medication used to treat COPD and asthma) was observed open with no open date noted. The manufacturer's recommendation for the fluticasone propionate and salmeterol inhalation powder was to discard 1 month after the foil pouch was opened. - One plastic squeeze bottle of timolol maleate ophthalmic solution 0.25% (medication used to treat eye conditions like glaucoma) was observed open with no open date noted. The manufacturer's recommendation for the timolol maleate ophthalmic solution was to be used within 4 weeks of opening. - One plastic squeeze bottle of prednisolone acetate ophthalmic solution 1% (medication used to treat eye inflammatory conditions of the eye) was observed open, with no open date noted. The manufacturer's recommendation for the prednisolone acetate ophthalmic solution was to discard 28 days after opening.	F0761		

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F0761 SS = E	Continued from page 6 - One plastic squeeze bottle of moxifloxacin ophthalmic solution 0.5% (medication used to treat bacterial eye infections) was observed open with no open date noted. The manufacturer's recommendation for the moxifloxacin ophthalmic solution was to discard any unused drops 4 weeks after the first opening. - One plastic squeeze bottle of eye drops ultra (used to treat dry eyes) was observed open with no open date noted. The manufacturer's recommendation for the eye drops ultra was to discard any remaining drops 3 months after opening. An interview was conducted with MA #2 on 6/17/25 at 2:00 pm. MA #2 revealed all medications were to be dated when they were opened. She stated when she opened a medication she wrote the date on the medication. MA #2 stated she was not permanently assigned to the Red Hall medication cart and she did know why the medications did not have an open date noted. An interview was conducted on 6/17/25 at 2:02 pm with Unit Manager #2 who stated medications should be dated by the nurse when they were opened. Unit Manager #2 stated there was no one specifically assigned to check the medication cart to ensure medications had an open date noted. During an interview on 6/18/25 at 12:44 pm with the Director of Nursing (DON) she revealed that all nurses were responsible to date medications when they were opened. The DON stated all nurses were responsible to check the medication carts to make sure medications were dated and removed if expired.	F0761		
F0812 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.	F0812	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F 812 Corrective action the resident found to have been affected by the deficient practice.	07/05/2025

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F0812 SS = D	Continued from page 7 (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 observation and staff interviews, the facility failed to remove expired fortified nutritional supplements stored for use in 1 of 2 nourishment rooms (Nourishment Kitchenette at Blue side). These practices had the potential to affect 2 of 2 residents who received tube feeding. The findings included: On 6/16/25 at 10:35 AM, during an observation with the Dietary Manager of the nourishment kitchenette on the Blue side hallway, in the cabinet, there were 18 packs of fortified nutritional supplement that expired on 4/1/25, and 6 packs of fortified nutritional supplements that expired on 5/1/25. On 6/17/25 at 9:45 AM, during an interview, the Dietary Manager indicated that the Central Supply staff was responsible for restocking the nutritional supplements in the Nourishment Kitchenettes and checking the expiration date. On 6/16/25 at 2:45 PM, during an interview, the Central Supply staff indicated that she was responsible for ordering nutritional supplements for the facility. She checked the nutritional supplements for expiration date weekly. The Central Supply staff indicated the last time she checked the Nourishment Kitchenette rooms on Red and Blue side hallways on 6/13/25. The Central Supply staff mentioned that she was very busy on 6/13/25 and probably overlooked a few expired items.	F0812	Continued from page 7 On 6/17/25, the Central Supply Director, the Unit Manager, the Dietary Manager and the DON immediately removed the expired fortified nutritional supplements and only the unexpired ones remained. Corrective action for other residents having the potential to be affected by the same deficient practice: On 6/17/25, the Central Supply Director, Dietary Manager, the DON and the Unit Managers removed all expired fortified nutritional supplements and ensured only unexpired nutritional supplements remained. The DON and Unit Managers ensured that the two residents with the potential to be affected were being provided with unexpired nutritional supplements. The Central Supply Director, Dietary Manager and the Unit Managers were educated on ensuring that expired nutritional supplements are disposed of immediately. Systemic Changes made to ensure that the deficient practice will not recur: On 6/19/25, the SDC and the DON initiated education for the Central Supply Director, Dietary Manager and Unit Managers on food procurement and storage with emphasis on ensuring that expired fortified nutritional supplements are disposed of immediately. The education was completed on 6/20/25. Any new hires will be trained as indicated above by the SDC and/or DON during orientation. Any Unit Managers, Dietary Manager and the Central Supply Staff who have not received education will not be allowed to work until their education is completed. Plans to monitor its performance to make sure that solutions are sustained: The facility Administrator introduced a nutritional supplement observation tool to be utilized by the DON, ADON and Unit Managers. The tool will be used 2 times a week for 2 weeks, 1 time a week for 2 weeks, and then monthly for 3 months until compliance is maintained. Any areas of non-compliance will be reported by the Administrator and/or DON to the QAA Committee quarterly or as needed for further recommendations to ensure compliance. The Administrator, the Assistant Administrator will utilize the presented audits to randomly check nutritional rooms weekly for four weeks and then monthly three months to ensure compliance is maintained. Any findings of concern will be reported by the Administrator to the QAA Committee quarterly or as needed for further recommendations to ensure compliance.	

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F0812 SS = D	Continued from page 8 On 6/17/25 at 9:05 AM, during an interview, the Director of Nursing indicated that the Central Supply staff member was responsible for ordering nutritional supplements for the residents. The Central Supply staff member made rounds weekly and as needed and communicated the nutritional supplement needs with the units' coordinators. Currently, none of the residents with tube feeding received the order for fortified nutritional supplements. The Central Supply staff member had a responsibility to restock the Nourishment Kitchenettes and remove the expired items. On 6/17/25 at 10:25 AM, during an interview, the Administrator expected the staff to restock the nourishment rooms and remove the expired items in a timely manner.	F0812	Continued from page 8 Date of compliance: 7/5/25	
F0842 SS = B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records,	F0842	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F 842 Corrective action the resident found to have been affected by the deficient practice; Residents #11, #43 and #80 still reside in the facility. On 06/19/2025, the DON and ADON ensured that only licensed nurses were documenting in these residents' medical records for any medications administered as ordered by the physician. On the same day, The DON and ADON educated medication aides on the expectations per facility policy. Corrective action for other residents having the potential to be affected by the same deficient practice: On 6/19/2025, the DON and ADON ensured that only licensed nurses were documenting in the residents' medical records for any medications administered as ordered by the physician. On the same day, The DON and ADON educated medication aides on the expectations per facility policy. On 6/19/25 and 6/20/25, the DON and SDC audited all medication aides on medication pass to ensure they were not documenting on any medications administered.	07/05/2025

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

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F0842 SS = B	Continued from page 9 regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F0842	Continued from page 9 Systemic Changes made to ensure that the deficient practice will not recur: On 6/19/25, the DON and SDC initiated education for all licensed nurses on the accuracy of documentation in resident medical records for any medications administered by the nurses and medication aides. Medication aides were also educated on their roles as per facility policy. The education was completed on 6/30/25. Any new hires will be trained as indicated above by the SDC and/or DON during orientation. Any licensed nurses and medication aides who have not received educated as indicated will not be allowed to work until their education is completed. Plans to monitor its performance to make sure that solutions are sustained: On 6/20/25, the Administrator and the DON introduced a resident medication administration accuracy tool. The tool will be used to observe that only licensed nurses are to document on any medications administered by nurses and all medication aides. The DON, SDC and Unit Managers will utilize this tool 1 time a week for each licensed nurse and medication aide for 4 weeks, then monthly for 3 months until medical record accuracy compliance is maintained. Any areas of non-compliance will be presented by the Administrator to the QAA committee monthly and/or as need for further recommendations to ensure compliance is sustained. Date of Compliance: 7/5/25	

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F0842 SS = B	Continued from page 10 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with residents and staff, the facility failed to maintain an accurate Medication Administration Record (MAR) when insulin that was administered by licensed nursing staff was signed off on the MAR as administered by Medication Aide (MA) #2. This deficient practice affected 3 of 27 sampled residents whose medical records were reviewed (Resident #11, Resident #43, and Resident #80). The findings included: a. Resident #11 was admitted to the facility on 10/10/18 with diagnoses which included diabetes. A physician order dated 4/09/24 for insulin lispro (fast acting) administer 10 units subcutaneous before meals every day for diabetes. A physician order dated 4/09/24 for insulin lispro administer subcutaneous before meals every day for diabetes; per sliding scale: If Blood Sugar is 150 to 199, give 2 Units. If Blood Sugar is 200 to 249, give 4 Units. If Blood Sugar is 250 to 299, give 6 Units. If Blood Sugar is 300 to 349, give 8 Units. If Blood Sugar is 350 to 399, give 10 Units. If Blood Sugar is 400 to 449, give 12 Units. If Blood Sugar is greater than 449, call MD. Review of Resident #11's MAR for June 2025 revealed the following: - 6/04/25 at 7:00 am Resident #11 was administered insulin lispro 10 units as ordered by the physician. The insulin lispro was signed out by MA #2. - 6/04/25 at 7:00 am Resident #11 was administered insulin lispro sliding scale coverage of 2 units for a blood sugar of 174 milligram per deciliter (mg/dl) as ordered by the physician. The insulin lispro sliding scale coverage was signed out by MA #2.	F0842		

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F0842 SS = B	Continued from page 11 - 6/04/25 at 11:15 am Resident #11 was administered insulin lispro 10 units as ordered by the physician. The insulin lispro was signed out by MA #2. - 6/08/25 at 7:00 am Resident #11 was administered insulin lispro 10 units as ordered by the physician. The insulin lispro was signed out by MA #2. - 6/08/25 at 7:00 am Resident #11 was administered insulin lispro sliding scale coverage of 2 units for a blood sugar of 188 mg/dl as ordered by the physician. The insulin lispro sliding scale coverage was signed out by MA #2. - 6/08/25 at 11:15 am Resident #11 was administered insulin lispro 10 units as ordered by the physician. The insulin lispro was signed out by MA #2. - 6/08/25 at 11:15 am Resident #11 was administered insulin lispro sliding scale coverage of 2 units for a blood sugar of 183 mg/dl as ordered by the physician. The insulin lispro sliding scale coverage was signed out by MA #2. The Minimum Data Set (MDS) quarterly assessment dated 6/11/25 revealed Resident #11 had moderate cognitive impairment and was coded for use of insulin. An interview was conducted with Resident #11 on 6/19/25 at 11:35 am who revealed at times a different person would give her insulin than the person that gave her the pills. An interview was conducted with MA #2 on 6/18/25 at 11:11 am who revealed she was not able to administer insulin to residents because it was outside her scope of practice as a Medication Aide. MA #2 stated that when she was assigned a resident that required insulin she was only able to check blood sugar but a nurse would have to administer the insulin when needed. MA #2 stated she would normally sign out the insulin administration by the Nurse supervising her because she was giving the other medications and signed everything out at the time the medications were administered. MA #2 stated that the Nurse that was assigned to supervise her would come and give the insulin while she was present and when she saw it was administered she would	F0842		

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F0842 SS = B	Continued from page 12 sign it out on the MAR. A telephone interview was conducted with Nurse #1 on 6/19/25 at 10:22 am who was assigned to supervise MA #2 on 6/04/25. Nurse #1 revealed when she had a MA assigned to work with her she administered all insulin to residents. Nurse #1 stated the MA was not able to administer insulin but they were able to check blood sugar levels and then she, as the nurse, would administer the insulin. Nurse #1 stated the MA would sign out the insulin after she (Nurse #1) administered it and she would just confirm all medications were signed out and completed. Nurse #1 stated it would be ideal for her to sign out the insulin, but she stated at times the MA would sign out the insulin. A telephone interview was conducted on 6/18/25 at 3:22 pm with Nurse #2 who was assigned to supervise MA #2 on 6/08/25. Nurse #2 revealed that he administered insulin to the residents for the Medication Aides because they were not allowed to administer insulin. Nurse #2 stated he would normally sign out the insulin after he administered it but he stated it could have been an error that he did not sign out Resident #11's insulin on 6/08/25. b. Resident #43 was admitted to the facility on 11/03/20 with diagnoses which included diabetes. The Minimum Data Set (MDS) quarterly assessment dated 5/10/25 revealed Resident #43 was cognitively intact and was coded for use of insulin. Resident #43 had a physician order dated 6/04/25 for insulin lispro (rapid-acting) insulin pen every shift before meals; amount to administer per sliding scale: If Blood Sugar is less than 60, call MD. If Blood Sugar is 100 to 150, give 0 Units. If Blood Sugar is 151 to 199, give 2 Units. If Blood Sugar is 200 to 249, give 4 Units. If Blood Sugar is 250 to 299, give 6 Units. If Blood Sugar is 300 to 349, give 8 Units. If Blood Sugar is 350 to 399, give 10 Units. If Blood Sugar is 400 to 449, give 12 Units. If Blood Sugar is greater than 450, call MD. Review of Resident #43's June 2025 MAR revealed the following:	F0842		

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F0842 SS = B	Continued from page 13 - 6/07/25 at 7:00 am Resident #43 was administered the insulin lispro sliding scale coverage of 2 units for a blood sugar of 180 mg/dl (milligrams per deciliter) as ordered as ordered by the physician. The insulin lispro sliding scale coverage was signed out by MA #2. - 6/07/25 at 5:00 pm Resident #43 was administered the insulin lispro sliding scale coverage of 8 units for a blood sugar of 331 mg/dl as ordered as ordered by the physician. The insulin lispro sliding scale coverage was signed out by MA #2. During an interview on 6/18/25 at 12:23 pm with Resident #43 he confirmed that MA #2 had never administered insulin to him at the facility. Resident #43 stated he knew she was not allowed to give him insulin and he would not allow it even if she tried. An interview was conducted with MA #2 on 6/18/25 at 11:11 am who revealed she was not able to administer insulin to residents because it was outside her scope of practice as a Medication Aide. MA #2 stated that when she was assigned a resident that required insulin she was only able to check blood sugar but a nurse would have to administer the insulin when needed. MA #2 stated she would normally sign out the insulin administration by the Nurse supervising her because she was giving the other medications and signed everything out at the time the medications were administered. MA #2 stated that the Nurse that was assigned to supervise her would come and give the insulin while she was present and when she saw it was administered she would sign it out on the MAR. An attempt to conduct a telephone interview on 6/18/25 at 3:28 pm and 6/19/25 at 10:33 am with Nurse #4 who was assigned to supervise MA #2 on 6/07/25 was unsuccessful. c. Resident # 80 was admitted to the facility on 3/11/25 with diagnoses which included diabetes. Resident #80 had a physician order dated 3/12/25 for insulin glargine (long-acting insulin) insulin pen; administer 15 units subcutaneous once day. The insulin glargine was to be administered between 7:00 am and 11:00 am.	F0842		

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F0842 SS = B	Continued from page 14 Review of the Medication Administration Record (MAR) revealed Resident #80's blood glucose was noted by Medication Aide (MA) #2 as 150 mg/dl (milligrams per deciliter) and he was administered insulin glargine 15 units as ordered by the physician on 6/09/25. The insulin glargine was signed out by MA #2. The Minimum Data Set (MDS) quarterly assessment dated 6/11/25 revealed Resident #80 was cognitively intact and was coded for use of insulin. An interview was conducted with Resident #80 on 6/18/25 at 11:41 am who revealed he got his pills and insulin from a nurse but he did get them from different people on some days. He stated he was not sure why that happened, but he stated it happened at times that a different nurse would give him insulin. An interview was conducted with MA #2 on 6/18/25 at 11:11 am who revealed she was not able to administer insulin to residents because it was outside her scope of practice as a Medication Aide. MA #2 stated that when she was assigned a resident that required insulin she was only able to check blood sugar but a nurse would have to administer the insulin when needed. MA #2 stated she would normally sign out the insulin administration by the Nurse supervising her because she was giving the other medications and signed everything out at the time the medications were administered. MA #2 stated that the Nurse that was assigned to supervise her would come and give the insulin while she was present and when she saw it was administered she would sign it out on the MAR. A telephone interview was conducted with Nurse #3 on 6/19/25 at 10:52 am who was assigned to supervise MA #2 on 6/09/25. Nurse #3 stated she administered insulin to the residents when MA #2 worked with her. Nurse #3 stated that when the MA would enter the blood sugar number in the MAR it would prompt the MA to complete all sections of the order before they could move on to sign out the next medication. Nurse #3 stated that it would put the MA initials for completion of the order. Nurse #3 stated that although she (Nurse #3) administered the insulin it would show that MA #2 administered the insulin because she was entering the blood sugar. Nurse #3 stated MA #2 did not administer insulin to any residents when she was assigned to	F0842		

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F0842 SS = B	Continued from page 15 supervise her on 6/09/25. During an interview on 6/18/25 at 12:25 pm Unit Manager #2 revealed a Medication Aide was not able to administer insulin and would get the nurse assigned to supervise their shift to administer all insulin. Unit Manager #2 stated the nurse that administered the insulin should sign out the medication not the Medication Aide. An interview was conducted with the Director of Nursing (DON) on 6/18/25 at 12:53 pm who revealed all Medication Aides at the facility know they were not able to administer insulin and she had never witnessed any Medication Aide administer any insulin. The DON stated each Medication Aide had a supervisory nurse assigned to them for their entire shift and that nurse was responsible to administer the insulin to the residents and document the administration.	F0842		