PRINTED: 12/07/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345576	B. WING _			l	C 13/2020
NAME OF PROVIDER OR SUPPLIER				STF	REET ADDRESS, CITY, STATE, ZIP CODE	117	10/2020
PARKVIEW HEALTH & REHAB CENTER				1716 LEGION ROAD CHAPEL HILL, NC 27517			
(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 000	INITIAL COMMENTS		F	000			
		-site complaint investigation -13-20. Event ID# WI7I11					
	0 of the 4 complaint a substantiated.	allegations were					
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F 6	656			12/2/20
	implement a compreh care plan for each respectives and timefra medical, nursing, and needs that are identificated assessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the rounder §483.10, including treatment under §483 (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside	cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ied in the comprehensive aprehensive care plan must g-are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required a 25 or §483.40 but are not esident's exercise of rights ding the right to refuse a 10(c)(6). Bervices or specialized as the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. The the resident and the tive(s)-					
ABORATORY I	I DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	 !F		TITLE		(X6) DATE

Electronically Signed 12/02/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			7 50.125.	_		,	С	
		345576	B. WING				13/2020	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		10.2020	
				1	716 LEGION ROAD			
PARKVIEV	V HEALTH & REHAB CI	ENTER		С	CHAPEL HILL, NC 27517			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 656	Continued From page	no 1		050				
1 030	Continued From pag	ge i		656				
	desired outcomes.							
		reference and potential for						
	_	cilities must document t's desire to return to the						
	community was assessed and any referrals to							
	local contact agencies and/or other appropriate entities, for this purpose.							
	(C) Discharge plans in the comprehensive care							
	plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this							
	section.							
	This REQUIREMENT is not met as evidenced							
	by:							
	Based on record review and staff interviews the				F656 Develop/Implement Comprehens	sive		
	facility failed to develop an individualized and				Care Plan			
	person-centered car							
	discharge plans for 3			Corrective Action:				
		sident #7) reviewed for safe			Residents #3, #6 and #7: Care plans for			
	and orderly discharge.				each resident affected were reviewed a			
					revised to include their discharge plans	5.		
	Findings included:				This was completed by the facility			
	4.5 :1 1//0	1 20 1 0 6 22			Minimum Data Set Coordinator on			
		idmitted to the facility on			12/01/20			
		diagnosis that included racture of sacrum, wedge			Identification of other residents who me			
	· ·			Identification of other residents who make the involved with this practice:	ау			
	and falls.	e of T11 and T12 vertebra			All current residents have the potential	to		
	and fails.				be affected by the alleged practice. On			
	The admission Minin	num Data Set (MDS) dated			11/16/2020 an audit of all current			
	The admission Minimum Data Set (MDS) dated 7-16-20 revealed Resident #3 was severely				residents was completed by the Minimi	um		
	cognitively impaired and required extensive				Data Set Coordinator, to ensure that ea			
	assistance with one person for bed mobility,				resident's care plan reflected discharge			
	dressing, toileting and personal hygiene and				plans.			
		e with 2 people for transfers.			,			
					Audit Results:			
	Resident #3's care p	olan dated 7-14-20 revealed			4 of 55 residents found to have dischar	ge		
	no goals or intervent				plans addressed in care plan.			
					51 of 55 residents identified as not hav	ing		
	During an interview			discharge plans addressed in care plar	١.			

Facility ID: 20180059

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
				_		(С
		345576	B. WING			11/	/13/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	V HEALTH & REHAB CE	NTER			716 LEGION ROAD CHAPEL HILL, NC 27517		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 656	Continued From page	e 2	F	656			
	supervisor on 11-13-2	20 at 10:15am, the nurse			All residents who were identified as no	t	
	stated she was new t	o the MDS role and was not			having discharge plans/goals care		
	aware the resident pe				planned had their care plans revised to	i	
		plans needed to contain a			include these items. These		
		nterventions. She explained,			corrections/revisions were made by the	;	
		discharged, they were			Minimum Data Set Coordinator on		
	•	arge summary that included			11/16/2020, 11/23/2020, 11/28/2020.		
	their medications and			Cyctomic Changes			
	The Director of Nursi			Systemic Changes: On 12/01/20 the facility Minimum Data	Set		
	The Director of Nursi			Coordinator, Director of Nursing, and	Set		
	12-13-20 at 12:00pm. The DON stated she was not aware there were not discharge goals or				Social Services Director received		
	interventions in the resident's person-centered				education on care plan requirements.		
	care plan.				This education specifically addressed t	he	
	'				fact that all resident care plans must		
	2. Resident #6 was a	dmitted to the facility on			reflect his/her discharge planning		
	6-30-20 with multiple	diagnosis that included			goals/plan.		
	age-related osteopor	osis with current pathological					
	fracture of the verteb	ra and diabetes.			The education focused on:		
				This in service was completed by the			
		num Data Set (MDS) dated			Regional Minimum Data Set Education		
		dent #6 was cognitively			and Compliance nurse consultant on		
		xtensive assistance with 2			12/01/20. This information has been		
	people for bed mobili			integrated into the standard orientation			
	assistance with one pand personal hygiene			training and in the required in-service refresher courses for all employees an	٨		
	and personal hygiene	; .			will be reviewed by the Quality Assurar		
	Resident #6's care n	an dated 7-1-20 revealed no			Process to verify that the change has	ice	
	goals or interventions				been sustained.		
		C					
	During an interview w	vith the MDS/nurse			Monitoring:		
	supervisor on 11-13-2			To ensure compliance, The Director of			
		to the MDS role and was not			Nursing and/or Assistant Director of		
	aware the resident pe			Nursing will audit the care plan for 5			
		plans needed to contain a			random residents to ensure that it refle		
		nterventions. She explained,			the discharge plan. This will be done o		
		discharged, they were			weekly basis for 4 weeks then monthly		
	-	arge summary that included			3 months. The results of this audit will		
	I their medications and	follow up appointments.			reviewed at the weekly QA Team Meet	ina.	1

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		345576	B. WING_				C	
NAME OF D	ROVIDER OR SUPPLIER	040070	1	٥.	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	11/13/2020	
NAME OF T	NOVIDEN ON 3011 EIEN				716 LEGION ROAD			
PARKVIE\	W HEALTH & REHAB	CENTER						
					CHAPEL HILL, NC 27517			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page 3 The Director of Nursing was interviewed on 12-13-20 at 12:00pm. The DON stated she was not aware there were not discharge goals or interventions in the resident's person-centered care plan.			656	Reports will be presented to the weekl QA Committee by the Director of Nursi and/or Minimum Data Set (MDS)			
					Coordinator to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director Nursing or Administrator for appropriate			
	3. Resident #7 was admitted to the facility on 6-9-20 with multiple diagnosis that included hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side.				action. Compliance will be monitored a ongoing auditing program reviewed at Weekly Quality of Life Meeting. Weekl QA Committee meeting is attended by Administrator, Director of Nursing,	the y		
	6-16-20 revealed R cognitively impaired assistance with one	imum Data Set (MDS) dated Resident #7 was moderately d and required extensive e person for bed mobility, and personal hygiene and			Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HII (Health Information Management), Die Manager, Wound Nurse.			
		with one person for transfers.			Date of Compliance: 12/11/2020			
	goals or interventio	plan dated 6-9-20 revealed no ns for discharge.						
	11-12-20 at 1:10pm resident was discha a discharge packet	with the nursing supervisor on n, the nurse stated when a arged, they were provided with that included their llow up instructions.						
	11-13-20 at 10:15a new to the MDS rol resident person-ce	pervisor was interviewed on m. The nurse stated she was le and as not aware the ntered comprehensive care ontain a discharge goal and						
	12-13-20 at 12:00p not aware there we	rsing was interviewed on m. The DON stated she was ere not discharge goals or resident's person-centered						

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		345576	B WING		C
NAME OF PROVIDER OR SUPPLIER PARKVIEW HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1716 LEGION ROAD CHAPEL HILL, NC 27517	11/13/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
	Continued From pag	Je 4	F 656		