**STATEMENT OF DEFICENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

PARKVIEW HEALTH & REHAB CENTER

<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>A desk review was conducted 12/31/20 and the facility is back in compliance effective 12/2/20. Event ID W17112</td>
<td></td>
</tr>
</tbody>
</table>

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1716 LEGION ROAD
CHAPEL HILL, NC 27517

**DATE SURVEY COMPLETED**

12/31/2020

**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

Electronically Signed

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.