PRINTED: 06/15/2023 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER PARKVIEW HEALTH & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1716 LEGION ROAD CHAPEL HILL, NO. 27517 PREFIX TAG. STATE LEGION ROAD CHAPEL HILL, NO. 27517 PREFIX TAG. PROJUCTORY OR LISC IDENTIFYING INFORMATION) PREFIX TAG. PROJUCTORY OR LISC IDENTIFYING INFORMATION PREFIX TAG. PROJUCTORY OR LISC IDENTIFY INFORMATION PREFIX TAG. PREFIX TAG. PROJUCTORY OR LISC IDENTIFY INFORMATION PREFIX TAG.		DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTI			SURVEY
PARKVIEW HEALTH & REHAB CENTER CAPPEL NILL, N. C. 27517 CAPPEL NILL, N			345576					-
PREFIX TAG			NTER		1716 LEGION ROAD		1 04	20,2020
An unannounced recertification and complaint investigation survey were conducted on 04/25/23 through 04/28/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #QXPF11. F 000 A recertification and complaint investigation survey were conducted from 04/24/23 through 04/28/23. Event ID# QXPF11. The following intakes were investigated NC00195314, NC00198426, NC00191598, NC00195218, NC00194773, NC00198426, NC0019538, and NC00201473. O of the 11 complaint allegations resulted in deficiency. F 553 Right to Participate in Planning Care F 553 SS=D CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EA	ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA		COMPLETION
investigation survey were conducted on 04/25/23 through 04/28/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #QXPF11. F 000 A recertification and complaint investigation survey were conducted from 04/24/23 through 04/28/23. Event ID# 0XPF11. The following intakes were investigated NC00195314, NC0019428, NC00191058, NC00195314, NC00194773, NC00195386, and NC00201473. 0 of the 11 complaint allegations resulted in deficiency. F 553 Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) \$483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request revisions to the person-centered plan of care. (ii) The right to participate in the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	E 000	Initial Comments		EC	00			
survey were conducted from 04/24/23 through 04/28/23. Event ID# QXPF11. The following intakes were investigated NC00195314, NC00198426, NC00191058, NC00195218, NC00194773, NC00194773, NC00195386, and NC00201473. 0 of the 11 complaint allegations resulted in deficiency. F 553 Right to Participate in Planning Care F 553 SS=D CFR(s): 483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 000	investigation survey was through 04/28/23. The compliance with the remergency Prepared	vere conducted on 04/25/23 ne facility was found in requirement CFR 483.73, ness. Event ID #QXPF11.	FC	00			
Right to Participate in Planning Care CFR(s): 483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the		survey were conducte 04/28/23. Event ID# intakes were investigate NC00198426, NC001 NC00194773, NC001 0 of the 11 complaint	ed from 04/24/23 through QXPF11. The following ated NC00195314, 191058, NC00195218, 195386, and NC00201473.					
development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the		Right to Participate in	-	F 5	53			5/26/23
		development and imperson-centered plan limited to: (i) The right to participate including the right to be included in the pland request meetings and revisions to the person (ii) The right to participate expected goals and of amount, frequency, and other factors related the plan of care. (iii) The right to be informanged to the plan of civ) The right to receive included in the plan of (v) The right to see the	plementation of his or her of care, including but not pate in the planning process, identify individuals or roles to inning process, the right to do the right to request pate in establishing the putcomes of care, the type, and duration of care, and any to the effectiveness of the formed, in advance, of of care. We the services and/or items of care, including the care plan, including the					

Electronically Signed 05/19/2023

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.

OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
	345576	B. WING _			C 04/28/2023		
ROVIDER OR SUPPLIER V HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1716 LEGION ROAD CHAPEL HILL, NC 27517		0-1/20/2020		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE		
right to sign after sign of care. §483.10(c)(3) The far of the right to participand shall support the planning process mu (i) Facilitate the incluresident representatir (ii) Include an assess strengths and needs (iii) Incorporate the recultural preferences in This REQUIREMENT by: Based on record revinterviews the facility intact resident to participation in care participation in care participation in care participation in care participation. Resident #12 was additionally the Residents name, name and the people meeting. The Social Manager reviewed the #12's family member the meeting. The medical record in Resident #12 was investigants.	cility shall inform the resident rate in his or her treatment resident in this right. The states of the resident and/or ve. Sign of the resident and/or ve. Sign of the resident's resident's resident's personal and resident's personal and resident failed to invite a cognitively ricipate in the planning of the of 3 residents reviewed for olan meetings. (Resident resident resident resident resident resident reviewed for olan meetings. (Resident reviewed for olan meetings) (Resident resident record for red a form titled," Care Plan resident residen	F	The statements made on this particle correction are not an admission not constitute an agreement with alleged deficiencies. To remain in compliance with a and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility sallegate compliance such that all alleged deficiencies cited have been on corrected by the dates indicated. F553 RIGHT TO PARTICIPAL PLANNING CARE Corrective Action: Resident #12 Care plan meeting scheduled for Resident invited planning meeting by Parkview 4/18/2023/ via verbal invitation.	n to and do th the Il federal y has taken in this correction tion of d will be d. ATE IN			
			be affected by alleged deficient	practice:			
	ROVIDER OR SUPPLIER V HEALTH & REHAB CE SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pageright to sign after sign of care. §483.10(c)(3) The fact of the right to participe and shall support the planning process mu (i) Facilitate the incluresident representativ (ii) Include an assess strengths and needs. (iii) Incorporate the recultural preferences in This REQUIREMENT by: Based on record revinterviews the facility intact resident to participation in care pure interviews the facility intact resident to participation in care pure interview of the electron Resident #12 was additionally the Residents name, name and the people meeting. The Social Manager reviewed the #12's family member the meeting. The medical record in Resident #12 was invigant meeting conductions.	A 345576 ROVIDER OR SUPPLIER WHEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to invite a cognitively intact resident to participate in the planning of the resident's care for 1 of 3 residents reviewed for participation in care plan meetings. (Resident #12) Resident #12 was admitted on 12/3/18. Review of the electronic medical record for Resident #12 revealed a form titled," Care Plan Attendance Sheet" dated 11/11/2022 contained the Residents name, Responsible Party's (RP) name and the people who had attended the meeting. The Social Worker and the Unit Manager reviewed the plan of care with Resident #12's family member. Resident #12 did not attend	ROVIDER OR SUPPLIER V HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 right to sign after significant changes to the plan of care. \$483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to invite a cognitively intact resident to participate in the planning of the resident's care for 1 of 3 residents reviewed for participation in care plan meetings. (Resident #12 was admitted on 12/3/18. Review of the electronic medical record for Resident #12 revealed a form titled," Care Plan Attendance Sheet" dated 11/11/2022 contained the Residents name, Responsible Party's (RP) name and the people who had attended the meeting. The Social Worker and the Unit Manager reviewed the plan of care with Resident #12's family member. Resident #12 did not attend the meeting. The medical record included no evidence that Resident #12 was invited to participate in the care plan meeting conducted on 11/11/2022.	A BUILDING 345576 345576 345576 345576 345576 345576 345576 345576 345576 345576 3500000000000000000000000000000000000	A BUILDING BUPPLIER 3.45576 3.45761 PROVIDER'S PLAN OF CORRECTION FITS LEGION ROAD CHAPPEL HILL, NC 27517 3.45576 PROVIDER'S PLAN OF CORRECTION FITS LEGIOLATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY) 3.455.310(c)(3) The facility shall inform the resident of the right to sign after significant changes to the plan of care. 3.483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident and/or resident representative. (ii) Incure an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to invite a cognitively intact resident to participate in the planning of the resident's care for 1 of 3 residents reviewed for participation in care plan meetings. (Resident #12 was admitted on 12/3/18. Resident #12 was admitted on 12/3/18. Review of the electronic medical record for Resident #12 revealed a form titled, "Care Plan Attendance Sheet" dated 11/11/2022 contained the Residents name, Responsible Party's (RP) name and the people who had attended the meeting. The medical record included no evidence that Resident #12 was invited to participate in the care plan meeting or order of order reviewed the plan of care with Resident #12 Care plan meeting scheduled for Resident invited to care planning meeting by Parkview on 4/18/2023/ via verbal invitation.		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345576	B. WING		C 04/28/2023
	ROVIDER OR SUPPLIER V HEALTH & REHAB C			STREET ADDRESS, CITY, STATE, ZIP CODE 1716 LEGION ROAD CHAPEL HILL, NC 27517	04/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 553	cognitively intact. Record review for Revidence of any car after 11/11/2022 and resident was incorp process. An interview on 4/2/2 #12, revealed he had meeting or had bee Resident #12 stated care planning meeting. During an interview Worker #1 (SW) extra a cognitive score be intact and should had meetings. SW #1 sameetings were provided responsible party and assessment date. So were responsible for meeting invitations. meeting in February the 2/1/23 MDS assinvitation letter sent no care plan meeting SW #1 was not sure received invitations. SW #1 further explain were done upon ad basis, following the MDS assessments.	revealed Resident #12 was desident #12 revealed no e plan meetings conducted d no evidence that the orated into his care planning 5/23 at 3:35 PM with Resident ad never attended a care plan n asked to attend one. If that he wanted to go to his ngs. on 4/27/23 at 9:26 AM, Social colained that all residents with extween 13-15 were cognitively ave been invited to care plan aid the invitations to care plan Resident #12 was set for a v 2023 following completion of dessment. There was no for this care plan meeting and g occurred for Resident #12. Why Resident #12 had not to the care plan meetings ined that care plan meetings mission and on a quarterly completion of the quarterly	F 55	have the potential to be affected by the alleged practice. A 100% audit of all current residents of are cognitively intact residents (BIMS score 13-15) will be completed in order validate whether they have been invite participate in the planning of their care during the past 90 days. This audit we completed by the facility Social Worker and Administrator by May 24, 2023. All residents identified as not having the invited to participate in their care pland conference will receive an invitation to scheduled care conference. This will completed for all affected residents not later than May 26, 2023. Systemic Changes: On 5/18/2023 The Minimum Data Set (MDS) Coordinator and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by Director of Nursing. The education focused on: The resident has the right to participate in the development and implementation of the her person-centered plan of care, including but not limited to: (i) The right participate in the planning process, including the right to identify individual roles to be included in the planning process, the right to request meetings the right to request meetings the right to request revisions to the person-centered plan of care. (ii) The to participate in establishing the expensionals and outcomes of care, the type, goals and outcomes of care, the type,	who er to ed to e ill be er been ning o a be o the is or int to ls or and right cted
	on 4/28/23 at 2:13 F	e Director of Nursing (DON) PM, revealed Resident #12 rvited and involved in their		amount, frequency, and duration of ca and any other factors related to the effectiveness of the plan of care. (iii)	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		345576	B. WING			C
	ROVIDER OR SUPPLIER N HEALTH & REHAB CE			STREET ADDRESS, CITY, STATE 1716 LEGION ROAD CHAPEL HILL, NC 27517	E, ZIP CODE	04/28/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI' CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)	5.475
F 553	care plan meetings. I meetings needed to be to include everyone in a care plan letter to a member, as well as a meeting, needed to be further explained all r	The DON revealed care plan be documented in the record in attendance. The delivery of resident and/or family it declination to attend a see documented. The DON esidents needed to at least atte in the care planning.	F5	right to be informed, i changes to the plan of to receive the service included in the plan of to see the care plan, sign after significant of care. The facility sersident of the right to her treatment and sharesident in this right. process must- (i) Fact the resident and/or resident and orientati required in-service reall employees and will Quality Assurance Protect the change has been Monitoring: To ensure compliance Nursing and/or Assist Nursing will interview residents to ensure the invited to participate in their care. This will be basis for 4 weeks the months. The results of reviewed at the week Reports will be prese QA Committee by the and/or Mini Data Set to ensure corrective appropriate. Any immit be brought to the Direction of the service and the plan in the pla	of care. (iv) The rights and/or items of care. (v) The rights and/or items of care. (v) The rights and the planting the planting of the planting of the planting and in the planting of the constant Director of the planting	that to an or

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345576	B. WING		C 04/28/2023	
NAME OF P	ROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/20/2023	_
DA DK\/IE\	V HEALTH & REHAB CE	NTED		1716 LEGION ROAD		
PARKVIEV	V HEALTH & KEHAD CE	NIEN		CHAPEL HILL, NC 27517		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D.4TE	ı
F 553	Continued From page		F 553	Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Informating Management), Dietary Manager, Wour Nurse	y S on	
F 636 SS=D	•	S .	F 636		5/26/23	
	a comprehensive, acc	luct initially and periodically				
	A facility must make a assessment of a residence goals, life history and resident assessment by CMS. The assess the following: (i) Identification and did (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (vi) Mood and behavior (vii) Psychological were (viii) Physical function (ix) Continence.	ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least demographic information e. S. or patterns. ell-being. ning and structural problems.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345576	B. WING _		0	C 4/28/2023		
	ROVIDER OR SUPPLIER V HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1716 LEGION ROAD CHAPEL HILL, NC 27517	1 -			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE				
F 636	regarding the addition on the care areas trig the Minimum Data Set (xviii) Documentation assessment. The as include direct observe with the resident, as ilicensed and nonlicer members on all shifts §483.20(b)(2) When timeframes prescribe chapter, a facility musassessment of a residumeframes specified through (iii) of this seprescribed in §413.34 apply to CAHs. (i) Within 14 calendal excluding readmission significant change in mental condition. (Fo "readmission" means following a temporary or therapeutic leave.) (iii) Not less than once This REQUIREMENT by: Based on record rev	ats and procedures. ing. of summary information hal assessment performed gered by the completion of et (MDS). of participation in sessment process must ation and communication well as communication with hised direct care staff is. required. Subject to the d in §413.343(b) of this est conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) ction. The timeframes 43(b) of this chapter do not redays after admission, has in which there is no the resident's physical or repurposes of this section, has a return to the facility we absence for hospitalization	F 6	The statements made on this particular correction are not an admission				
	(MDS) assessments Assessment Referen			not constitute an agreement wi alleged deficiencies. To remain in compliance with a	th the			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345576	B. WING _			1	C 28/2023	
NAME OF P	ROVIDER OR SUPPLIER	l	<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	20.2020	
				1	716 LEGION ROAD			
PARKVIEV	V HEALTH & REHAB CE	NTER			CHAPEL HILL, NC 27517			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 636	Continued From page	e 6	F	336				
	12 sampled residents	s (Resident #19, and #52).			and state regulations the facility has ta or will take the actions set forth in this	ken		
	Findings include:				plan of correction. The plan of correction constitutes the facility ☐s allegation of	n		
	1. Resident #19 was	admitted to the facility on			compliance such that all alleged			
	10/28/22. A review of				deficiencies cited have been or will be			
	•	S assessment with an ARD			corrected by the dates indicated.			
	of 11/4/22 was signed	d as completed on 11/14/22.			5000 0 1 . 4			
	An interview with MC	S Coordinator on 4/27/23 at			F636 – Comprehensive Assessment at Timing	10		
		e did not sign the MDS			Corrective actions have been taken for	الد		
	assessments as com	•			affected residents as follows:	ali		
		that the Corporate MDS			¿ Resident #19: Assessment with Al	RD		
		ned the assessments after			11/4/22 was completed on 11/14/2022			
		id was unable to say why the			the facility Minimum Data Set nurse.	,		
	assessments were si	gned as completed late.			¿ Resident #52: Assessment with A of 11/23/22 was completed on 12/8/22			
	A telephone interview	on 4/28/23 at 9:07 AM, with			the facility Minimum Data Set nurse.	Бу		
		lurse revealed she signed			and reduity initiality Bata decinaries.			
		sments, both remotely and in			Corrective action for residents with the			
	-	ot know which assessments			potential to be affected by the alleged			
	were signed late.				deficient practice.			
					All residents have the potential to be			
		strator on 4/28/23 at 2:15			affected by the alleged deficient practic			
		S assessments should be			A 100 % audit of all current residents w			
		manner. She went on to			completed in order to identify any resid			
	•	OS Nurse was a Licensed			with a comprehensive assessment that	•		
		corporate MDS nurses were			has not been completed within the			
	Registered Nurses, a completed assessme				required timeframe. This audit will be completed by the facility MDS team an	٨		
	completed assessme	iiis.			Administrator no later than 5/24/23.	u		
	2 Resident #52 was	admitted to the facility on			Administrator no later trial 3/24/23.			
		Resident #52's admission			Any comprehensive MDS identified by	the		
		h an ARD of 11/23/22 was			audit as being late, will be completed a			
	signed as completed				submitted to the state database. All			
					comprehensive MDS assessments will	be		
	An interview with MD	S Coordinator on 4/27/23 at			up to date no later than 5/26/2023			
	9:31 AM, revealed shassessments as com	e did not sign the MDS pleted. The MDS						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345576	B. WING _				C	
NAME OF D	ROVIDER OR SUPPLIER	343370	B: Willo		TREET ADDRESS, CITY, STATE, ZIP CODE	04/	28/2023	
NAIVIE OF PI	ROVIDER OR SUPPLIER							
PARKVIEV	V HEALTH & REHAB CE	NTER			716 LEGION ROAD			
				С	HAPEL HILL, NC 27517			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 636	Continued From page	e 7	F 6	36				
		that the Corporate MDS ned the assessments after			Systemic Changes			
		d was unable to say why the			On 5/18//23, the Administrator complet	ed		
	assessments were sig	gned as completed late.			an in-service training for the facility			
					Minimum Data Set Coordinator that			
		on 4/28/23 at 9:07 AM, with			included the importance of ensuring the			
		lurse revealed she signed			each resident receive a comprehensive assessment according to the rules stat			
		sments, both remotely and in ot know which assessments			in Chapter 2 of the RAI (resident	eu		
	were signed late.	or anow which accessments			assessment instrument) Manual.			
	Interview with Admini	strator on 4/28/23 at 2:15			OBRA-required comprehensive			
	PM, indicated all MDS	S assessments should be			assessments include the completion of	:		
		manner. She went on to			both the MDS and the CAA process, as	3		
		OS Nurse was a Licensed			well as care planning. Comprehensive			
		corporate MDS nurses were			assessments are completed upon			
	Registered Nurses, a completed assessme				admission, annually, and when a significant change in a resident's status			
	completed assessme	iiis.			has occurred or a significant correction			
					a prior comprehensive assessment is	10		
					required. They consist of: Admission			
					Assessment, Annual Assessment, and			
					Significant Change in Status Assessme	ent,		
					and Significant Correction to Prior			
					Comprehensive Assessment.			
					The Admission assessment is a			
					comprehensive assessment for a new			
					resident and, under some circumstance	es,		
					a returning resident that must be			
					completed by the end of day 14, counti			
					the date of admission to the nursing ho	me		
					as day one if:this is the resident's first time in th	ie		
					facility, OR	3		
					 the resident has been admitted to 	this		
					facility and was discharged return not			
					anticipated, OR			
					the resident has been admitted to	this		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SUI COMPLET	
						С	
		345576	B. WING _			04/28/	/2023
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	DE		
				1716 LEGION ROAD			
PARKVIE	W HEALTH & REHAB	CENTER		CHAPEL HILL, NC 27517			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA	_	(X5) COMPLETION DATE
F 636	Continued From p	age 8	F 6	facility and was discharged anticipated and did not retur days of discharge. The ARD (item A2300) must later than day 14, counting the admission as day 1. Since at 12:00 a.m. and ends at 11:50 ARD must also cover this time example, if a resident is admission as day 1. Since at a.m. on Wednesday (day 1) RAI is required by the end of Tuesday (day 14). The MDS completion date (item MDS completion date, but than. The CAA(s) completion date, but than. The CAA(s) completion date (item V0200B2) must be no later to the care plan completion day V0200C2) must be no later to calendar days after the CAA completion date (item V0200 completion date + 7 calendar the Annual assessment is a comprehensive assessment that must be completed on a basis (at least every 366 day SCSA or an SCPA has been since the most recent completed (item A2300) must be set will after the ARD of the previous comprehensive assessment previous compr	t be set no the date of a day begins 59 p.m., the me period. If nitted at 8:3 a, a complet of the day item Z0500 (4. This date ame as the t not later on date (item than 7 a(s) (0B2) (CAA(ar days). at for a reside an annual ys) unless an completed rehensive an annual ys) unless an completed rehensive an annual ys) unless an annual ys) annual ys) unless an annual ys) unless an annual ys) unless an annual ys) annual ys) unless a	s at For 30 red B) m I. (s) ent an d hys	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	C	X3) DATE SURVEY COMPLETED	
						С	
		345576	B. WING _	· · · · · · · · · · · · · · · · · · ·		04/28/2023	
NAME OF P	ROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CO	DE		
				1716 LEGION ROAD			
PARKVIE	W HEALTH & REHAB	CENTER		CHAPEL HILL, NC 27517			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATI	(X5) COMPLETION DATE	
F 636	Continued From p	rage 9	F 6	calendar days). The MDS co (item Z0500B) must be no lated days after the ARD (ARD + 2 days). This date may be early same as the CAA(s) completed not later than. The CAA(s) date (item V0200B2) must be than 14 days after the ARD (calendar days). This date may same as the MDS completion not earlier than. The care please date (item V0200C2) must be than 7 calendar days after the completion date (item V0200C completion date + 7 calendar The Significant Change State Assessment is a comprehene assessment for a resident the completed when the IDT has that a resident meets the significant change guidelines for either improvement or decline. It can be performed at any time after the completion of an Admission and its completion dates (MDS/CAA(s)/care plan) dependent that the IDT's determination date that the IDT's determination that the criteria are met (determination date days). The MDS completion Z0500B) must be no later the from the ARD (ARD + 14 cal and no later than 14 days after met. This information has been in	atter than 14 14 calendar lier than or the tion date, but completion e no later (ARD + 14 ay be the en date, but lan completion the no later ne CAA(s) DB2) (CAA(s) or days). The completion the completi	ne tt on) ,	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345576	B. WING				00/0000
	ROVIDER OR SUPPLIER N HEALTH & REHAB CE	1		S1 17	TREET ADDRESS, CITY, STATE, ZIP CODE 716 LEGION ROAD HAPEL HILL, NC 27517	04/	28/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	UST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 636	Continued From pag	e 10	F	536	the standard orientation training for new Minimum Data Set Coordinators. The administrator will ensure that all assessments are being completed time by nurse at center or remotely. The RN MDS nurse will ensure assessments at locked once completed to ensure assessments are transmitted timely. R MDS nurse will notify Corporate when assessments are completed and ready transmission. Transmission will be completed daily. The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements. The Director of Nursing/Administrator of designee will begin auditing the facility's compliance with ensuring that comprehensive Minimum Data Set assessments are scheduled and completed within required timeframes a stated in Chapter 2 of the RAI (resident assessment instrument) Manual using quality assurance survey tool entitled "Comprehensive Assessments and Tim Audit Tool" to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months or until substantial compliance is achieved and maintained. Reports will be presented the weekly Quality Assurance committed the weekly Quality Assurance committed.	ely I re IN re at nat cted re s t the ning in d to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(
		345576	B. WING			04/	28/2023
	ROVIDER OR SUPPLIER V HEALTH & REHAB CE	NTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 716 LEGION ROAD HAPEL HILL, NC 27517		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 636		g Resident Assessments		636 640	by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director Nursing, Minimum Data Set Coordinate Unit Manager, Support Nurse, Therapy Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing Concerns in the corrector of Sursing Concerns of Sursing	of or, ',	5/26/23
SS=D	§483.20(f) Automated requirement- §483.20(f)(1) Encodir a facility completes a facility must encode the each resident in the facility Annual assessment (ii) Annual assessment (iii) Significant change (iv) Quarterly review a (v) A subset of items (v) A subset of items (vi) Background (face is no admission assess §483.20(f)(2) Transmafter a facility comple a facility must be capa CMS System informat contained in the MDS standard record layout	I data processing Ing data. Within 7 days after resident's assessment, a fine following information for accility: Interest updates. In the in status assessments. It updates assessments. I upon a resident's transfer, and death. I sheet) information, if there is sment. I within 7 days tes a resident's assessment, able of transmitting to the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345576	B. WING		C 04/28/2023	
NAME OF PROVIDER OR SUPPLIER PARKVIEW HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1716 LEGION ROAD CHAPEL HILL, NC 27517	04/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 640	14 days after a facility assessment, a facility encoded, accurate, athe CMS System, ind (i)Admission assessment (ii) Annual assessment (iii) Significant correct (v) Significant correct assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, at (viii) Background (facinitial transmission of does not have an ads \$483.20(f)(4) Data for transmit data in the for a State which has by CMS, in the formal approved by CMS. This REQUIREMENT by: Based on record revisacility failed to trans assessments to the CM Medicaid Services (CM timeframe for 2 of 12 (Resident #11 and #1. Resident #11 was a 10/24/22.	nittal requirements. Within y completes a resident's y must electronically transmit and complete MDS data to cluding the following: ment. Int. e in status assessment. ction of prior full assessment. ction of prior quarterly s upon a resident's transfer, and death. ce-sheet) information, for an fMDS data on resident that mission assessment. Intermet. The facility must permat specified by CMS or, an alternate RAI approved at specified by the State and It is not met as evidenced Ties wand staff interviews, the mit Minimum Data Set (MDS) Centers for Medicare & CMS) within the regulatory residents reviewed 19).	F 64	The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correctic constitutes the facility sallegation of compliance such that all alleged	al ken	
	MDS assessments w	#11's most recent admission with an Assessment		deficiencies cited have been or will be corrected by the dates indicated.		

OLIVILIY	O I OIT MEDIO/ ITE &	WEDIO/ WE CEITTIOLO				CIVID ITC	7. 0000 0001
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
						С	
		345576	B. WING			04/	28/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	PARKVIEW HEALTH & REHAB CENTER				716 LEGION ROAD HAPEL 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 APPROPRI DEFICIENCY)		COMPLETION DATE
F 640	Continued From page	e 13	F	640			
		D) of 10/28/22 revealed it			F-640 Encoding/Transmitting Resident		
	was signed as compl	eted on 11/6/22. The			Assessments		
	assessment was tran	smitted to CMS on			Corrective action for affected residents		
	12/8/2022.				Resident #11: Specific deficiency for the		
		0 1 1 1 1 2 0 0 11 1			resident was corrected by the Minimun		
		Corporate MDS Consultant			Data Set assessment with an Assessm	ent	
		M, revealed she completed nents. The corporate billing			Reference Date of 10/28/2022 being completed on 11/6/2022 by the facility		
		assessments. She was			Minimum Data Set Nurse. Assessmen	ıt.	
		nents were transmitted late.			was submitted/accepted by state		
					database on 12/8/2022.		
	During an interview o	on 4/28/23 at 10:42 AM, the			Resident #19: Specific deficiency for the	ıis	
	Director of Receivabl	es from the Corporate Billing			resident was corrected by the Minimun	1	
	•	the MDS assessments were			Data Set assessment with an Assessm	ent	
	-	rning by a support person			Reference Date of 9/6/ 2022 being		
	from the billing depar			completed on 9/12/2022 y the facility			
		ansmitted Monday through			Minimum Data Set Nurse. Assessmen	I	
	were transmitted.	ents that were in the queue			was submitted/accepted by state database on 10/13/2023.		
	were transmitted.			Corrective action for residents with the			
	An Interview on 4/28/			potential to be affected by the alleged			
	Director of Nursing ([deficient practice:		
	assessments needed to be transmitted in a timely						
	manner per regulatio	ns.			A 100% audit of all residents who have		
	0.0				had an MDS assessment completed		
	2.Resident #19 was o				within the past 30 days will be complet	ed	
	on 10/28/22.	and subsequently readmitted			in order to validate that the MDS was transmitted to the state database within	•	
	011 10/20/22.				the required timeframe. This audit will	•	
	a. A review of Re	esident #19's initial admission			completed by the facility MDS team an		
		nent with an ARD of 9/6/22,			Administrator no later than 5/26/2022.		
		ned as completed on 9/12/22.			resident MDS assessments will be up		
	-	transmitted to CMS on			date including being transmitted to the		
	10/13/22.				state database by the required due dat no later than 5/26/2023.	е	
	b. A review of Re	esident #19's most recent					
	·	S assessment with an ARD			Systemic Changes		
		d it was signed as completed					
	on 11/14/22. The ass	essment was transmitted to			On 5/18/23, the Administrator provided	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345576	B. WING			C 04/28/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	120/2023	
					716 LEGION ROAD			
PARKVIEW HEALTH & REHAB CENTER					CHAPEL HILL, NC 27517			
	OUMMARY OTATEMENT OF DESIGNATION			ID PROVIDER'S PLAN OF				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					E ATE	(X5) COMPLETION DATE	
F 640	Continued From page	e 14	F 6	340				
	CMS on 12/8/22.				education to the Minimum Data Set			
					Coordinator on the importance of			
	An interview with the	Corporate MDS Consultant			scheduling and completing all Minimur	n		
	on 4/28/23 at 9:07 Af	M, revealed she completed			Data Set assessments according to			
	_	nents. The corporate billing			regulated timeframes per chapter 2 of			
		assessments. She was			Resident Assessment Instrument man			
	unaware the assessr	nents were transmitted late.			The education also included requirement	ents		
	During on interview o	on 4/28/23 at 10:42 AM, the			for encoding Minimum Data Set data:			
		les from the Corporate Billing			Within 7 days after completing a resident's Minimum Data Set assessm	ent		
	department revealed			or tracking record, the provider must	CIIL			
	transmitted every mo			encode the Minimum Data Set data (i.e	a			
	from the billing depar			enter the information into the facility	,			
		ansmitted Monday through			Minimum Data Set software).			
		ents that were in the queue			The encoding requirements are as			
	were transmitted.				follows:			
					- For a comprehensive assessment			
		/23 at 2:13 PM with the			(Admission, Annual, Significant Chang			
	Director of Nursing (I				Status, and Significant Correction to P			
		to be transmitted in a timely			Comprehensive), encoding must occur			
	were late assessmen	ns. He was aware that there			within 7 days after the Care Plan Completion Date (V0200C2 + 7 days).			
	were late assessmen	its.			- For a Quarterly, Significant Correct	stion		
					to Prior Quarterly, Discharge, or	Juon		
					Prospective Payment System			
					assessment, encoding must occur with	iin		
					7 days after the Minimum Data Set			
					Completion Date (Z0500B + 7 days).			
					- For a tracking record, encoding			
					should occur within 7 days of the Even	t		
					Date (A1600 + 7 days for Entry records			
					and A2000 + 7 days for Death in Facili	ty		
					records).			
					The administrator will ensure that all			
					assessments are being completed time	ely		
					by nurse at center or remotely. The RN	-		
				MDS nurse will ensure assessments a				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
345576	B. WING		C	
	1 2: 11:10 _	CTREET ADDRESS CITY STATE 71D CODE	04/28/2023	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW HEALTH & REHAB CENTER		1716 LEGION ROAD		
		CHAPEL HILL, NC 27517		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 640 Continued From page 15	F 6	locked once completed to ensure assessments are transmitted timely. In MDS nurse will notify Corporate when assessments are completed and ready transmission. Transmission will be completed daily. The monitoring procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correction in compliance with the regulator requirements; The Director of Nursing, Administrator designee will review 5 random resident who have had any of the following Minimum Data Set types (Admission, Quarterly, Annual, Significant Change, day or Discharge Tracking) completed during the past 30 days in order to validate whether or not the assessment was completed within the required timeframes according to Chapter 2 of the Resident Assessment Instrument manualing the Quality Assurance Tool titled "Encoding/Transmitting MDS Within Required Timeframe." This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, He Information Management, Dietary Manager and the Administrator	at hat cted ry or ts 5 at the ual	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345576	B. WING _	B. WING			C 28/2023	
	ROVIDER OR SUPPLIER V HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 640	Continued From page 16		F	640	The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursir	ng.		
F 759 SS=D	CFR(s): 483.45(f)(1) §483.45(f) Medication The facility must ensu §483.45(f)(1) Medicat percent or greater; This REQUIREMENT		F	759			5/26/23	
	Based on observations, record review and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by a medication error rate of 10.34% (3 errors out of 29 opportunities) for Resident #235 and Resident #62. The findings included: 1a. A medication administration for Resident #235 was observed on 4/27/23 at 9:26 AM, Nurse #1 administered a simethicone 125 milligram (mg) tablet orally. Review of physician orders 4/14/23 revealed Resident #235 was prescribed simethicone tablet chewable 80 mg by mouth four times a day for neartburn. An interview on 4/27/23 at 2:25 PM, Nurse #1 stated she gave the 125 mg simethicone dose, even though the order was for 80 mg. The 125 mg was the standard dosage provided in the medication cart for the over-the-counter				The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has tal or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F759 Free of Medication Error Rate 5 percent or More Based on observation, record review, a staff, responsible party, resident interviews the facility failed to maintain the medication error rate at 5% or below for Resident #235 and #61. Corrective action for resident(s) affected by the alleged deficient practic For resident #235, on 4/27/2023 nurses 1 was educated by the Director of Nurses.	al ken on and : : : : : : :		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			71. 501251	_		С		
		345576	B. WING			04/28/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-1	20,2020	
				1716 LEGION ROAD				
PARKVIEV	V HEALTH & REHAB CE	INTER		CHAPEL HILL, NC 27517				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE	
F 759	Continued From page	e 17	F	759				
	· -	ner revealed she could have			on the correct			
	contacted Central Su				procedure for administering ordered			
	simethicone tablets.	, , , , , , , , , , , , , , , , , , ,			medications to include following the six			
					rights of medication			
	The physician intervi	ew on 4/27/23 at 3:18 pm,			administration to assure medications a	re		
	revealed she was no	realed she was not aware that simethicone 125			administered as ordered by the physici	an.		
	mg had been adminis	stered to Resident #235			The nurse was also			
	instead of 80 mg. She further revealed that 125				educated on notification of the physicia			
	mg simethicone was an acceptable dosage for				a medication is not available as ordere	d		
	Resident #235.				and how to utilize			
	During on interview o	on 4/27/22 of 2:27 DM tha			the backup pharmacy to assure	ad		
	_	on 4/27/23 at 3:27 PM, the etary revealed the facility's			medications are administered as order. The nurse was observed on	su.		
		dications were supplied by a			5/01/23 by the Director of Nurses and			
		he ordered over-the-counter			complied with facility policy on medicat	ion		
		d by the physician. The			administration and			
	nurse documented th	- · · · ·			was able to verbalize process to follow	for		
		dication and dose on a form			assuring medications were available to			
	located at the nurse's	s station. The vender filled			administered as			
	and delivered orders	-			ordered.			
		ed the medication from the			For resident # 62, on 4/27/23 nurse # 2			
	vender, the facility ph	narmacy, or a local			was educated by the Director of Nurse	3		
	pharmacy.				on the correct			
	An intension on 1/20	122 at 2:15 DM, the Director			procedure for administering ordered			
		23 at 3:15 PM, the Director			medications to include following the six			
	had a form that the n	realed each nursing station			rights of medication administration to assure medications a	rΔ		
		counter medication. He			administered as ordered by the physici			
		e was a back-up pharmacy to			and notification of	u.,		
		nedication orders for new			the physician of new complaints of pair	١.		
		ealed the nurse should have			The nurse was observed on 5 / 11 /23			
	notified the physician				the Director of Nurses	-		
		the physician order dose			and complied with facility policy on			
		s available on the cart during			medication administration and was able	∍ to		
	medication pass.				verbalize process for pain			
					assessment and notification of the			
	1b. During the medic				physician.			
		at 9:26 AM for Resident			2. Corrective action for residents with t	те		
	I #∠35. Nurse #1 did n	ot administer nasal sprav	1		potential to be affected by the alleged		1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345576	B. WING			C		
NAME OF D	ROVIDER OR SUPPLIER	0-70070		STREET ADDRESS, CITY, STATE, ZIP CODE	1 (04/28/2023		
NAME OF FI	NOVIDER OR SUFFLIER							
PARKVIEV	V HEALTH & REHAB CE	NTER		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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 759	Continued From page	e 18	F 75	59				
	sodium chloride nasa one spray in each no	ll solution 0.65% (saline),		deficient practice.				
				On 5/8/2023 the Director of				
		an orders 4/14/23 revealed		Nurses/Assistant Director of Nu				
	·	rescribed sodium chloride		observed administration of med				
	nostril three times a	(saline) 1 spray in each		by nurse #1 and nurse # 2 to as compliance with the administra				
	(nosebleeds).	lay for opisiaxis		ordered medications	tion of			
	(Hosebiceds).			following the facility medication				
	Nurse #1 was intervie	ewed on 4/27/23 at 2:25 PM,		administration process.				
		al spray was not given		Measures /Systemic changes to	o prevent			
		ked and missed the order for		reoccurrence of alleged deficien				
	the nasal spray for m	orning medication pass.		On 5 /1/2023 the Director of	·			
				Nursing/Assistant Director of N	urses			
		ministration was observed on		began education of all full time,	part			
		or Resident #62. Nurse #2		time, per-diem nurses/agency r				
	_	s of diclofenac sodium		medication aides. Education wi	ll be			
	topical gel 1% to the	back of the left hand.		focused on medication				
				administration as ordered by ph	-			
		an orders revealed two		mid-level practitioners to includ	e following			
	1%:	sodium external topical gel		the six rights of medication administration, follo	wing			
	•	3 for diclofenac sodium		physician orders and applying				
		%, 2 grams applied for		medications as ordered to the				
		n three times a day, and		correct body site.				
		3 for diclofenac sodium gel		The pharmacy consultant will consultant will consultant will be	•			
		to the lower back four times		medication administration pass	i			
	a day for lower back	pain.		observations with licensed nurses/medication aides and re	port the			
	On 4/27/23 at 5:43 D	M, Nurse #2 stated there		findings to the Director of Nurse	•			
		enac sodium topical gel 1%,		assure compliance is	JJ 10			
		#62's back and shoulder		sustained.				
	•	Resident #62 denied pain		This information has been integ	arated into			
		ted his left hand and wrist		the standard orientation training				
		ed she would contact the		required in service refresher c				
	•	r to include left hand and		all staff identified above and wil				
	wrist treatment for pa			reviewed by the Quality Assura				
	·			process to verify that the chang	je has			
	An interview on 4/28	/23 at 3:15 PM, the DON		been sustained. Any staff who	does not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345576	B. WING			C			
NAME OF F	DOVIDED OD CURRUIER	343370	1 2:		FREET ADDRESS, CITY, STATE, ZIP CODE	04/	28/2023		
NAME OF P	ROVIDER OR SUPPLIER								
PARKVIE	W HEALTH & REHAB CE	NTER			16 LEGION ROAD				
				CI	HAPEL 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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 759	759 Continued From page 19		F 7	759					
	revealed when a residual pain in a new area, the completed an assess	dent told the nurse about a se nurse should have ment, notified the physician, order for the right patient, sse, right time, and			receive scheduled in service training to 5/25/2023 will not be allowed to work useraining has been completed. 3. Monitoring Procedure to ensure that plan of correction is effective and that specific deficiency cited remains corrected and in compliance with regulatory requirements. The Director of Nurses or Assistant Director of Nurses will randomly observed adherence to orders by physicians or mid-level practitioners. This will be done on random shifts including weekends. The Director of Nurses or Assistant Director of Nurses or Assistant Director of Nurses complete the Quality Assurance audit tool for adherence to the facility medication administration policy and process weekly x 2 then monthly x 3. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting is attended by the Administrate Director of Nursing, Assistant Director Nursing, Minimum Data Set Coordinator, Therapy Manager, and the Dietary Manager.	the /or /e will the or, of			