STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345576	A. BUILDING _____ B. WING _____	C 11/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HEALTH & REHAB CENTER	1716 LEGION ROAD CHAPEL HILL, NC 27517

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F 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted on 11-13-20. Event ID# WI7I11 0 of the 4 complaint allegations were substantiated.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		12/2/20

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

Electronically Signed | 12/02/2020

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F 656	Continued From page 1 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident'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 facility failed to develop an individualized and person-centered care plan that addressed discharge plans for 3 of 3 residents (Resident #3, Resident #6 and Resident #7) reviewed for safe and orderly discharge. Findings included: 1.Resident #3 was admitted to the facility on 7-9-20 with multiple diagnosis that included unspecified zone 2 fracture of sacrum, wedge compression fracture of T11 and T12 vertebra and falls. The admission Minimum Data Set (MDS) dated 7-16-20 revealed Resident #3 was severely cognitively impaired and required extensive assistance with one person for bed mobility, dressing, toileting and personal hygiene and extensive assistance with 2 people for transfers. Resident #3's care plan dated 7-14-20 revealed no goals or interventions for discharge. During an interview with the MDS/nurse	F 656	F656 Develop/Implement Comprehensive Care Plan Corrective Action: Residents #3, #6 and #7: Care plans for each resident affected were reviewed and revised to include their discharge plans. This was completed by the facility Minimum Data Set Coordinator on 12/01/20 Identification of other residents who may be involved with this practice: All current residents have the potential to be affected by the alleged practice. On 11/16/2020 an audit of all current residents was completed by the Minimum Data Set Coordinator, to ensure that each resident’s care plan reflected discharge plans. Audit Results: 4 of 55 residents found to have discharge plans addressed in care plan. 51 of 55 residents identified as not having discharge plans addressed in care plan.	

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F 656	Continued From page 2 supervisor on 11-13-20 at 10:15am, the nurse stated she was new to the MDS role and was not aware the resident person-centered comprehensive care plans needed to contain a discharge goal and interventions. She explained, when a resident was discharged, they were provided with a discharge summary that included their medications and follow up appointments. 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. 2. Resident #6 was admitted to the facility on 6-30-20 with multiple diagnosis that included age-related osteoporosis with current pathological fracture of the vertebra and diabetes. The admission Minimum Data Set (MDS) dated 7-7-20 revealed Resident #6 was cognitively intact and required extensive assistance with 2 people for bed mobility and transfers, extensive assistance with one person for toileting, dressing and personal hygiene. Resident #6's care plan dated 7-1-20 revealed no goals or interventions for discharge. During an interview with the MDS/nurse supervisor on 11-13-20 at 10:15am, the nurse stated she was new to the MDS role and was not aware the resident person-centered comprehensive care plans needed to contain a discharge goal and interventions. She explained, when a resident was discharged, they were provided with a discharge summary that included their medications and follow up appointments.	F 656	All residents who were identified as not having discharge plans/goals care planned had their care plans revised to include these items. These corrections/revisions were made by the Minimum Data Set Coordinator on 11/16/2020, 11/23/2020, 11/28/2020. Systemic Changes: On 12/01/20 the facility Minimum Data Set Coordinator, Director of Nursing, and Social Services Director received education on care plan requirements. This education specifically addressed the fact that all resident care plans must reflect his/her discharge planning goals/plan. The education focused on: This in service was completed by the Regional Minimum Data Set Education and Compliance nurse consultant on 12/01/20. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will audit the care plan for 5 random residents to ensure that it reflects the discharge plan. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting.	

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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. 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. The admission Minimum Data Set (MDS) dated 6-16-20 revealed Resident #7 was moderately cognitively impaired and required extensive assistance with one person for bed mobility, dressing, toileting and personal hygiene and limited assistance with one person for transfers. Resident #7's care plan dated 6-9-20 revealed no goals or interventions for discharge. During an interview with the nursing supervisor on 11-12-20 at 1:10pm, the nurse stated when a resident was discharged, they were provided with a discharge packet that included their medications and follow up instructions. The MDS/nurse supervisor was interviewed on 11-13-20 at 10:15am. The nurse stated she was new to the MDS role and as not aware the resident person-centered comprehensive care plans needed to contain a discharge goal and interventions. 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	F 656	Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinator to ensure corrective action is initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 12/11/2020	

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F 656	Continued From page 4 care plan.	F 656		