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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
E 000	Initial Comments The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #FQYG11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 10/14/19 through 10/17/19. 1 of the 2 complaint allegations were substantiated resulting in a deficiency.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews with the legal representative, nurse practitioner interview and staff interview the facility failed to include or	F 552	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	11/14/19

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

Electronically Signed | 11/09/2019

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.

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 552	Continued From page 1 inform the legal representative of Resident #117 in a decision to begin the use of an antipsychotic medication for 1 of 1 resident reviewed for medical decision making. Findings included: Resident #117 was admitted on 7/10/19 with cumulative diagnoses which included status post fractured neck of the left femur. Review of the admission Minimum Data Set assessment dated 7/17/19 coded the resident as being severely cognitively impaired. Review of the computerized admission packet revealed the Marketing Director completed Resident #117 admission to the facility. Review of the mental health Nurse Practitioner 's (NP) initial evaluation dated 8/2/19. This evaluation in part revealed Resident #117 had episodes of crying, hallucinating, and anxiety as evidenced by looking for people who aren't there. After this evaluation, the NP ordered on 8/2/19 Seroquel Tablet (a antipsychotic drug) 12.5 milligrams (mg) by mouth (po)two times a day. Record review revealed the legal representative had not been consulted or informed about the Seroquel order on 8/2/19 by Nurse #4 (who transcribed the order). Review of the Medication Administration Record (MAR) revealed Seroquel 12.5 mg po was scheduled to be administered at 9 AM and 9 PM and had been administered on 8/2/19 at 9 PM ,8/3/19 -8/4/19 at 9 AM and 9 PM and 8/5/19 at 9 AM. Review of the progress notes dated 8/5/19 at 5:20 PM revealed the legal representative was notified about the medication change (3 days post the Seroquel order) On 8/7/19 at 10:30 AM a care conference was held and attended by the interdisciplinary team,	F 552	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F552 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to include/inform the legal representative of Resident #117 in a decision to begin the use of an antipsychotic medication. 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #117 was discharged from the facility on 08/13/2019 and therefore corrective action could not be completed. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 10/21/2019 a corrective action was obtained and completed. A 100 % audit of all new medication orders were reviewed by The Director of Nurses/Unit Managers to ensure that the legal representative/resident had been informed of any new orders for medications. Results: All residents and/or legal representatives were notified	

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 552	Continued From page 2	F 552		

Resident #117's legal representative for healthcare and family member. The care conference "summarize updates/changes made in response" to the Seroquel medication and the facility not notifying the legal representative and didn't want the Seroquel initiated and requested the drug be stopped.
Further review of the MAR revealed the initial "H" was entered in the space of the electronic MAR to indicate Seroquel 12.5 mg was held and not administered. These hold dates were 8/5/19 at 9 PM and 8/6/19 at 9 AM to 08/08/2019 at 9 AM.
Continued review of the MAR (after the care conference) revealed the 9 PM dose of Seroquel on 8/8/19 and the 9 am and 9 PM doses on 8/9/19 were administered to the resident.
Another review of the physician orders revealed no orders to hold and/or discontinue Seroquel until 8/9/19 at 1:45 PM.

An interview via the phone with the legal representative on 10/15/19 at 1:28 PM stated he was the legal representative for healthcare decisions and expressed on admission to the Admissions Coordinator that he did not want any medications prescribed during Resident #117 stay at the facility unless prior approval was provided.
Interview via the phone on 10/15/19 at 3:44 PM with Marketing Director stated she could not remember Resident #117 and would have communicated with the Director of Nurses (DON) for any medical needs (such as medications).
A second telephone interview with the legal representative was conducted on 10/16/19 at 2:59 PM stated no facility staff called to inform him that Seroquel had been prescribed. "I wanted to be informed about any changes" in Resident #117's care. Additionally, the legal

of any new orders for medication changes in the last 7 days. Any notification issues that were identified during this audit were corrected immediately.

2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 11/7/19 the Director of Nurses/Staff Development Coordinator began education of all full time, part time and as needed nurses and agency nurses on the resident/legal representative right to be informed of and participate in, his or her treatment and the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care or treatment to include medications. The in-service will be completed by 11/14/2019 at which time all nurses must be in-serviced prior to working. The Director of Nursing will ensure that that any of the above identified staff who does not complete the in-service training by 11/14/2019 will not be allowed to work until the training is completed. The in-service was incorporated into the new employee facility orientation.

3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Director of Nurses/Unit Managers will monitor the notification of the

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 552	Continued From page 3 representative stated a meeting on 8/7/19 at the facility was held to let the staff know Resident #117 was drowsy, and I did not want her to be administered the drug Seroquel. However, the facility continued to give her Seroquel. Interview with the DON on 10/16/19 at 3:30 PM revealed she was unaware of the resident's order for Seroquel. The DON stated normally, she would have follow-up on any orders for antipsychotics and she called the legal representative on 8/5/19 to obtain a written consent for the use of an antipsychotic. The DON expected her nurses to notify family members and or legal representative of medical changes, Interview on 10/16/19 at 3:54 PM with Nurse #4 stated Seroquel was a new order. Usually with a new order or medication change I would notify the responsible party/legal representative, but I did not this time and not sure why I did not. Interview on 10/17/19 at 10:21 AM with the NP (who prescribed Seroquel) via telephone was conducted. The NP stated a referral to see the resident was in the physician's communication book and was unaware of the legal representative request to not start the Seroquel. Continued interview with the NP stated a mistake was made to order and to continue the administration of the Seroquel. I did not notify the RP as I usually would do. Unable to interview the nurse who administered the Seroquel on 8/8/19. Interview on 10/17/19 at 3:47 PM Nurse #5 (nurse who administered the Seroquel on 8/9/19 at 09 AM after the care plan meeting) was conducted. Nurse #5 stated Seroquel was administered because there was no hold on the administration, and I received a pop-up message	F 552	resident/legal representative of new medication orders by monitoring the medication order listing and clinical dashboard during the Daily Clinical Meeting Monday through Friday for compliance with facility policy weekly x 4 weeks and monthly x 3 months. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. The Clinical Team will review in the Quality Assurance Meeting weekly until resolved. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 552	Continued From page 4 in the Electronic MAR to administer.	F 552		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the minimum data set (MDS) assessment for the areas of special treatments and diagnoses for 2 of 18 sampled residents reviewed for MDS accuracy (Residents #57 and #28). Findings included: 1. Resident #57 was admitted to the facility on 9/7/19 and diagnosis included hypertensive chronic kidney disease with stage 5 chronic kidney disease, end stage renal disease, and dependence on renal dialysis. Review of Physician order dated 9/7/19 revealed order for Hemodialysis 3 times a week for end stage renal disease. Resident #57's Care plan dated 9/8/19 revealed resident was to receive hemodialysis 3 times per week due to renal disease The Admission MDS assessment for Minimum data set (MDS) dated 9/14/19 identified resident did not receive dialysis during the 7 day look back period. An interview was conducted with Nurse #1 on 10/17/19 at 1:30 pm and she stated she has worked in the facility for 5 months and works with	F 641	F641 Accuracy of Assessments For resident #57, a corrective action was obtained on 11/07/19. " The specific deficiency was corrected on 11/07/19 by modifying the Minimum Data Set assessment with an Assessment Reference Date of 09/14/19 and correcting the coding for O0100J (Dialysis) to reflect that resident had received dialysis treatment during the assessment reference lookback period. This was completed by the Minimum Data Set Consultant on 11/07/19. Corrected Minimum Data Set assessment was re-submitted to and accepted by the State Database in Batch #218 on 11/07/19. For resident #28, a corrective action was obtained on 11/07/19. " The specific deficiency was corrected on 11/08/19 by modifying the Minimum Data Set assessment with an Assessment Reference Date of 07/31/19. Corrections were made to I0300 (Atrial Fibrillation); I0600 (Congestive Heart Failure); I5800 (Depression) in order to reflect that these diagnoses were active during the assessment reference lookback period. This correction was made by the Minimum	11/8/19

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 641	Continued From page 5 Resident #57 and he goes to dialysis 3 times a week. During an interview on 10/17/19 at 5:53 pm with the with MDS Coordinator revealed the special treatments (section O) on Resident #57's 09/14/19 MDS should have been coded for dialysis and she was not sure why it was not coded correctly. On 10/17/19 at 7:10 pm an interview was conducted with the Administrator and he stated he expected the MDS to be completed accurately. 2. Resident #28 was admitted to facility on 7/24/19 and diagnosis included atrial fibrillation, congested heart failure, and major depressive disorder. An admission minimum data set (MDS) assessment dated 7/31/19 for Resident #28 did not identify atrial fibrillation, congested heart failure, and major depressive disorder as active diagnoses. An interview conducted on 10/17/19 at 6:08 pm with MDS Coordinator and she confirmed that the active diagnoses section (section I) on Resident #28's MDS assessment of 7/31/19, did not include atrial fibrillation, congested heart failure, and major depressive disorder as active diagnoses. On 10/17/19 at 7:10 pm an interview with the Administrator was conducted and he stated he expected the MDS assessments to be coded accurately.	F 641	Data Set Nurse Consultant on 11/08/19. Corrected Minimum Data Set assessment was re-submitted to and accepted by the State Database in Batch #220 on 11/08/19. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of Minimum Data Set assessments completed during the past six months (05/07/19 □ 11/07/19) for all current residents who have the following: (1) receive dialysis treatments; (2) have diagnosis of Congestive Heart Failure; (3) have diagnosis of Major Depression and/or (4) have diagnosis of Atrial Fibrillation was completed. This audit was completed in order to ensure that the Minimum Data Set Assessments completed during the past six months were accurately coded in order to reflect resident□s status during assessment reference lookback timeframe for: dialysis treatments, diagnosis of atrial fibrillation, diagnosis of major depression and/or diagnosis of congestive heart failure. Any coding errors that were identified during this audit were corrected immediately. This audit was conducted by the Minimum Data Set Nurse Consultant on 11/07/19. Audit Results: " Dialysis: 2 of 2 residents who receive dialysis treatments were coded accurately for O0100J (Dialysis) on	

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 641	Continued From page 6	F 641	Minimum Data Set assessments completed during the past six month timeframe of 05/07/19 □ 11/07/19. " Congestive Heart Failure: 4 of 5 residents who have diagnosis of congestive heart failure and have had a Minimum Data Set assessment completed during the past six month timeframe of 05/07/19 □ 11/07/19 had I0600 coded accurately. 1 of 5 residents noted with inaccurate coding of I0600. This assessment was modified and corrected by the Minimum Data Set Consultant on 11/07/19 and was re-submitted to and accepted by the state database on 11/08/19 in Batch #220. " Atrial Fibrillation: 9 of 11 residents who have diagnosis of atrial fibrillation and have had a Minimum Data Set assessment completed during the past six month timeframe of 05/07/19 □ 11/07/19 were noted to have been coded accurately for atrial fibrillation in Section I of the assessment. 2 of 11 residents were noted with inaccurate coding of Section I (Atrial Fibrillation). These two minimum data set assessments were modified and correctly coded to reflect active diagnosis of atrial fibrillation. These corrections were completed by the Minimum Data Set Nurse Consultant on 11/07/19 and were re-submitted to and accepted by the state database on 11/08/19 in Batch #220. " Major Depression: 28 of 33 residents who have a diagnosis of major depression were noted to have had accurate coding of I5800 (major depression) on minimum data set assessments that were completed between 05/07/19-11/07/19. 5	

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 641	Continued From page 7	F 641		

of 33 residents were noted to have inaccurate coding of I5800 (major depression) on minimum data set assessment completed during the timeframe of 05/07/19-11/07/19. The assessments for these 5 residents were modified and corrected on 11/08/19 by the Minimum Data Set Nurse Consultant and were re-submitted to the state database on 11/08/19 in Batch #220.

Systemic Changes

On 11/08/19, the Regional Minimum Data Set Nurse Consultant completed an in service training for the facility Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record prior to completion of Sections O0100J (Dialysis); I0300 (Atrial Fibrillation); I0600 (Congestive Heart Failure) and I5800 (Major Depression) of the Minimum Data Set assessment. The education emphasized the importance of the minimum data set assessment being coded accurately in order to reflect the actual condition of resident during the lookback timeframe, in order to drive an appropriate care plan for resident.

This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 641	Continued From page 8	F 641	The Director of Nursing or designated Nurse Manager will begin auditing the coding of Sections O0100J (Dialysis); I0300 (Atrial Fibrillation) for Comprehensive MDS assessments and I8000 Other Diagnosis for Quarterly MDS assessments; I0600 (Congestive Heart Failure) and I5800 (Major Depression) of the Minimum Data Set Assessment using the quality assurance survey tool entitled Accurate Coding of Sections O (Dialysis) and Section I (Congestive Heart Failure, Atrial Fibrillation and Major Depression) Audit Tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 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 as appropriate. The Clinical Team will review in the Quality Assurance Meeting weekly until resolved. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, 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.	
F 692	Nutrition/Hydration Status Maintenance	F 692		11/14/19

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 692 SS=D	Continued From page 9 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to ensure that a low potassium, fluid restricted diet was followed per the physician's order for 1 of 1 resident reviewed for dialysis (Resident #25) and failed to provide follow-up for a nutritional recommendation from the Registered Dietitian for 1 of 4 residents reviewed for nutrition (Resident #30). Findings Included: A facility policy titled "Dialysis Protocol" dated 1/2010 identified under Protocol #4 "If the	F 692	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F692 The plan of correcting the specific	

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 692	Continued From page 10	F 692		

resident required fluid restrictions, intake and output records must be maintained. Fluid restrictions must be care planned to notify staff of how much intake was allowed on each shift and staff should also monitor for signs of fluid imbalances".

1. Resident #25 was admitted to the facility on 2/4/19 and his diagnoses included end stage renal disease, dialysis dependent, congestive heart failure, diabetes and glaucoma.

Review of the physician ' s orders for Resident #25 identified an order for a 1000 milliliter (ml) fluid restriction per day 850 ml from dietary and 150 ml from nursing, cardiac, low potassium diet with an order date of 2/21/19.

The meal tray card for Resident #25 was provided by the Dietary Manager (DM) and identified his diet as cardiac, low potassium, 1000 ml fluid restriction. 240 ml of coffee and 120 ml of juice was provided at breakfast and 240 ml of tea was provided at lunch and dinner.

A care plan dated 3/4/19 for Resident #25 stated he was on a fluid restriction of 1000 ml per day 850 ml from dietary and 150 ml from nursing. Interventions included to educate resident, family and visitors on fluid restriction and monitor resident for signs / symptoms of fluid overload.

A quarterly minimum data set (MDS) dated 8/8/19 for Resident #25 identified he received dialysis, received a therapeutic diet, was independent with set-up for eating and his cognition was intact.

A dietitian note for Resident #25 dated 8/15/19 stated current body weight was 133.7 pounds

deficiency. The plan should address the processes that lead to the deficiency cited:
The facility failed to ensure that a low potassium, fluid restricted diet was followed per the physician's order for Resident #25 and failed to provide follow-up for a nutritional recommendation from the Registered Dietitian for Resident #30.
1. Corrective action for resident(s) affected by the alleged deficient practice:

For resident #25, a corrective action was obtained and completed on 10/17/2019. The Dietary Service Director modified the resident□s tray card to eliminate high potassium foods and to ensure proper fluid amounts were correctly indicated. The Dietary Service Director observed the tray to ensure resident received the correct diet. Education of Low Potassium diet was provided to dietary staff on 11/8/2019 then it was posted within the kitchen in several locations. Excess drinks were removed from the resident□s room. Education to the resident was provided by the Director of Nursing on 10/18/2019.

For resident #30, a corrective action was obtained and completed on 11/1/2019. The Registered Dietician recommendations were submitted to the Director of Nursing, RN supervisor, and Dietary Service Director following the Dietitian□s visit. The Registered Dietician recommendations were reviewed by the physician on 11/1/2019 & approved. New orders were written for this resident to

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 692	Continued From page 11	F 692		

(lbs.) with weight fluctuations related to hemodialysis. Weight was overall stable. Receiving a low potassium, cardiac, regular texture diet with a 1000 ml fluid restriction. Meal intakes were optimal. Renvela (a phosphate binder) with meals. Nutritional needs likely met and continue to monitor.

Review of a dialysis report for Resident #25 dated 9/30/19 identified potassium level was 6.1 milliequivalents per liter (mEq/L) and above the goal of 5.5 mEq/L).

The meal intake record for Resident #25 for 10/3/19 through 10/15/19 identified 1360 ml fluid intake on 10/5/19, 1440 ml fluid intake on 10/6/19 and 1240 ml fluid intake on 10/7/19. The record revealed multiple days were blank.

The October 2019 medication administration record (MAR) for Resident #25 revealed an order for a 1000 ml per day fluid restriction, dietary would give 850 ml per day and nursing would give 150 ml per day. The MAR identified to give 50 ml on the 7:00 am to 3:00 pm shift, 50 ml on the 3:00 pm to 11:00 pm shift and 50 ml on the 11:00 pm to 7:00 am shift. Review of the documented fluid intakes were as follows: 10/1/19 - 220 ml, 10/2/19 - 340 ml, 10/3/19 - 80 ml, 10/4/19 - 150 ml, 10/5/19 - 350 ml, 10/6/19 - 290 ml, 10/7/19 - 170 ml, 10/8/19 - 220 ml, 10/9/19 - 230 ml, 10/10/19 - 340 ml, 10/11/19 - 220 ml, 10/12/19 - 130 ml, 10/13/19 - 160 ml, 10/14/19 - 220 ml and 10/15/19 - 160 ml.

An observation on 10/16/19 of Resident #25 ' s room revealed a 4-ounce (oz) container of orange juice and a 4oz container of cranberry juice were on his bedside table. There were 5 - 4oz

comply with the nutritional recommendation. Education was provided by the Registered Dietitian to the Director of Nursing, RN supervisor, & Dietary Service Director on 11/7/2019.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

All residents have the potential to be affected by the alleged deficient practice. On 11/7/2019, the Dietary Service Director completed a diet audit. This audit was completed for all residents with a therapeutic diet and/or fluid restriction. All residents on therapeutic diets and/or fluid restrictions were audited to ensure diets were entered in PCC and PCC Tray card as ordered, correctly Care Planned, and all residents with prescribed restrictions were provided necessary education by the Dietary Service Director. On 10/18/2019 the Director of Nursing audited resident rooms that had ordered fluid restrictions for the presence of drinks in excess of their restrictions with none found.

All residents have the potential to be affected by the alleged deficient practice. On 11/7/2019, the Director of Nursing completed an audit of all nutritional recommendations received from the Registered Dietitian. The Director of Nursing audited all residents with nutritional recommendations to ensure MD response was received and any new orders were entered into PCC as ordered. No deficient findings were found at the

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 692	Continued From page 12 containers of orange juice, 3 - 4oz containers of cranberry juice and 10 - 8oz cans of soda on the resident ' s dresser. The resident was not present in his room. An observation and partial interview was conducted with Resident #25 on 10/17/19 at 9:44 am. The resident was Spanish speaking and couldn ' t understand all the questions asked. He did state he went to dialysis yesterday and would go again tomorrow. He pointed to the juice present in his room and stated he did drink these. An interview on 10/17/19 at 10:27 am with Nursing Assistant (NA) #3 revealed she worked with Resident #25 and overall, he was very independent with his care. She stated the resident was on a fluid restriction and she believed this was because he went to dialysis. NA #3 explained the nurse would notify the NAs if a resident was on a fluid restriction and it was also listed on their tablets where they obtained and entered information about the residents. She added dietary and nursing each got so much fluid per day to provide to the resident. NA #3 stated she believed residents on fluid restrictions could have a water pitcher in their room, but with a specific amount of fluid. She added she did not know why Resident #25 had so many extra juices and sodas in his room. An interview on 10/17/19 at 11:00 am with Nurse #3 revealed she was the nurse for Resident #25. She stated the resident was on a fluid restriction and the nurses had a specific amount they could give him with his medications on each shift and dietary had a certain amount they provided with his meals. Nurse #3 explained the nurses documented how much fluid they provided per	F 692	time of the audit. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 11/7/19 in-service education was initiated by the Dietary Service Director and Staff Development Coordinator to all full time, part time, and as needed dietary and nursing and agency staff. The in-service will be completed by 11/14/19 at which time all dietary and nursing staff must be in-serviced prior to working. The DON and Dietary Service Director will ensure that any of the above identified staff who does not complete the in-service training by 11/14/19 will not be allowed to work until the training is completed. The in-service will be incorporated into the new employee facility orientation. Topics included: " All residents that are admitted with a therapeutic diet and/or have a therapeutic or fluid restriction implemented during their stay must receive education and parameters of restriction. " Therapeutic diet and/or fluid restrictions must be Care Planned. Any diet noncompliance or refusals from resident must be Care Planned when and if noted. " Therapeutic diets and fluid restrictions must be entered in PCC and PCC Tray card as ordered and be consistent between the two systems.	

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 692	Continued From page 13 shift on the MAR and the NAs documented how much fluid he consumed with his meals on his meal intake record. She added she was not sure if there was a cumulative total of the fluids he consumed per day. Nurse #3 stated typically fluids weren ' t kept in a resident ' s room if they were on a fluid restriction. She added she had observed Resident #25 had multiple containers of juice and sodas in his room and these were the brands the facility used. Nurse #3 indicated the extra fluids in his room needed to be removed. A phone interview on 10/17/19 at 1:27 pm with the Registered Dietitian (RD) revealed Resident #25 was on a low potassium, fluid restricted diet. She stated she was not sure if the facility kept a cumulative total of fluids per day that the resident consumed. She added she would only monitor if dietary was following their portion of the fluid restrictions correctly. The RD explained she was not aware that Resident #25 had an accumulation of extra fluids, including orange juice, in his room. She stated the resident received Renvela but was not aware of his elevated potassium level. The RD added she had not spoken to the dialysis RD about the resident. An interview on 10/17/19 at 3:00 pm with the Director of Nursing (DON) revealed the facility would define what fluids were provided from dietary and nursing for fluid restrictions. She stated the nurses documented how much fluid the resident drank per shift on the MAR. She added if she was the residents nurse, she would ask the NAs how much fluid the resident drank and put the total fluid consumed that shift on the MAR. The DON explained it didn ' t look like the nurses were documenting this and there was not a cumulative 24-hour total of the resident ' s fluid	F 692	" Fluid restrictions must be broken down to indicate amount to be received from nursing and dietary. Intakes and outputs to be documented as ordered. Staff to encourage compliance, monitor room for excess fluids, and ensure fluids are given as ordered. " Registered Dietician recommendations are to be reviewed and approved by physician services. Dietary Manager or designee will review nutritional recommendations in the clinical meeting for compliance weekly. The Registered Dietitian will review all nutritional recommendations for compliance at her monthly review. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor for compliance by observing residents that receive a therapeutic diet and/or fluid restriction weekly x 4 weeks then monthly x 3 months using the Diet Restriction Audit tool. The Dietary Service Director will then continue monthly per policy. The Dietary Service Director will also complete a Test Tray Audit weekly x 4 and then continue monthly per policy. The Director of Nursing/Dietary Manager/Unit Manager will monitor the Registered Dietary Recommendation Process weekly x 4 weeks and monthly x 3 months for compliance. Reports will be	

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 692	Continued From page 14 consumption. She added this should have been completed per the facility protocol for fluid restrictions. The DON explained she was not aware Resident #25 had multiple containers of fluids in his room and he should not be provided with orange juice. 2. Resident #30 was admitted to the facility on 3/23/19 and her diagnoses included cerebral vascular accident, hepatitis with ascites and anemia. A quarterly minimum data set (MDS) dated 8/23/19 for Resident #30 identified she was on a therapeutic diet, required extensive one-person assist with eating and her cognition was intact. Review of the physician ' s orders for Resident #30 revealed an order for a low potassium diet dated 3/23/19. The meal tray card for Resident #30 was provided by the Dietary Manager (DM) indicated she was on a low potassium diet. It noted for lunch and supper meals to not provide beans, legumes or potatoes. A dietitian note dated 8/15/19 for Resident #30 stated her current body weight was 129.8 pounds (lbs.) and BMI was 23.7 indicating normal weight status. Weight fluctuated related to ascites and diuretic therapy. Patient was receiving a low potassium diet and meal intakes were 26 to 100%. Labs reviewed from 6/17/19 revealed albumin was low, and potassium was within normal limits. Recommended to remove low potassium restriction. An interview on 10/14/19 at 10:58 am with	F 692	presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. The Clinical Team will review in the Quality Assurance Meeting weekly until resolved. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting until resolved. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager.	

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 692	Continued From page 15	F 692		

Resident #30 revealed she often had the same food items and they would not allow her to have any creamed potatoes. She stated no one told her why she couldn ' t have them. Resident #30 added she used to be on dialysis, but she no longer had to go.

An observation on 10/14/19 of Resident #30 revealed she was eating her lunch meal in her room. She had received a low potassium diet.

An interview on 10/17/19 at 10:20 am with Resident #30 revealed she would like to have some potatoes and she didn ' t understand why she was still receiving a low potassium diet when she was no longer receiving dialysis.

An interview on 10/17/19 at 10:47 am with Nursing Assistant (NA) #3 revealed she worked with Resident #30. She stated the resident ' s meal intake fluctuated depending on what she was served.

A phone interview on 10/17/19 at 1:35 pm with the Registered Dietitian (RD) revealed if she had a recommendation for a resident, she documented it on a recommendation sheet and provided a copy to the Director of Nursing (DON), the Unit Manager and the DM. She explained nursing would provide her recommendations to the resident ' s physician. The RD stated she didn ' t know for sure why her recommendation to discontinue Resident #30 ' s potassium restriction was not done. She added there was currently not a system in place to notify her if the recommendations were not approved by the physician or to follow-up that the recommendations were addressed. She added she was not aware Resident #30 was concerned

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 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 692	Continued From page 16 about not receiving potatoes because she was on a low potassium diet. An interview on 10/17/19 at 2:50 pm with the DON revealed the RD either emailed or provided her with a hard copy of any nutritional recommendations she had. She explained the RD ' s recommendations were provided to the resident ' s physician for follow-up right away and she would expect a response within 24 hours. The DON reviewed the RD recommendation form and was unable to locate any information about discontinuing the potassium restriction for Resident #30. She stated she was not sure why this was not completed or if the recommendation had been processed.	F 692		