STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(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 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 and resident interviews the facility failed to accurately code Minimum Data Set Assessments for 1 of 1 dialysis resident (Resident #55), 1 of 1 resident coded as having a restraint (Resident #103) and 1 of 1 resident coded as requiring 2 person assistance with eating (Resident #42). Findings included: 1. Resident #55 was admitted to the facility on 5/21/18 with diagnoses that included end stage renal disease - on dialysis, chronic kidney disease, type II diabetes mellitus and hypertension among others. A review of Resident #55's most recent Minimum Data Set (MDS) Assessment dated 9/26/18 and coded as a quarterly assessment revealed Resident #55 to be cognitively intact. Resident #55 was coded as having a diagnosis of dependence on renal dialysis yet was coded as not having received dialysis services prior to or during her admission to the facility. A review of Resident #55's care plan revealed a care plan area that reported Resident #55 had a diagnosis of end stage renal disease and received renal dialysis. An interview with Resident #55 on 11/27/18 at 11:49AM revealed she had been going to dialysis for approximately 4 years. She reported she	F 641	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Resident #55 Minimum Data Set (MDS) Assessment section of Special Treatment, Procedures, and Programs was reviewed and analyzed by the MDS Coordinator. MDS Coordinator will modify the assessment related to Dialysis and resubmit for accuracy of the resident's assessment. Resident #42 MDS Assessment section of ADL Functional Status was reviewed and analyzed by the MDS Coordinator. MDS Coordinator will modify the assessment related to Eating and resubmit for accuracy of the resident's assessment. Resident #103 MDS Assessment sections of Special Treatments, Procedures, and Programs was reviewed and analyzed by the MDS Coordinator. MDS Coordinator will modify the assessment related to	12/21/18

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

Electronically Signed | 12/21/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(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 1 received treatment on Monday, Wednesday and Friday every week and that she would leave the facility around 5:00AM and return to the facility around lunch time. During an interview with Hall Nurse on 11/27/18 at 11:57AM, it was reported that Resident #55 goes to dialysis on Monday, Wednesday and Friday every week. She reported Resident #55 had been going to dialysis "for many years". An interview with MDS Coordinator was completed on 11/29/18 at 11:46AM. During this interview, it was reported that Resident #55's MDS Assessment dated 9/26/18 should have reflected that Resident #55 had received dialysis services while a resident in the facility. It was also reported the MDS Assessment had been completed by a temporary employee that was no longer at the facility. MDS Coordinator reported the temporary employee must have over looked the coding error. During an interview with the Director of Nursing on 11/29/18 at 11:54AM revealed Resident #55's MDS Assessment dated 9/26/18 should have reflected the dialysis treatment that Resident #55 was currently receiving. She reported it was her expectation that MDS Assessments be coded accurately and reflect corresponding treatments that residents received. It was reported by the Administrator during an interview on 11/29/18 at 12:01 PM that it was her expectation that MDS Assessments be coded accurately and correctly. She reported that Resident #55's MDS Assessment dated 9/26/18 was not coded correctly when Resident #55 was coded as not receiving dialysis.	F 641	Restraints and resubmit for accuracy of the resident's assessment. MDS Coordinators will be provided education by the Director of Case Mix & Compliance regarding Federal and State regulation to ensure MDS Assessment accuracy in the sections of Special Treatment, Procedures, and Programs and ADL Functional Status. Director of Case Mix & Compliance or designee, will review MDS Assessments for all newly completed comprehensive assessments for December and forward to ensure MDS Assessment accuracy in the sections of Special Treatment, Procedures, and Programs and ADL Functional Status. Director of Case Mix & Compliance or designee, will conduct weekly 10% audits of MDS Assessments to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(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 2	F 641		

2. Resident #103 was admitted to the facility on 09/13/18 and readmitted on 10/21/18 with diagnoses that included dementia and kidney disease. The Minimum Data Set (MDS) dated 10/28/18 specified the resident had a limb restraint that was used less than daily when the resident was in the bed.

On 11/26/18 at 10:29 AM observations were made of the resident in bed that revealed there was no limb restraint in use.

On 11/27/18 at 3:32 PM the MDS Coordinator was interviewed and reported the facility had no restraints that the coding of a restraint for Resident #103 was an error.

On 11/29/18 at 11:43 AM the Administrator was interviewed and stated coding a restraint on the MDS was a data entry error and would be corrected.

3. Resident #42 was admitted to the facility on 12/29/17 with diagnoses which included insulin dependent diabetes mellitus (IDDM), chronic gastroesophageal reflux disease (GERD), anemia and others.

A review of Resident #42's Care Area Assessment (CAA) summary for Nutrition dated 01/05/18 revealed the resident was able to feed self all her meals.

A review of Resident #42's quarterly Minimum Data Set (MDS) dated 09/07/18 revealed she was assessed by the facility as being cognitively intact for daily decision making. The MDS also revealed she required extensive assistance of 2 staff members for eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(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 3	F 641		

A review of a Registered Dietitian noted dated 09/07/18 revealed Resident #42 was on a regular consistent carbohydrate diet (CCD) and her intake was approximately 78 percent for her meals. The note also stated the resident had good acceptance of between meal snacks and fluids.

An observation on 11/26/18 at 11:40 AM revealed Resident #42 up in her recliner with fluids on her table beside her recliner. The resident stated the food at the facility was ok and some meals were better than others. Resident #42 stated she ate her meals in her room and was able to feed herself her meals. She stated there had never been a time that she could not feed herself since she was admitted to the facility.

An interview on 11/29/18 at 12:43 PM with the MDS Coordinator revealed they relied on a report generated from data entry of the nurse aides (NAs) to formulate the activity of daily living (ADL) scores utilized in their MDS reporting. The MDS coordinator stated he had not been the nurse who had keyed the score of extensive assistance with eating for Resident #42 and stated he would have questioned the documentation that led to that score because he knew her and knew she fed herself.

An interview on 11/29/18 at 12:55 PM was conducted with the Director of Nursing (DON). The DON stated she would have questioned the report that stated Resident #42 required 2 staff to feed her. She stated she would have expected the MDS to have been coded correctly and stated the MDS coordinator would modify the assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(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 687	Continued From page 4	F 687		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to arrange podiatry services for 2 of 2 residents, one resident (resident #10) who had requested her toenails be trimmed and another resident (Resident #22) whom nursing had requested his toenails be trimmed, both reviewed for foot care in dependent resident. 1. Resident #10 was admitted to the facility on 10/22/14 and readmitted on 02/12/18 with diagnoses which included congestive heart failure, major depression, insulin dependent diabetes mellitus and others. A review of Resident #10's most recent quarterly Minimum Data Set (MDS) dated 11/08/18 revealed the resident was moderately cognitively impaired for daily decision making, required set up for eating and extensive to total assistance with other activities of daily living (ADL). The MDS further revealed Resident #10 had no	F 687	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Podiatry appointments were scheduled for Resident #10 & Resident #22. Residents were seen by the Podiatrist on 12/7/18. NA #1 & Nurse #1 were reeducated on implementing the process for podiatry referrals. Facility wide observations on all active residents in facility will be conducted by the RN Supervisors to ensure resident's toenails were clipped and clean. RN	12/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(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 687	Continued From page 5 refusals of care. A review of Resident #10's care plan dated 10/31/18 revealed she had a care plan for activities of daily living (ADL). The goal was for Resident #10 to continue to participate in her ADL as able, accept staff assistance as needed and not have any complications through the next review date of 12/24/18. Some of the interventions included attempt to follow requested schedule for ADL assistance and assist with consultation appointments as needed. A review of the chart revealed there were no notes from the podiatrist on Resident #10's chart. An observation and interview on 11/26/18 at 10:47 AM with resident #10 revealed her toenails on both feet were approximately ¼ to ½ inch beyond the toe on each foot. Resident #10 stated she had asked the NAs and nurses (could not remember their names) about trimming her toenails but it had not been done yet. Resident #10s great toes had thick nails extending approximately ½ inch beyond her toe. An observation on 11/29/18 at 9:46 AM revealed Resident #10s toenails were still long after she had been given a shower earlier in the week and the resident stated they still had not cut her toenails and asked who she needed to talk to about getting them cut. An interview on 11/29/18 at 9:48 AM with NA #1 revealed Resident #10 had not asked her to trim her toenails but NA #1 stated she had told Nurse #1 they needed to be trimmed. An interview on 11/29/18 at 9:56 AM with the Clinical Nurse Supervisor #1 (CNS) was	F 687	Supervisors will inspect resident's toenails and trim, as appropriate by 12/7/2018. For residents that require additional services, they will be referred to the Podiatrist by the facility social workers. Assistant Director of Nursing (ADON) and Clinical Supervisors educated licensed nursing staff to address nail status during the weekly head to toe assessment immediately and to be completed 12/14/2018. Any other staff members who do not receive the training by the specified date, 12/14/2018, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. All licensed nurses are to assess residents toe nails weekly to include findings such as the need for the resident's toenails to be trimmed or cleaned, or a podiatry referral. All head to toe assessments are checked for completion within 24 hours by the Clinical RN Supervisors to ensure compliance. Clinical Supervisors will conduct observations with 20 residents, for 4 weeks. At the end of 4 weeks, will conduct observations with 10 residents, for 4 weeks. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. Continued monitoring will be determined by the QAPI Committee, based on compliance results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(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 687	Continued From page 6	F 687		

conducted. CNS #1 observed Resident #10s toenails and stated they should have been trimmed especially if she had requested they be trimmed.

A phone interview on 11/29/18 at 2:03 PM with Nurse #1 revealed she was not aware that Resident #10's toenails needed trimming but was aware of another resident's toenails needing to be trimmed and had reported it to the Social Worker (SW) for follow up. Nurse #1 stated no one had told her that Resident #10's toenails were long and needed to be trimmed.

A review of the podiatry lists for October 2018 and December 2018 revealed Resident #10 had not been seen in October and was not on the list to be seen in December.

An interview on 11/29/18 at 2:21 PM with SW #1 revealed the SW who was responsible for scheduling podiatry services left abruptly without any correspondence and there was no work-related contact with her after her departure. SW #1 stated the SW that left was the social worker who scheduled all podiatry services for the residents in the facility. SW #1 stated she had looked through the other SW's records and stated there was no indication that Resident #10 needed podiatry services. SW #1 stated they had recently changed contracted services for podiatry and was not sure if Resident #10 had been added to the resident listing to be seen in December. SW #1 stated if she was not on the list they could add her to be seen on 12/19/18 unless nursing told her she needed to be seen before that date and then she would arrange for her to be seen by one of the two local podiatrists contracted for services. SW #1 stated she was not aware of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(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 687	Continued From page 7	F 687		

schedule for diabetics with the podiatrist because she had never scheduled the podiatry services. SW #1 stated their referrals came from nursing at the morning meetings of the department heads and the care planning meetings for residents and no one had mentioned Resident #10 needing podiatry services at either of these meetings. SW #1 stated Resident #10 would be added to the list to be seen in December unless someone told her she need to be seen before that time.

An interview on 11/29/18 at 3:00 PM with the Director of Nursing (DON) revealed it was her expectation that fingernails and toenails be observed during weekly skin assessments and that any resident needing podiatry services be identified and reported to the social workers (SWs) to schedule podiatry services. The DON stated they had recently had a staff SW leave and she was the one who scheduled podiatry services but stated the other SWs had assumed her responsibilities.

2. Resident #22 was admitted to the facility on 05/31/18 with diagnoses which included type 2 diabetes mellitus (DM), heart failure, early onset Alzheimer's disease, chronic kidney disease and others.

A review of Resident #22's most recent comprehensive Minimum Data Set (MDS) dated 08/30/18 revealed he had moderately impaired cognition for daily decision making and was extensive assistance of 1 staff member for most of his activities of daily living (ADL). The MDS also revealed he was frequently incontinent of bowel and bladder and used briefs.

A review of Resident #22's care plan dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(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 687	Continued From page 8	F 687		

11/28/19 revealed he had a care plan for activities of daily living (ADL). The goal was for Resident #22 to continue to participate in his ADL as able, and to maintain his current level of function through the next review. Some of the interventions included provide assistance to ensure resident receives good hygiene, encourage resident to participate as able and assist with consultation appointments as needed.

A phone interview on 11/29/18 at 2:03 PM with Nurse #1 revealed she was aware that Resident #22 needed podiatry services and had reported the need to the Social Worker (SW) who was at the time responsible for scheduling podiatry services. Nurse #1 stated the SW who scheduled podiatry services for all the residents in the facility had left about 2 weeks ago. Nurse #1 stated she assumed one of the other SWs had picked up where she left off with scheduling podiatry services but stated she had not asked recently about Resident #22 being seen for podiatry services. She stated nurse aide (NA) #2 had told her about Resident #22 needing podiatry services and stated she had observed his toenails during his weekly skin assessments and stated he really needed his toenails trimmed.

An observation on 11/29/18 at 2:14 PM of Resident #22's toenails revealed both great toes with nails approximately ¾ of an inch beyond the end of his toes, thick and appeared to be growing into the nail bed. The nails on the second toes are approximately ½ inch beyond the end of the toe and turned sideways and the rest of the toenails on the other toes are approximately ¼ to ½ inch beyond the end of the toes. An interview with the resident revealed his toes were painful if someone touched them, but otherwise they did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(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 687	Continued From page 9	F 687		

not hurt.

An interview was conducted on 11/29/18 at 2:20 PM with the DON who came to observe Resident #22's toenails. The DON stated his toenails were unacceptable and should have already been addressed by the staff.

A review of the podiatry lists for October 2018 and December 2018 revealed Resident #22 had not been seen in October and was not on the list to be seen in December.

An interview on 11/29/18 at 2:21 PM with SW #1 revealed the SW who was responsible for scheduling podiatry services left abruptly without any correspondence and there was no work-related contact with her after her departure. SW #1 stated the SW that left was the social worker who scheduled all podiatry services for the residents in the facility. SW #1 stated she had looked through the other SW's records and stated there was no indication that Resident #22 needed podiatry services. SW #1 stated they had recently changed contracted services for podiatry and was not sure if Resident #22 had been added to the resident listing to be seen in December. SW #1 stated if he was not on the list they could add him to be seen on 12/19/18 unless nursing told her he needed to be seen before that date and then she would arrange for him to be seen by one of the two local podiatrists contracted for services. SW #1 stated she was not aware of the schedule for diabetics with the podiatrist because she had never scheduled the podiatry services. SW #1 stated their referrals came from nursing at the morning meetings of the department heads and the care planning meetings for residents and no one had mentioned Resident #22 needing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(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 687	Continued From page 10 podiatry services at either of these meetings. SW #1 stated Resident #22 would be added to the list to be seen in December unless someone told her she need to be seen before that time. An interview on 11/29/18 at 3:00 PM with the Director of Nursing (DON) revealed it was her expectation that fingernails and toenails be observed during weekly skin assessments and that any resident needing podiatry services be identified and reported to the social workers (SWs) to schedule podiatry services. The DON stated they had recently had a staff SW leave and she was the one who scheduled podiatry services but stated the other SWs had assumed her responsibilities.	F 687		