#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING \_\_\_ 345096 B. WING 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE OAKS HUNTERSVILLE, NC 28078 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 641 Accuracy of Assessments F 641 12/21/18 SS=D 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 DISCLAIMER: interviews the facility failed to accurately code Preparation and/or execution of this Plan Minimum Data Set Assessments for 1 of 1 of Correction does not constitute dialysis resident (Resident #55), 1 of 1 resident admission or agreement by the provider of coded as having a restraint (Resident #103) and the truth of the facts alleged or 1 of 1 resident coded as requiring 2 person conclusions set forth in this statement of assistance with eating (Resident #42). deficiencies. The Plan of Correction is prepared and/or executed solely because Findings included: it is required by the provisions of Federal and State law. 1. Resident #55 was admitted to the facility on 5/21/18 with diagnoses that included end stage Resident #55 Minimum Data Set (MDS) renal disease - on dialysis, chronic kidney Assessment section of Special Treatment, disease, type II diabetes mellitus and Procedures, and Programs was reviewed hypertension among others. A review of Resident and analyzed by the MDS Coordinator. #55's most recent Minimum Data Set (MDS) MDS Coordinator will modify the Assessment dated 9/26/18 and coded as a assessment related to Dialysis and guarterly assessment revealed Resident #55 to resubmit for accuracy of the resident's be cognitively intact. Resident #55 was coded as assessment. having a diagnosis of dependence on renal dialysis yet was coded as not having received Resident #42 MDS Assessment section of dialysis services prior to or during her admission ADL Functional Status was reviewed and to the facility. analyzed by the MDS Coordinator. MDS Coordinator will modify the assessment A review of Resident #55's care plan revealed a related to Eating and resubmit for care plan area that reported Resident #55 had a accuracy of the resident's assessment. diagnosis of end stage renal disease and received renal dialysis. Resident #103 MDS Assessment sections of Special Treatments, Procedures, and An interview with Resident #55 on 11/27/18 at Programs was reviewed and analyzed by the MDS Coordinator. MDS Coordinator 11:49AM revealed she had been going to dialysis for approximately 4 years. She reported she will modify the assessment related to LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

12/21/2018

### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345096 B. WING 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE OAKS HUNTERSVILLE, NC 28078 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 641 Continued From page 1 F 641 received treatment on Monday, Wednesday and Restraints and resubmit for accuracy of Friday every week and that she would leave the the resident's assessment. facility around 5:00AM and return to the facility around lunch time. MDS Coordinators will be provided education by the Director of Case Mix & During an interview with Hall Nurse on 11/27/18 Compliance regarding Federal and State at 11:57AM, it was reported that Resident #55 regulation to ensure MDS Assessment accuracy in the sections of Special goes to dialysis on Monday, Wednesday and Friday every week. She reported Resident #55 Treatment, Procedures, and Programs and ADL Functional Status. had been going to dialysis "for many years". An interview with MDS Coordinator was Director of Case Mix & Compliance or completed on 11/29/18 at 11:46AM. During this designee, will review MDS Assessments interview, it was reported that Resident #55's for all newly completed comprehensive MDS Assessment dated 9/26/18 should have assessments for December and forward reflected that Resident #55 had received dialysis to ensure MDS Assessment accuracy in services while a resident in the facility. It was the sections of Special Treatment, also reported the MDS Assessment had been Procedures, and Programs and ADL completed by a temporary employee that was no Functional Status. longer at the facility. MDS Coordinator reported the temporary employee must have over looked Director of Case Mix & Compliance or the coding error. designee, will conduct weekly 10% audits of MDS Assessments to ensure During an interview with the Director of Nursing compliance. Any identified issues will be on 11/29/18 at 11:54AM revealed Resident #55's corrected at that time. Results of the MDS Assessment dated 9/26/18 should have monitoring will be shared with the reflected the dialysis treatment that Resident #55 Administrator and Director of Nursing on a was currently receiving. She reported it was her weekly basis and with QAPI monthly for a expectation that MDS Assessments be coded period of 90 days at which time frequency of monitoring will be determined by the accurately and reflect corresponding treatments that residents received. QAPI Committee. 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.

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/27/2018 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	2) MULTIPLE CONSTRUCTION BUILDING			SURVEY PLETED
		345096	B. WING			11/	29/2018
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTERS	SVILLE OAKS				2019 VERHOEFF DRIVE IUNTERSVILLE, NC 28078		
(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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 641	<ol> <li>Resident #103 war 09/13/18 and readmit diagnoses that include disease. The Minimu 10/28/18 specified the restraint that was use resident was in the be On 11/26/18 at 10:29 made of the resident i was no limb restraint</li> <li>On 11/27/18 at 3:32 F was interviewed and restraints that the cool Resident #103 was at</li> <li>On 11/29/18 at 11:43 interviewed and state MDS was a data entry corrected.</li> <li>Resident #42 was 12/29/17 with diagnos dependent diabetes in gastroesophageal refi anemia and others.</li> <li>A review of Resident i Assessment (CAA) su 01/05/18 revealed the self all her meals.</li> <li>A review of Resident i Data Set (MDS) dated assessed by the facilit for daily decision make</li> </ol>	s admitted to the facility on the domentia and kidney im Data Set (MDS) dated e resident had a limb ed less than daily when the ed. AM observations were in bed that revealed there in use. PM the MDS Coordinator reported the facility had no ding of a restraint for n error. AM the Administrator was ed coding a restraint on the y error and would be admitted to the facility on ses which included insulin nellitus (IDDM), chronic flux disease (GERD), #42's Care Area ummary for Nutrition dated e resident was able to feed #42's quarterly Minimum d 09/07/18 revealed she was ity as being cognitively intact king. The MDS also d extensive assistance of 2	F	641			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/27/2018 MAPPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MUL A. BUILD		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED				
		345096	B. WING			11/	29/2018	
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE			
HUNTERS	VILLE OAKS			12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 641	A review of a Registe 09/07/18 revealed Reconsistent carbohydra intake was approxima meals. The note also good acceptance of b fluids. An observation on 11. Resident #42 up in he table beside her reclir food at the facility was better than others. Recher meals in her room herself her meals. Sh been a time that she of she was admitted to t An interview on 11/29 MDS Coordinator revo generated from data of (NAs) to formulate the scores utilized in their coordinator stated he had keyed the score of eating for Resident #4 questioned the docum score because he know herself. An interview on 11/29 conducted with the Di The DON stated she report that stated Resident for the stated resident.	red Dietitian noted dated esident #42 was on a regular ate diet (CCD) and her ately 78 percent for her o stated the resident had between meal snacks and /26/18 at 11:40 AM revealed er recliner with fluids on her her. The resident stated the s ok and some meals were esident #42 stated she ate h and was able to feed he stated there had never could not feed herself since he facility. /18 at 12:43 PM with the ealed they relied on a report entry of the nurse aides e activity of daily living (ADL) r MDS reporting. The MDS had not been the nurse who of extensive assistance with 42 and stated he would have nentation that led to that ew her and knew she fed /18 at 12:55 PM was irector of Nursing (DON). would have questioned the sident #42 required 2 staff to she would have expected n coded correctly and stated	F	641				

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345096 B. WING 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE OAKS HUNTERSVILLE, NC 28078 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 687 Continued From page 4 F 687 F 687 12/21/18 F 687 Foot Care CFR(s): 483.25(b)(2)(i)(ii) SS=D §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: DISCLAIMER: Based on observations, record reviews, resident and staff interviews, the facility failed to arrange Preparation and/or execution of this Plan podiatry services for 2 of 2 residents, one of Correction does not constitute admission or agreement by the provider of resident (resident #10) who had requested her toenails be trimmed and another resident the truth of the facts alleged or conclusions set forth in this statement of (Resident #22) whom nursing had requested his toenails be trimmed, both reviewed for foot care deficiencies. The Plan of Correction is in dependent resident. prepared and/or executed solely because it is required by the provisions of Federal and State law. 1. Resident #10 was admitted to the facility on 10/22/14 and readmitted on 02/12/18 with diagnoses which included congestive heart Podiatry appointments were scheduled for failure, major depression, insulin dependent Resident #10 & Resident #22. Residents diabetes mellitus and others. were seen by the Podiatrist on 12/7/18. NA #1 & Nurse #1 were reeducated on A review of Resident #10's most recent quarterly implementing the process for podiatry Minimum Data Set (MDS) dated 11/08/18 referrals. revealed the resident was moderately cognitively impaired for daily decision making, required set Facility wide observations on all active up for eating and extensive to total assistance residents in facility will be conducted by with other activities of daily living (ADL). The the RN Supervisors to ensure resident's MDS further revealed Resident #10 had no toenails were clipped and clean. RN

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345096 B. WING 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE OAKS HUNTERSVILLE, NC 28078 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 687 Continued From page 5 F 687 refusals of care. Supervisors will inspect resident's toenails and trim, as appropriate by 12/7/2018. For A review of Resident #10's care plan dated residents that require additional services, 10/31/18 revealed she had a care plan for they will be referred to the Podiatrist by activities of daily living (ADL). The goal was for the facility social workers. Resident #10 to continue to participate in her ADL as able, accept staff assistance as needed and Assistant Director of Nursing (ADON) and not have any complications through the next Clinical Supervisors educated licensed review date of 12/24/18. Some of the nursing staff to address nail status during interventions included attempt to follow requested the weekly head to toe assessment schedule for ADL assistance and assist with immediately and to be completed consultation appointments as needed. 12/14/2018. Any other staff members who do not receive the training by the specified A review of the chart revealed there were no date, 12/14/2018, (due to FMLA, leave, notes from the podiatrist on Resident #10's chart. etc.) will be required to complete training An observation and interview on 11/26/18 at prior to working a scheduled shift at the 10:47 AM with resident #10 revealed her toenails facility upon their return. on both feet were approximately $\frac{1}{4}$ to $\frac{1}{2}$ inch beyond the toe on each foot. Resident #10 stated All licensed nurses are to assess she had asked the NAs and nurses (could not residents toe nails weekly to include remember their names) about trimming her findings such as the need for the toenails but it had not been done yet. Resident resident's toenails to be trimmed or #10s great toes had thick nails extending cleaned, or a podiatry referral. All head to approximately 1/2 inch beyond her toe. toe assessments are checked for completion within 24 hours by the Clinical An observation on 11/29/18 at 9:46 AM revealed RN Supervisors to ensure compliance. Resident #10s toenails were still long after she Clinical Supervisors will conduct had been given a shower earlier in the week and observations with 20 residents, for 4 the resident stated they still had not cut her weeks. At the end of 4 weeks, will conduct toenails and asked who she needed to talk to observations with 10 residents, for 4 about getting them cut. weeks. Any identified issues will be corrected at that time. Results of the An interview on 11/29/18 at 9:48 AM with NA #1 monitoring will be shared with the revealed Resident #10 had not asked her to trim Administrator and Director of Nursing on a her toenails but NA #1 stated she had told Nurse weekly basis and with QAPI monthly. #1 they needed to be trimmed. Continued monitoring will be determined by the QAPI Committee, based on An interview on 11/29/18 at 9:56 AM with the compliance results. Clinical Nurse Supervisor #1 (CNS) was

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 12/27/2018 MAPPROVED O. 0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		345096	B. WING		14	1/29/2018		
NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP COL	DE			
HUNTERS				19 VERHOEFF DRIVE NTERSVILLE, NC 28078				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 687	toenails and stated the trimmed especially if st trimmed. A phone interview on Nurse #1 revealed sh Resident #10's toena aware of another resi trimmed and had repo (SW) for follow up. N told her that Resident and needed to be trim A review of the podiat December 2018 revea- been seen in October be seen in December An interview on 11/29 revealed the SW who scheduling podiatry s any correspondence a work-related contact of SW #1 stated the SW worker who schedule the residents in the fa had looked through th stated there was no in needed podiatry serving recently changed com and was not sure if R to the resident listing SW #1 stated if she w add her to be seen or told her she needed t and then she would a one of the two local p	bbserved Resident #10s ley should have been she had requested they be 11/29/18 at 2:03 PM with he was not aware that ils needed trimming but was dent's toenails needing to be orted it to the Social Worker lurse #1 stated no one had t #10's toenails were long nmed. try lists for October 2018 and aled Resident #10 had not r and was not on the list to r. 0/18 at 2:21 PM with SW #1 o was responsible for ervices left abruptly without	F 687					

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FOR	ED: 12/27/2018 RM APPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>	(2) MULTIPLE CONSTRUCTION BUILDING			E SURVEY IPLETED
		345096	B. WING			11	1/29/2018
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTERS	SVILLE OAKS				12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 687	schedule for diabetics she had never schedu SW #1 stated their ret the morning meetings and the care planning no one had mentioner podiatry services at e #1 stated Resident #1 to be seen in Decemb she need to be seen h An interview on 11/29 Director of Nursing (D expectation that finge observed during week that any resident need identified and reporter (SWs) to schedule po stated they had recen she was the one who but stated the other S responsibilities. 2. Resident #22 was a 05/31/18 with diagnos diabetes mellitus (DM Alzheimer's disease, for others. A review of Resident is comprehensive Minim 08/30/18 revealed he cognition for daily dec extensive assistance of his activities of dail	a with the podiatrist because led the podiatry services. ferrals came from nursing at of the department heads meetings for residents and d Resident #10 needing ither of these meetings. SW 10 would be added to the list ber unless someone told her before that time. /18 at 3:00 PM with the ON) revealed it was her rnails and toenails be dy skin assessments and ding podiatry services be d to the social workers diatry services. The DON thy had a staff SW leave and scheduled podiatry services Ws had assumed her admitted to the facility on ses which included type 2 I), heart failure, early onset chronic kidney disease and #22's most recent hum Data Set (MDS) dated had moderately impaired cision making and was of 1 staff member for most y living (ADL). The MDS frequently incontinent of d used briefs.	F	687			

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		MEDICAID SERVICES				10. 0938-039
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION	· · ·	(X3) DATE SURVEY COMPLETED	
		345096	B. WING		1	1/29/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTER	SVILLE OAKS			12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 687	11/28/19 revealed he of daily living (ADL). #22 to continue to pa and to maintain his cont through the next revie interventions included ensure resident receil encourage resident tre assist with consultation A phone interview on Nurse #1 revealed sh #22 needed podiatry the need to the Social the time responsible services. Nurse #1 s scheduled podiatry set in the facility had left #1 stated she assum- picked up where she podiatry services but recently about Reside podiatry services. Sh had told her about Re- services and stated set toenails during his we stated he really need An observation on 11 Resident #22's toenal with nails approximate end of his toes, thick into the nail bed. The are approximately ½ toe and turned sidew toenails on the other ½ inch beyond the en	had a care plan for activities The goal was for Resident rticipate in his ADL as able, urrent level of function ew. Some of the d provide assistance to ves good hygiene, o participate as able and on appointments as needed. 11/29/18 at 2:03 PM with he was aware that Resident services and had reported al Worker (SW) who was at for scheduling podiatry tated the SW who ervices for all the residents about 2 weeks ago. Nurse ed one of the other SWs had left off with scheduling stated she had not asked ent #22 being seen for he stated nurse aide (NA) #2 esident #22 needing podiatry the had observed his eekly skin assessments and ed his toenails trimmed. /29/18 at 2:14 PM of ils revealed both great toes ely <sup>3</sup> ⁄ <sub>4</sub> of an inch beyond the and appeared to be growing e nails on the second toes inch beyond the end of the ays and the rest of the toes are approximately <sup>1</sup> ⁄ <sub>4</sub> to nd of the toes. An interview ealed his toes were painful if	F 6	87		

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# FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345096 B. WING 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE OAKS HUNTERSVILLE, NC 28078 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED O. 0938-0391
STATEMENT	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED			
		345096	B. WING			11	/29/2018
NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	- <b>·</b>	
HUNTERS	SVILLE OAKS				2019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 687	podiatry services at e #1 stated Resident #2 to be seen in Decemb she need to be seen An interview on 11/29 Director of Nursing (D expectation that finge observed during week that any resident nee identified and reporte (SWs) to schedule po stated they had recer she was the one who	ither of these meetings. SW 22 would be added to the list per unless someone told her	F	687			

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