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F 000	INITIAL COMMENTS An onsite complaint investigation was conducted on 1/24/23 through 1/25/23. Event ID# F14P11. The following intakes were investigated: NC00196938, NC00197001 and NC00196626 . 17 of 17 allegations were unsubstantiated.	F 000		
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, resident interview, staff interview and record reviews, the facility failed to provide foot care and arrange podiatry services for 1 of 3 dependent residents reviewed for skin care. Resident #1 was discovered to have a buildup of skin between her toes and had curled toenails which extended 1.5 inches beyond the base of the nail. The findings included: Resident #1 was admitted to the facility on 11/19/20. The diagnoses included polyneuropathy diabetes and peripheral vascular disease. The quarterly Minimum Data Set dated 12/1/22	F 687	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. The deficiency cited has been or will be corrected by the date or dates indicated. F687 Foot Care 1. Resident #1 has had foot care and new orders obtained to assist in keeping feet moist. A podiatry appointment is scheduled for Thursday 2/14/23. 2. All residents have the potential to be	2/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/10/2023

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

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F 687	Continued From page 1 indicated Resident #1's cognition was intact, and she was coded as totally dependent on staff for all activities of daily living. Review of the care plan dated 12/1/22, identified a problem as Resident #1 had an ADL self-care performance deficit related to activity Intolerance, stroke, right-sided hemiparesis. The goal included Resident #1 would maintain current level of function in all Activities of Daily Living (ADLs). The interventions included a boot (what kind of boot) would always stay on right leg, except for bathing. Provide sponge bath when a full bath or shower cannot be tolerated. Review of the podiatry schedule from August 2022 through January 2023, revealed Resident #1 was not scheduled to be seen until 2/13/32. Further review revealed there was no consultation report or notation in Resident #1's chart that she had been seen by the podiatrist seen since 8/16/22. Review of the 8/16/22 podiatry report revealed the condition of Resident #1's toenails were as follows: thickened on 2 millimeters (mm) 1st great toe left. Yellow on left great toe. Crumbly on left great toe. Dystrophic on left great toe, left 2nd toe, left 3rd toe, left 4th toe, left 5th toe. Nails on right foot toes were not evaluated due to presence of a boot. The treatment included all dystrophic nails on the left foot were reduced in length as needed to prevent pain and other symptoms. All the thickened or mycotic nails described were debrided to prevent pain and infection. Follow Up: Diabetic Foot established patient exam in 2-3 months.	F 687	affected by this deficient practice. 3. 100% of residents will have assessments completed feet for proper foot and nail care and follow up provided as indicated. These assessments will be completed by 2/13/23 by the Director of Nursing and designees. 4. All licensed nursing staff will receive education on completion of weekly skin assessments and appropriate follow up as indicated by 2/15/23. Education will be completed by Director of Nursing or designee. All new hires will receive education during orientation prior to patient assignment. Any staff that did not receive this education by 2/15/23 will not be allowed to work until education is received. 5. All CNAs will receive education on routine foot care as well as education related to signs and symptoms that require a report to the nurse for follow up. This education will be provided by 2/15/23 by the Director of Nursing or designee. All new hires will receive this education during orientation prior to patient assignment. Any staff that did not receive this education by 2/15/23 will not be allowed to work until education is received. 6. All residents currently receive weekly skin assessments. The Director of Nursing or designee will audit nurses' accurate completion of weekly skin assessments. The Director of Nursing or designee will audit 10 skin assessments weekly for 4 weeks then 5 skin assessments weekly for 4 weeks. 7. Director of Nursing or designee will	

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Review of Resident #1's skin assessments done by nursing dated 12/12/22, 12/20/22, 12/28/22, 1/10/23 and 1/17/23, there was no documentation of the condition of Resident 1#s toenails from either foot, or other concerns regarding the resident's feet.

An observation was conducted on 1/24/23 at 9:15 AM. Resident #1 was lying in bed, when the resident pulled the covers off her feet, Resident #1's feet and toenails on both feet were observed to have visible thick layers of what appeared to be dirt and thick layers of skin between the toes, and thick, calcified, dry patches on the bottoms of her feet. The toenails were observed to be curled over each toe on both feet and were about 1.5 inches in length from the base of the nail, very thick, with jagged edges, and the toenails had grown long enough to be in contact with the adjacent toes. The bottoms and back of her feet were observed to have thick, scaly, dry skin, and hard brown patches on the bottoms of the feet. A strong foul odor was detected near her feet as she moved them around in the bed. Resident #1 stated staff were not washing her feet regularly. She and her family had requested for her toenails to be cut for several months and had been told the podiatrist only visited every three months. Resident #1 stated "I don't like covers over my toes because of the pressure on my toenails/feet causing her pain." She further stated no-one had followed up with her or the family of when the next time she would be seen by the podiatrist.

An interview was conducted on 1/24/23 at 9:22 AM; with the Nurse Aide #3(NA) who stated the aides were not to cut the toenails of resident's who were diabetics. NA#3 further stated the aides should report the condition of the toenails, such

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assess 10 residents weekly for 4 weeks then 5 residents weekly for 4 weeks to ensure provision of proper footcare.

8. Findings will be reported to the Quality Assurance Performance Improvement committee for recommendations and modifications until a pattern of compliance is achieved.

9. Date of completion: 2/15/23

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as if the toenails were getting too long or sharp, the condition should be reported to the nursing staff so the resident could be scheduled for the podiatrist. NA #3 stated she had worked with Resident #1 on a regular basis and the toenails had been in the current condition for several months. NA#1 stated the condition of the toenails had been reported to nursing. She was not specific how many times it had been reported to the charge nurse. NA#3 said she was not exactly sure what condition changes should be reported to nursing and she was uncertain when the podiatry appointment had been schedule.

An interview was conducted on 1/24/23 at 9:23 AM, Nurse Aide #4 stated they were told by nursing they shouldn't cut toenails of residents who were a diabetic. The NA did not indicate whether a list of diabetic residents was provided to the aides but should report the condition of the toenails to nursing. The diabetic residents' toenails would be addressed by the podiatrist. She added she had not been trained on what to look for to specifically report as a change of resident foot condition. NA#2 stated she had worked with Resident #1 on a regular basis and the toenails had been in the current condition for several months. NA #4 state the condition of the toenails had been reported to nursing, but she was uncertain when the podiatry appointment had been scheduled.

An observation and interview were conducted on 1/24/23 at 9:53 AM, the Regional Nurse and Nurse #7 were present. The Regional Nurse assessed Resident #1's feet and confirmed Resident #1's feet needed to be cleaned and the toenails needed to be cut/trimmed. The Regional Nurse further stated it was the responsibility of

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the Nurse Aides to report to nursing when the toenails needed to be cut for all residents, especially diabetic residents. She explained nursing staff were responsible for doing a full head to toe assessment and document on the weekly skin assessment for any changes of the resident's body including the condition of the toenails. She stated the toenails needed to be trimmed because of their length, there was a lack of cleanliness of the feet, and there were hard patches on the bottom of the resident's feet. Nurse #7 stated the nursing staff were responsible for doing a head-to-toe assessment of the resident and document any change of condition of the resident's body including the feet and document on the skin assessment form. Nurse #7 further stated she had assessed the resident from head to toe on 1/23/23 but had not noticed the condition of Resident #1's feet. Nurse #7 confirmed Resident #1's feet needed to be washed and a referral made for podiatry services.

An interview was conducted on 1/24/23 at 10:57 AM, the Social Work Director (SWD) stated the podiatrist visits the facility every three months and any diabetic resident would be added to the schedule when nursing reported a resident needed podiatry services. The SWD confirmed Resident #1 had not been on the podiatry list in the last 5 months. She further stated nursing was provided with a clinic form to be completed when any resident needed to be scheduled for outside services. She added there was no system in place if a resident missed the scheduled day for podiatry services. SWD further stated she was currently working on a schedule for the podiatry services visit to include new residents and Resident #1 was added to the 2/13/23 schedule visit after an inquiry was made. Nursing was

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F 687	Continued From page 5 responsible for letting the social work department know when outside/clinic services were needed when a resident misses the podiatry visit. An interview was conducted on 1/24/23 at 1:01PM, the Family Member stated she had spoken with several staff members regarding the condition of Resident #1's feet and requested a referral for podiatry. The family member added the nursing staff had told her Resident #1 would be seen every three months. She reported when she inquired about the referral in November 2022, she received no response. The family member stated she did receive a call today, 1/24/23, that Resident #1 would be seen in February 2023. The family member continued, and stated she was "appalled" that staff were not washing Resident #1's feet during bathing/showers and had not noticed Resident #1 needed to be seen by the podiatrist. She said she had reported to the Director of Nursing (DON), the unit nurse and charge nurse when Resident #1 complained of pain in her feet and felt staff were disregarding her concern by telling her the resident's pain was part of her other health conditions. The family member further stated she had frequently observed Resident# 1's feet to be dirty with thick dry skin stuck between her toes with and they had a bad odor. The family member expressed dissatisfaction in that it had been well past three months since her toenails had been cut/trimmed. An interview was conducted on 1/24/23 at 2:42 PM, Nurse #5 stated the Nurse Aides were expected to provide foot care during baths/showers, report any change of condition of the resident's feet, and notify the nurse the resident's toenails need to be cut/trimmed. She said the charge nurse would do a weekly full body	F 687		

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F 687	Continued From page 6 assessment on the residents and document any changes, including the condition of the resident's feet so appropriate referrals could be made. She explained the charge nurse would provide the social workers with the names of the residents who would need to be seen for podiatry. She further stated the nurses would also document in the physician/nurse practitioner notebook to inform them of the change in resident foot condition as they would for other concerns. An interview was conducted on 1/24/23 at 4:34 PM, NA #8 who worked 2nd shift stated Resident #1 shower schedule was for second shift, and she had not been washing the resident's feet on a regular basis or checking the condition of the resident's toenails. NA #8 reported Resident #1's feet had been in this condition since her employment began in March 2022. NA#8 further stated she had been told nursing would cut/trim all diabetic resident toenails and/or refer them out to a podiatrist. NA#8 did not specify who told her Resident #1 was diabetic. She added she had not been trained on what specific to report regarding the condition of a resident's toenails. An interview was conducted on 1/24/23 on 11:20 AM, The Administrator stated Nurse Aides and nursing were responsible for ensuring residents skin/toenails etc... were being checked and cleaned during personal care and Nurse Aides should report to nursing any resident that needed podiatry services. He explained Nurse Aides could cut resident toenails that were not diabetic and should be cleaning and checking between toes to ensure the area was thoroughly clean. He further stated the wound care nurse should also be checking residents' feet when performing wound care of affected areas and documenting	F 687		

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on the wound care list the resident needed podiatry services. The Administrator added residents' feet should be checked on all residents when skin assessments were being completed and the condition of the resident's feet/toenails should be reflected on the assessment. The Administrator stated nursing should be notifying the social workers to let them know when a resident needed to be seen by an outside service. The Administrator stated there was no direct system in place to ensure residents who missed appointments would receive a follow-up appointment. In addition, the Administrator added nursing should be cutting resident toenails in between appointments until the resident could be scheduled.

An interview was conducted on 1/25/23 at 9:00 AM, the Director of Nursing stated the podiatrist was scheduled every 3 months and it was expected that any diabetic residents who needed podiatry service be added to the schedule. She said the Nurse Aides were responsible for reporting to nursing when diabetic resident's toenails were extremely long or sharp, and/or needed podiatry trim/cut the nails. The DON further stated the Nurses were responsible for completing the weekly full body assessments which would include the condition of resident's toenails. The nurses would document if they had cut/trim toenails and/or the resident was referred for podiatry services. The nurses would let the Social Workers know which residents needed to be referred to the podiatrist. The DON added the nurses were authorized to cut/trim toenails for residents who did not need podiatry services.

An interview was conducted on 1/25/20 at 10:30 AM, the Nurse Practitioner #2(NP) stated during

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F 687	Continued From page 8 his routine visits he did not assess a resident's feet unless staff identified a concern with the resident's feet and then a podiatry referral would be done. NP #2 stated during his visit on 1/9/23 with Resident #1, her feet were not observed. The NP added any resident could be seen for toenail care in between podiatry visits if the toenails were growing very long, had thick/long sharp edges, and/or needed to be cut/trimmed before the three months visit by the podiatrist. The NP further stated staff would need to inform him when a diabetic resident needed a referral for podiatry services. The NP added he was unaware of the condition of Resident #1's toenails until he received a call on 1/24/23.	F 687		