

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED 02/14/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED G 01/31/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL			STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303		
(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 000	INITIAL COMMENTS	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Transitional Care and Rehabilitation – Hillcrest does not admit that the deficiencies listed on the HCFA Form 2567 exist, nor does the facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.		
F 282 SS=E	<p>An abbreviated survey (KY #17685) was conducted on 01/30/12 through 01/31/12. KY #17685 was substantiated with deficiencies cited.</p> <p>483.20(k)(3)(iii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure care was provided in accordance with the written plan of care for five residents (#1, #5, #6, #7 and #8), in the selected sample of eight residents. According to his/her written plans of care, fingernails and toenails were to be cleaned and checked during showers/baths two times a week. Observations during the abbreviated survey revealed the residents to have long toenails, and care was not being completed according to his/her plan of care. Additionally, Resident #1 was care planned to be turned every two hours. Several observations of the resident during the abbreviated survey, on 01/30-31/12, revealed he/she was lying on his/her back.</p> <p>The findings include: The Director of Nursing (DON) revealed she could not provide a policy/procedure on following care plans, but stated the staff were expected to provide care according to each residents' written</p>	F 282	<p>F282</p> <p>I. How corrective action will be accomplished for those affected:</p> <p>Residents #1, 5, 6 7 & 8's toenails were cut on 1/31/12. All care plans were reviewed by Director of Nursing, Assistant Director of Nursing and the Unit Managers and changes made as appropriate on 2/1/12. Changes on care plans were discussed with residents who were alert and oriented.</p>	2/24/12	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: J. D. [Signature] TITLE: _____ (X6) DATE: 3/16/12

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 282	<p>Continued From page 1 plan of care.</p> <p>1. A record review revealed Resident #1 was admitted to the facility on 09/10/10 with diagnoses to include History of Cerebral Vascular Accident, Depression, Hypertension and Coronary Artery Disease. A review of the annual Minimum Data Set (MDS), dated 12/14/11, revealed the resident had a Brief Interview of Mental Status (BIMS) score of "15." The resident was assessed to be cognitively intact and required extensive assistance of one or two staff with his/her activities of daily living.</p> <p>A review of the comprehensive care plan, "Routine Care Needs," dated 09/20/10, revealed to "shampoo, shower/bath two times a week. Fingernails and toenails were to be cleaned and checked."</p> <p>A review of the nursing assistant flow sheets, dated November 2011, December 2011, and January 2012, revealed "shampoo, shower/bathe two times a week. Fingernails and toenails were to be cleaned and checked. Further review revealed the resident was to be provided a bed bath daily.</p> <p>Observations of Resident #1, on 01/30/12 at 12:18 PM, 2:15 PM, 4:15 PM, and 5:45 PM, and on 01/31/12 at 7:25 AM, 9:30 AM, 12:45 PM, 1:14 PM and 3:25 PM, revealed the resident was lying on his/her back in the bed. Additionally, an observation of the resident during a head to toe skin assessment, on 01/31/12 at 12:45 PM, revealed he/she to have long toenails on his/her feet.</p>	F 282	<p>Since resident #1 sometimes refuses to turn and reposition on a schedule, we will offer to turn resident but respect a decision not to turn at that time. Education was done with resident #1 by the Director of Nursing on 2/1/12 which detailed potential negative outcomes due to not changing positions often.</p> <p>II. How corrective action will be accomplished for those residents having potential to be affected:</p> <p>Each resident in the building had their nails assessed, cleaned and trimmed as needed on 2/2/12 by the Director of Nursing, Assistant Director of Nursing and Unit Managers.</p> <p>The Staff Development Coordinator will educate all nursing staff on Policy 65020 on AM Care by 2/17/12.</p> <p>In addition Certified Nursing Assistants attending care plans will be sharing specific information on nail care and any refusals of care in order to keep care plans updated and specific to resident's needs. This will be effective 2/6/12. Unit Manager's and Minimum Data Set</p>		

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F 282	<p>Continued From page 2</p> <p>An interview with Resident #1, on 01/31/12 at 12:45 PM, revealed the staff did not come and turn him/her very often during the day. Resident #1 stated it hurt for him/her to lay on his/her side. Additionally, the resident stated he/she received bed baths only by choice.</p> <p>An interview with State Registered Nurse Aide (SRNA) #1, on 01/31/12 at 9:25 AM, revealed she provided care for the resident. She stated during the morning when bed baths or showers were given, they were supposed to clean and trim fingernails, as well as toenails. SRNA #1 revealed they did not always get toenails trimmed; however, they made the charge nurse aware. Additionally, she stated, at the end of the day, when they signed the resident's care plan, this indicated they had completed the care for the day according to the care plans.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 01/31/12 at 9:44 AM, revealed the staff provided all activities of daily living for the resident. The resident was care planned for turning every two hours, and he/she refused on occasions. The SRNAs were supposed to let her know when the residents refused care so it could be documented on the flow sheets. Additionally, the resident was provided a bed bath twice a week and the SRNAs were supposed to check fingernails and toenails at that time. If the residents' nails needed care, then they were supposed to trim the nails, unless the resident was diabetic. The nurses trim the diabetic residents' nails. At the end of the day, she checked the residents to ensure the care was completed, and signed the flow sheets which indicated the SRNAs completed the care</p>	F 282	<p>(MDS) Coordinators are responsible for ensuring aide attendance at these meetings.</p> <p>An audit will be performed of each Resident's Plan of Care to insure resident's plan is communicated through the Assignment sheets for all staff to review. This will be accomplished by 2/24/12. Unit Managers, Director of Nursing, and the Assistant Director of Nursing will be responsible.</p> <p>All residents with the Brief Interview for Mental Status (BIMS) of 13 or greater that require assistance with bed mobility will be interviewed to determine their preference for a turn schedule. Care plans will be changed to reflect their preferences. Director of Nursing, Assistant Director of Nursing, and Unit Managers will be responsible to ensure care plans are updated as appropriate. This will be done by 2/24/12.</p>		

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F 282	<p>Continued From page 3 according to his/her plan.</p> <p>An interview with SRNA #2, on 01/31/12 at 10:06 AM, revealed she provided care for Resident #1 on 01/30/12. She stated the resident always took a bed bath and he/she washed his/her own face, and the staff completed the remainder of the resident's bath. She stated the resident refused to let the staff trim his/her toenails, but he/she did have the podiatrist trim his/her toenails. Resident #1 was to be turned every two hours as well, but he/she did not want to be off his/her back. SRNA #2 revealed she reported to the nurse whenever the resident refused to turn. She stated when she signed the care plan at the end of the day, it indicated she completed the resident's care according to his/her plan.</p> <p>An interview with SRNA #4, on 01/31/12 at 3:20 PM, revealed the resident did not turn/reposition himself/herself, although the resident did maneuver himself/herself while in the bed. Staff put a pillow under the resident and they "did well" to turn him/her two times during each shift. If the resident refused care, then she made the charge nurse aware.</p> <p>2. A record review revealed Resident #5 was admitted to the facility on 10/06/08 with diagnoses to include Dementia other than Alzheimer's, Chronic Fatigue Syndrome and Seborrhea. A review of the quarterly MDS, dated 01/23/12, revealed the resident was severely cognitively impaired and rarely/never made decisions. Further review revealed Resident #5 was totally dependent on one or two staff for activities of daily living.</p>	F 282	<p>III. What measures will be put in place/systemic changes made to ensure correction:</p> <p>Effective 2/6/12 aides will attend the care plan conference for the residents they care for. They will be sharing specific information on nail care and any refusals of care in order to keep care plans updated and specific to resident's needs. Unit Manager's and MDS Coordinators are responsible for ensuring aide attendance at these meetings.</p> <p>All refusals of care will be discussed by the Inter Disciplinary Team and care planned accordingly. Unit Managers, Director of Nursing, Assistant Director of Nursing will be responsible.</p> <p>Effective 2/6/12, any daily refusals will be discussed at Standup meeting and changes made to the care plan as needed. Inter Disciplinary Team is responsible for changing the care plan accordingly. The Director of Nursing is responsible for ensuring the system change is incorporated into daily practice.</p>		

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F 282	<p>Continued From page 4</p> <p>A review of the comprehensive care plan, "Routine Care Needs," dated 01/05/11, revealed "bed bath only. Fingernails and toenails were to be cleaned and checked."</p> <p>A review of the nursing assistant flow sheets, dated November 2011, December 2011 and January 2012, revealed a bed bath only two times a week. Fingernails and toenails were to be cleaned and checked. Further review revealed Resident #5 received a bed bath daily in November 2011 and December 2011. The staff initiated the flow sheet which indicated they completed the resident's care according to the care plan.</p> <p>Observation of Resident #5 during a head to toe skin assessment, on 01/31/12 at 7:50 AM, revealed he/she had long toenails on his/her feet.</p> <p>3. A record review revealed Resident #6 was admitted to the facility on 04/01/05, and re-admitted on 02/08/11, with diagnoses to include Seizure Disorder, Cerebral Palsy and Hypertension. A review of the annual MDS, dated 11/18/11, revealed the resident was severely cognitively impaired, and was totally dependent on one or two staff for activities of daily living.</p> <p>A review of the comprehensive care plan, "Routine Care Needs," dated 02/18/11, revealed to "shampoo, shower/bed bath two times a week with partial bed baths all other days. Fingernails and toenails were to be cleaned and checked."</p> <p>Observation of Resident #6, on 01/31/12 at 3:00 PM, revealed he/she was lying in bed, awake, alert, and had long toenails on both feet.</p>	F 282	<p>IV. How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The Director of Nursing, Assistant Director of Nursing, and each Unit Manger will be responsible to conduct random audits on 10 residents a week to ensure interventions have been implemented as indicated.</p> <p>Audits will be reviewed weekly by the Director of Nursing and the results of the audits will be discussed at the monthly PI Meetings for the next three months to ensure compliance.</p>		

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F 282	<p>Continued From page 5</p> <p>4. A record review revealed Resident #7 was admitted to the facility on 08/04/08, and re-admitted on 07/10/09, with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Anxiety and Chronic Urinary Retention.</p> <p>A review of the comprehensive care plan, "Routine Care Needs," dated 05/25/11, revealed to "shampoo, shower/bed bath two times a week. Fingernails and toenails were to be cleaned and checked."</p> <p>Observation of Resident #7, on 01/31/12 at 2:55 PM, revealed the resident was lying in bed on his/her back with both of his/her legs off the bed. Further observation revealed the resident had long toenails on both feet.</p> <p>5. A record review revealed Resident #8 was admitted to the facility on 04/15/06, and re-admitted on 08/29/06, with diagnoses to include Chronic Respiratory Failure, Congestive Heart Failure and Depression.</p> <p>A review of the comprehensive care plan, "Routine Care Needs," dated 05/18/11, revealed to "shampoo, shower/bed bath two times a week with bed baths all other days. Fingernails and toenails were to be cleaned and checked."</p> <p>Observation of Resident #8, on 01/31/12 at 3:19 PM, revealed the resident had long toenails.</p> <p>An interview with Registered Nurse (RN) #2, on 01/31/12 at 12:45 PM, revealed nail care was a part of the residents' daily care. The SRNAs</p>	F 282			

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F 282	Continued From page 6 trimmed the residents' nails whenever the residents were bathed or showered. The SRNAs could not trim the nails of diabetic residents, the nurse had to trim those residents' nails. An interview with RN #3, on 01/31/12 at 7:50 AM, revealed the SRNAs and nurses trimmed the residents' nails. She stated the residents' nails were usually trimmed on shower days and as needed, whenever the nurse completed the skin assessments. An interview with the Director of Nursing (DON), on 01/31/12 at 4:05 PM, revealed the staff were expected to provide care according to the care plan. An interview with the Administrator, on 01/31/12 at 4:35 PM, revealed she was responsible to ensure the facility operated on a daily basis. She stated the resident (#1) was not discussed in the daily meetings related to refusal of showers, but refusing to turn. She expected the staff to follow the residents' care plans accordingly.	F 282			
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was	F 312	F312 I. How corrective action will be accomplished for those affected: Residents #1, 5, 6 7 & 8's toenails were cut on 1/31/12. All care plans were reviewed and changes made as appropriate on 2/1/12. Changes on care plans were discussed with resident who were alert and oriented.	2/24/12	

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F 312	<p>Continued From page 7</p> <p>determined the facility failed to ensure residents who were unable to carry out activities of daily living (ADLs) received the necessary service to maintain good nutrition, grooming, and personal and oral hygiene for five residents (#1, #5, #6, #7 and #8), in the selected sample of eight residents. Observations, on 01/31/12, revealed the residents had long toenails, and the residents were care planned to have fingernails and toenails cleaned and checked two times a week during showers/baths.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "A.M. Care," dated 04/28/09, revealed "A.M. care is provided to refresh the resident, provide cleanliness, comfort and neatness to prepare the resident for breakfast, to assess the resident's condition and needs and to promote psychosocial well being. After breakfast provide nail care, if applicable and appropriate."</p> <p>1. A record review revealed Resident #1 was admitted to the facility on 09/10/10 with diagnoses to include History of Cerebral Vascular Accident, Depression, Hypertension and Coronary Artery Disease. A review of the annual Minimum Data Set (MDS), dated 12/14/11, revealed the resident had a Brief Interview of Mental Status (BIMS) score of "15." The resident was assessed to be cognitively intact and required extensive assistance of one or two staff with his/her activities of daily living.</p> <p>A review of the comprehensive care plan, "Routine Care Needs," dated 09/20/10, revealed to "shampoo, shower/bath two times a week.</p>	F 312	<p>II. How corrective action will be accomplished for those residents having potential to be affected:</p> <p>The Staff Development Coordinator will educate all nursing staff on Policy 65020 on AM Care by 2/17/12.</p> <p>Each resident in the building had their nails assessed, cleaned and trimmed as needed on 2/2/12 by the Director of Nursing, Assistant Director of Nursing and Unit Managers.</p> <p>In addition Certified Nursing Assistants attending care plans will be sharing specific information on nail care and any refusals of care in, order to keep care plans updated and specific to resident's needs. This will be effective 2/6/12. Unit Managers and MDS Coordinators are responsible for ensuring aide attendance at these meetings.</p>		

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F 312	<p>Continued From page 8</p> <p>Fingernails and toenails were to be cleaned and checked."</p> <p>A review of the nursing assistant flow sheets, dated November 2011, December 2011, and January 2012, revealed "shampoo, shower/bathe two times a week. Fingernails and toenails were to be cleaned and checked. Further review revealed the resident was to be provided a bed bath daily.</p> <p>An observation of the resident during a head to toe skin assessment, on 01/31/12 at 12:45 PM, revealed he/she to have long toenails on his/her feet.</p> <p>An interview with State Registered Nurse Aide (SRNA) #1, on 01/31/12 at 9:25 AM, revealed nail care was a part of the daily care of the resident and on shower days. She stated the resident was not able to trim his/her nails and relied on the staff for assistance. She stated the resident did not always want his/her nails trimmed.</p> <p>An interview with SRNA #2, on 01/31/12 at 10:06 AM, revealed the resident was dependent on the staff for his/her ADLs. Resident #1 refused to allow the staff to trim his/her toenails. He/she had the podiatrist to trim his/her nails when he came to the facility. Nail care was provided with showers two times a week and if nails needed to be trimmed, then they trimmed them at the time.</p> <p>An interview with Registered Nurse (RN) #2, on 01/31/12 at 12:45 PM, revealed nail care was a part of the residents' daily care. The SRNAs trimmed the residents' nails whenever the residents were bathed or showered. The SRNAs</p>	F 312	<p>An audit will be performed of each Resident's Plan of Care on each unit to insure resident's plan is communicated through the Assignment sheets for all staff to review. This will be accomplished by 2/24/12. UM's, DNS, ADNS will be responsible.</p> <p>All residents with BIMS of 13 or greater that require assistance with bed mobility will be interviewed to determine their preference for a turn schedule. Care plans will be changed to reflect their preferences. DNS, ADNS, UM's will be responsible to ensure care plans are updated as appropriate. This will be done by 2/24/12.</p> <p>III. What measures will be put in place/systemic changes made to ensure correction:</p> <p>Effective 2/6/12 aides will attend the care plan conference for the residents they care for. All refusals of care will be discussed by the IDT and care planned accordingly. UM's, DNS, ADNS will be responsible.</p>		

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(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 312	<p>Continued From page 9</p> <p>could not trim the nails of diabetic residents, the nurse had to trim those residents' nails.</p> <p>2. A record review revealed Resident #5 was admitted to the facility on 10/06/08 with diagnoses to include Dementia other than Alzheimer's, Chronic Fatigue Syndrome and Seborrhea. A review of the quarterly MDS, dated 01/23/12, revealed the resident was severely cognitively impaired and rarely/never made decisions. Further review revealed Resident #5 was totally dependent on one or two staff for activities of daily living.</p> <p>A review of the comprehensive care plan, "Routine Care Needs," dated 01/05/11, revealed "bed bath only. Fingernails and toenails were to be cleaned and checked."</p> <p>A review of the nursing assistant flow sheets, dated November 2011, December 2011 and January 2012, revealed a bed bath only two times a week. Fingernails and toenails were to be cleaned and checked. Further review revealed Resident #5 received a bed bath daily in November 2011 and December 2011.</p> <p>Observation of Resident #5 during a head to toe skin assessment, on 01/31/12 at 7:50 AM, revealed he/she had long toenails on his/her feet.</p> <p>An interview with RN #3, on 01/31/12 at 7:50 AM, revealed the SRNAs and nurses trimmed the residents' nails. She stated the residents' nails were usually trimmed on shower days and as needed, whenever the nurse completed the skin assessments. She stated the resident's nails should be trimmed.</p>	F 312	<p>Effective 2/6/12, any daily refusals will be discussed at Standup meeting and changes made to the care plan as needed. IDT team is responsible for changing the care plan accordingly. DNS is responsible for ensuring the system change is incorporated into daily practice.</p> <p>IV. How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The DNS, ADNS, and each Unit Manger will be responsible to conduct random audits on 10 residents a week to ensure interventions have been implemented as indicated.</p> <p>Audits will be reviewed weekly by the DNS and the results of the audits will be discussed at the monthly PI Meetings for the next three months to ensure compliance.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	<p>Continued From page 10</p> <p>3. A record review revealed Resident #6 was admitted to the facility on 04/01/05, and re-admitted on 02/08/11, with diagnoses to include Seizure Disorder, Cerebral Palsy and Hypertension. A review of the annual MDS, dated 11/18/11, revealed the resident was severely cognitively impaired, and was totally dependent on one or two staff for activities of daily living.</p> <p>A review of the comprehensive care plan, "Routine Care Needs," dated 02/18/11, revealed to "shampoo, shower/bed bath two times a week with partial bed baths all other days. Fingernails and toenails were to be cleaned and checked."</p> <p>Observation of Resident #6, on 01/31/12 at 3:00 PM, revealed he/she was lying in bed, awake, alert, and had long toenails on both feet.</p> <p>4 A record review revealed Resident #7 was admitted to the facility on 08/04/08, and re-admitted on 07/10/09, with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Anxiety and Chronic Urinary Retention.</p> <p>A review of the comprehensive care plan, "Routine Care Needs," dated 05/25/11, revealed to "shampoo, shower/bed bath two times a week Fingernails and toenails were to be cleaned and checked."</p> <p>Observation of Resident #7, on 01/31/12 at 2:55 PM, revealed the resident was lying in bed on his/her back with both of his/her legs off the bed. Further observation revealed the resident had long toenails on both feet.</p>	F 312			

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F 312	<p>Continued From page 11</p> <p>5. A record review revealed Resident #8 was admitted to the facility on 04/15/06, and re-admitted on 08/29/06, with diagnoses to include Chronic Respiratory Failure, Congestive Heart Failure and Depression.</p> <p>A review of the comprehensive care plan, "Routine Care Needs," dated 05/18/11, revealed to "shampoo, shower/bed bath two times a week with bed baths all other days. Fingernails and toenails were to be cleaned and checked."</p> <p>Observation of Resident #8, on 01/31/12 at 3:19 PM, revealed the resident had long toenails</p> <p>An interview with the DON, on 01/31/12 at 1:15 PM, revealed the SRNAs take care of the residents' nails, unless they are diabetic. If the resident was diabetic or had thick toenails, then the nurse addressed the issue. The nails were a part of routine care of the resident by the SRNAs and they should be looking at them and trimming them when needed. The nurses monitored the nails weekly when they completed the skin assessments and they should also address them.</p> <p>An interview with the Administrator, on 01/31/12 at 4:35 PM, revealed she expected the staff to follow the facility's policy/procedures related to the care of the resident.</p>	F 312			