

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

PRINTED: 02/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185366	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER CORBIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 270 BACON CREEK ROAD CORBIN, KY 40702	
(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 A standard health survey was conducted on 01/21-23/13. Deficient practice was identified at a scope and severity of "E"	F.000	Please See Attached	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		

RECEIVED
FEB 19 2013
DEPARTMENT of Health Care
Southern Enforcement Branch

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

C. Messer

Administrator 2/19/13

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 225	<p>Continued From page 1</p> <p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy it was determined the facility failed to ensure an incident of possible neglect was immediately reported to the state survey and certification agency for one of twenty sampled residents (Resident #1). Resident #1 was assessed by the facility to require two person assistance with toileting and transfers. On 12/10/12, one staff person attempted to transfer the resident to the toilet, however, the resident was unable to stand and the staff person assisted the resident to the bathroom floor. The facility conducted an investigation into the incident and implemented disciplinary action toward the employee involved in the incident. However, the facility failed to consider the incident as possible neglect and failed to ensure the incident was immediately reported to the appropriate the state agencies.</p> <p>The findings include:</p> <p>A review of the facility's Abuse Policy (not dated) revealed the policy would not condone resident abuse, neglect, or exploitation of residents. The policy further stated all allegations involving mistreatment, neglect, or abuse including injuries of an unknown source or misappropriation of resident property would be reported immediately</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>to the Director of Nurses and/or the Administrator of the facility and to other officials in accordance with State Law, including the state survey and certification agency.</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident 02/11/09 with diagnoses to include Hypertension, Diabetes Mellitus, Anxiety, Cerebrovascular Accident with right sided hemiplegia, and Neurogenic Bladder. Review of the quarterly assessment (reference date 11/10/12), revealed the facility assessed Resident #1 to require extensive assistance of two (2) staff persons for transfers and toileting needs. The resident was also assessed to have limitation in range of motion one (1) side. Continued review of the medical record revealed staff had assessed Resident #1 using a "Brief Interview for Mental Status" (BIMS) document, to be alert and oriented.</p> <p>Review of the Comprehensive Care Plan (dated 12/04/12); revealed the facility addressed Resident #1 to be at risk for falls. Interventions included for staff to transfer the resident safely with assistance, as needed, and to assist the resident with toileting every two (2) hours, and as needed. Review of the Nurse Aide care plan revealed staff assessed Resident #1 to require the assistance of two (2) staff persons to provide transfers and toileting needs.</p> <p>Review of the fall investigation report dated 12/10/12, revealed Certified Nurse Aide (CNA) #4 was transferring Resident #1 to the toilet by herself when the resident's left leg became weak causing the resident to lose his/her balance. The</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>report noted Resident #1 was lowered to the floor by CNA #4 and that the resident did not sustain injury. Further review of the investigation also revealed Resident #1 required the assistance of two (2) staff persons for toileting/transfers related to weakness.</p> <p>Interview conducted with CNA #4 on 01/23/13 at 9:50 AM revealed the CNA was aware Resident #1 required the assistance of two staff for transfers. The CNA stated she checked in the hallway to see if another staff person was available to assist with the transfer; however, did not see anyone. CNA #4 stated she attempted to transfer the resident from the wheelchair to the toilet, the resident's legs became weak, and the resident was unable to continue standing. The CNA stated she lowered the resident to the floor and called for help. CNA #4 further stated she had received a written warning after the incident and was re-educated to follow the resident's individual care plan to provide safe transfers.</p> <p>Interview conducted with Licensed Practical Nurse (LPN #1) on 01/23/13, at 11:25 AM, revealed she was called to the resident's room on 12/10/12 and observed Resident #1 sitting on the floor in the bathroom. LPN #1 stated she initiated the investigation and determined the resident had been transferred with only one (1) staff person assist. LPN #1 stated she reported the incident to the Unit Coordinator.</p> <p>The Unit Coordinator (UC) stated in interview conducted on 01/23/13 at 11:25 AM Resident #1 had previously been a one (1) person transfer. However, the UC stated in December 2012, after the resident had been readmitted to the facility</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>from the hospital, staff assessed the resident to be weaker and noted the resident required two (2) staff for transfer/toileting. The UC stated she updated the nurse aide care plan and inserviced all the staff on these changes on 12/10/12. The UC stated she also discussed these changes with Resident #1 and the resident verbalized understanding. The UC stated she was responsible to complete the investigation and to submit the report to the Director of Nursing (DON) and/or Administrator. The UC stated she was not responsible to report to the state agencies and did not believe the incident had been considered as possible neglect.</p> <p>Interview conducted with Resident #1 on 01/23/13, at 11:35 AM, revealed the resident was aware he/she needed two (2) staff for transfers/toileting. Resident #1 stated the CNA did not know he/she needed two (2) people and he/she did not tell the CNA. Resident #1 stated his/her legs became weak and the CNA lowered the resident to the floor. In addition, the resident denied injuries as a result of the incident.</p> <p>Interview conducted with the facility Administrator on 01/23/13, at 2:40 PM, revealed she had reviewed the incident /investigation report dated 12/10/12 for Resident #1. The Administrator stated CNA #4 received a written disciplinary notice and re-education. In addition, the Administrator stated all other nursing staff was immediately inserviced regarding following safe transfer procedures. The Administrator stated at the time of the incident, she had not considered the incident as possible neglect and had not reported the incident to the appropriate state agencies. However, the Administrator</p>	F 225			

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F 225	Continued From page 5 acknowledged in interview that the incident should have been reported immediately to the state agencies.	F 225	Please See Attached		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facilities policy, it was determined the facility failed to provide maintenance services to maintain a sanitary, orderly, and comfortable interior for two of twenty sampled and three of five un-sampled residents (Residents #10, #15, B, C, and E). Observations during the environmental tour on 01/21/13, 01/22/13, and 01/23/13 revealed Residents #10, #15, B, C, and E were sitting in wheel-chairs and the vinyl covered arm rests of the wheel-chairs were cracked, torn, and in need of repair. The findings include: Review of the Maintenance log and room checklist revealed the arm-rests of wheel chairs were to be checked every week and repairs were to be made as needed. Observation during the environmental tour 01/21/13, 01/22/13, and 01/23/13 revealed Resident #10, #15, B, C, and E sitting in wheel-chairs and the vinyl covered arm rests of the wheelchairs were observed to be torn/cracked	F 253			

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F 253	Continued From page 6 and in need of repair. Based on documentation on the maintenance logs, the arm rests of the wheelchairs utilized by Residents #10, #15, B, C, and E were assessed by maintenance staff and there were no repairs made for December 2012. Interview with the Maintenance Supervisor on 01/23/13 at 3:30 PM revealed the maintenance check lists were utilized to review all wheel chairs in the building. According to the Maintenance Supervisor, he observed wheelchairs in the building on a monthly basis and was unaware the arm rests of the wheelchairs utilized by Resident #10, #15, B, C, and E were torn and cracked. The maintenance supervisor stated he had simply missed them when he had checked the wheel chairs in December 2012 for repairs. Interview with the Administrator on 01/23/13 at 3:30 PM revealed the maintenance repair form was to be utilized by anyone in the facility when any item was in need of repair. According to the Administrator, staff should have reported the wheel chair arms to the Maintenance Supervisor for repair.	F 253			
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363	Please See Attached		

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F 363	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure twenty-one (21) of twenty-one (21) residents that were on a regular diet received the preplanned portion size of pie at lunch on 01/21/13. A review of the facility's menu spreadsheet for the lunch meal on 01/21/13 revealed residents on a regular diet were to receive one slice of "lemon pie 8 cut". However, interviews and observation of the lunch meal revealed facility staff failed to ensure the residents received the portion size of pie as planned on the menu spreadsheet.</p> <p>The findings include:</p> <p>A review of the facility's policy entitled "Spreadsheet Compliance", undated, revealed the facility spreadsheets were available to the dietary staff at each meal to ensure proper foods were given and served in the proper amounts. According to the policy, the spreadsheets were to be positioned in a manner for the cook and staff that served the dessert to easily see.</p> <p>Observation of the lunch meal service on 01/21/13 at 11:30 AM revealed twenty-one of the twenty-one residents on regular diets received an extremely small portion size of lemon pie.</p> <p>An interview was conducted with the facility Dietary Aide on 01/21/13 at 11:30 AM. The Dietary Aide stated the pie was cut in smaller portions because she was afraid there was not enough pie to serve all the residents.</p> <p>An interview was conducted with the facility</p>	F 363			

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F 363	Continued From page 8 Dietary Manager on 01/21/13 at 1:30 PM. The facility Dietary Manager acknowledged, based on observation, the portions served to the residents were inadequate and should have been larger as called for by the menu spreadsheet. An interview was conducted with the facility Registered Dietitian (RD) on 01/21/13 at 2:30 PM. The RD stated the portion size on the menu spread sheet was for pies that "yielded" eight slices per pie; however, the RD stated the facility had received boxed pies that "yielded" ten slices per pie. The RD stated the Dietary Aide had sliced fourteen (14) portions from each pie rather than ten (10) slices as indicated by the instructions on the pie that had been received. The facility RD acknowledged the pie slices served to the residents were too small and should have been sliced into larger portions for the residents.	F 363			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	Please See Attached		

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F 441	Continued From page 9 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain an effective infection control program designed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection for one (1) of twenty (20) sampled residents and two (2) unsampled residents (Resident #9, Resident A and Resident D). On 01/21/13, staff were observed to touch Resident #9, Resident A and Resident Ds food with bare hands while preparing trays and assisting the resident to with their meals. The findings include:	F 441			

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F 441	<p>Continued From page 10</p> <p>Review of facility policy Feeding a Person (undated) revealed staff were not to touch any food with their bare hands. According to the policy, utensils were to be used for food assembly.</p> <p>1. Observation of the noon meal service on 01/21/13 at 11:25 AM revealed unsampled Resident A's tray was being prepared by State Registered Nurse Aide (SRNA #1). SRNA #1 was observed to remove the resident's bread from a bag with bare hands and placed the resident's bread on the tray. The resident was observed to eat the bread.</p> <p>An interview conducted with SRNA #1 on 01/23/13 at 1:10 PM revealed the SRNA was not allowed to touch the resident's food with bare hands; however, SRNA #1 stated she forgot to use the bag to handle and prepare the resident's bread.</p> <p>2. Observation of the noon meal on 01/21/13 at 11:20 AM revealed SRNA #3 used bare hands to remove bread from a wax paper bag for Resident D and placed the bread on the resident's plate.</p> <p>Interview with SRNA #3 on 01/23/13 at 1:20 PM revealed staff should not touch any food with bare hands. The SRNA stated she realized she had removed the bread for Resident D with her bare hands and acknowledged; however, she should have used the paper or a fork to remove the bread from the wrapping.</p> <p>3. Observation of the evening meal on 01/21/13</p>	F 441			

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F 441	<p>Continued From page 11</p> <p>at 6:35 PM revealed SRNA #2 delivered a tray to Resident #9, prepared the tray and began to assist the resident to eat. SRNA #2 was observed to remove the resident's bread from a bag with bare hands, fold the bread in half, and hand the bread to resident #9. The resident was observed to eat the bread.</p> <p>An interview conducted with SRNA #2 on 01/23/13 at 1:40 PM, revealed SRNA #2 was aware not to touch the residents' food with bare hands, however, when preparing the bread for Resident #9 to eat she had forgotten not to touch the food.</p> <p>An interview with the Dietary Manager on 01/23/13 at 1:20 PM revealed staff should not touch any residents' food with their bare hands. The Dietary Manager stated she monitored meals twice a week and had not identified any problems with staff using bare hands.</p> <p>An interview with the Registered Dietician on 01/23/13 at 1:25 PM revealed staff should not use bare hands for any reason to touch residents' food.</p>	F 441			

**Corbin Health and Rehabilitation
Annual Survey January 21-23, 2013
Plan of Correction**

F 225

- 1. Resident #1 did not suffer any negative effects from this incident. The physician and responsible party were notified. The appropriate agencies are aware of the incident involving resident #1.**

- 2. The Administrator and Director of Nursing reviewed all incident reports for the past year to ensure there were no other such incidents of this nature. No other discrepancies were found. Other alert and oriented residents requiring assist of two staff members were interviewed to ensure proper assistance is always being provided as assessed, again, with no problems or concerns identified. In addition, all residents requiring any assist were checked to ensure appropriate staff assistance is documented on Kardex. Staff were interviewed to ensure they know to look at Kardex to ensure they use the appropriate number of staff for transfers.**

- 3. In order to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures, in-servicing has been conducted. The Administrator and Director of Nursing were in-serviced by the Director of Operations on January 29, 2013. All administrative staff was also in-serviced on January 29, 2013 per Administrator. The Director of Nursing then in-serviced all staff beginning January 29, 2013, on abuse/neglect reporting. The in-service addressed thorough investigation, the immediate removal of alleged perpetrators to prevent further potential of abuse while the investigation is in progress, and reporting any/all allegations of abuse to the appropriate state agencies. Any allegations will be reported by the Administrator or by the Director of Nursing or Clinical Coordinator in her absence to the appropriate state agencies and followed through per protocol.**

- 4. In order to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures, in-servicing has**

been conducted. The CQI committee, as well as, the Administrator and Director of Nursing, will review all investigative reports and incident reports on an ongoing basis during weekly CQI meetings to ensure all incidents involving abuse/neglect or suspected abuse/neglect are reported to the appropriate state agencies as required. Any irregularities will be corrected immediately with continued follow-up and review.

5. Date of Completion: February 15, 2013.

**Corbin Health and Rehabilitation
Annual Survey January 21-23, 2013
Plan of Correction**

F 253

- 1. The Wheelchair arms have been replaced on the wheelchairs belonging to residents #10, #15, B, C and E.**
- 2. A thorough environmental round was completed to ensure that there were no items/areas in need of repair or replacement. All wheelchairs, recliners, etc. of all residents have been inspected to ensure there are no cracks or tears in wheelchair arms, with no further problems identified.**
- 3. All nursing staff have been in-serviced by the Director of Nursing; all Housekeeping staff have been in-serviced by the Housekeeping Supervisor; and the Maintenance and Housekeeping Supervisors have been in-serviced by the Administrator on the importance of providing maintenance services to maintain a safe, sanitary, orderly, and comfortable interior for the residents. Specifically these in-services covered the importance of immediately removing any equipment or furniture from use which was in need of repair and utilizing the CQI referral form to notify Maintenance services of these items/areas in need of repair, etc. The Housekeeping Supervisor will do ongoing weekly inspections of all wheelchairs and document on the inspection log, including those stored in various rooms throughout the facility, and take any wheelchairs in need of repair to the Maintenance Supervisor for repair.**
- 4. Thorough environmental rounds will be conducted weekly by the Housekeeping and/or Maintenance Supervisor to ensure that maintenance services are being provided to maintain a safe, sanitary, orderly, and comfortable interior for the residents. The CQI Committee will review all CQI referral sheets and the wheelchair inspection log completed by the Housekeeping Supervisor on an ongoing basis during the weekly CQI meetings. Any irregularities will be corrected immediately and will have continued follow-up and review.**
- 5. Completion Date: February 12, 2013.**

**Corbin Health and Rehabilitation
Annual Survey January 21-23, 2013
Plan of Correction**

F 363

- 1. All 21 residents affected by the disproportionate serving size are now receiving the correct portion size of pie, as set by manufacturer's guidelines.**
- 2. All residents are receiving correct portion sizes of all foods as set by manufacturer's guidelines. The menus are planned and followed in order to meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, and the National Academy of Sciences.**
- 3. The Dietary Manager was in-serviced by the Registered Dietician regarding the importance of following manufacturer's guidelines regarding portion sizes as well as following the planned menus in order to meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition board of the National Research Council, and the National Academy of Sciences. All dietary staff were then in-serviced by the Dietary Manager regarding the same and were able to demonstrate understanding.**
- 4. The Dietary Manager observed all meals for three days to ensure the correct serving sizes were being followed according to manufacturer guidelines and that menus are planned and followed in order to meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, and the National Academy of Sciences. Thereafter, these observations will be done for 3 meals every week by the Dietary Manager and/or Registered Dietitian for one month, then 3 meals monthly for one quarter. Any identified concerns will be corrected immediately and reported to the CQI Committee for further review and follow-up.**
- 5. Date Completed: February 13, 2013.**

**Corbin Health and Rehabilitation
Annual Survey January 21-23, 2013
Plan of Correction**

F 441

- 1. Residents #9, A, and D, have had no negative effects from this deficiency and are receiving care and services in accordance with professional standards of quality. The physician and responsible party for each of these residents were notified of this incident, with no new orders.**

- 2. All residents are receiving meal service and assistance with meals as ordered and following the professional standards of quality, specifically, not handling food with bare hands, as observed by the Clinical Coordinators on both units and the Dietary Manager.**

- 3. All SRNAs and NATRs, as well as dietary staff, have been in-serviced by the Director of Nursing on following the infection control program, including the importance of providing a safe, sanitary and comfortable environment in order to help prevent the development and transmission of disease and infection. Also, specifically the procedures used to ensure bare hands never make contact with resident's food. SRNA's #1, #2, and #3, have received one on one counseling and education by the Director of Nursing to make sure they understand their infection control violations and what the correct procedures were for no bare handed contact with food in order to maintain a safe, sanitary and comfortable environment.**

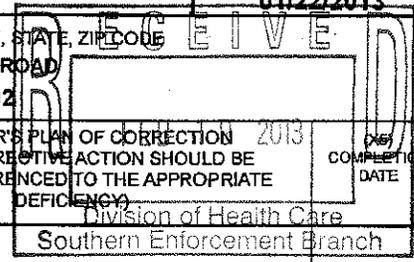
- 4. The Dietary Manager and Unit Clinical Coordinators observed meal passes for three consecutive days to ensure there was no bare hand contact with resident's food and that staff members were following the infection control program in order to maintain a safe, sanitary and comfortable environment in order to help prevent the development and transmission of disease and infection. The Dietary Manager and/or Registered Dietitian, as well as Clinical Coordinators, will continue to observe 3 meal passes every week for one month and then 3 meal passes monthly for one quarter. Any identified concerns will be corrected immediately and reported to the CQI Committee for further review and follow-up.**

- 5. Date Completed: Feb 13, 2013**

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

PRINTED: 02/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185366	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2013
NAME OF PROVIDER OR SUPPLIER CORBIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 270 BACON CREEK ROAD CORBIN, KY 40702	
(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
K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1991 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type III (000) SMOKE COMPARTMENTS: Six COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II natural gas generator A life safety code survey was initiated and concluded on 01/22/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "D" level.	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	K 062	Please See Attached	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

C. M. Messer

TITLE

Administrator 2/19/13

(X6) DATE

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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K 062	<p>Continued From page 1</p> <p>continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: .Based on observation and interview, the facility failed to ensure the sprinkler system was maintained according to NFPA standards. This deficient practice affected one (1) of six (6) smoke compartments, staff and approximately sixteen (16) residents. The facility has the capacity for 100 beds with a census of 97 the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 01/22/13, at 10:45 AM with the Director of Maintenance (DOM), three (3) sprinkler heads located in the attic above the brief storage room was observed to be covered with blown in insulation. This would prevent the sprinkler head from reacting as intended in a fire situation. An interview with the DOM on 01/22/13, at 10:45 AM revealed he was not aware the sprinkler heads were covered with insulation.</p> <p>Reference: NFPA 13 (1999 edition).</p> <p>4-6.1.4 Obstruction to Discharge. Automatic sprinklers shall not be obstructed by auxiliary devices, piping, insulation, and so forth, from detecting fire or from proper distribution of water.</p>	K 062		

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K 076 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the oxygen storage room as required. This deficient practice affected one (1) of six (6) smoke compartments, staff and approximately sixteen (16) residents. The facility has the capacity for 100 beds with a census of 97 the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 01/22/13 at 9:15 AM with the Director of Maintenance (DOM), five (5) oxygen cylinders were observed to be unsecured in the oxygen storage room. Combustibles were also observed within five (5) feet of the oxygen tanks. An interview with the DOM on 01/22/13 at 9:15 revealed he was unaware the oxygen tanks were unsecured. The</p>	K 076	Please See Attached		

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K 076	<p>Continued From page 3</p> <p>DOM stated he was unaware combustibles should not be within five (5) feet of oxygen tanks.</p> <p>Reference: NFPA 99 1999 edition</p> <p>4-3.1.1.2 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft.) above the floor as a precaution against their physical damage.</p> <p>4-3.5.2.2 2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly.</p> <p>4-5.1.1.1 Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.</p> <p>8-3.1.11.2 c. Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or incompatible materials by either: 1. A minimum distance of 20 ft (6.1 m), or 2. A minimum distance of 5 ft (1.5 m) if the entire storage location is protected by an automatic sprinkler system designed in accordance with</p>	K 076			

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K 076	Continued From page 4 NFPA 13, Standard for the Installation of Sprinkler Systems, or Storage for nonflammable gases greater than 3000 ft ³ (85 m ³) shall comply with 4-3.1.1.2 and 4-3.5.2.2.	K 076			

**Corbin Health and Rehabilitation
Annual Survey January 21-23, 2013
Plan of Correction**

K 062

- 1. The sprinkler heads observed to be covered by blown insulation have been cleared and cleaned to ensure there is no obstruction to prevent them from detecting fire or from proper distribution of water.**
- 2. The remaining sprinkler heads have been evaluated to ensure they are in reliable operating condition and that there are no obstructions to prevent them from detecting fire or from proper distribution of water.**
- 3. The Administrator in-serviced the Maintenance Manager on the importance of performing an ongoing annual evaluation of all sprinklers to ensure they are in reliable operating condition and that they are not obstructed by auxiliary devices, piping, insulation, and so forth, from detecting fire or from proper distribution of water. Evaluations will also be conducted as needed after any construction or maintenance work that could cause insulation to shift and therefore obstruct sprinklers. In addition to this, our facility has a contract with an outside contracted sprinkler inspector to conduct quarterly inspections and testing of our sprinkler system to ensure it is in reliable operating condition.**
- 4. The Maintenance Manager will bring sprinkler inspection reports before the CQI committee following testing by the contracted sprinkler inspector, annually, and after any maintenance project in which sprinklers could be affected for review. Any irregularities will be immediately corrected and reported to the CQI Committee for further review and follow-up.**
- 5. Completion Date: Feb 11, 2013**

**Corbin Health and Rehabilitation
Annual Survey January 21-23, 2013
Plan of Correction**

K 076

- 1. The unsecured oxygen tanks were immediately secured in the designated storage area. All combustibles were immediately removed from the oxygen storage area.**
- 2. All oxygen tanks are now being stored in proper holding containers and not stored within 5 feet of combustibles. Empty oxygen tanks which were in the facility from other agencies, often arriving with residents when admitted to facility, have been returned to the perspective DME companies. This provided for adequate storage in the segregated racks for oxygen tanks in storage area. The storage racks are marked indicating "Empty" or "Full," and provided secure holding racks which prevents them from being knocked over or falling. This secure storage area is protected by an automatic sprinkler system. All combustibles were removed from within a 5 feet area of oxygen tanks. In addition to this, an additional storage rack has been ordered to allow for extra tank storage in case needed.**
- 3. The Director of Nursing in-serviced all nursing staff on the proper procedure for storing full and empty oxygen tanks. The in-service also included keeping all combustible material from within 5 feet of the stored tanks.**
- 4. The Administrator and IC Clinical Coordinator conducted daily inspections of the oxygen storage room daily for one week. Hereafter, the inspections will be completed by the IC Clinical Coordinator and/or Director of Nursing three times weekly for one month, then once weekly for one quarter. Any irregularities will be immediately corrected and reported to the CQI committee for follow-up.**
- 5. Date of Completion: Feb 13, 2013.**