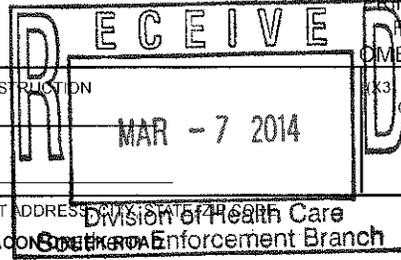


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

2nd SCD

PRINTED: 02/28/2014  
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  C 01/29/2014
NAME OF PROVIDER OR SUPPLIER  CORBIN HEALTH & REHABILITATION CENTER			STREET ADDRESS 270 BACON CREEK RD 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 01/27-29/14. Deficient practice was identified with the highest scope and severity at "D" level.  An abbreviated standard survey (KY21194) was also conducted at this time. The complaint was substantiated with deficient practice identified at "D" level.	F 000			
F 253 SS=D	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 facility policy, it was determined the facility failed to provide maintenance and housekeeping to maintain a sanitary, orderly, and comfortable interior. Observations during the survey on 01/27/14, 01/28/14, and 01/29/14 revealed the base of the cabinet sink and baseboard in the smoke room located on the 100 hallway had rough/sharp edges. In addition, the flooring and baseboards in resident rooms 101 and 209 were observed to be dirty during the survey on 01/27/14, 01/28/14, and 01/29/14.  The findings include:  A review of the facility's Policies/Protocols (not dated) revealed any staff member could complete the Continuous Quality Improvement (CQI) Referral form (not dated) and give the completed	F 253	See attached		

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

TITLE

(X6) DATE

*[Signature]* Administrator

3/7/14

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 253	<p>Continued From page 1</p> <p>form to their Department Head. According to the policy/protocol, the Department Head was required to give the completed form to someone in the Maintenance Department to request repairs.</p> <p>A review of the Daily Housekeeping Assignment Sheet (not dated) revealed all floors must be mopped, free from debris, and all baseboards were to be cleaned after the floors had been buffed. The sheet revealed the housekeeper was to turn in the form at the end of the shift, and by signing the sheet the housekeeper stated that all work was completed.</p> <p>Observations of the smoke room during the environmental tour on 01/27/14, 01/28/14, and 01/29/14 revealed the area located at the base of the sink where the cabinet and baseboard met was rough with sharp edges. In addition, observation of the hallways between the 100 Unit and the 200 Unit revealed the baseboards were dirty and in need of cleaning. Observation of room 101 on 01/28/14 at 10:55 AM, 3:25 PM, 6:20 PM, and 01/29/14 at 8:25 AM and 9:30 AM revealed the floor was dirty and a rubber glove was observed on the floor underneath a chair located in the corner of the room. Observation of room 209 on 01/29/14 at 1:15 PM and 2:30 PM revealed a buildup of dirt on the baseboards and debris on the floor.</p> <p>Interview with Housekeeper #1 on 01/29/14 at 10:05 AM revealed the floors in the facility were to be swept and mopped on a daily and as needed basis; and all of the resident rooms and bathrooms were to be cleaned by Housekeeping. Housekeeper #1 was in the process of cleaning resident room 101, and agreed there was a</p>	F 253		

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F 253	Continued From page 2 buildup of dirt and debris on the floor.  Interview with Housekeeper #2 on 01/29/14 at 10:10 AM revealed resident rooms, as well as common rooms and offices, were cleaned daily and the floors were to be swept and mopped by the housekeepers. Housekeeper #2 was in the process of cleaning resident rooms during the interview, and said the floors were dirty and "sticky."  The Housekeeping Supervisor stated in interview conducted on 01/29/14 at 10:40 AM that she "made rounds" daily and "spot" checked rooms for cleanliness, and had not identified any problems. The Housekeeping Supervisor acknowledged the floors/baseboards in resident rooms 101 and 209 were dirty and needed to be cleaned. According to the Housekeeping Supervisor, baseboards were cleaned once a month after the floors had been cleaned and buffed. Interview with the Housekeeping Supervisor revealed the baseboards probably need to be cleaned more often than monthly.  Interview with the Maintenance Director on 01/29/14 at 1:25 PM revealed Department Heads made "rounds" daily and submitted requests of any area that was in need of repair to the Maintenance Department. The Maintenance Director stated he was unaware of the rough, sharp edges on the base of the sink cabinet in the bathroom located in the smoke area, and acknowledged the base of the sink cabinet needed to be repaired.	F 253		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	See Attached	

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F 282	<p>Continued From page 3</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:</p> <p>Based on interview, record review, and review of the facility policy, it was determined the facility failed to ensure staff followed the care plan for one of twenty sampled residents (Resident #20). Staff failed to conduct an accurate weekly skin assessment for Resident #20 as directed by the Plan of Care.</p> <p>The findings include:</p> <p>Review of the facility policy entitled Care Plan and Protocol (revised August 2012) revealed a care plan was developed for each resident with measurable objectives to meet a resident's medical and nursing needs.</p> <p>A review of Resident #20's medical record revealed the resident was admitted from the local hospital on 12/30/13 with diagnoses that included Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Chronic Bronchitis, Chronic Pain, Hypertension and Anxiety/Depression, and a history of Myocardial Infarction.</p> <p>A review of the Comprehensive Care Plan for Resident #20, dated 01/07/14, revealed skin assessments were to be completed weekly and as needed.</p> <p>A review of the initial assessment completed by</p>	F 282			

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F 282	<p>Continued From page 4</p> <p>Licensed Practical Nurse (LPN) #3 on 12/30/13 revealed the resident had ecchymotic (bruised) areas to hands, arms, face, abdomen, and lower extremities. Documentation revealed the resident's abdomen was soft and non-tender and his/her bowel sounds were active in all four quadrants.</p> <p>A review of the initial skin assessment completed 12/30/13 of Resident #20 by LPN #3 revealed "Skin warm and dry with natural color, capillary refill less than 20 seconds, skin turgor within normal limits, ecchymotic areas noted to hands, arms, legs, abdomen, and face. Redness noted to buttocks but is blanchable; scab noted to right shin is healing. No open areas or breakdown areas noted."</p> <p>A review of a weekly skin assessment conducted on 01/04/14 of Resident #20 by LPN #3 revealed "Skin assessment complete. Skin warm and dry with natural color, capillary refill less than 20 seconds, skin turgor within normal limits, no open areas, redness, or open areas noted. Ecchymotic spots to both arms, and hands, and skin intact."</p> <p>A review of the local Emergency Room (ER) report for Resident #20, dated 01/06/14 at 2:55 PM, revealed, "Blackened adhesive noted on patient's chest in the approximate position cardiac leads were placed during [his/her] last hospital stay. One cardiac lead of the same type used in this facility present upon arrival on patient's right lower chest. The lead was removed by the ER staff. ER staff removed the leads that Emergency Medical Services (EMS) used with no blackened areas around those leads, and EMS crew verified the leads were applied in route to the hospital." The ER note</p>	F 282		

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F 282	<p>Continued From page 5</p> <p>further revealed, "An arm band with the patient's information was present from the 12/30/13 hospital visit on the patient's arm upon arrival to the ER."</p> <p>Certified Nursing Assistant (CNA) # 5 acknowledged in an interview conducted on 01/28/14 at 1:50 PM the cardiac lead documented by the ER staff to be located on the resident's right lower chest on the visit of 01/06/14 was present on Resident #20's right chest wall while at the facility from 12/30/13 through 01/06/14. The CNA stated she saw the "sticky skin patch" and thought it was a pain patch for the resident. CNA #5 stated, "We are taught not to remove the patches from residents' skin, so I left the patch alone." CNA #5 stated, "I just washed right over the top of the patch and never said anything to the nurses; I thought they had put it on the resident."</p> <p>Interview with LPN #3 on 01/28/14 at 2:12 PM revealed he had conducted the initial and weekly assessments for Resident #20 upon, and during, the resident's admission to the facility on 12/30/13. LPN #3 stated upon admission Resident #20 had numerous bruises to arms, legs, and abdomen, and pictures were taken. However, LPN #3 stated he did not see the cardiac lead to the right chest wall on 12/30/13 during the initial assessment or on 01/04/14 during the weekly skin assessment. LPN #3 stated a head to toe approach was required for the skin assessments, and did not know why he had not observed the cardiac lead on the initial assessment or the weekly assessment.</p> <p>Interview with the Director of Nursing (DON) and the Administrator on 01/29/14 at 2:15 PM</p>	F 282		

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F 282	Continued From page 6 revealed the nursing supervisors, the DON, and the Administrator conducted "rounds" daily to ensure care was provided to residents. According to the DON and Administrator, "rounds" included "spot checks" of CNAs and nurses while they performed their duties. The DON stated nurses were required to conduct a "head to toe" assessment of each resident on a weekly basis, and were to use a "head to toe" approach, paying close attention to areas of concern. According to the DON, it was the nurse's responsibility to remove armbands or "patches" from residents and would not be the responsibility of the CNAs to remove them. The DON stated she was not aware staff had failed to remove the cardiac leads from the resident or why staff had failed to identify and/or document the presence of the leads when they had conducted the initial or weekly skin assessment.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of facility policy, and review of documentation from a hospital, the facility failed to provide the necessary care and services to promote the	F 309	See Attached		

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F 309	<p>Continued From page 7</p> <p>highest practical, physical wellbeing for one of twenty sampled residents (Resident #20). Resident #20 was admitted to the facility on 12/30/13 from the hospital. On 01/06/14, Patient #20 was transferred to the hospital and, based on documentation, hospital staff noted Resident #20 continued to have the hospital identification bracelet and a cardiac lead on the right chest wall that had been used during the resident's hospitalization prior to the resident's admission to the facility. The cardiac lead was observed to have a blackened, sticky substance around the circumference of the lead.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Skin Ulcers (not dated) revealed all residents admitted to the facility would have a complete skin assessment with documentation of any known or potential risks of skin breakdown. The policy further revealed upon admission or readmission to the facility, all residents would receive a head to toe assessment for identification of any skin condition. According to the policy, the nurses were to make a notation of any areas in the nurse's note, initiate a skin integrity assessment form, and assess the resident at least one time per week utilizing the skin integrity assessment.</p> <p>Review of Resident #20's medical record revealed the resident was admitted from a hospital on 12/30/13 with diagnoses that included Chronic Obstructive Pulmonary Disease, History of Myocardial Infarction, Coronary Artery Disease, Chronic Bronchitis, Chronic Pain, Hypertension, and Anxiety/Depression.</p> <p>A review of the admission notes on 12/30/13 at</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>3:00 PM written by Licensed Practical Nurse (LPN) #3 revealed the resident arrived by EMS from the local hospital. The LPN documented the resident's skin was warm and dry to touch and his/her vital signs were within normal limits. A skin assessment was conducted and noted the resident had bruising to hands, arms, face, abdomen, and lower extremities. In addition, documentation revealed the resident complained of a sore in the mouth and could not eat or swallow.</p> <p>A review of an initial nursing assessment completed by LPN #3 on 12/30/13 and a nursing assessment on 01/04/14 revealed the resident did not have any open areas on the skin, had bruised areas to the arms, hands, and abdomen, and the resident's skin turgor was within normal limits.</p> <p>However, documentation revealed staff transferred Resident #20 to the hospital on 01/06/14 due to the resident's request. A review of the hospital Emergency Room (ER) report revealed on 01/06/14 at 2:55 PM, staff observed "an arm band with the patient's information was present from the 12/30/13 hospital visit on the patient's arm upon arrival to the ER." The ER report also revealed, "One cardiac lead of the same type used in this facility was present upon arrival on the patient's right lower chest. The lead was removed by the ER staff. Blackened adhesive was noted on the patient's chest in the approximate position cardiac leads were placed during [his/her] last hospital stay."</p> <p>Interview with Certified Nurse Aide (CNA) #5 on 01/28/14 at 1:50 PM revealed from 12/30/13 through 01/06/14, she had observed a "sticky skin</p>	F 309			

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F 309	Continued From page 9 patch" on the resident's chest and "thought it was a pain patch" for the resident. CNA #5 stated, "I just washed right over the top of the patch and never said anything to the nurses; I thought they had put it on the resident." CNA #5 stated, "We are taught not to remove any pain patches from residents' skin, so I left the patch alone."  Interview with LPN #3 on 01/28/14 at 2:12 PM revealed upon admission on 12/30/13, Resident #20 had numerous bruises to arms, legs, and abdomen, and pictures were taken. However, LPN #3 stated she did not see a cardiac lead to the resident's right chest wall during the initial assessment on 12/30/13 or on 01/04/14 during the weekly skin assessment. LPN #3 stated a head to toe approach was required for the skin assessments, and stated she did not know why the cardiac lead was missed on the initial assessment or the weekly assessment.  Interview with the Director of Nursing (DON) and the Administrator on 01/29/14 at 2:15 PM revealed "spot checks" were conducted of CNAs and nurses while they performed their duties. The DON acknowledged CNAs were not required to remove hospital armbands or patches from residents but should report them to the nurses in order for the nurses to remove the items. The DON stated nurses were to conduct weekly skin assessments and did not know why the nurse had not observed the armband or the cardiac lead.	F 309		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each	F 514	See Attached	

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F 514	<p>Continued From page 10</p> <p>resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility policy, record review, and interview, it was determined the facility failed to maintain an accurate clinical record for one of twenty sampled residents. Resident #10's code status changed from Do Not Resuscitate (DNR) to Full Code status on 06/03/13. However, the current physician's order for the DNR status was not located in the resident's medical record and, as a result, was not readily accessible to facility staff.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Protocol for Initiating Cardiopulmonary Resuscitation (CPR) dated October 2013 revealed facility staff should verify the code status/advanced directive information prior to initiation of CPR to ensure resident's wishes were followed.</p> <p>A review of the medical record for Resident #10 revealed the facility admitted the resident on 01/14/11 with diagnoses including Hypertension, Coronary Artery Disease, Anxiety, Depression,</p>	F 514		

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F 514	<p>Continued From page 11</p> <p>Psychiatric Disorder, and Hypothyroidism. A review of a physician's telephone order dated 06/03/13 revealed Resident #10 requested to be made a "Full Code" status, and the physician and resident's responsible party were notified at that time. Continued review of the medical record revealed current physician's orders dated 01/14/14 that also noted Resident #10 had a "Do Not Resuscitate" (DNR) status. In addition, the medical record contained the emergency medical services (EMS) DNR consent form signed by the responsible party (RP) on 05/13/13. However, on 01/28/14, observation of the inside cover of the resident's medical record revealed the resident was a "Full Code" status.</p> <p>An interview was conducted with Licensed Practical Nurse (LPN) #6 at 1:25 PM on 01/27/14. The LPN stated Resident #10 was a "Full Code" status. The LPN stated the facility had all residents' code status documented in a red notebook at the nurses' station.</p> <p>Observation of the red notebook at 1:25 PM on 01/27/14 revealed Resident #10 was noted to be a "Full Code."</p> <p>An interview was conducted with LPN #7 at 2:30 PM on 01/27/14. The LPN stated the physician's telephone order dated 06/03/13 had been removed from the resident's medical record and placed in the Medical Records Department for storage before facility staff had transferred the order to the physician's orders in the medical record.</p>	F 514		

## **Corbin Health and Rehabilitation**

### **POC**

#### **F253**

- 1. The floors and baseboards in rooms 101 and 209 have been cleaned. The cabinet in the smoke room has been temporarily fixed with rough/sharp edges filed smooth. A new cabinet has been ordered to replace the cabinet in the smoke room and will be installed as soon as it arrives.**
- 2. In order to ensure necessary housekeeping and maintenance services are providing and maintaining a sanitary, orderly and comfortable interior, a full inspection of all resident access areas, including resident rooms, hallways and common areas, was conducted with no discrepancies found.**
- 3. An in-service with housekeeping staff was completed on January 31, 2014 by the housekeeping supervisor reviewing and educating staff on the steps that must be completed each day in the cleaning routine, and the importance of ensuring necessary housekeeping and maintenance services are always provided to maintain a sanitary, orderly and comfortable interior. Further, an in service with all staff was completed outlining the CQI referral form process for any maintenance or other needs.**
- 4. In order to ensure that necessary housekeeping and maintenance services are provided to maintain a sanitary, orderly and comfortable interior, the CQI designees, (Housekeeping Supervisor and Administrator), will conduct a full inspection of all resident access areas, including resident rooms, hallways, and common areas five days weekly for one month, then three times weekly for three months. Any areas needing cleaned will be addressed immediately. Any area in need of repair will be reported immediately to the maintenance supervisor. Any equipment in need of repair will be removed immediately from use. All findings will be reviewed by the CQI committee monthly.**
- 5. Completion date: February 28, 2014**

**Corbin Health and Rehabilitation  
POC**

**F282**

- 1. Resident no longer resides at facility.**
- 2. The plan of care for each resident was reviewed to determine that the resident is receiving care in accordance by their written plan of care by qualified personnel. Additionally, a thorough skin assessment was completed on each resident by Administrative Nursing staff to verify accurate and complete skin assessment & documentation. There were no discrepancies found.**
- 3. An in-service with all nursing staff was completed on February 7, 2014 by the Director of Nursing and on February 6, 2014 by Administrator to address the need to ensure that each resident was receiving care in accordance with the residents' written plan of care. Specifically, the procedure for completion of a thorough skin assessment, the need for accurate documentation, and following the resident's individualized plan of care was reviewed. An in-service was also conducted with all nurse aides on February 6, 2014 by Administrator emphasizing the importance of providing care in accordance with the residents' plan of care and reporting to nursing staff any irregularities or questionable areas seen on resident's skin while providing care.**
- 4. CQI Committee designee (Clinical Coordinators) will conduct random audits of residents' plan of care and make observations to ensure that care is being provided in accordance with the plan of care. This audit will also include the CQI representative completing a full skin assessment on the resident to verify accuracy of completed skin assessment. These audits will be completed on five residents per unit each week for one month, then five residents per unit per month for three months. Any irregularities will be reported to the CQI committee.**
- 5. Completion date: February 28, 2014**

## Corbin Health and Rehabilitation

POC

F309

1. Resident no longer resides in facility.
2. The medical record for each resident has been reviewed to ensure that each resident is receiving the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. There were no discrepancies found.
3. An in-service with all nursing department staff was completed on February 7, 2014 by Director of Nursing and again on February 6, 2014 by Administrator regarding the importance of providing the necessary care and services to attain or maintain the highest practical physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The in-service also addressed the importance of providing thorough skin assessments and accurate documentation, reporting abnormal findings immediately to nurse and/or MD to ensure care and services are provided to attain/maintain highest practical well-being as outlined in the plan of care.
4. The CQI designee (Clinical Coordinators) will conduct random audits of resident's medical record, as well as make direct observations, to ensure residents are receiving care and services to attain/maintain the highest practicable level of physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Audits will be completed on five residents per unit each week for one month, then five residents per unit per month for three months. Any irregularities will be reported to the CQI committee.
5. Completion date: February 28, 2014

**Corbin Health and Rehabilitation  
POC**

**F514**

- 1. The physicians' order for Resident #10 was corrected immediately to reflect correct code status. Facility staff met with Resident #10 and resident's guardian to ensure code status was correct.**
- 2. A review of all resident's records was completed to ensure that each resident record is being maintained in accordance with professional standards and practices, that the records are complete, and accurately documented and is reflective of the residents' assessments, plan of care and services provided. Additionally, specific emphasis was placed on verification of the accuracy & documentation of the code status of each resident.**
- 3. An in-service was conducted on January 31, 2014 by Administrator with all nursing staff, including clinical coordinators, to emphasize the importance of ensuring that resident's records are being maintained in accordance with professional standards and practices, that the records are complete, and accurately documented and is reflective of the residents' assessments, plan of care and services provided. Specific emphasis was placed on verification of the accuracy & documentation of the code status of each resident.**
- 4. The CQI designee, (Clinical Coordinator) will review all new admission and readmission to ensure that the resident's records are being maintained in accordance with professional standards and practices, that the records are complete, and accurately documented and is reflective of the residents' assessments, plan of care and services provided. Specifically, code status will be reviewed to ensure accurately documented in the physician's orders and in all appropriate areas. This will be an ongoing procedure to ensure the clinical record of each resident is in accordance with the accepted professional standard of practices. Any irregularities will be corrected immediately and reported to the CQI Committee.**
- 5. Completion date: February 28, 2014**

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

PRINTED: 02/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185366</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/28/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CORBIN HEALTH &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>270 BACON CREEK ROAD CORBIN, KY 40702</b>
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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 01/28/14. 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 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all	K 064	<div data-bbox="954 1050 1364 1365" data-label="Image"> </div> <p>See Attached</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>C. M. [Signature]</i>	TITLE  <i>Administrator</i>	(X6) DATE  <i>2/21/14</i>
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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 064	<p>Continued From page 1</p> <p>health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the kitchen had signage in place for the proper use of the Class-K portable fire extinguisher. This deficient practice affected one of six smoke compartments and staff. The facility has the capacity for 100 beds with a census of 97 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 01/28/14 at 9:50 AM with the Director of Maintenance (DOM), a Class-K portable fire extinguisher located in the kitchen area was observed not to have signage near the extinguisher for the proper use of the extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system.</p> <p>An interview on 01/28/14 at 9:50 AM with the DOM revealed he was aware this extinguisher was required to have the proper signage in place; however, the DOM stated the signage must have been removed at some time.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 10 (1998 Edition).</p> <p>2-3.2.1 A placard shall be conspicuously placed</p>	K 064			

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K 064	Continued From page 2 near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.	K 064			
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the safety of residents, staff, and other occupants of the building by allowing unapproved portable space heating units in office areas. This deficient practice affected one of six smoke compartments, staff, and approximately 15 residents. The facility has the capacity for 100 beds with a census of 97 on the day of the survey.  The findings include:  During the Life Safety Code tour on 01/28/14 at 9:35 AM with the Director of Maintenance (DOM), a portable space heater was observed in the 100 Unit supervisor's office. Facilities must provide factory documentation that the heater is approved for use in these areas.  An interview with the DOM on 01/28/14 at 9:35 AM revealed he was aware of the requirements for the proper use of portable space heaters;	K 070	<i>See Attache d</i>		

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K 070	Continued From page 3 however, he did not know the heater was in use in this office.	K 070			
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical power strips were being used in an approved manner. This deficient practice affected one of six smoke compartments, staff, and approximately 15 residents. The facility has the capacity for 100 beds with a census of 97 on the day of the survey.  The findings include:  During the Life Safety Code survey on 01/28/14, at 9:40 AM with the Director of Maintenance (DOM), a patient bed was observed to be plugged into a multi-outlet adapter (power strip) in resident room 107. Generally, power strips with surge protection may be used for resident TVs, computers, radios, etc., on an as needed basis but not to be used with medical equipment or high draw appliances to help prevent against electrical shock and fire.  An interview on 01/28/14, at 9:40 AM with the	K 147	<i>See Attached</i>		

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K 147	<p>Continued From page 4</p> <p>DOM revealed he was aware power strips could not be used with medical equipment; however, he was not aware a power strip was being used in a resident room.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D</p> <p>2. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147			

**Corbin Health and Rehabilitation  
POC**

**K064**

- 1. The correct signage explaining the proper use of the Class-K portable fire extinguisher was obtained and permanently mounted in the kitchen area on January 31, 2014. The signage indicated that the Class-K extinguisher is to be used as a secondary measure to the range hood extinguisher system.**
- 2. All other signage is correctly placed in appropriate areas.**
- 3. An in-service was conducted on February 3, 2014 by dietary manager with the kitchen staff regarding the new signage and ensuring their understanding of the procedures for using the range hood extinguisher and the primary source to extinguish a fire and the Class-K extinguisher as a secondary measure. Staff were also instructed to notify supervisory staff immediately if there was any damage to or if the signage were to become displaced.**
- 4. The CQI designee (Dietary Manager) will check signage weekly to ensure that it remains in place. This will be an ongoing measure.**
- 5. Completion date: Feb 28, 2014**

**Corbin Health and Rehabilitation  
POC**

**K070**

1. The space heater was immediately removed from facility due to the prohibition of space heating devices in all health care occupancies.
2. All other areas were checked and no other concerns were identified.
3. An in-service was conducted February 21, 2014, by maintenance supervisor and Administrator with all staff informing them of the prohibition of space heater devices within this facility.
4. To ensure the use of space heaters does not reoccur, the CQI designees (Housekeeping Supervisor and Administrator) will make a full facility inspection five days weekly for one month and then three days weekly for three months. Any space heater devices found will be immediately removed from facility and event will be reported to the CQI Committee for further follow up.
5. Completion date: February 28, 2014

**Corbin Health and Rehabilitation  
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**K147**

1. The power strip was immediately removed from resident's room and all medical equipment was plugged into appropriate designated electrical outlets. On February 3, 2014, more electrical outlets were installed in resident's room to provide adequate access to electricity for resident's multiple electronics. Resident was educated not to remove or change outlet use for any medical equipment and to contact facility staff with any future needs in this area.
  
2. All areas of the facility were checked for power strips and inappropriate use of electrical outlets. No other concerns were identified.
  
3. In-services were conducted with Housekeeping staff on January 31, 2014 by Housekeeping Supervisor and with all housekeeping staff on February 21, 2014 by Maintenance Supervisor. The in-services reviewed the importance of reporting to Maintenance or Housekeeping Supervisor any use of power strips observed within the facility and the need for them to observe electrical outlets daily to ensure all medical equipment is plugged into appropriate outlets.
  
4. The CQI designee (Housekeeping or Maintenance Supervisor) will make a full facility inspection five days per week for one month and then three days per week for three months. Any power strip devices found in inappropriate use will be immediately removed from facility and event will be reported to the CQI Committee for further follow up.
  
5. Completion date: Feb 28, 2014