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

PRINTED: 09/23/2010
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
OCT - 8 2010
Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185366		C 09/09/2010

NAME OF PROVIDER OR SUPPLIER
CORBIN NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
270 BACON CREEK ROAD, P O BOX 1190
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 September 7-9, 2010. Deficient practice was identified with the highest scope and severity at "F" level. An abbreviated standard survey (KY15039) was also conducted at this time. The allegation was unsubstantiated with no deficient practice identified related to the allegation.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined the facility failed to ensure three (3) of twenty (20) sampled residents (residents #6, #14, and #17) received activities based on the identified interests and needs of the resident. The findings include: 1. Review of the medical record revealed resident #6 was admitted to the facility on June 4, 2010, with diagnoses that included Aphasia, Cerebral Vascular Accident, Dysphagia, and Senile Dementia. Review of the comprehensive admission assessment for resident #6, dated as completed on June 15, 2010, revealed the resident had been assessed to be severely	F 248	**PLEASE SEE ATTACHMENT**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: C L Messer
TITLE: Administrator
(X6) DATE: 10/8/10

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 248	Continued From page 1 cognitively impaired and to require extensive assistance from staff for all activities of daily living. Review of the activity assessment for resident #6 revealed the resident had been assessed to be involved in activities from one-third to two-thirds of the time while awake. The resident was assessed to have the television on for auditory stimulation and enjoyed activities in the resident's room. Review of the activity documentation contained in the medical record of resident #6 dated August 13, 2010, August 15, 2010, and August 24, 2010, revealed the resident had a television in the room for audio stimulation and the facility would continue to offer audio stimulation. Observations of resident #6 on September 7, 2010, from 2:45 p.m. to 5:34 p.m., and on September 8, 2010, from 10:20 a.m. to 1:00 p.m., revealed the resident to be in the room in bed with eyes closed. Resident #6's bed was adjacent to the hallway door and the resident could not visualize the roommate's area of the room. The resident had no television or radio present in the room. Resident #6's roommate was observed to watch his/her personal television with the audio off. The roommate's television was not in the line of sight for resident #6. Interview on September 8, 2010, at 1:00 p.m., with the facility Activities Director (AD) revealed the AD was unaware the resident did not have a television. According to the AD, the resident's roommate had a television that was on continuously. The AD was unaware the roommate did not have the audio on when watching television. The AD stated he/she conducted one-to-one conversations with the	F 248		

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F 248	Continued From page 2 resident but had no documentation to verify the activity. 2. Review of the medical record of resident #14 revealed the resident had been admitted to the facility on August 2, 2009, with diagnoses of Diabetes Mellitus, Atherosclerotic Heart Disease, Cerebral Vascular Accident, and Encephalopathy. Review of the significant change comprehensive assessment for resident #14 dated as completed January 9, 2010, revealed the resident had been assessed to have modified independence with decision-making and required the extensive assistance of one to two staff members for the activities of daily living other than eating. The resident was assessed to be involved in activities one-half to two-thirds of the time while awake. The resident was assessed to enjoy the activities of watching television and talking or conversing. Review of the individual resident activities log for resident #14 for August and September 2010 revealed staff documented that the resident viewed television daily. Observations of resident #14 on September 8, 2010, from 9:10 a.m. to 11:10 a.m., revealed resident #14 in the resident's room in a wheelchair reading a book. The resident's room did not contain a television. Interview with resident #14 on September 8, 2010, at 10:45 a.m., revealed resident #14 did not have a television in the room and had not had a television since admission to the facility. According to resident #14, he/she did not enjoy watching television. Interview with the AD on September 9, 2010, at 10:40 a.m., revealed the AD had assumed	F 248		

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F 248	Continued From page 3 resident #14 had a television and viewed the television on a daily basis. 3. Review of the medical record revealed resident #17 was admitted to the facility on May 19, 2010, with diagnoses of Pituitary Dwarfism, Acute Respiratory Failure, and Anoxic Brain Injury secondary to a drug and alcohol overdose. Review of the Quarterly MDS dated August 30, 2010, revealed the facility assessed resident #17 as being in a comatose state and to be totally dependent on staff for all aspects of care. Further review of the Quarterly MDS revealed the facility assessed resident #17 as being involved in activities one-third to two-thirds of the time. Review of the Initial Activity Assessment (not dated) revealed the facility had failed to complete the form related to resident #17's individual interests. The form only contained general information such as resident #17's name, birthday, date of admission, diagnoses, and that resident #17 was comatose, nonverbal, and required total care. The section of the Initial Activity Assessment that addressed previous living arrangements, former occupation, education, voting interests, religious preference, past and current interests, resident quotes, cognition, and communication had been left blank. Review of the Social Service Progress Notes dated May 20, 2010, revealed a sound machine was placed at resident #17's bedside for audio stimulation. Review of the individual resident activities sheet dated August 2010 revealed staff had documented that resident #17 listened to a radio and television independently.	F 248		

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F 248	Continued From page 4 Observation on September 9, 2010, at 9:30 a.m., 10:30 a.m., and 11:30 a.m., revealed resident #17 did not have a television and the sound machine was not on. A family interview conducted on September 9, 2010, at 9:55 a.m., with resident #17's father revealed resident #17 had been a professional wrestler, traveled nationally, loved most sports, slept during the day, and stayed awake at night. Interview on September 9, 2010, at 1:30 p.m., with the Activities Director (AD) revealed the AD was responsible for completing the Initial Activity Assessment and making entries on the Social Service Progress Notes. Upon review of resident #17's Initial Activity Assessment, the AD stated due to lack of time the AD had failed to contact the family regarding the information required on the activity form. The AD stated the AD was aware resident #17 had been a professional wrestler prior to admission to the facility; however, the AD had not considered providing tapes or audio of wrestling for resident #17. The AD was not aware that resident #17 liked most sports and the AD did not know that resident #17 did not have a television.	F 248		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to meet professional standards of quality for one (1)	F 281	**PLEASE SEE ATTACHMENT**	

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F 281	Continued From page 5 of twenty (20) sampled residents. Resident #1 received a medication not ordered by the resident's physician. The findings include: Observation of the medication pass on the IC Unit on September 7, 2010, at 3:35 p.m., revealed the Charge Nurse (CN) administered Ativan 0.5 milligram, Carvedilol 3.125 milligrams (blood pressure medication), Metoprolol 50 milligrams, Dilantin 200 milligrams, and Clonidine 0.1 milligram orally to resident #1. The CN obtained a blood pressure of 134/70 and a pulse of 72 beats per minute prior to administering the medication. Observation further revealed the CN failed to reconcile the medication with the Medication Administration Record (MAR) to assure resident #1 received the right physician-ordered medications. Review of the medical record revealed resident #1 was admitted to the facility on January 22, 2010, with diagnoses to include Hypertension, Senile Dementia, Seizure Disorder, Cerebral Aneurysm, Chronic Obstructive Pulmonary Disease, Depression, and Aphasia. A review of the physician's orders for resident #1 dated September 1, 2010, revealed the resident did not have an order for Carvedilol to be given, nor was Carvedilol noted on the MAR. An interview with the CN on September 7, 2010, at 4:15 p.m., revealed he/she looked in the resident's medication drawer and found two additional doses of Carvedilol 3.125 milligrams (blood pressure medication) in the box labeled Clonidine 0.1 milligram. The CN was unaware of how the medication had gotten in the drawer.	F 281		

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F 281	Continued From page 6 The CN stated he/she felt the medication could have gotten into the wrong box from the pharmacy. The CN further stated the CN was unsure how it actually happened but was aware he/she should have looked more closely at the medications and the Medication Administration Record (MAR). The CN further stated it was the facility policy to notify the resident's physician as well as the responsible party if a resident received the wrong medication. A review of the facility's Medication Administration Policy revealed the policy directed nurses that if there was any doubt concerning the administration of a medication, the physician's order must be verified before the medication was administered. The policy did not address the five rights of medication administration to include the right drug, right dose, right route, right time, and right patient, to prevent medication errors, which is a standard for medication administration, and can be found on the internet written by Lippincott, Williams, and Wilkins with a copyright date of 2010.	F 281		
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 and record review, the facility	F 309	**PLEASE SEE ATTACHMENT**	

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F 309	Continued From page 7 failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of twenty (20) sampled residents. The facility failed to follow the bowel elimination protocol for resident #12. The findings include: Review of resident #12's medical record revealed the resident was admitted to the facility on August 14, 2009. Diagnoses included Diabetes Mellitus, Hyperlipidemia, Chronic Airway Obstruction, Hypertension, Cerebrovascular Accident, Hemiparesis, Depression, Anxiety, Left Hip Replacement, and a history of Chronic Constipation. Review of the Quarterly Minimum Data Set (MDS) dated May 10, 2010, revealed the facility assessed resident #12 as having modified independence in cognition, to require the extensive assistance of two staff persons for bed mobility and transfer, to require the extensive assistance of one staff person for dressing and hygiene, and to be totally dependent on staff with bathing. Resident #12 was assessed as incontinent of bowel and bladder. Review of the bowel incontinence assessment dated August 24, 2009, revealed upon admission the resident had a history of bowel incontinence, was incontinent once a day or less, and produced soft formed stool. Review of resident #12's output record for May 2010 showed no bowel movement for four days, May 23-26, 2010. A small firm/formed bowel movement was documented for resident #12 on May 27, 2010, then for the next three days no bowel movements were recorded.	F 309		

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F 309	Continued From page 8 Review of the facility bowel care protocol revealed the nurse on the third shift (10:00 p.m. shift) was required to review the intake and output records at the end of the shift and make a list of residents who needed bowel care. Residents that had not had a bowel movement recorded for three days were to be placed on the bowel care list. The first shift (6:00 a.m. shift) medication aide and/or nurse was required to review the list daily and initiate the bowel care regimen. The bowel care regimen stated that on the first shift the resident would receive oral laxatives during the first medication pass, if ordered by the physician. If the resident had no bowel movement by the second shift, a laxative suppository would be administered to the resident at the beginning of the shift, if ordered by the physician. If the resident still had no bowel movement, the third shift would provide a soap suds enema for the resident, if ordered by the physician. If after these interventions the resident had no bowel movement, the physician would be consulted for additional orders. Review of resident #12's physician's orders dated May 2010 revealed an order for milk of magnesium to be given to this resident as needed for constipation and a soap suds/fleets enema to be given as needed for constipation. Review of the treatment administration record (TAR) for May 2010 revealed no documentation that milk of magnesium was administered to resident #12; however, an enema was administered to the resident on May 19, 2010. Interview on September 9, 2010, at 1:30 p.m., with the licensed practical nurse (LPN) who worked the third shift (10:00 p.m. to 6:00 a.m.) and provided care for resident #12 on May 25,	F 309		

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F 309	Continued From page 9 2010 and May 26, 2010, revealed it was the responsibility of the third shift (10:00 p.m. to 6:00 a.m.) nurse to review the bowel movements for each resident. The LPN further stated if no bowel movement was recorded for a resident for three days the resident was put on the bowel care list. The LPN further stated that the day shift (6:00 a.m. to 2:00 p.m.) nurse was responsible to review residents who were added on the bowel care list and to initiate treatment per the bowel care protocol. Further interview with the LPN revealed a bowel care form was completed in May 2010 for resident #12 after three days of no bowel movement. However, the facility could not provide evidence of a bowel care form for resident #12 during the month of May 2010. Review of the nursing notes for May 2010 revealed no record of interventions provided for resident #12 during the month of May 2010 concerning bowel movements, and no documentation of the physician being notified of resident #12's lack of a bowel movement for four days. Interview with the Unit Manager on September 8, 2010, revealed no record of resident #12 being on the bowel care list for the month of May 2010. Interview on September 9, 2010, at 2:15 p.m., with the Unit Manager further revealed no documentation was found in the resident's medical record concerning interventions provided in May 2010, in regard to the resident's multiple days with no bowel movement.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	**PLEASE SEE ATTACHMENT**	

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F 323	Continued From page 10 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain an environment free of accident hazards over which the facility had control for one (1) of twenty (20) sampled residents (resident #4). The findings include: Review of the medical record for resident #4 revealed the resident was readmitted to the facility on June 14, 2010, with diagnoses of Insulin Dependent Diabetes Mellitus, Osteoarthritis, and Anxiety. Review of the Significant Change in Status Assessment (SCSA) dated June 18, 2010, revealed the facility assessed resident #4 as having modified independence in daily decision-making. Review of the RAPS dated June 17, 2010, revealed resident #4 was alert and oriented with occasional confusion. Observation of resident #4's room on September 8, 2010, at 10:00 a.m. and 1:05 p.m., revealed two four-pound cartons of Epsom Salt had been placed on top of the resident's night stand. Review of the monthly physician's orders for September 2010 revealed no physician's order for Epsom Salt for resident #4.	F 323		

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F 323	Continued From page 11 Interview on September 8, 2010, at 1:05 p.m., with resident #4 revealed the Epsom Salts were used to bathe the resident's feet to help reduce the swelling and pain in the resident's feet and legs. Resident #4 stated the Epsom Salts were purchased by a family member. Review of a store receipt revealed the Epsom Salt was purchased on August 30, 2010. Resident #4 stated the CNAs would fill a wash basin with warm water and add the Epsom Salt to the water so the resident could soak his/her feet. Interview on September 8, 2010, at 1:05 p.m., with CNA #1 revealed the CNAs prepared a wash basin with warm water and added approximately two tablespoons of Epsom Salt to the warm water for resident #4 to soak the resident's feet. The CNA stated the treatment was not on the assignment sheet but the CNAs did the treatment when the resident asked. CNA #1 stated the CNAs had prepared the Epsom Salt soaks for resident #4 for approximately eight months. Interview on September 8, 2010, at 2:00 p.m., with LPN #1, who was responsible for resident #4's care, revealed the LPN was not aware that the CNAs had prepared Epsom Salt soaks for resident #4. LPN #1 stated residents should not have medications at the bedside. Interview on September 8, 2010, at 2:05 p.m., with the Unit Manager (UM) revealed the UM was not aware of Epsom Salt being stored at resident #4's bedside. The UM identified the Epsom Salt as a drug which required a doctor's order for resident use. The UM stated the nurses were responsible for any medication administration and/or treatment for residents.	F 323		

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F 323	Continued From page 12 Review of the information on the carton of Epsom Salt revealed a toxin warning label which identified that the product should be kept out of children's reach and to call the Poison Control Center if ingestion occurred. Review of the facility's Material Safety Data Sheet (MSDS) book revealed no information related to Epsom Salt/Magnesium Sulfate had been included in this book.	F 323		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the foods served during the evening meal for the 100 Hall residents on September 7, 2010, were palatable and served at the proper temperatures to prevent foodborne illness. The findings include: Observation of the evening meal service revealed the first closed unheated meal cart was transferred from the kitchen to the main dining room on September 7, 2010, at 5:20 p.m. The first 100 Hall cart was delivered to the floor at 5:40 p.m. After residents in the dining room were served, facility staff was observed to remove resident trays from the dining room cart and place	F 364	**PLEASE SEE ATTACHMENT**	

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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 364	Continued From page 13 them on the first 100 Hall cart. The last tray was served from the 100 Hall cart at 5:50 p.m., and food temperatures were obtained. The food temperatures obtained from a mechanical soft dinner tray removed from the cart at 5:50 p.m. on September 7, 2010, were as follows: Hot Dog - ground meat was 112 degrees Fahrenheit and tasted tepid, the Mashed Potatoes were 116 degrees Fahrenheit and tepid when tasted, the Baked Beans were 110 degrees Fahrenheit and tasted tepid, and the 2% Milk was 55 degrees Fahrenheit and tasted warm. A review of the facility policy/procedure related to Meal Pass (not dated) revealed hot foods were required to be served at 135 degrees Fahrenheit or above and cold foods were required to be served at 41 degrees Fahrenheit or below. An interview conducted with the Registered Dietitian (RD) on September 7, 2010, at 5:55 p.m., revealed the facility staff should have delivered the food trays to the resident rooms from the initial food cart rather than transferring the trays to the other cart. The RD stated random food temperatures were obtained from the meal service and no problems had been identified related to inappropriate food temperatures.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**PLEASE SEE ATTACHMENT**	

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	185366		C 09/09/2010

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F 371	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of facility logs, it was determined the facility failed to ensure food was stored at the required temperature in the walk-in freezer. The freezer was observed on September 7, 2010 and September 8, 2010, to have a temperature above zero (0) degrees Fahrenheit. This failure affected ninety-five (95) of the one hundred (100) residents who received their meals from the facility's kitchen (five residents received gastrostomy tube feedings). The findings include: Observations on September 7, 2010, at 10:50 a.m., revealed the temperature of the walk-in freezer located in the facility's kitchen was 38 degrees Fahrenheit. The freezer was monitored by a temperature gauge on the outside of the freezer. Observation revealed there was no thermometer on the inside of the freezer. Observation of the walk-in freezer on September 8, 2010, at 3:05 p.m., revealed the temperature gauge on the outside of the freezer had a reading of 30 degrees Fahrenheit and a thermometer on the inside of the freezer also read 30 degrees Fahrenheit. Observations of the individual ice cream containers stored in the back of the freezer revealed the ice cream was not frozen solid. The ice cream had not melted but was of a soft consistency. Review of the temperature logs maintained by the facility revealed from September 1, 2010 to	F 371		

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F 371	Continued From page 15 September 7, 2010, the freezer temperature had read from -3 degrees Fahrenheit to -4 degrees Fahrenheit each day. Interview with the facility Registered Dietitian (RD) on September 8, 2010, at 10:15 a.m., revealed the freezer was required to maintain a temperature of 0 degrees Fahrenheit or below. The RD was not aware the freezer had not been maintaining the required temperature. A follow-up interview with the RD on September 9, 2010, at 9:45 a.m., revealed the facility maintenance personnel had determined the freezer had been set for defrost mode. According to the RD, the staff was unaware the freezer was in defrost mode or how the freezer came to be in defrost mode. Interview with the facility cook on September 8, 2010, at 10:15 a.m., revealed the facility had placed a thermometer inside the freezer on September 8, 2010, and the temperature at the start of the day had been -4 degrees Fahrenheit. According to the cook, for the last several days the temperature in the freezer had been within acceptable limits (0 degrees or below) at the beginning of the day but rose during the day. The cook had not reported the rising freezer temperatures to Maintenance.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431	**PLEASE SEE ATTACHMENT**	

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F 431	Continued From page 16 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to label all drugs and biologicals in accordance with currently accepted professional principles. The facility had one (1) vial of open (in use) insulin that did not have the date when the vial was opened written on the bottle. The facility also had a multi-dose bottle of Bacteriostatic 0.9% Sodium Chloride opened, with no date on the bottle indicating when the bottle was opened.			

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F 431	Continued From page 17 The findings include: Observation of the facility's medication room on the IC Unit of the facility on September 9, 2010, at 10:30 a.m., revealed Bacteriostatic 0.9% Sodium Chloride in a multi-use vial, sitting in a tray on the counter. The bottle was opened and available for use; however, the vial did not contain a date to indicate when the bottle was opened. An interview was conducted with the Unit Manager (UM) for the IC Unit of the facility on September 9, 2010, at 1:55 p.m. The UM revealed he/she did not know why the bottle of Bacteriostatic 0.9% solution had not been dated after being opened. The UM further revealed if a medication or flush was opened the nurse would be required to date the bottle when it was opened if the bottle was to be used for multiple doses. Observation of the facility's medication room on the Skilled Unit of the facility on September 9, 2010, at 11:15 p.m., revealed a bottle of Novolin 70/30 Insulin was opened, available for use, and did not contain a date to indicate when the bottle was opened. An interview was conducted with the UM for the Skilled Unit on September 9, 2010, at 1:45 p.m. The UM stated the bottle of Novolin 70/30 Insulin had been sent with the resident from another facility, and should have been discarded. The UM further stated it was the facility's policy to date any bottle of medication that had been opened and was available for multi-use. A review of the facility policy that addressed Insulin Expiration revealed staff was required to	F 431		

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F 431	Continued From page 18 date the vial at the time the vial was first punctured for withdrawal of a dose. The facility was asked for a policy regarding the dating of multi-use bottles of medication for injection or flush. The Corporate Nurse stated the facility had no policy regarding the dating of multi-use bottles of medication or solutions used for flushing of intravenous lines or for injection.	F 431		
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. (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	F 441	**PLEASE SEE ATTACHMENT**	

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F 441	Continued From page 19 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 review of facility policy, it was determined the facility failed to maintain an effective infection control program. Observation during wound care revealed staff failed to wash/sanitize hands before providing a treatment, after removing gloves during the treatment, after completing the treatment, and between resident contact for one (1) of twenty (20) sampled residents (resident #4). The findings include: Observation on September 8, 2010, at 10:00 a.m., revealed LPN #1 provided wound care to resident #4. LPN #1 failed to wash/sanitize hands prior to providing treatment to resident #4. LPN #1 removed a soiled dressing from resident #4's right buttock. LPN #1 removed the gloves from his/her hands after removing the soiled dressing and donned a second pair of gloves but failed to wash/sanitize the hands after removing the soiled gloves. LPN #1 completed the wound care and failed to wash/sanitize hands after the wound care was completed. Further observation revealed LPN #1 then transported resident #4 via wheelchair to the Physical Therapy Department. Continued observation revealed LPN #1 hugged a resident sitting in the hallway and proceeded on	F 441		

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F 441	Continued From page 20 to greet another resident and touched that resident's arm. Interview on September 8, 2010, at 10:25 a.m., with LPN #1 revealed the LPN was knowledgeable of the requirement that hands should be washed between glove changes and between resident contact. LPN #1 stated the LPN was nervous and forgot to wash his/her hands. Interview on September 8, 2010, at 10:35 a.m., with the UM revealed hands were to be washed between resident contact and any time gloves were removed to prevent cross-contamination and transmission of germs. Review of the facility's policy entitled Guidelines for Hand Hygiene (not dated) directed staff to wash hands before having direct contact with a resident and after removing gloves.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Chipped corners on walls needing repair were observed in twelve (12) resident rooms. A dripping faucet was observed	F 465	**PLEASE SEE ATTACHMENT**	

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F 465	Continued From page 21 in one (1) resident bathroom. Torn sheetrock was observed in two (2) resident bathrooms. A hole in the sheetrock was observed in one (1) resident room. Torn walls were observed in two (2) resident rooms. Torn chair covers were observed in six (6) resident rooms. One (1) resident room contained a nightstand with a handle missing. One (1) resident bathroom was observed to have a broken soap dispenser. Two (2) resident bathrooms were observed to have stained tile. One (1) resident bathroom was observed to have a broken towel rack. One (1) resident bathroom door was observed to be sticking and scraping the floor. Two (2) resident rooms were observed to have chipped doors. A raised hump in the hallway with cracked tile was observed. Trim was missing beside a door at the end of a hallway. The findings include: Observations of the facility from September 7-9, 2010, revealed the following areas were in need of maintenance/ housekeeping services: 1. The bathroom sink in resident room 101 was observed to be continuously dripping. 2. Resident rooms 103, 105, 107, 117, 202, 203, 212, 215, 216, 222, 224, and 226 were observed to have chipped sheetrock in the corners. 3. Resident rooms 104 and 123 were observed to have torn sheetrock in the bathrooms. 4. Resident room 106 was observed to have a hole in the sheetrock inside the door. 5. Resident rooms 106 and 216 were observed	F 465		

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F 465	Continued From page 22 to have torn sheetrock on the wall, at the head of the beds. 6. Resident rooms 114, 116, 117, 126, 203, and 212 all were observed to have chairs with torn seat covers. 7. Resident room 116 was observed to have a nightstand with a handle missing from the bottom drawer. 8. Resident room 118 was observed to have a broken soap dispenser in the bathroom. 9. Resident room 119 was observed to have rust-colored stained tile in the bathroom behind the toilet. 10. Resident room 124 was observed to have gray stains on the floor tile in the bathroom. 11. Resident room 119 was observed to have a broken towel rack in the bathroom. 12. Resident rooms 224 and 226 both were observed to have chipped doors. 13. Resident room 200 was observed to have a bathroom door sticking and scraping the floor. 14. The hallway in front of resident rooms 121 and 122 was noted to have a raised area in the floor across the entire hallway with the floor tile observed to be cracked. 15. The trim at the end of the hallway by the outside door beside resident room 215 was observed to have a piece missing on the bottom on the right side of the door.	F 465		

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F 465	Continued From page 23 An interview was conducted with the Maintenance Supervisor (MS) and the Housekeeping Supervisor (HS) on September 9, 2010, at 2:15 p.m. The MS stated he/she did make maintenance rounds on a regular basis and if staff found any areas needing repair they were required to complete a maintenance request form and send it to the Maintenance Department. The HS stated he/she made random checks of residents' rooms daily; however, he/she did not check every room.	F 465		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and clinical record review, it was determined the facility failed to maintain an accurate clinical record for one (1) of twenty (20) sampled residents (resident #14). The findings include:	F 514	**PLEASE SEE ATTACHMENT**	

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F 514	Continued From page 24 Observations of resident #14 on September 7, 2010, at 9:10 a.m., revealed the resident to be in bed receiving morning care from staff. The resident was observed to have two full side rails in the raised position. Resident #14 used the side rails to move in the bed to assist staff with care. A review of the medical record of resident #14 revealed the resident was admitted to the facility on August 2, 2009, with diagnoses that included Diabetes Mellitus, Arteriosclerotic Heart Disease, Cerebral Vascular Accident, and Encephalopathy. Review of the comprehensive significant change assessment for resident #14, dated January 9, 2010, revealed the resident was assessed to use the side rails to increase bed mobility. Review of the Minimum Data Set (MDS) for resident #14 revealed under section P4 Devices and Restraints the facility had not documented the resident's use of side rails. Review of the quarterly assessment for resident #14 dated as completed on August 3, 2010, revealed no documentation of the resident's use of side rails. Interview on September 9, 2010, at 10:05 a.m., with the MDS Coordinator responsible for the completion of resident #14's assessments revealed the resident did use the side rails to assist with bed mobility. According to the MDS Coordinator, the MDS Coordinator had not coded the use of side rails for resident #14 because the MDS Coordinator did not consider the side rails a restraint. Interview with the Director of Nursing (DON) on September 9, 2010, at 10:50 a.m., revealed the MDS for resident #14 had been coded incorrectly. The DON stated the side rails were in use for the resident and should have been coded.	F 514		

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

PRINTED: 09/23/2010
FORM APPROVED
OMB NO. 0938-0391

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Corbin Health and Rehabilitation Center

Plan of Correction

Annual Survey

September 7-9, 2010

F 248 483.15(f)(1) Activities Meet Interests/Needs of Each Resident

SS=D

1. Resident # 6 has television in room and it is being played at various times throughout the day for audio stimulation. AD is documenting one-to-one conversations with resident. A radio also provided for resident for audio stimulation and is played at various times throughout the day. Resident # 14 has television in room for use as desired. Resident #17 has television in room where sports and other programs can be played for audio stimulation. A sound machine is also in use for audio stimulation at various times throughout the day. The Activities Assessment for resident #17 has been completed with assistance from family.

2. Reviews of all residents Activities Assessments were done to ensure they were fully completed. All rooms were also checked to ensure that appropriate forms of entertainment/stimuli were present.

3. The Administrator provided in-service training with the Activities Director regarding the importance of fully completing Activities Assessment in order to provide the most appropriate activities and stimulation for each resident. Nursing assistants were also in-serviced on the importance of activities of interest for each residence including, but not limited to, listening to the radio, sound machine, or television.

4. The QA Committee will monitor the in room activity preferences and review activity assessments of five residents weekly to ensure their activities of interest are being provided one month, and then monthly for the next three months. Any irregularities will be corrected immediately and reported to the QA Committee for further review.

5. September 17, 2010

Corbin Health and Rehabilitation Center

Plan of Correction

Annual Survey

September 7-9, 2010

F 281 483.20(k)(3)(i) Services Provided Meet Professional Standards

SS=D

1. Resident #1 is receiving all medications as ordered per nurse following appropriate administration guidelines. The physician and responsible party were notified immediately of resident receiving incorrect medication. The resident was monitored per physician orders and blood pressure was check regularly to ensure there were no adverse effects until medication had time to be inactive.

2. All resident's medications were checked for accuracy.

3. The Director of Nursing and Administrator in-serviced all nursing staff regarding the appropriate protocol and guidelines to be followed with medication administration. This in-service included reconciling medication with Medication Administration Record to assure residents received the correct physician-ordered medication. In-service also covered the five rights of medication administration. The in-service was completed with all nursing staff and medication aides by September 10, 2010. All nurses have been scheduled to view a medication administration video on proper medication administration.

4. The QA committee designee will observe 4 nurses or medication aides administering medications per week for one month, then monthly for one quarter. These audits will focus specifically on the 5 rights of medication administration which include the right drug, the right dose, the right route, right time and the right resident. Any irregularities will be corrected immediately and reported to the QA committee for further review.

5. October 15, 2010

Corbin Health and Rehabilitation Center

Plan of Correction

Annual Survey

September 7-9, 2010

F 309 483.25 Provide Care/Services For Highest Well Being

SS=D

1. Resident #12 is receiving appropriate bowel output monitoring and intervention as needed per bowel elimination protocol.

2. All residents were reviewed to ensure bowel protocol was followed and intervention was initiated as needed.

3. Bowel output records for all residents were reviewed to ensure the bowel protocol was followed and intervention was initiated if needed. All nursing staff was in-serviced by unit supervisors on correct bowel elimination protocol including notifying physician, initiating interventions when needed, and correct documentation of interventions. In-services were completed by September 10, 2010.

4. The QA designee will monitor the bowel output records of all residents daily for one week, weekly for one month and then monthly for the quarter. Any irregularities will be addressed immediately and then reported to the QA committee for review.

5. September 10, 2010

Corbin Health and Rehabilitation Center

Plan of Correction

Annual Survey

September 7-9, 2010

F 323 483.25(h) Free of Accident Hazards/Supervision/Devices

SS=D

1. Epson Salt was immediately removed from Resident #4's room. Physician's order for use was obtained and Epsom salt was labeled and put in medication room. MSDS was obtained for Epsom salt and placed in MSDS manual.

2. All rooms throughout the facility were checked to ensure no medications were in any other rooms.

3. All staff were in-serviced by Administrator on protocol prohibiting any medication being kept in resident's room including prescribed medication or over-the-counter medication.

4. A letter was composed and given to resident and/or sent to resident's responsible parties explaining medication including over-the-counter medications should not to be taken to residents in there room. Furthermore, if any such medication was brought to the facility it should be given immediately to nurses for physician notification. The QA committee designee will randomly check 5 rooms weekly for one month and then monthly for one quarter to ensure protocol regarding medications in resident's rooms is followed. Any irregularities will be addressed immediately and reported to the QA committee for review.

5. October 1, 2010

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September 7-9, 2010

F 364 483.35(d)(1)-(2) Nutritive Value/Appear, Palatable/Prefer Temp

1. All food trays are being delivered to residents with food meeting appropriate temperatures.
2. All residents receiving meals from the kitchen at our facility could have been affected by this deficiency.
3. Trolley cards were developed for each food cart where kitchen staff document the time it leaves the kitchen and nurse aides document what time last tray was removed to be given to residents. Dietary staff was in-serviced by RD regarding appropriate time frames for food delivery and use of trolley cards. Nurse aides were also in-serviced on use of trolley cards and acceptable time-frame for tray delivery. RD evaluated meal delivery and completed temperature checks to ensure appropriate temperatures were being maintained.
4. Dietary manager will complete three weekly temperature checks on randomly selected trays to ensure appropriate temperatures are maintained. This will be completed on a regular basis. Any irregularities will be addressed and corrected immediately and reported to the QA committee for review.
5. September 17, 2010

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September 7-9, 2010

F 371 483.35(i) Food Procure, Store/Prepare/Serve-Sanitary

1. Freezer temperatures are being maintained at or below zero degrees Fahrenheit.

2. All residents who receive meals from the facility kitchen could have potentially been affected by this deficiency. All freezers and refrigerators were checked to ensure they were at appropriate temperature.

3. The Maintenance Director evaluated freezer. If was found that freezer was in defrost mode. Maintenance corrected this setting. All dietary staff were in-serviced on September 10, 2010, to report any temperature above acceptable range to dietary manager, maintenance director, or administrator immediately.

4. A temperature log will be kept for dietary aides to check and record temperatures twice daily. In addition to the routine twice daily temperature checks by dietary aides, the Dietary Manager will complete random checks of freezer temperature to ensure freezer temperature remains within acceptable range. Any irregularities will be reported to maintenance for evaluation and reported to the QA committee for review.

5. September 10, 2010

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September 7-9, 2010

F 431 483.60(b), (d), (e) Drug Records, Label/Store Drugs and Biologicals

1. All opened vials of medication not properly dated were disposed of immediately. All open vials of medication are now properly dated.

2. The medication rooms on both units were checked to ensure all opened vials were properly dated.

3. Unit Supervisors in-serviced all nursing staff and medication aides on proper protocol for dating any vial of medication opened for multiple uses.

4. Unit Supervisor and/or DON will check med rooms daily for one week, weekly for one month and then monthly to ensure proper dating of all multi-use vials of medication when opened. The QA designee will also conduct random checks of each med room to ensure protocol for dating multi-use vials of medication is followed. Any irregularities will be corrected immediately and reported to the QA committee for review.

5. September 10, 2010

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September 7-9, 2010

F 441 483.65 Infection Control, Prevent Spread, Linens

1. Resident #4 is receiving wound care with nurses following all appropriate infection control standards including washing hands before care, after removing gloves and after wound care is complete.

2. All residents in the facility could have potentially been affected by this deficiency.

3. An in-service was conducted with all nursing staff by Unit Supervisors regarding proper hand washing/glove changing techniques, including washing hands before care, after removal of gloves and after care is complete. In-services were completed by September 10, 2010.

4. The QA designee will observe wound care for 2 residents per week for one month, then one resident per week for the quarter to ensure proper infection control standards are utilized including appropriate hand washing throughout procedure. Any irregularities will be corrected immediately and will be reported to the QA committee for further review.

5. September 10, 2010

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September 7-9, 2010

F 465 483.70(h) Safe/Functional/Sanitary/Comfortable Environment

SS=E

1. The bathroom sink leak in resident room 101 was fixed on September 9, 2010.

   Corner guards have been ordered for not only rooms 103,105,107, 117, 202, 203, 212, 215, 216, 222, 224, and 226, but also for all other resident rooms to ensure protection from chipping if bumped by wheelchairs. The torn sheetrock in the bathrooms of resident rooms 104 and 123 has been repaired. The hole in the sheetrock beside the door in room 106 has been repaired. The torn walls in rooms 106 and 216 have been repaired. The chairs in rooms 114, 116, 117, 126, 203, and 212 have been sent out to be re-upholstered. The missing handle on night stand in room 116 has been replaced. The soap-dispenser in the bathroom of room 118 has been replaced. Flooring to replace stained flooring in bathrooms of rooms 119 and 124 has been ordered. The broken towel bar in room 119 was immediately removed and has been replaced. The bathroom door that dragged floor in room 200 has been repaired. Door edge guards have been added to chipped areas of doors for room 224 and 226. Tile has been ordered to replaced the raised bump/cracked tile in front of rooms 121 and 122. The missing trim at the end of the hallway by room 215 has been replaced.

2. The maintenance and housekeeping supervisors have checked the entire facility to ensure safe, functional, sanitary and comfortable environment is maintained.

3. All staff were in-serviced on September 17, 2010, on the importance of reporting any needed repairs to maintenance immediately for repair and completing a work order. Maintenance director to complete daily rounds to check facility for needed repairs. Housekeeping Assistant Supervisor to make daily rounds in all resident rooms to ensure all areas are in good repair.

4. The QA Committee designee will check five rooms from various halls weekly for one month and then five rooms per month for 3 months to ensure all areas are in good repair. Any irregularities will be corrected immediately or reported to maintenance director for repair.

5. October 22, 2010

Corbin Health and Rehabilitation Center

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September 7-9, 2010

F 514 483.75(l)(1) Res Records-Complete/Accurate/Accessible

SS=D

1. Resident #14 now has half bed rails on bed to assist with bed mobility and MDS has been checked to code bedrail use under section P4.
2. All residents with bedrail use have been re-assessed and MDS reviewed for appropriate coding.
3. Administrator and DON have in-serviced Unit Supervisors, nursing staff, and MDS staff on proper bed rail assessment and MDS coding.
4. The QA designee will review three residents weekly for one month and then monthly to ensure proper assessment documentation of bed rails if in use.
5. September 17, 2010