

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

PRINTED: 05/04/2015
FORM APPROVED
OMB NO. 0938-0391

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|---|---|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185386 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/20/2015 |
| NAME OF PROVIDER OR SUPPLIER CORBIN HEALTH & REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 279 BACON CREEK ROAD CORBIN, KY 40702 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENTS | F 000 | | |
| F 225 SS=D | <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance</p> | F 225 | - See attached. | |

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

Rebecca A. Hill

TITLE

Administrator

(X6) DATE

5-15-15

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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185368 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 04/20/2015 |
| NAME OF PROVIDER OR SUPPLIER CORBIN HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 270 BACON CREEK ROAD CORBIN, KY 40702 | | |
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| F 225 | <p>Continued From page 1</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy and facility investigation, it was determined the facility failed to ensure all alleged violations involving mistreatment, neglect, or abuse were reported immediately to the Administrator and other officials in accordance with state law for one (1) of three (3) sampled residents (Resident #1). Resident #1 reported an allegation of abuse to State Registered Nurse Aide (SRNA) #1 on 04/20/15 at 1:50 PM. The SRNA immediately reported the allegation to Licensed Practical Nurse (LPN) #1. However, the LPN failed to report the allegation to administrative staff or to other state agencies as required by facility policy.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Abuse Policy," last revised December 2011, revealed all allegations which involved mistreatment, neglect, or abuse including injuries of unknown source or misappropriation of resident property would be reported immediately. The policy stated staff was to report allegations to the Director of Nursing and/or the Administrator and to other officials in accordance with state law, including the state survey and certification agency.</p> <p>Review of the medical record for Resident #1</p> | F 225 | - See attached. | | |

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| F 225 | <p>Continued From page 2</p> <p>revealed the facility admitted the resident on 01/15/14 with diagnoses that included Dementia and Anemia. Review of the resident's quarterly Minimum Data Set Assessment (MDS), dated 03/25/15, revealed staff assessed that Resident #1 required extensive assistance with transferring and bathing. The assessment further revealed Resident #1 had moderately impaired cognitive skills and was not interviewable, with a Brief Interview for Mental Status (BIMS) score of 99.</p> <p>Interview with SRNA #1 on 04/20/15 at 1:50 PM revealed Resident #1 had stated to the SRNA that he/she was "going to find that black man and kill him" and that he/she had "never been grinded on like that in eighty-two (82) years." The SRNA acknowledged the resident's statement was an allegation of abuse, and stated she notified the nurse (later identified as LPN #1) immediately of the resident's allegation.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 at 12:30 PM on 04/20/15 confirmed she had been notified of Resident #1's allegation on 04/12/15. The LPN stated she had not notified administrative staff as required because "there was no black man on the unit" at the time the allegation was voiced.</p> <p>Interview with the facility's Nurse Consultant on 04/20/15 at 1:15 PM revealed Resident #1's allegation was identified from a review of the facility's Incident reports on 04/14/15 (2 days after the resident had voiced the allegation to facility staff). The nurse consultant stated she reported the allegation to state agencies and began an investigation, as required, when she identified the resident's allegation.</p> | F 225 | - See attached. | | |

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| NAME OF PROVIDER OR SUPPLIER CORBIN HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 270 BACON CREEK ROAD CORBIN, KY 40702 | | |
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| F 225 | Continued From page 3 Interview with the facility Administrator on 04/20/15 at 3:15 PM revealed staff had been trained to report all allegations to administrative staff immediately. The Administrator stated staff should have reported the allegation voiced by Resident #1 immediately. | F 225 | - See attached. | | |