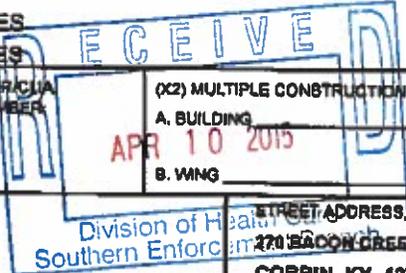


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/02/2015
FORM APPROVED
OMB NO. 0938-0391



| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/19/2015 |
|--|--|--|--|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER CORBIN HEALTH & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 270 BACON CREEK ROAD CORBIN, KY 40702 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| F 000 | INITIAL COMMENTS | F 000 | | |
| F 282 SS=E | <p>A standard health survey was conducted on 03/17-19/15. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for two (2) of twenty (20) sampled residents (Resident #3 and Resident #12). The facility developed a care plan with interventions for Resident #3 and #8's nails to be trimmed weekly. Observations on 03/18/15, during skin assessments for Resident #3 and Resident #12, revealed the residents' fingernails and toenails were long and in need of trimming.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Care Plan and Protocol," revised August 2012, revealed a care plan would be developed for each resident with measurable objectives to meet a resident's medical and nursing needs.</p> <p>1. Review of the medical record for Resident #12 revealed the facility admitted the resident on</p> | F 282 | - See attached. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca A. Fair TITLE: Administrator (X6) DATE: 4/10/15

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 60 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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| 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 282 | <p>Continued From page 1</p> <p>08/31/12, with diagnoses that included Parkinson's disease, Hypertension, and Acute Renal Failure. Review of a quarterly MDS for Resident #12 dated 12/30/14, revealed the resident required total assistance of one person for personal hygiene. Review of a plan of care for Resident #12 dated 07/17/14, revealed staff would check the resident's nail length, and trim and clean his/her nails weekly.</p> <p>Observation of a skin assessment for Resident #12 on 03/18/15, at 10:45 AM completed by Registered Nurse (RN) #1, revealed the resident was observed to have long fingernails and toenails that were in need of trimming. However, RN #1 was not observed to trim the resident's nails.</p> <p>Interview conducted with RN #1 on 03/19/15, at 1:30 PM, revealed she had placed Resident #12 on the list of residents to be seen by the podiatrist. The RN stated she was required to check a resident's fingernails and toenails when conducting a skin assessment. The RN stated she should have trimmed Resident #12's fingernails, but had not identified the fingernails were long and in need of trimming.</p> <p>4. Review of the medical record for Resident #3 revealed the facility admitted the resident on 12/12/06, with diagnoses that included Down's syndrome, Prostate Hyperplasia, and Contractures. Review of a quarterly Minimum Data Set (MDS) dated 03/02/15, revealed the resident required the total assistance of one person for personal hygiene. Review of the plan of care for Resident #3 dated 09/19/14, revealed nail care would be provided weekly.</p> | F 282 | - 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 282 | Continued From page 2 Observation of a skin assessment for Resident #3 completed by Licensed Practical Nurse (LPN) #1 on 03/18/15, at 2:40 PM, revealed the resident's toenails were long and in need of trimming. Interview conducted with LPN #1 on 03/19/15, at 2:45 PM, revealed she was responsible to ensure Resident #3's nails were trimmed. LPN #1 stated Resident #3's toenails were long and thick and would need to be trimmed by the podiatrist. Interview conducted with the Director of Nursing (DON) on 03/19/15, at 5:05 PM, revealed RN #1 should have trimmed Resident #12's nails when completing his/her skin assessment on 03/18/15. The DON stated LPN #1 should have placed Resident #3's name on the list of residents to be seen by the podiatrist. The DON revealed nurses were required to assess a resident's nails when conducting a weekly skin assessment. The DON stated she had not identified any concerns with nail care not being provided previously. | F 282 | - See attached. | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure necessary services to | F 312 | | |

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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 312 | <p>Continued From page 3</p> <p>maintain grooming and personal hygiene were provided for two (2) of twenty (20) sampled residents (Resident #3 and Resident #12). Observation on 03/18/15, during skin assessments for Resident #3 and Resident #12, revealed the residents' nails were long and in need of trimming.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Protocol for Nail Care," undated, revealed nail care would be provided weekly.</p> <p>1. Review of Resident #12's medical record revealed the facility admitted the resident on 08/31/12, with diagnoses that included Hypertension, Parkinson's disease, and Acute Renal Failure.</p> <p>Review of a quarterly Minimum Data Set (MDS) dated 12/30/14, revealed Resident #12 required the total assistance of one person for personal hygiene. Review of Resident #12's plan of care dated 07/17/14, revealed nursing staff would check the resident's nail length and trim and clean his/her nails weekly.</p> <p>Observation of a skin assessment for Resident #12 on 03/18/15, at 10:45 AM completed by Registered Nurse (RN) #1 revealed the resident's fingernails and toenails were long and in need of trimming. RN #1 did not trim the resident's nails during the skin assessment.</p> <p>Interview conducted with RN #1 on 03/18/15, at 1:30 PM, revealed she should have trimmed Resident #12's fingernails, but did not identify the fingernails were long and in need of trimming.</p> | F 312 | - 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 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 312 | <p>Continued From page 4</p> <p>RN #1 stated a podiatrist would have to trim the resident's toenails. The RN stated she was required to check a resident's fingernails and toenails when conducting a skin assessment.</p> <p>2. Review of Resident #3's medical record revealed the facility admitted the resident on 12/12/06, with diagnoses that included Contractures, Down's syndrome, and Prostate Hyperplasia.</p> <p>Review of a quarterly MDS dated 03/02/15, revealed Resident #3 required the total assistance of one person for personal hygiene. Review of Resident #3's plan of care dated 09/19/14, revealed nail care would be provided weekly.</p> <p>Observation of a skin assessment for Resident #3 completed by Licensed Practical Nurse (LPN) #1 on 03/18/15, at 2:40 PM, revealed the resident's toenails were observed to be long and in need of trimming.</p> <p>Interview conducted on 03/19/15, at 2:45 PM with LPN #1, revealed she was responsible to ensure Resident #3's nails were trimmed. The LPN stated Resident #3's toenails were long, thick, and hard to cut and would need to be trimmed by the podiatrist.</p> <p>An interview with the Director of Nursing (DON) on 03/19/15, at 5:05 PM, revealed RN #1 should have trimmed Resident #12's nails on 03/18/15. In addition, the DON stated Resident #3's name should have been placed on a list to be seen by the podiatrist. The DON revealed nurses were required to assess a resident's nails when conducting a weekly skin assessment. The DON</p> | F 312 | - See attached. | | |

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| F 312 | Continued From page 5 stated she had not identified any concerns with nail care not being provided. | F 312 | | |
| F 322 | 483.25(g)(2) NG TREATMENT/SERVICES - SS=D RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure residents who were fed by a gastrostomy tube received the appropriate services to ensure residents' tube feeding formula was labeled with the type of feeding and the date and time it was initiated for two (2) of twenty (20) sampled residents (Resident #8 and Resident #16). Observation on 03/17/15 of Resident #8 | F 322 | - See attached. | |

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| NAME OF PROVIDER OR SUPPLIER CORBIN HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 278 BACON CREEK ROAD CORBIN, KY 40702 | | |
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| F 322 | <p>Continued From page 6</p> <p>and Resident #16 revealed the residents' gastrostomy tube feedings were not labeled with the type of formula or the date and time the tube feeding was initiated.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Administration of Medications per Gastrostomy Tube Policy," undated, revealed the policy did not address labeling gastrostomy tube feedings. No other policy was provided by the facility. An interview with the Director of Nursing (DON) on 03/19/15, at 5:05 PM, revealed nursing staff should label all tube feeding bags or bottles with the type of tube feeding and the date and time the tube feeding was initiated.</p> <p>1. Review of the medical record for Resident #8 revealed the facility admitted the resident on 11/30/11 with diagnoses that included Hypertension, Senile Dementia, Congestive Heart Failure, Small Bowel Obstruction, Anemia, Depression, Anxiety, and Alzheimer's Disease.</p> <p>Review of a Quarterly Minimum Data Set (MDS) assessment dated 02/03/15 for Resident #8 revealed the resident had a gastrostomy tube feeding. Review of physician's orders for Resident #8 dated 03/01/15, revealed an order for the resident to receive TwoCal (nutritional supplement) at 80 milliliters per hour via gastrostomy tube.</p> <p>Review of the Comprehensive Care Plan for Resident #8, dated 03/04/15, revealed Resident #8 received TwoCal nutritional supplement at 80 milliliters per hour via gastrostomy tube for 14 hours from 8:00 PM to 10:00 AM per feeding</p> | F 322 | - 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 322 | <p>Continued From page 7 pump.</p> <p>Observation of Resident #8 on 03/17/15, at 8:25 AM and 9:51 AM revealed tube feeding was infusing via the resident's gastrostomy tube. However, the formula was not labeled as to the type of tube feeding or the date and time the tube feeding was initiated.</p> <p>2. Review Resident #16's medical record revealed the facility admitted the resident on 04/19/13, with diagnoses that included Cardiac Dysrhythmias, Alzheimer's, and Hypothyroidism.</p> <p>Review of a significant change in condition MDS assessment dated 12/31/14 revealed Resident #16 received gastrostomy tube feedings. Review of physician's orders dated 03/01/15, revealed an order for Osmolite 1.2 at 45 milliliters per hour via gastrostomy tube. Review of Resident #16's plan of care dated 01/08/15, revealed the nurse would ensure the resident was receiving the correct formula as it was ordered by the physician.</p> <p>Observation of Resident #16 on 03/17/15, at 8:35 AM, revealed Osmolite 1.2 was observed to be infusing via Resident #16's gastrostomy tube at 45 milliliters per hour. However, observation of the tube feeding bottle revealed the time the bottle was initiated was not documented on the bottle.</p> <p>Interview conducted with Registered Nurse (RN) #1 on 03/19/15, at 1:30 PM, revealed she had provided care for Resident #8 and Resident #16 on 03/17/15. The RN stated Resident #8's tube feeding bag should have been labeled with the tube feeding type and date and time the tube feeding was initiated, and did not know why it was</p> | F 322 | - See attached. | |

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| F 322 | Continued From page 8 not labeled. Interview conducted with the Director of Nursing (DON) on 03/19/15, at 5:05 PM, revealed nursing staff should label all tube feeding bags or bottles with the type of tube feeding as well as the date and time the tube feeding was initiated. The DON stated she made rounds several times daily throughout the facility and randomly checked tube feeding formula. The DON stated she had not identified any concerns with tube feeding bags or bottles not being labeled. | F 322 | - See attached. | | |

Corbin Health and Rehabilitation Center**Plan of Corrections****Annual Survey****March 17-19, 2015****F282**

1. Resident #3 and #12 are receiving appropriate nail care and services by nursing staff in accordance with the written plan of care.
2. The plan of care for each resident was reviewed by clinical coordinators for each unit to determine that the residents are receiving care, specifically nail care in accordance of their written plan of care by qualified personnel. Additionally, observations of all resident's nails were completed by clinical coordinators to verify that nail care services were being done in accordance with their written plan of care. No problems were identified.
3. Inservices were held with all nursing staff on 3/20/15 and 4/1/15 by Director of Nursing and Administrative Staff. The Inservices addressed the importance of following the written plan of care in regards to all care, with emphasis on nail care, grooming, and personal hygiene. Also on notification of MD for podiatry services if necessary.
4. The CQI Committee designee will conduct random audits of resident's plan of care and make observations to plan of care and their nail care to ensure the written plan of care is being followed by qualified personnel. These audits will be completed on five residents per unit each week for one month and then monthly for one quarter. Any concerns will be corrected immediately and reported to the CQI committee for further follow-up.
5. April 30th, 2015

Corbin Health and Rehabilitation Center**Plan of Correction****Annual Survey****March 17-19, 2015****F312**

1. Resident #3 and Resident #12's MD's were notified for podiatry consult and arrangements were made immediately and Resident #12's finger nails were trimmed immediately. Resident #3 and Resident #12 is receiving necessary care and services to maintain good grooming and personal hygiene.
2. All resident nails were checked by the clinical coordinator on each unit to ensure proper nail care was performed. Also residents were observed to ensure they were receiving necessary services to maintain good grooming and personal hygiene. No problems were identified.
3. Inservices were held with all nursing staff on 3/20/14 and 4/1/15 by Director of Nursing and Administrative Nursing staff to address the importance of providing all residents with necessary services to maintain good grooming and personal hygiene with emphasis on nail care protocol.
4. The CQI designee will observe five residents weekly for one month and then monthly for a quarter to ensure all residents are receiving necessary services to maintain good grooming and personal hygiene specifically, nail care. Any irregularities will be corrected immediately and reported to the CQI committee for further follow-up.
5. April 30, 2015

Corbin Health and Rehabilitation Center**Plan of Correction****Annual Survey****March 17-19, 2015****F322**

1. Resident #8 and Resident #16 is receiving the appropriate services to ensure residents' tube feeding formula is labeled with the type of feeding and the date and time it was initiated.
2. All residents who are fed by gastrostomy tube were checked per Clinical Coordinators to ensure all were receiving appropriate services and that the tube feeding formula is labeled with the type of feeding and the date and time it was initiated. No other problems were identified.
3. Inservices were held on 3/20/15 and 4/1/15 per Director of Nursing and Administrative Nursing for all Nursing staff regarding Tube Feeding protocol with an emphasis on ensuring residents' tube feeding formula is labeled with the type of feeding and the date and time it was initiated.
4. The CQI designee will conduct random audits of residents' who are fed by gastrostomy tube to ensuring the accurate tube feeding formula being labeled with the type of feeding and the date and time it was initiated by making observations and review of clinical record for accuracy of type of feeding, rate and frequency. These audits will be completed on five residents per week for one month and then monthly for one quarter. Any concerns will be corrected immediately and reported to the CQI committee for further follow-up.
5. April 30, 2015

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 183366 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 03/18/2015 |
| 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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| 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 SPRINKLERED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II natural gas generator A life safety code survey was initiated and concluded on 03/18/15. 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 "F" level. | K 000 | See attached. | |
| K 038 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily | K 038 | | |

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

Rebecca A. Vile

TITLE

Administrator

(X6) DATE

4/10/15

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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|---|---|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER CORBIN HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 270 BACON CREEK ROAD CORBIN, KY 40702 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| K 038 | Continued From page 1 accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that door-locking arrangements met National Fire Protection Agency (NFPA) requirements. This deficient practice affected two (2) of six (6) smoke compartments, staff, and approximately sixty-two (62) 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 03/18/15 at 8:50 AM, with the Director of Maintenance (DOM), a door leading to an exterior courtyard from the resident TV room was observed to have a slide bolt type latch mounted greater than 48 inches above the floor. An interview with the DOM on 03/18/15 at 8:50 AM revealed he was not aware of height requirements for door lock/latching devices. During the survey an additional resident TV room was observed to have a slide bolt style latch mounted greater than 48 inches above the floor. Reference: NFPA 101 (2000 Edition). 7.2.1.5.4* | K 038 | - See attached. | | |

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185366 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 03/18/2015 |
|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER CORBIN HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 270 BACON CREEK ROAD CORBIN, KY 40702 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| K 038 | Continued From page 2 A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations. | K 038 | <i>- See attached.</i> | |
| K 047 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that doors that could be mistaken for exits had signage stating that these doors were not exits. This deficient practice effected six (6) of six (6) smoke compartments and occupants of the building. 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 03/18/15 at 8:40 AM, with the Director of Maintenance (DOM), a door leading to an inner courtyard was observed not to have signage stating that this | K 047 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185366 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 03/18/2015 |
| NAME OF PROVIDER OR SUPPLIER CORBIN HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 270 BACON CREEK ROAD CORBIN, KY 40702 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| K 047 | <p>Continued From page 3</p> <p>was not an exit. "No Exit" signage is required on doors that are likely to be mistaken for an exit. During the survey six other doors leading to the inner courtyard were observed not to have the required "No Exit" signage.</p> <p>An interview with the DOM on 03/18/15 at 8:40 AM revealed he was not aware the "No Exit" signage had been removed.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approved existing signs.</p> <p>A.7.10.8.1 The likelihood of occupants mistaking passageways or stairways that lead to dead-end spaces for exit doors and becoming trapped governs the need for exit signs. Thus, such areas should be marked with a sign that reads as follows: NO EXIT</p> | K 047 | - See attached. | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186388 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 03/18/2016 |
|---|---|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER CORBIN HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 270 BACON CREEK ROAD CORBIN, KY 40702 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| K 047 | Continued From page 4 Supplementary identification indicating the character of the area, such as TO BASEMENT, STOREROOM, LINEN CLOSET, or the like, is permitted to be provided. (See A.7.10.2.) | K 047 | - See attached. | | |

Corbin Health and Rehabilitation Center**Life Safety Code Plan of Corrections****March 18, 2015****K038**

- 1. All slide bolt type latches in TV Rooms were immediately removed from doors.**
- 2. All doors leading to the exterior were checked per Director of Maintenance to ensure there was no slide bolt type latches mounted on any doors. No further latches were noted.**
- 3. Director of Maintenance and Administrator Inserved per Regional Director of Operations on March 20, 2015, regarding Life Safety Code Standard for latches or other fastening devices on a door shall be provided with a releasing device having an obvious method of operation and that the releasing mechanism for any latch shall be located not less than 34 inches and not more than 48 inches above the finished floor.**
- 4. The CQI designee will conduct random audits by visual observation of five facility exterior doors weekly for one month and then monthly for a quarter to ensure facility is meeting the national Fire Protection Agency requirements for door-locking arrangements. Any irregularities will be corrected immediately and reported to CQI committee for follow-up.**
- 5. April 30, 2015**

Corbin Health and Rehabilitation Center**Life Safety Code Plan of Corrections****March 18, 2015****K047**

- 1. All Exit doors to courtyards had "NO EXIT" signs displayed on them immediately.**
- 2. Director of Maintenance checked all doors to courtyard and any other door that could likely be mistaken for an exit to ensure a sign, "NO EXIT", was displayed. No further problems were identified.**
- 3. Director of Maintenance and Administrator were inserviced by Regional Director of Operations on March 20, 2015, on guidelines for appropriate signage to any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit.**
- 4. The CQI designee will conduct random audits on courtyard doors by visual observation to ensure proper signage is visible and correctly displayed. This will be done weekly for one month and monthly for a quarter. Any problems will be corrected immediately and reported to the CQI committee for further follow-up.**
- 5. April 30, 2015**