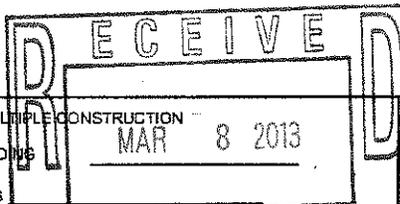


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185366	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 02/14/2013
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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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(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
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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>An abbreviated standard survey (KY19731) was initiated on 02/12/13 and concluded on 02/14/13. The complaint was substantiated with deficient practice identified at "D" level.</p> <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	Please See Attached	

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

[Signature]

TITLE

Administrator

(X8) DATE

3/8/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>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/procedure it was determined the facility failed to ensure an allegation of abuse was immediately reported to the Administrator of the facility for one of three sampled residents (Resident #1). State Registered Nurse Aides (SRNAs) #1 and #4 alleged that on 01/15/13 Licensed Practical Nurse (LPN) #1 verbally abused Resident #1. However, SRNAs #1 and #4 failed to report the allegation to Administration until 01/29/13.</p> <p>The findings include:</p> <p>A review of the facility's abuse policy, not dated, revealed all allegations of abuse were required to be reported immediately to the Director of Nursing (DON) and/or the Administrator.</p> <p>A review of the facility's abuse investigation dated 02/02/13 revealed on 01/29/13, SRNA #1 reported to the DON "concerns" regarding LPN #1. The report stated that on 01/15/13 LPN #1 told Resident #1 to "get in bed and [she/he] better stay there." The report further revealed SRNA #1 informed the DON that LPN #1 instructed staff not to assist Resident #1 back to the resident's</p>	F 225		

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F 225	<p>Continued From page 2</p> <p>room. Further review of the facility investigation revealed the DON immediately reported the allegation to the Administrator and LPN #1 was placed on suspension pending the investigation.</p> <p>A review of Resident #1's medical record revealed the facility admitted the resident on 01/08/13 with diagnoses including Hypertension and Senile Dementia. A review of the facility's assessment for Resident #1, dated 01/15/13, revealed the facility assessed the resident to be cognitively impaired, and an interview with the resident was not attempted.</p> <p>Interview with SRNA #1 on 02/12/13 at 7:24 AM revealed on 01/15/13 LPN #1 took Resident #1 to the resident's room and told the resident to "go to bed and not get back up." SRNA #1 stated LPN #1 spoke "inappropriately" to Resident #1.</p> <p>Interview with SRNA #1 further revealed later that same night Resident #1 was attempting to find his/her room and SRNA #3, who was training SRNA #1, informed her that LPN #1 had stated for staff not to take the resident to the resident's room and to let the resident find his/her own room. SRNA #1 stated the resident was very confused and begging staff to take/assist him/her to the room. SRNA #1 stated another SRNA did get up and assist the resident to the room. Further interview revealed SRNA #1 did consider LPN #1's actions toward Resident #1 to be abuse. SRNA #1 stated she did not inform the DON or Administrator of the incident until 01/29/13, 14 days later, because she had only been employed at the facility for 3 days and she had been "scared" to report the incident. SRNA #1 stated she had been trained by the facility on the requirements of reporting abuse and</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>acknowledged she should have reported the incident immediately.</p> <p>Interview with SRNA #4 on 02/13/13 at 9:39 AM revealed she had been in Resident #1's room on the evening of 01/15/13 when LPN #1 inserted an indwelling urinary catheter for the resident. SRNA #4 stated when the LPN inserted the catheter, the resident said it hurt and LPN #1 said, "I don't care if it hurts." SRNA #4 stated the LPN did not make the comment in a loud tone and was not sure if Resident #1 heard the LPN make the statement. In addition, SRNA #4 stated later that evening Resident #1 was attempting to find his/her room and SRNA #3 informed her that LPN #1 had told staff not to assist the resident back to the room and to let the resident find his/her room. SRNA #4 stated because she had not been told directly by LPN #1 not to assist Resident #1 to his/her room, she did not consider reporting the information as abuse. However, interview further revealed SRNA #4 thought the comment LPN #1 made related to the catheter hurting on the evening of 01/15/13 was abuse but did not report it because she was "afraid" due to being new at the facility.</p> <p>SRNA #3 stated in interview conducted on 02/13/13 at 7:30 PM that she did not recall LPN #1 telling staff not to assist Resident #1 back to his/her room on the evening of 01/15/13 and stated she did not tell staff that the LPN had instructed them not to assist the resident. Interview further revealed SRNA #3 had never heard LPN #1 speak inappropriately to Resident #1. In addition, SRNA #3 stated she had been trained on abuse by the facility and was aware if she observed abuse to report it immediately.</p>	F 225		

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F 225	Continued From page 4 SRNA #13 was identified as the SRNA that assisted Resident #1 back to his/her room on the evening of 01/15/13. Numerous attempts were made to contact SRNA #13 on 02/12/13 at 9:55 AM, and on 02/13/13 at 9:00 AM and 8:00 PM; however, the SRNA failed to return the calls. Interview with the DON on 02/12/13 at 10:21 AM revealed on 01/29/13 SRNA #1 called and informed her that she would not be back to work. When the DON asked SRNA #1 why she would not be back to work SRNA #1 told her of the alleged abuse that occurred on 01/15/13 with Resident #1 and LPN #1. The DON further stated after receipt of the call from SRNA #1 she immediately informed the Administrator of the allegation and placed LPN #1 on suspension during the investigation. The DON stated all staff was trained on the process of reporting abuse during their orientation. Interview with the Administrator on 02/12/13 at 6:00 AM revealed when the facility became aware of the incident they immediately reported the allegation to the state agencies. In addition, the Administrator stated all staff and residents were interviewed related to abuse and the care LPN #1 provided. The Administrator stated no staff or residents voiced any concerns related to abuse or the care LPN #1 had provided to the residents.	F 225			

**Corbin Health and Rehabilitation
Complaint Survey 2-14-13
Plan of Correction**

F 225

- 1. Resident #1 did not suffer any negative effects from this incident. The physician and responsible party were notified. The appropriate agencies are aware of the incident involving resident #1.**
- 2. The Administrator and Director of Nursing interviewed all staff and residents to ensure there were no other allegations of abuse or neglect involving LPN #1 or any other staff member. No other discrepancies were found. LPN #1 has been terminated.**
- 3. In order to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures, in-servicing has been conducted. The Director of Nursing re-inserviced all staff beginning February 14, 2013 on immediate abuse/neglect reporting. The in-service addressed thorough investigation, the immediate removal of alleged perpetrators to prevent further potential of abuse while the investigation is in progress, and immediately reporting any/all allegations of abuse to the appropriate state agencies. All employees voiced their understanding of the abuse policy and procedures and were able to verbalize what should be reported, their knowledge that all allegations must be reported to the DON and Administrator immediately, and what process they should see happen following their report of an allegation, and when/how to follow up on their report. All employees receive ongoing training on the abuse policy and reporting procedures at least quarterly.**
- 4. In order to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures, in-servicing has been conducted. The CQI committee, as well as, the Administrator and Director of Nursing, will discuss all investigative reports and incident reports on an ongoing basis during weekly CQI meetings to ensure all incidents involving abuse/neglect or**

suspected abuse/neglect are immediately reported to the appropriate state agencies as required. The Administrator and DON will complete 5 random staff interviews weekly X1 month and then quarterly x6 months about the abuse reporting process. Any irregularities will be corrected immediately with continued follow-up and review.

5. Date of Completion: March 4, 2013.