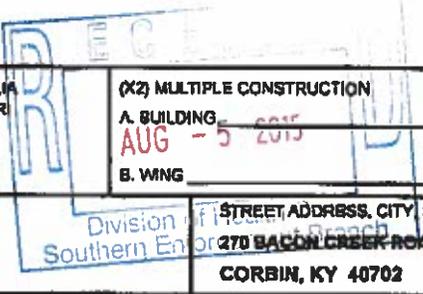


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/24/2015  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185386	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <u>AUG - 5 2015</u> B. WING:	(X3) DATE SURVEY COMPLETED  C 07/10/2015
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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
F 000  F 282 SS=D	<p><b>INITIAL COMMENTS</b></p> <p>An abbreviated standard survey (KY23450) was initiated on 07/09/15 and concluded on 07/10/15. The complaint was substantiated with deficient practice identified at "D" level.</p> <p><b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></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, review of the facility's policy, and review of the facility's investigation, it was determined the facility failed to ensure services were provided in accordance with the written plan of care for one (1) of three (3) sampled residents (Resident #1). The facility assessed and had care plan interventions in place for Resident #1 that required the resident to receive extensive assistance of two (2) staff members with transfers. However, on 08/19/15 at approximately 12:30 AM facility staff failed to utilize two (2) staff members to transfer the resident. As a result, Resident #1 sustained a fall that resulted in minor injury (bruising).</p> <p>The findings include:  Review of the facility's policy titled "Care Plan Policy and Protocol," revision date 08/2012, revealed the plan of care would be developed based on completion of the comprehensive</p>	F 000  F 282	- See attached.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca A. Olin TITLE: Administrator DATE: 8/5/15

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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F 282	<p>Continued From page 1</p> <p>assessment. Further review of the policy revealed the plan of care would be periodically reviewed and revised after each assessment and on an as needed basis. Continued review of the policy revealed the Kardex (Nursing Assistant Care Plan) would be utilized as a guide for Nurse Aides in providing care on a daily basis.</p> <p>Observation of Resident #1 on 07/09/15 at 1:35 PM revealed State Registered Nurse Aide (SRNA) #1 and SRNA #2 transferred the resident from the toilet to the wheelchair.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 04/17/15 revealed the facility assessed Resident #1 to require extensive assistance of two (2) staff persons for transfers. The MDS further revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 6, indicating Resident #1 was not interviewable.</p> <p>Review of the Comprehensive Care Plan, dated 01/28/15, revealed the facility had implemented an intervention for Resident #1 to have assistance with transfers and to encourage the resident to participate as tolerated. Review of the Resident Kardex revealed Resident #1 was non-ambulatory and staff was directed to use extensive assistance of two (2) staff members for transfers.</p> <p>Review of the facility investigation dated 06/19/15, revealed SRNA #3 attempted to transfer Resident #1 from the toilet to the resident's wheelchair and the resident's knee "gave out" and the resident fell on top of the SRNA. Continued review of the investigation revealed the resident was assessed and</p>	F 282	- See attached.		

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F 282	Continued From page 2 complained of back and knee pain and was sent to the Emergency Room for an evaluation with minor injuries identified.  Review of a statement obtained from SRNA #3 by the facility on 06/19/15 revealed the SRNA transferred Resident #1 without the assistance of another staff member from the wheelchair to the toilet and from the toilet back to the wheelchair. During the transfer, the resident's knee "gave out" causing the resident to fall. The statement further revealed SRNA #3 was aware Resident #1 required the assistance of two (2) staff members for transfers. The statement did not address why SRNA #3 transferred the resident without assistance from another staff person, and SRNA #3 was unable to be reached for interview.  Interview on 07/08/15 at 9:30 AM with Registered Nurse (RN) #1 revealed SRNA #3 did not request the RN's assistance to transfer Resident #1 to the toilet and was not aware of the SRNA asking any other staff for assistance. RN #1 revealed the resident was assessed after the fall and transferred to the Emergency Room for an evaluation for complaints of back and knee pain. The interview further revealed the administrative staff was notified of the fall immediately and SRNA #3 was suspended.  Interview on 07/09/15 at 9:52 AM with the Administrator and the Director of Nursing (DON) revealed SRNA #3 had been in-serviced on using the appropriate number of staff required to transfer a resident on 06/02/15 and was terminated from employment on 06/19/15 due to not following Resident #1's care plan.	F 282	- See attached.		
F 323	483.25(h) FREE OF ACCIDENT	F 323			

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F 323 SS=D	<p>Continued From page 3</p> <p><b>HAZARDS/SUPERVISION/DEVICES</b></p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility policy, and review of the facility investigation, it was determined the facility failed to ensure adequate supervision to prevent accidents was provided for one (1) of three (3) sampled residents (Resident #1). The facility assessed Resident #1 to require extensive assistance of two (2) staff members for transfers. However, on 06/19/15, one (1) staff member attempted to transfer Resident #1 from the toilet to the resident's wheelchair without the assistance of another staff member and the resident sustained a fall that resulted in minor injuries (bruising).</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Plan Policy and Protocol," revision date 08/2012, revealed the Kardex (Nursing Assistant Care Plan) would be utilized as a guide for Nurse Aides in providing care on a daily basis.</p> <p>Review of the medical record for Resident #1 revealed the facility admitted the resident on 01/14/15 with diagnoses to include Diabetes</p>	F 323	- See attached.		

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F 323	<p>Continued From page 4</p> <p>Mellitus, Dementia, Hypertension, and Bipolar Disorder.</p> <p>Observation of Resident #1 on 07/09/15 at 1:35 PM revealed State Registered Nurse Aide (SRNA) #1 and SRNA #2 transferred the resident from the toilet to the wheelchair without problems or concerns.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/17/15, revealed the facility assessed Resident #1 to require the extensive assistance of two (2) staff persons for transfers. The MDS further revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment and was not interviewable.</p> <p>Review of the Comprehensive Care Plan, dated 01/26/15, revealed the facility had addressed that Resident #1 required assistance with transfers and for staff to encourage the resident to participate with transfers as tolerated.</p> <p>Review of the Resident Kardex revealed Resident #1 was non-ambulatory and staff was directed to use extensive assistance of two (2) staff members for transfers.</p> <p>Review of the facility investigation, dated 06/19/15, revealed on 06/19/15 at 12:30 AM, SRNA #3 attempted to transfer Resident #1 from the toilet to the resident's wheelchair without the assistance of two (2) persons and the resident's knee "gave out" and the resident fell on top of the SRNA. Continued review of the investigation revealed the resident was assessed and complained of back and knee pain and was sent</p>	F 323	- See attached.		

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F 323	<p>Continued From page 5</p> <p>to the Emergency Room for an evaluation with minor injuries (bruising) identified.</p> <p>Review of a statement obtained from SRNA #3 by the facility on 06/19/15 revealed the SRNA transferred Resident #1 without the assistance of another staff member from the wheelchair to the toilet and from the toilet back to the wheelchair. During the transfer from the toilet to the wheelchair, the resident's knee "gave out" causing the resident to fall. The statement further revealed SRNA #3 was aware Resident #1 required the assistance of two (2) staff members for transfers. The statement did not address why SRNA #3 did not get assistance from another staff person prior to transferring Resident #1, and attempts to reach the SRNA were unsuccessful.</p> <p>Interview on 07/08/15 at 9:30 AM with Registered Nurse (RN) #1 revealed SRNA #3 did not request the RN's assistance to transfer Resident #1 and was not aware of the SRNA asking any other staff for assistance. RN #1 revealed the resident was assessed and transferred to the Emergency Room for an evaluation for complaints of back and knee pain. The interview further revealed the administrative staff was notified of the fall immediately and SRNA #3 was suspended from duty.</p> <p>Interview on 07/09/15 at 9:52 AM with the Administrator and the Director of Nursing (DON) revealed SRNA #3 had been in-serviced on using the appropriate number of staff required to transfer a resident on 06/02/15 and was terminated from employment on 06/19/15 related to this incident.</p>	F 323	- See attached		