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

PRINTED: 09/25/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185366	B. WING_				C 15/2020
NAME OF PROVIDER OR SUPPLIER CORBIN HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 270 BACON CREEK ROAD CORBIN, KY 40702				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	KY32052) and a COV control survey was control survey was control survey was control and to be in compliant of the control and Centers for Medicare and Centers for Disease.	dard survey (KY31524 and /ID-19 focused infection onducted on 09/15/2020. unsubstantiated and no identified. The facility was ance with 42 CFR 483.80 has implemented the & Medicaid Services (CMS) ase Control and Prevention practices to prepare for	F	000			
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE	!		TITLE		(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/25/2020 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

TAGE OF PROVIDER OR SUPPLIER CORRIN HEALTH AND REHABILITATION CENTER CORRIN HEALTH AND REHABILITATION CENTER CORRIN TAGE (ICACH DEPICIENCY MUST BE PRECEDED OF FULL REGULATORY OR LISC DENTIFYING INFORMATION) E 000 Initial Comments A COVID-19 focused Emergency Preparedness survey was conducted on 09/15/2020. The facility was found to be in compliance with 42 CFR 48.3.73 Emergency Preparedness related to E0024. No deficient practice was identified.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER CORBIN HEALTH AND REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments A COVID-19 focused Emergency Preparedness survey was conducted on 09/15/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to			185366	B. WING					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments A COVID-19 focused Emergency Preparedness survey was conducted on 09/15/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 270 BACON CREEK ROAD				
A COVID-19 focused Emergency Preparedness survey was conducted on 09/15/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
	E 000	A COVID-19 focused survey was conducte facility was found to b CFR 483.73 Emerger	d on 09/15/2020. The be in compliance with 42 ncy Preparedness related to	E	000				
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	1 ADOD ATOR		1	2					

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.

Office of Inspector General

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
					С			
		100416	B. WING		09/15/2020			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CORBIN H	HEALTH AND REHABILIT	ATION CENTER 270 BACO CORBIN, F	N CREEK ROA (Y 40702	AD.				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE			
N 000	Initial Comments		N 000		i			
N 000	A complaint investigated KY32052) and a COV control survey was control complaints were deficient practice was	tion (KY31524 and //D-19 focused infection inducted on 09/15/2020. unsubstantiated and no identified. The facility was ance pursuant to 42 CFR	N 000					

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

TITLE

(X6) DATE

KHUZ11