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

PRINTED: 08/21/2020 FORM APPROVED OMB NO. 0938-0391

I 185386 INMIG OF PROVIDER OR SUPPLIER CORBIN HEALTH AND REHABILITATION CENTER CORBIN HEALTH AND REHABILITATION CENTER (EACH DEPOISON MUST SEE PRECEDED BY FULL PROFILE TAG (EACH OCREENT) AND FE CONFIDENCE CONTRIBUTION OF CONTRIBUTION	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 STREET ADDRESS, CITY, STATE, ZIP CODE 270 BACON CREEK ROAD CORBIN, KY 40702 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOUND INITIAL COMMENTS An abbreviated standard survey (KY32204) and a COVID-19 focused infection control survey was initiated on 08/13/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for			185366	B WING	B WNG				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS An abbreviated standard survey (KY32204) and a COVID-19 focused infection control survey was initiated on 08/12/2020 and concluded on 08/13/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for				*27 51	270 BAC	ON CREEK ROAD			13/2020
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		An abbreviated standa COVID-19 focused initiated on 08/12/202 08/13/2020. The contant and no deficient practicality was found to the CFR 483.80 Infection implemented the Cert Medicaid Services (Cobisease Control and recommended practic COVID-19. The total	dard survey (KY32204) and infection control survey was 20 and concluded on inplaint was unsubstantiated tice was identified. The period in compliance with 42 in Control and has inters for Medicare & SMS) and Centers for Prevention (CDC) coes to prepare for a census was 89.		000				

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 (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		185366	B. WNG			C 08/13/2020	
NAME OF PROVIDER OR SUPPLIER CORBIN HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CI 270 BACON CREEK CORBIN, KY 4070	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH C	PROVIDER'S PLAN OF CORRECTION (X5 (EACH CORRECTIVE ACTION SHOULD BE COMPLI CROSS-REFERENCED TO THE APPROPRIATE DAT DEFICIENCY)		
E 000	survey was initiated of concluded on 08/13/2 to be in compliance v	2020. The facility was found rith 42 CFR 483.73 ness related to E0024. No	EO	00	BENGENCIY		
LABORATORY	DIRECTOR'S OR PROVIDER.	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		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.

FORM APPROVED Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: ____ C B. WNG_ 100416 08/13/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 270 BACON CREEK ROAD **CORBIN HEALTH AND REHABILITATION CENTER CORBIN, KY 40702** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE DATE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **CROSS-REFERENCED TO THE APPROPRIATE** DEFICIENCY) N 000 Initial Comments N 000 A complaint investigation (KY32204) and a COVID-19 focused infection control survey was initiated on 08/12/2020 and concluded on 08/13/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE

U3PP11