

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
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 03/19/2026
NAME OF PROVIDER OR SUPPLIER Corbin Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 270 Bacon Creek Road Corbin, KY 40702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and facility policy review, the facility failed to provide housekeeping services to ensure a clean and sanitary environment for 7 of 24 sampled residents (Resident (R)3, R14, R46, R49, R71, R78, and R79). The findings include: Review of the undated facility policy titled Protocol for Maintenance Services states that housekeeping and maintenance will maintain a sanitary, orderly, and comfortable interior and environment. It further states that any staff member can put in a work order. 1. Observation on 03/16/2026 at 9:18 AM, of R3's room revealed the wall had scuffed paint and marks on the wall. In interview with R3, at the time of observation, she stated, Those walls have been like that ever since I moved in here. I asked about it a few times, but nothing has been done to fix it. R3 further stated she had been there for almost four years; however, could not recall who she spoke to about fixing the walls. 2. Observation on 03/16/2026 at 9:26 AM, of R14's room, revealed the wall had scuff marks where the paint was missing. 3. Observation on 03/16/2026 at 9:39AM, of R46's room, revealed a black substance all over the bottom of the shower in the resident's room. 4. Observation on 03/16/2026 at 10:04 AM, of R49's room, revealed the wall had several places that had tiny holes. Further observation revealed the wall had several places that were scuffed and the paint was missing. 5. Observation on 03/16/2026 at 10:12 AM, of R71's room, revealed the paint was scuffed and missing off the wall. 6. Observation on 03/16/2026 at 10:28 AM, of R78's room, revealed several places on the wall that were scuffed and needed to be painted. 7. Observation on 03/16/2026 at 10:46 AM, of R79's room, revealed the light in the bathroom was broken and dangling down from the ceiling. Interview with the Housekeeping Manager was attempted; however, the Manager was unable to be interviewed due to being off work for vacation. In interview on 03/17/2026 at 11:42 AM, the Maintenance Director stated anyone in the entire facility could place a work order (for repairs needing to be completed). He said, We have little books that are at the nurse's stations and if anyone sees anything that needs fixed, they just fill that out and give it to me and I will take care of it. I try to prioritize what needs fixed. When asked by the State Survey Agency (SSA) Surveyor if he had any outstanding projects, he stated he did not have any at this time. In interview on 03/17/2026 at 12:13 PM, the Director of Nursing (DON) stated he was not aware of any maintenance issues with the facility. He reported anyone could place a work order. The DON further stated it was his expectation if staff saw something that needed to be fixed for them to place a work order. During interview with Housekeeping Aide 1 on 03/17/2026 at 12:37 PM, stated she had been educated, when she started, that if she saw anything needing to be fixed, she was supposed to let the nurse know and either fill out a work order or ask the nurse to fill one out. She further stated, They have instructed us to notify maintenance if we see things that need repaired when we are cleaning. In interview on 03/18/2026 at 8:17 AM, the Administrator stated it was his expectation for the facility to be kept in good condition by maintenance. He said if anyone saw anything needing to be fixed, for (continued on next page)		

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.

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

TITLE

(X6) DATE

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	them to notify him or maintenance. The Administrator said, We try to do walking rounds every month where we go through the whole facility and check for things that need fixed. He further stated it was his expectation for the residents' walls to be painted and fixed if there were scuffs or marks on them.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and review of facility policy, the facility failed to protect a resident's right to dignity for 4 of 24 sampled residents (Resident (R)44, R45, R64, R87). The findings include: Review of the facility policy titled, Policy on Foley Catheter Changes, undated, revealed there was no reference to the dignity covers for catheter bags in the policy. The policy was the only policy provided by the facility regarding Foley catheters. 1). Observation on 03/16/2026 at 10:31 AM, 03/17/2026 at 10:53 AM, 03/18/2026 at 9:20 AM, the clocks in R44's and R87's rooms were not set for the correct time. During interview on 03/16/2026 at 10:26 AM, R87 stated (regarding the clock not having the correct time), It happens sometimes. I think the batteries run down. I would like to know what time it is though. She further stated, it's behind on time. They need to put batteries in it. During interview on 03/16/2026 at 10:31 AM, R44 stated, the clock needs reset. It gets me all messed up on time. 2(a). Observation on 03/16/2026 at 9:00 AM and 3:03 PM; on 03/18/2026 at 11:52 AM; and 03/19/2026 at 10:50 AM, revealed R45 was observed to have a foley catheter with an uncovered drainage bag attached to the bedside. During interview on 03/16/2026 at 9:00 AM, R45 stated she was not sure how long her (foley catheter) bag had not had a dignity cover on it. R45 further stated the bag sure looked pretty with the little skirt on it. The resident further stated not having a cover on the catheter bag did not really bother her; however, she said she did not like other seeing the bag not covered. 2(b). Observation on 03/16/2026 at 3:03 PM, 03/18/2026 at 9:16 AM, 11:42 AM, and 03/19/2026 at 10:50 AM revealed R64 had a foley catheter with an uncovered drainage bag attached to the bedside. During interview on 3/18/2026 at 9:16 AM and 3:31 PM, R64 stated (regarding the dignity bag for the foley catheter) she would, rather have it and liked it when it was there. She said she knew the cover (for the drainage bag) had been missing as it had been torn and taken off a few days ago. R64 further stated she did not like others seeing the bag without a cover. During interview on 03/19/2026 at 2:00 PM, State Registered Nurse Aide (SRNA) 1 stated SRNA's were responsible for replacing the privacy bags for residents' catheters. He said he checked resident's (privacy) bags every morning and replaced them as needed. The SRNA reported sometimes nurses also replaced the dignity bag as needed. He further stated the supplies for replacement bags were available in the supply closet or in the medication rooms. During interview on 3/19/2026 at 2:12 PM, Licensed Practical Nurse (LPN) 2 stated she was not sure who was responsible for ensuring residents' catheter bags were covered. She further stated however, she would find out who was responsible. She said she was not aware the dignity bag covers were missing for R64 and R45. The LPN further stated all foley catheter bags should have a dignity cover. During interview on 3/19/2026 at 2:14 PM, Clinical Coordinator 1 stated all nursing staff were responsible for replacing missing/torn catheter bags. She said the bags were changed twice a month or as needed. Clinical Coordinator 1 reported If staff knew they (the bags) were missing, the bags would be changed as soon as possible. She further stated the supplies for catheter bags were available in the supply closet. She said all staff were to be aware if foley catheter cover bags were not in place. The Clinical Coordinator further stated she was not aware R45 and R64 did not having dignity bag, but they should have covers on the drainage bags at all times. During interview on 03/19/2026 at 2:26 PM, the Director of Nursing (DON) stated he expected the dignity covers for the foley catheter bags to be in place at all times to maintain the resident's dignity. He further stated the nurses were responsible for ensuring the bag covers were in place. During interview on 03/19/2026 at 3:15 PM, the Administrator stated his expectation was for the dignity covers to be in place at all times. He further stated he would also expect a torn or missing cover to be replaced quickly.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and facility policy review, the facility failed to ensure the resident was clinically appropriate to self-administer medications for 1 of 24 sampled residents (Resident (R)23).The findings include: Review of the facility's policy titled, Administering Medication Policy, undated, revealed medication was to be administered by licensed medical or nursing personnel as prescribed. The policy further stated that self-administration of medications may be permitted when approved by the interdisciplinary team. Observation on 03/16/2026 at 3:04 PM, revealed a white, round, opened/unlabeled medication in a medication cup on R23's overbed table. During interview, at the time of observation, R23 stated the medication in the cup was Tylenol and had been left by nurse. Record review for all residents within the facility revealed the facility had no residents with medication self-administration orders. During interview 03/16/2026 at 3:24 PM, Licensed Practical Nurse (LPN) 2 stated, you don't leave opened medications with a resident because another resident could take the medication, or medication could be taken at the wrong time. She reported there had to be a doctor's order to allow medications to be left at a resident's bedside for the resident to self-administer, including Tylenol. LPN 2 said R23 did not have an order to self-administer medications. When the State Survey Agency (SSA) Surveyor asked LPN 2 about the opened medication on R23's overbed table, the LPN stated, I thought she took that, and went to R23's room to ensure R23 took the Tylenol. During interview on 03/18/2026 at 1:03 PM, Clinical Manager 1, stated, meds (medications) should not be left at bedside at any time. She said the only exception would be if there was a doctor's order for a medication to be left at bedside for the resident to self-administer. Clinical Manager 1 reported if medications were left at bedside it might interfere with other medications, or another person might take it and have a negative reaction. During interview on 03/19/2026 at 2:38 PM, the Director of Nursing (DON) stated no medications were to be left out at a resident's bedside without a physician's order. The DON reported if medications were left out without an order that should have been reported to the nursing coordinator and then to him. The DON further stated the expectation was for the facility's medication administration policy to be followed. During interview on 03/19/2026 at 3:14 PM, the Administrator stated medications should not be left at bedside without a physician's order. The Administrator further stated the expectation was that the facility's medication administration policy to be followed.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview, and review of facility documents and policy, the facility failed to establish a system to ensure thorough accounting of the disposition of all controlled drugs to enable accurate reconciliation of those drugs, which had the potential to affect those residents with narcotic medications out of the 24 total sampled residents. The findings include: Review of the facility policy titled, Protocol for Narcotic Count, undated, revealed controlled drugs were to be counted every shift by the nurse leaving and the nurse coming on duty. Further review revealed the Shift Drug Count Record was to be signed by the nurse leaving and the nurse coming on duty to signify the count was done and was correct. Review of the facility's Shift Drug Count Records for February and March 2026, revealed numerous staff signatures not documented across all four of the medication carts (indicating medication reconciliation had not consistently been documented as completed during shift change as required). Per review of the forms: the 200 Front Hall medication cart had 40 missing signatures for February 2026 and 24 missing signatures for March 1-15th. Continued review revealed the 100 Front Hall medication cart had 14 missing signatures for March 1-15th, and 24 missing signatures for February; and the 100 back hall medication cart had 22 missing signatures for February. Further review of the records revealed the review of the drug count records and the copies provided by the facility on 03/17/2026, had added signatures that were not on the records at the original review. During interview on 03/16/2026 at 4:04 PM, Licensed Practical Nurse (LPN) 4 stated on hand-off of the medication carts at shift change, two licensed staff were to reconcile the narcotic counts and both were to sign the counts to indicate they were correct. LPN 4 further stated it was important to sign the narcotic sheets to help protect themselves and the residents from misappropriation of narcotic medications. During interview on 03/19/2026 at 2:47 PM, Clinical Coordinator 1 stated she collected the Shift Drug Count Records monthly and those records were stored in her office, and at some point went to medical records. The Clinical Coordinator reported she was not sure if checking the narcotic records to ensure they were complete was her responsibility; however, she said she probably should be checking to see if they were complete. She stated her expectation was for each staff member to complete the count at shift change, and to sign the narcotic count as completed. Clinical Coordinator 1 further stated not signing off the completed counts could cause issues if medications were missing. During interview on 03/19/2026 at 2:26 PM, the Director of Nursing (DON) stated two licensed nurses were to sign off on the narcotics sheet upon hand-off of the medication cart at shift change. He said If any discrepancy was noted staff were to immediately contact the on-call administration person. The DON reported not signing off on the narcotic count sheet at hand-off of the cart could cause significant issues if medications were missing. He explained the Clinical Coordinators were responsible for oversight to ensure the staff signatures were completed as required. He stated he did not perform oversight; however, said he would trust his staff responsible for doing that would ensure it was done. The DON further stated not checking to ensure completion of the narcotic count records could cause issues regarding missing narcotics and inability to track the narcotics. During interview on 03/19/2026 at 3:15 PM, the Administrator stated her expectation was for two staff to count narcotics, and both sign the narcotic count sheet attesting that the counts were correct as required. The Administrator further stated he should have been providing oversight to ensure the narcotic counts were being performed and documented as required.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. The facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to ensure its personnel handled, stored, processed, and transported linens so as to prevent the spread of infection which had the potential to affect residents using the facility's protective underpads. Additionally, the facility failed to ensure necessary environmental cleaning and disinfection for 2 of 24 sampled residents (Resident (R)53 and R90). The findings include: Review of the facility policy titled, Infection Prevention & Control Program Policy, undated, revealed personnel were to handle, store, process, and transport linens i(n a manner) to prevent the spread of infection. Continued review revealed bowel and bladder incontinence was noted as a high risk for infection conditions and the facility should have personal protective equipment (PPE) available to all staff to keep them as free from body fluid contamination as possible. 1). Review of R53's and R90's Kardex (care plan for aides) showed both residents required supervision or assistance for toilet use. R53's Kardex noted he was incontinent at times. Observation on 03/16/2026 at 10:18 AM, revealed multiple briefs soiled with a yellowish substance in R53's and R90's bathroom in a garbage can. Further observation revealed there was no garbage bag in the can. During interview on 03/16/2026 at 10:23 AM, Housekeeping Aide 2 stated the State Registered Nursing Aides (SRNA's) were responsible for removing soiled briefs from residents' rooms. The Housekeeping Aide further stated the SRNA's were to replace residents' garbage bags as needed. During interview on 03/18/2026 at 9:31 AM, SRNA 5, stated SRNA's were to remove soiled briefs immediately after finishing with resident care. She reported SRNA's were responsible for disposing of soiled briefs. SRNA 5 further stated the SRNA's should take garbage bag and all when dealing with soiled briefs. During interview on 03/18/2026 at 3:34 PM, Clinical Manager 1 stated SRNA's were to take care of disposing of soiled briefs. The Clinical Manager further stated for residents' rooms (of residents who changed their own briefs) the SRNA's were to check those rooms every two hours. 2). Observation on 03/17/2026 at 9:10 AM, revealed Laundry Aide 1, touched her full chest, stomach area, and upper legs with clean protective underpads as she was folding them. During interview on 03/17/2026 at 9:20 AM, Housekeeping Aide 1 stated the laundry aides did not have any type of PPE they wore while separating dirty clothing. The Housekeeping Aide reported there was no way to ensure the clean laundry was not being contaminated by the dirty clothing since the laundry aides wore no PPE. Housekeeping Aide 1 further stated the laundry aides had not had PPE available to use in several years.		