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

PRINTED: 07/29/2020 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185288				l	С
NAME OF PROVIDER OR SUPPLIER		103200	B. WING			06/03/2020	
ESSEX N	NURSING AND REHAI			STREET ADDRESS, CITY, STATE, Z 9600 LAMBORNE BOULEVARD LOUISVILLE, KY 40272	IP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETION DATE
F 000	A COVID-19 Focus initiated, on 05/21/2 06/03/2020. The fa compliance with 42 regulations and has Medicare & Medicare Centers for Disease (CDC) recommende COVID-19. Total cells In addition, an abbre on 05/21/2020 throucomplaint #KY3161	sed Infection Control Survey 2020 and concluded on cility was found in CFR 483.80 infection control implemented the Centers for id Services (CMS), and control and Prevention and practices to prepare for	1	OOO	[HE APPROPS	RIATE	DATE
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	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.

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/29/2020 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A: BUILDI	TIPLE CONSTRUCTION, ING	(X3) DA	(X3) DATE SURVEY COMPLETED	
	185288					С	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP OF STREET ADDRESS, CITY, STATE, ZIP OF STATE, ZIP O						6/03/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE	
	concluded on 06/03 to be in compliance	ed Emergency Preparedness I on 05/21/2020 and /2020. The facility was found with 42 CFR 483.73 related	E 00	00			
	to E-0024 (b)(6).						
			1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
RATORY D	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	ATI 100	TITLE			

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

(X6) DATE

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If continuation sheet 1 of 1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** (X3) DATE SURVEY A. BUILDING: COMPLETED 100518 C B. WING 06/03/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **ESSEX NURSING AND REHABILITATION CENT** 9600 LAMBORNE BOULEVARD LOUISVILLE, KY 40272 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 05/21/20202 and concluded on 06/03/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. In addition, a complaint survey to investigate KY 31619 was conducted on 05/21/2020 through 06/03/2020. The complaint was unsubstantiated and no deficiencies cited. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE STATE FORM

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Office of Inspector General