

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

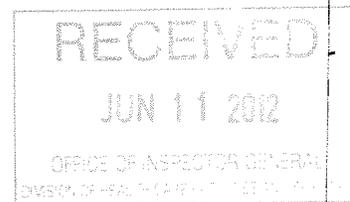
PRINTED: 06/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/01/2012
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NAME OF PROVIDER OR SUPPLIER ESSEX NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9600 LAMBORNE BOULEVARD LOUISVILLE, KY 40272
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F 000	INITIAL COMMENTS An abbreviated standard survey was initiated and concluded on 06/01/12 investigating KY18231. KY18231 was unsubstantiated, however, there was an unrelated deficiency cited.	F 000	Essex Nursing and Rehabilitation Center, LLC acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality care of the residents. The plan of correction is submitted as a written allegation of compliance. Essex Nursing and Rehabilitation Center's response to the Statement of Deficiencies and the plan of correction does not denote agreement with the Statement of Deficiencies nor does it constitute and admission that any deficiency is accurate. Furthermore, Essex Nursing and Rehabilitation Center, LLC, reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal procedures and/or any other administrative or legal proceeding.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431		



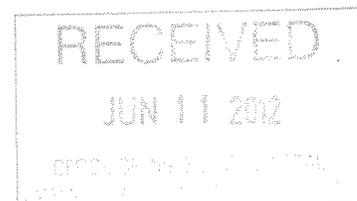
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert Datt</i>	TITLE Administrator	(X6) DATE 6/6/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting 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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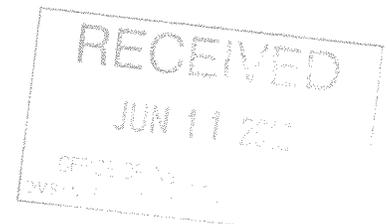
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F 431	<p>Continued From page 1 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy Medication Administration, it was determined the facility failed to have the medication cart under the direct observation of the person administering medication or have the medication cart locked for one (1) of six (6) medication carts. The medication cart on the Canterbury Cove Hall was found unlocked and not being observed by nursing personnel during the medication pass.</p> <p>The findings include:</p> <p>Record review of the facility's policy regarding Medication Administration, undated, revealed the policy did not address the security of the medication cart during the medication pass.</p> <p>Observation, on 06/01/12 at 10:15 AM, on the Canterbury Cove Hall revealed the medication cart outside of the room of a resident, the drawers facing outward into the hall and unlocked. Two nursing personnel were facing a resident in the room during the medication administration, both of their backs to the cart. The personnel were identified as Certified Medication Technician (CMT) #1 and Licensed Practical Nurse (LPN) #1.</p> <p>Observation, on 06/01/12 during the tour of the facility which began at 10:00 AM, revealed Resident "B" wandering into the rooms of three(3)</p>	F 431	<p>Tag F 431 SS=D</p> <p>Essex Nursing and Rehabilitation Center, LLC, administration understands the risks involved regarding potential risks for cognitively impaired residents and acknowledges that any cognitively impaired individual of the facility could be at risk if accessing medications from an unlocked medication and/or treatment cart.</p> <p>Re-evaluation of residents "A" and "B" and "D" validate cognitive impairments, as well as wandering behaviors. To help ensure safety for these identified residents, as well as the entire resident population, the following plan of correction has been implemented.</p> <p>All licensed nurses and Kentucky Medication Aides (C.M.T.'s) employed at Essex Nursing and Rehabilitation Center, LLC, have received in-service training regarding the proper procedures for locking medication and treatment carts that are in use and not in direct observation. This in-service was completed on 06/06/2012 by the Staff Development Coordinator. All pertinent employees currently on vacation will receive the in-service education upon return to duty.</p>	<p>06/06/2012 6-7-12 per DON by PB 6-12-12</p>	



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F 431	<p>Continued From page 2</p> <p>different residents. Twice Resident "B" was redirected out of the rooms which were not his/hers by Housekeeper #1 when Housekeeper #1 had observed the resident in the rooms. Resident "B" was assessed by the facility with cognitive impairment.</p> <p>Observation, on 06/01/12 during the tour of the facility which began at 10:00 AM, revealed Resident "D" in a wheelchair going up and down the halls inside the facility, to include the Canterbury Cove Hall where the unlocked medication cart was observed. Resident "D" was assessed by the facility with cognitive impairment.</p> <p>Observation, on 06/01/12 at 10:10 AM, revealed Resident "A" in a wheelchair moving up and down the Canterbury Cove Hall. The resident had stopped and pulled on this surveyors shirt, spoke unintelligible, patted this surveyor and continued up the hall in his/her wheelchair in the direction of the medication cart. The facility assessed Resident "A" with cognitive impairment.</p> <p>Interview, on 06/01/11 at 10:15 AM, with CMT #1 revealed the policy related to the medication cart was to have only the side open that you were using and have the cart in front of the door of the resident receiving the medication. She stated the cart was to be locked when not in view. She stated if she had been in-serviced on the medication cart it had been a while. CMT #1 offered no answer to the consequences to the resident if a resident accessed the medication cart.</p> <p>Interview, on 06/01/12 at 10:20 AM, with LPN #1 revealed she was unaware the medication cart</p>	F 431	<p>Random QA audits of all medication and treatment carts have been initiated to monitor all shifts to ensure that medication and treatment carts are locked if not under direct observation of the responsible staff member. These QA audits will continue to be performed by the Administrator, Assistant Director of Nursing, QA Nurse and RN House Supervisors to monitor all shifts for compliance. The audits will be performed at least weekly by the above-stated individuals for all three shifts for three months and will then be performed randomly thereafter. All newly-hired CMT's and licensed nurses, from this point forward, will be trained on this procedure in orientation and sign an acknowledgment of receipt of training.</p> <p>Resident behaviors will continue to be monitored by nursing staff and documented accordingly in the medical record. All events and incidents will continue to be monitored in the daily QA Executive Committee meeting to help ensure resident safety and to ensure solutions are sustained.</p>	



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F 431	<p>Continued From page 3</p> <p>was unlocked. She stated the cart should always be locked or within eyesight and she had been trained to keep the cart locked. She indicated residents do wander in the facility and if it was noted that a resident got into the medication cart, she would check the medications to make sure none were missing. She offered no consequences to the resident if a resident accessed the medication cart other than she would hope and pray a resident would not get into an unlocked cart.</p> <p>Interview, on 06/01/12 at 10:25 AM, with the South Charge Nurse revealed the medication carts are monitored all the time by spot checks. She stated staff were in-serviced on the medication carts and it was an ongoing process within the facility. The facility did have residents that wander and she stated she assumed harm could come to the residents from an unlocked cart. The policy for the medication cart was if you were working off the cart, you could pull it in the doorway of the resident's room and the medication cart must be in visual site.</p> <p>Interview, on 06/01/12 at 10:30 AM, with the North Charge Nurse revealed the policy regarding medication carts was for the carts to remain locked. The cart may be unlocked to pull meds, then locked back, she stated. She stated the carts were monitored during the walk through of the halls. She indicated there were residents that wander in the facility and they could get into an unlocked medication cart. She further stated if the resident did not know any better and took a medication from an unlocked cart, they could be injured or die. She stated there are some dangerous meds kept in the medication carts.</p>	F 431			

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F 431	<p>Continued From page 4</p> <p>Interview, on 06/01/12 at 10:40 AM, with the Director of Nursing (DON) revealed the facility did not have a policy on the medication carts. The facility adheres to standard nursing, what they are taught with respect to the security of the medication carts. She stated the staff had been in-serviced on the medication carts, including that the medication carts were to remain locked unless the cart was in view. In addition, it was revealed medication carts were monitored by checking the cart (that it was locked) as the staff passed by. She did not speculate the consequences to the resident if an unlocked cart was accessed by a resident.</p> <p>Interview, on 06/01/12 at 2:30 PM, with Registered Nurse (RN MDS) #1 revealed there was a medication pass policy. She stated the medication cart was to be locked at all times when you were not standing by the cart. It was revealed the staff had been in-serviced on the medication carts. Additionally, seh stated there was a risk to the residents if the cart was not locked or observed.</p>	F 431		
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