STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185241	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Manor	2344 Amsterdam Road Villa Hills, KY 41017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 44001 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to notify the resident's physician of a significant change in the resident's physical status for 2 of 11 sampled residents, Resident (R) 2 and R3. 1. On 12/01/2024, in the early hours of the morning, R3 was observed by Registered Nurse (RN) 2 to have a significant change in mental status. Despite this critical finding, RN2 failed to notify the physician about the resident's condition. At 7:00 AM, during the shift change report, RN2 relayed to Licensed Practical Nurse (LPN) 1 that the resident's mental status had deviated from the baseline during the night. However, neither nurse assessed R3 or notified the physician of his change in mental status. At approximately 11:30 AM, R3's family alerted LPN1 that R3 was febrile, unresponsive, and had tremors. The family requested the nurse to call emergency medical services (EMS) for transfer to the local emergency department (ED). R3 presented to the ED in an altered mental status, septic, and in atrial fibrillation with rapid ventricular response (AFib RVR). Immediate Jeopardy (IJ) was identified on 12/20/2024 and was determined to exist on 11/26/2024, in the area of 42 CFR S483.10 Resident Rights, F580 at a Scope and Severity (S/S) of a J related to KY00044335. The facility was notified of the IJ on 12/20/2024 at 1:08 PM. On 12/20/2024 at 1:08 PM, the facility's Executive Director, Unit Manager, and Infection Preventionist were provided a copy of the IJ Template and notified that the facility failed to ensure the physician was notified of a change in condition for Resident (R) 3 when the resident experienced a significant altered mental status and life-threatening deterioration. This failure to notify the physician of the need to alter treatment is likely to cause serious injury, impairment, or death. The facility provided an acceptable IJ Removal Plan, on 01/02/2025 at 1:45 PM, alleging removal of the IJ on 01/02/2025. The State Survey Agency (SSA) validated the IJ had been removed on 01/02/2025 at 1:45 PM as alleged, after an acceptable Removal Plan was received and further interviews, observations, and record reviews were conducted to verify the immediate corrections. Remaining non-compliance continued at a S/S of a G (isolated actual harm that is not immediate jeopardy) at F580. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. In addition, on 10/18/2024, an unstageable wound to R2's left heel was found by the physical therapy (PT) staff. The nursing staff was notified. However, the nursing staff failed to notify the physician of a change in condition (CIC) immediately. A review of a progress note dated 10/23/2024 by the Wound Care Physician revealed the provider noted a newly acquired unstageable deep tissue injury (DTI) measuring (length (L) x width (W) x depth (D)): 5.0 x 8.0 x 0.1 centimeter (cm) with etiology (cause) noted from pressure. Refer to F655, F684, F686 The findings include: Review of the facility's policy titled, Notification of Change of Condition, undated, revealed the facility would consult with the resident's medical provider when there was a significant change in the resident's physical health. 1. Closed Record Review of R3's Face Sheet, located in the resident's electronic medical record (EMR), revealed the facility admitted the resident on 11/26/2024 with diagnoses to include post laminectomy syndrome (chronic pain following back surgery; a laminectomy was removing part or all of the bony arch that covered the spinal cord); post-surgical infection of the intrathecal (the space between the spinal cord and the membranes that protect it) pain pump, and idiopathic peripheral neuropathy. Review of R3's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/01/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 14 out of 15, which indicated R3 was cognitively intact. Continued review revealed R3 was assessed as being independent with activities of daily living (ADL), and R3 ambulated per self via wheelchair and walker. Review of R3's Nurse's Note, dated 12/01/2024 at 11:52 AM and authored by LPN1, revealed R3 was transferred to the local ED. LPN1 stated R3's family alerted staff that R3 was not responding. LPN1 stated upon assessment, R3 was lethargic, difficult to arouse, and would only respond to painful stimuli. She noted bodily tremors were observed. Review of R3's ED Provider Notes, dated 12/01/2024, revealed R3 presented to the ED in an altered mental status, septic, and in atrial fibrillation with rapid ventricular response (AFib RVR). R3 was febrile. His mental status was noted as somnolent, opened eyes to verbal stimuli, but was not conversant. Further review of the note revealed the physician stated, Upon my evaluation the patient had a high probability of imminent or life-threatening deterioration due to presentation which required my direct attention, intervention, and immediate management. During an interview with Family Member (F) 2 on 12/18/2024 at 12:23 PM, she stated when family came to visit R3 on 12/01/2024 at 11:10 AM, they found R3 unresponsive, feverish, sweaty, and exhibiting seizure like activity. F2 stated the family alerted LPN1 of R3's CIC, and they requested LPN1 to call emergency medical services (EMS) for transfer to the local emergency department. F2 stated R3 was admitted to the local hospital's critical care unit (CCU) for several weeks. She stated R3 had returned home and required an additional 10 weeks of intravenous [IV] antibiotic therapy. Additionally, F2 stated LPN1 admitted she was made aware of R3's CIC at 7:00 AM, during the shift change report. F2 stated LPN1 told her LPN1 had not seen R3 or assessed him that morning. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with LPN1 on 12/18/2024 at 11:58 AM, she stated she received in report from RN2 that R3 was lethargic and had an altered mental status overnight, but RN2 reported to her that R3 was fine after aides changed him. She further stated she did not assess R3's condition at the beginning of her shift. Furthermore, LPN1 stated she did not chart or notify the physician of the resident's CIC. LPN1 stated at the time the family made her aware of his CIC at around 11:00 AM, she had not seen R3 and had not given him his 9:00 AM dose of IV antibiotics. During an interview with the Advanced Practice Registered Nurse (APRN) on 12/20/2024 at 1:15 PM, she stated she expected the nursing staff to notify the provider of any changes in the resident's mental or physical condition. The APRN stated nursing staff should notify the provider immediately when a resident's mental status changed. She further stated that making the provider aware of a CIC was necessary for the resident's safety and well-being. During a telephone interview with the Medical Director on 12/19/2024 at 12:40 PM, he stated the nurse on duty should have communicated changes in the resident's condition immediately to the providers. He stated nurses were to use their nursing judgment and notify the provider on-call in emergency situations. Per the interview, the Medical Director stated it was his expectation that staff followed all facility policies to ensure the safety of the residents. 2. Closed Record Review of R2's Face Sheet, located in the resident's EMR, revealed the facility admitted the resident on 10/09/2024 with diagnoses to include idiopathic hydrocephalus, peripheral vascular disease, and chronic total occlusion of artery of the extremities. Review of R2's admission MDS, with an ARD of 10/14/2024, revealed the facility assessed the resident to have a BIMS score of nine out of 15, which indicated R2 was moderately cognitively impaired. Continued review revealed R2 was assessed as being dependent (helper did all the effort) with mobility, toileting, and transfers. R2 was assessed as needing substantial/maximal assist (helper did more than half the effort) with positioning in bed. Review of R2's Physical Therapy Treatment Encounter Note, dated 10/18/2024 at 5:11 PM, revealed the Physical Therapist (PT) noted an unstageable wound to R2's left heel. According to the note, PT notified nursing staff and educated them to float R2's heels when in bed. Review of R2's EMR revealed there was no documentation by nursing on 10/18/2024 related to the wound found by PT. Additionally, there was no documentation indicating the facility notified the physician about R2's change in physical condition. Review of R2's Occupational Therapy (OT) Treatment Encounter Note, dated 10/19/2024 at 11:16 AM, revealed R2 attempted activities of daily living (ADL) tasks but could not continue due to a wound that caused a barrier to OT treatment. The note stated the resident is struggling to move the left leg. Review of R2's EMR revealed there was no documentation by nursing on 10/19/2024 related to the wound found by PT. Additionally, there was no documentation indicating the facility notified the physician about R2's change in physical condition. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R2's Occupational Therapy (OT) Treatment Encounter Note, dated 10/21/2024 at 4:01 PM, revealed the resident had a new wound on her left lower extremity and nursing instructed OT not to stand [R2] this date. Review of R2's EMR revealed no documentation regarding the wound's worsening condition or an order for non-weight bearing status by nursing on 10/21/2024. Review of R2's Physical Therapy Treatment Encounter Note, dated 10/21/2024 at 4:58 PM, revealed the PT noted, after attempting gait training, that nursing entered the therapy gym and examined R2's left heel ulcer. According to PT, the ulcer appeared to have grown in size since 10/18/2024 and was secreting bloody drainage. Nursing instructed PT to hold gait training. Review of R2's EMR revealed no documentation regarding the wound's worsening condition by nursing on 10/21/2024. Additionally, there was no documented evidence nursing staff informed the physician about R2's change in physical condition. Review of R2's EMR revealed new orders were given by the Advanced Practice Nurse Practitioner (APRN) on 10/21/2024 at 11:39 AM, for bilateral pressure boots and new skin treatment orders. Review of Wound Evaluation and Management Summary, dated 10/23/2024, revealed the wound specialty physician noted R2 to have developed an unstageable deep tissue injury to her left heel measuring (L x W x D): 5.0 x 8.0 x 0.1 cm, with etiology noted from pressure. New treatment and medication orders were given. During an interview with F1 on 12/16/2024 at 9:26 AM, she stated R2 was currently receiving treatment at another facility for an unstageable pressure ulcer (PU) on her left heel, which she developed while at the facility. F1 expressed concern that the former Director of Nursing (DON) did not listen to the family's concerns or notify the medical provider when physical therapy discovered the pressure ulcer. During an interview with the PT Manager on 12/17/2024 at 10:55 AM, she stated she observed a change in R2's heel on 10/18/2024. The PT Manager stated the wound was closed and had a slight discoloration to the skin, but the area was red and blanchable. She stated she collaborated with the nursing staff to offload pressure and apply boots to both feet. According to the PT Manager, the wound status changed significantly from Friday (the 18th) to Monday (the 21st). She stated, on 10/21/2024, the area on R2's left heel was an open blister, and she could not complete her therapy session due to pain in R2's left foot. She stated she requested nursing staff to assess R2's left heel wound. She stated, upon assessment, the wound had grown in size and was secreting blood and drainage. During an interview with the Infection Preventionist/Wound Care Nurse (IP/WCN) on 12/19/2024 at 10:17 AM, she stated, on 10/22/2024, she completed a skin assessment on R2 and found an open area on the resident's left heel. She stated she notified the Wound Care Physician, who provided new treatment orders. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Wound Care Physician on 12/19/2024 at 12:06 PM, she stated on 10/23/2024, she examined R2's wound and found that the resident had an unstageable deep tissue injury on the left heel caused by pressure. She stated she ordered a new treatment regimen and prescribed an oral antibiotic. Additionally, she stated she instructed the staff to have the resident wear pressure-relieving boots and to ensure the wound was offloaded. During an interview with the former DON on 12/16/2024 at 1:45 PM, she stated R2 had not been at the facility for long, and her daughter had some medical background. She stated R2 developed a wound on her left heel while at the facility and was seen by the wound care team. She stated she could not state who called the physician, but she was confident nursing staff had notified the physician immediately when the wound was discovered. She stated the nurses on duty at the time of the discovery of the wound no longer worked at the facility. During an interview with the Interim Director of Nursing (IDON) on 12/19/2024 at 9:38 AM, she stated it was her expectation for all nursing staff to follow the facility's policies and procedures regarding a resident's CIC. She stated nursing staff should notify the physician immediately of any injury, fall, or decline in status as per the policies and procedures. The IDON stated following procedures related to a resident's CIC ensured the resident received appropriate and timely care. During an interview with the Executive Director on 12/19/2024 at 1:08 PM, she stated it was her expectation that staff followed the facility's policy to notify the physician to ensure safe and appropriate care for all residents. The facility provided an acceptable removal action plan on 01/02/2025 at 1:45 PM that read verbatim: Resident #3 was discharged from [Facility Name] on 12/1/24. Identification of Residents Affected or Likely to be affected: All residents currently at [Facility Name]. Actions to prevent occurrence/recurrence: l. An Ad Hoc QAPI meeting was held with DON, Medical Director and ED on 12/20/24 discussing IJ regarding Notification of Changes for Medical Director input. 2. Notification of Changes policy was reviewed immediately by the Director of Clinical Risk Management. Completed 12/20/24 3. The Director of Clinical Risk Manager provided education for the Director of Nursing, Executive Director and Nurse Managers regarding the Notification of Changes policy. Completed 12/20/24. 4. The Executive Director, Corporate Clinical Leadership Team, Director of Clinical Risk, DON discussed the Notification of Changes policy and the plan for the abatement. Completed 12/20 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Education was provided by Nurse Managers for all nurses and KMAs regarding Notification of Changes policy. Agency nurses were educated prior to their shift by DON/Nurse Managers. 25/28 completed = 93%, 1 nurse on leave will be educated by DON/Nurse Managers prior to her return to work., 2 staff still to complete prior to their next shift. 6. Starting 12/21/24 all nurses and KMAs who are hired will be educated by the DON/Nurse Managers regarding the Notification of Changes policy prior to working. 7. All progress notes were reviewed from 11/26/24 to current by DON/Nurse Manager for changes in condition of identified residents and proper notification of MD and Responsible Party as appropriate. Completed 12/20/24 8. Information was given to STNAs, housekeepers and dietary staff regarding what to do when you notice a change in a residents' condition. Information sent by ED via text. Completed 12/20/24. 9. Beginning 12/21/24 - The 24 hour report sheet and the 24 hour summary in Point Click Care {PCC) will be reviewed by DON/Nurse Manager daily 7 times per week for appropriate notification of changes in the morning Clinical Meeting. 10. Starting DON/Nurse Managers administer quizzes to nurses and KMAs regarding Notification of Changes in Condition and report results to QAPI team. If a question is missed, DON/Nurse Managers will educate the nurse immediately and document the education. 11. DON reported audit results regarding notification of changes missed at the 12/27 QAPI meeting and will continue to report audit results and how findings were resolved to QAPI weekly for 4 weeks then every other week until substantial compliance is achieved. 12. QAPI meeting on 12/27/24 was attended by Medical Director, Nurse Practitioner, ED, DON, Diet Tech, Nurse Managers, IP Nurse, Social Worker designee, Director of Facilities, Business Office Manager, MOS nurse, Director of Therapy and Life Enrichment Director. IJ abatement plan audits, results, and follow up were discussed. 13. Next QAPI meeting scheduled for 1/3/25. Date facility alleges IJ removal: 1/2/2025

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 44001 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the resident's right to privacy was honored for 1 of 11 sampled residents, Resident (R) 8. On 12/18/2024, Licensed Practical Nurse (LPN) 1 lifted R8's shirt and exposed her abdomen while she administered an insulin injection to the resident. R8 was seated at a dining table with three other residents eating lunch. The findings include: Review of the facility's policy titled, Resident Rights, dated 10/24/2022, revealed the resident had a right to be treated with respect and dignity. Further review revealed the resident had a right to personal privacy and confidentiality to include personal privacy for medical treatment. Review of R8's Face Sheet, located in the resident's electronic medical record (EMR), revealed the facility admitted the resident on 11/28/2024 with diagnoses to include left hemiplegia and hemiparesis following cerebral infarction (stroke), type 2 diabetes mellitus, and chronic obstructive pulmonary disease (COPD). Review of R8's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/02/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, which indicated R8 was cognitively intact. Review of R8's Physician Orders, dated 11/2024, revealed the resident was to be administered insulin lispro subcutaneous solution 200 units/milliliter (u/mL), per sliding scale before meals and at bedtime for type 2 diabetes. Observation on 12/18/2024 at 12:45 PM of the lunch service in the common area of Household B, LPN1 lifted R8's shirt, which exposed the right side of her abdomen. LPN1 then administered an insulin injection in the right upper quadrant of R8's abdomen, while R8 was seated at a dining table with three other residents who were also eating lunch. During interview with R8 on 12/18/2024 at 1:35 PM, she stated when LPN1 asked her about getting her insulin injection, she consented to receive it at the table while she ate lunch. She stated LPN1 was late administering medications. She stated had she not received her insulin injection in the dining area, she would have been required to return to her room for the injection, resulting in her food getting cold. Additionally, R8 stated it was common practice for nursing staff to administer medication during meals or outside of residents' rooms. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with LPN1 on 12/18/2024 at 12:47 PM, she stated she did not provide privacy for R8 while administering the insulin injection. She stated R8 had given her permission to perform the injection at the dining table while R8 was having lunch. LPN1 stated she was having a busy day and was behind on giving medications. When the State Survey Agency (SSA) Surveyor asked LPN1 if she had consulted all the residents about their comfort with watching her administer an injection while they ate, she stated, No. Furthermore, LPN1 stated, according to facility policy, every resident had the right to privacy and dignity. When asked if she ensured privacy during the medication administration for R8, she stated that she did not. During interview with the interim Director of Nursing (IDON) on 12/18/2024 at 1:19 PM, she stated nursing staff must always adhere to facility policies and protocols concerning resident rights and privacy. She stated even though the resident had given permission, the facility's protocol required medication to be administered privately in the resident's room. The IDON stated it was unacceptable for LPN1 to administer an injection to a resident in public view while the resident and others were eating a meal. She stated it was her expectation that nursing staff would follow the facility policy to ensure the resident's privacy and dignity. During interview with the Executive Director on 12/19/2024 at 1:08 PM, she stated it was her expectation that staff followed the facility's policy to include the resident's right to dignity and privacy. She stated following facility policies and protocols was important to ensure safe and appropriate care for all residents. During interview with the Director of Clinical Risk Management on 12/20/2024 at 12:51 PM, he stated the facility adhered to all nursing care standards set by the Centers for Medicare and Medicaid Services (CMS).

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 44001 Based on interview, record review, and review of the facility's policy, the facility failed to develop and implement a baseline care plan within 48 hours for each resident that included instructions needed to provide effective and person-centered care of the resident to meet professional standards of quality care for 2 of 11 sampled residents, Resident (R) 2 and R3. 1. On 11/26/2024, the facility admitted R3 with an intrathecal (the space between the spinal cord and the membranes that protect it) pain pump infection, which was being treated with intravenous (IV) antibiotic therapy via a peripherally inserted central catheter (PICC) line. The facility failed to develop a person centered baseline care plan with interventions to address R3's infection, antibiotic therapy, care of the PICC line, or physician notification for worsening condition. Immediate Jeopardy (IJ) was identified on 12/20/2024 and was determined to exist on 11/26/2024, in the area of 42 CFR S483.21 Baseline Care Plan, F655 at a Scope and Severity (S/S) of a J. The facility was notified of the IJ on 12/20/2024 at 1:11 PM. On 12/20/2024 at 1:11 PM, the facility's Executive Director, Unit Manager, and Infection Preventionist were provided a copy of the IJ Template and notified that the facility's failure to ensure a baseline person-centered care plan was developed based on R3's admission assessment to ensure resident safety is likely to cause serious injury, impairment, or death. The facility provided an acceptable IJ Removal Plan, on 01/02/2025 at 1:45 PM, alleging removal of the IJ on 01/02/2025. The State Survey Agency (SSA) validated the IJ had been removed on 01/02/2025 at 1:45 PM as alleged, after an acceptable Removal Plan was received and further interviews, observations, and record reviews were conducted to verify the immediate corrections. Remaining non-compliance continued at a S/S of a G (isolated actual harm that is not immediate jeopardy) at F655. 2. Additionally, the facility admitted R2 on 10/09/2024 and assessed the resident to be at risk for developing pressure injuries. On 10/18/2024 an unstageable wound to R2's left heel was identified by the Physical Therapy staff, with nursing staff notified by them. R2's baseline care plan, still in effect, did not address or revise for R2's existing skin issues or breakdown. Refer to F580, F684, F686, and F760 The findings include: Review of the facility's policy titled, Baseline Care Plan, dated 02/27/2023, revealed it was developed and implemented to include the minimum healthcare information necessary to properly care for a resident. Per the policy, baseline care plans would be developed and implemented within 48 hours of a resident's admission. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of R3's Face Sheet, located in the resident's electronic medical record (EMR), revealed the facility admitted the resident on 11/26/2024 with diagnoses to include post laminectomy syndrome (chronic pain following back surgery; a laminectomy was removing part or all of the bony arch that covered the spinal cord), post-surgical infection of the intrathecal pain pump, and idiopathic peripheral neuropathy. Review of R3's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/01/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated R3 was cognitively intact. Continued review revealed R3 was assessed as having a wound infection, was taking antibiotics, and had a PICC line to receive the antibiotics at time of admission. Review of R3's Physician Orders, located in the resident's electronic medical record (EMR), revealed on 11/26/2024, R3 was ordered cefepime (an antibiotic), 2 grams (gm) intravenous (IV) twice daily at 9:00 AM and 9:00 PM for the treatment of infections. Additionally, on the same date, R3 was prescribed metronidazole (antibiotic), 500 milligrams (mg) one oral tablet taken every eight hours for infections. Continued review revealed scheduled PICC line flush using heparin (an anti-coagulant) 10 units/milliliter (u/ml); use 5 ml IV every 12 hours then flush the PICC with 10 ml normal saline and follow with 5 ml of 10 units/ml heparin in a 10 cubic centimeter (cc) syringe. Additionally, per the orders, nurses were to monitor and document any signs and symptoms of infection every shift. Review of R3's Baseline Care Plan, dated 11/26/2024, located in the resident's EMR, revealed there was no documented evidence showing the facility had created a baseline care plan with treatments and interventions to address R3's current infection, antibiotic therapy, care of the PICC line, or physician notification for worsening condition. Review of R3's Nurse's Note, dated 12/01/2024 at 11:52 AM and authored by Licensed Practical Nurse (LPN) 1, revealed R3 was transferred to the local ED. LPN1 stated R3's family alerted staff that R3 was not responding. LPN1 stated upon assessment, R3 was lethargic, difficult to arouse, and would only respond to painful stimuli. She noted bodily tremors were observed. Review of R3's ED Provider Notes, dated 12/01/2024, revealed R3 presented to the ED in an altered mental status, septic, and in atrial fibrillation with rapid ventricular response (AFib RVR). R3 was febrile. His mental status was noted as somnolent, opened eyes to verbal stimuli, but was not conversant. Further review of the note revealed the physician stated, Upon my evaluation the patient had a high probability of imminent or life-threatening deterioration due to presentation which required my direct attention, intervention, and immediate management. During an interview with LPN1 on 12/18/2024 at 11:58 AM, she stated the nurse was responsible for the resident's admission. She stated she had not been aware she was responsible for initiating baseline care plans for residents. LPN1 stated further the MDS Nurse initiated and revised care plans as needed. 2. Closed Record Review of R2's Face Sheet, located in the resident's electronic medical record (EMR), revealed the facility admitted the resident on 10/09/2024, with diagnoses to include idiopathic hydrocephalus, peripheral vascular disease, and chronic total occlusion of artery of the extremities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185241	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R2's admission MDS, with an ARD of 10/14/2024, revealed the facility assessed the resident to have a BIMS score of nine out of 15, which indicated R2 was moderately cognitively impaired. Continued review revealed R2 was assessed as being at risk for developing pressure ulcers/injuries. Review of R2's Baseline Care Plan, dated 10/09/2024, located in the resident's EMR, revealed there was no documented evidence showing the facility had created a baseline care plan to address impaired skin. Further review indicated R2's baseline care plan did not include any documentation regarding actual skin breakdown, nor were there any treatments or interventions implemented to prevent further worsening. During an interview with F1 on 12/16/2024 at 9:26 AM, she stated R2 was currently receiving treatment at another facility for an unstageable pressure ulcer (PU) on her left heel, which she developed while at the facility. F1 stated the family requested a transfer to a local facility on 10/25/2024. During an interview with the PT Manager on 12/17/2024 at 10:55 AM, she stated she observed a change in R2's heel on 10/18/2024. The PT Manager stated the wound was closed and had a slight discoloration to the skin, but the area was red and blanchable. She stated she collaborated with the nursing staff to offload pressure and apply boots to both feet. According to the PT Manager, the wound status changed significantly from Friday (the 18th) to Monday (the 21st). On 10/21/2024 the area on R2's left heel was an open blister, and she could not complete her therapy session due to pain in her left foot. She stated she requested nursing staff to assess R2's left heel wound. Upon assessment, she stated the wound had grown in size and was secreting blood and drainage. During a telephone interview with the Wound Care Physician on 12/19/2024 at 12:06 PM, she stated on 10/23/2024, she examined R2's wound and found that the resident had an unstageable deep tissue injury on the left heel caused by pressure. She stated she ordered a new treatment regimen and prescribed an oral antibiotic. Additionally, she stated she instructed the staff to have the resident wear pressure-relieving boots and to ensure the wound was offloaded. During an interview with Registered Nurse (RN) 4 on 12/18/2024 at 12:51 PM, she stated the admitting nurse or Unit Manager initiated the baseline care plan based on the resident's diagnoses and discharge paperwork. RN4 stated interventions were initiated by nursing staff that addressed the resident's current needs to prevent decline such as infections or skin breakdown. RN4 stated care plans needed to be initiated the day of admission and reviewed by the Supervising Nurse or MDS Nurse within 48 hours. She stated nursing staff or nursing leadership should revise the plan of care to include services to prevent pressure ulcers. During an interview with RN6 on 01/03/2025 at 3:34 PM, she stated the baseline care plan should include nurse-initiated interventions based on diagnoses and discharge paperwork and be completed on the day of admission. She stated the baseline care plan should be reviewed by the MDS Nurse within 48 hours. She stated each care plan should be resident-centered. RN6 stated resident assessments and diagnosis codes helped the nursing staff ensure that interventions addressing the resident's current needs were initiated, which was crucial for improving care and preventing declines in health. (continued on next page)

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	185241	A. Building B. Wing	01/03/2025

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Infection Preventionist/Wound Care Nurse (IP/WCN) on 12/19/2024 at 10:17 AM, the IP/WCN stated that R2's care plan should have identified the existing skin breakdown upon admission due to her diagnosis of an arterial pressure injury to the left calf. She stated interventions should have been included to prevent further deterioration of the wound or the development of new wounds. During an interview with the MDS Nurse on 01/03/2025 at 11:06 AM, she stated baseline care plans should be initiated within 48 hours of a resident's admission. She stated if she was in the building when a newly admitted resident arrived at the facility, she assisted the admitting nurse with assessments and documenting a baseline care plan. The MDS Nurse stated, however, sometimes residents were admitted late on the evening shift or on a weekend, and in those cases, the process was for nursing management to review the baseline care plans within 48 hours. The MDS Nurse stated the baseline care plan should include health and safety concerns to prevent a decline in the resident's health. She stated the baseline care plan should also include any special needs such as antibiotic therapy, IV therapy, or PICC line care. According to the MDS Nurse, she stated she did not know why R2 and R3's baseline care plans were not completed to include interventions to reflect the residents' needs at the time of admission. During an interview with the Interim Director of Nursing (IDON) on 12/18/2024 at 10:06 AM, she stated the facility's process for initiating a new resident's baseline care plan was for the admitting nurse to initiate it within 48 hours, with interventions that addressed the resident's immediate needs. The IDON stated those interventions should include health and safety concerns to prevent a decline in the resident's health. She stated the baseline care plan should also include any special needs such as antibiotic therapy, IV therapy, or PICC line care. The IDON was unable to identify the process breakdown in ensuring that R2 and R3's baseline care plans were completed. During an interview with the Executive Director on 12/19/2024 at 1:08 PM, she stated it was her expectation that staff followed the facility's policies. She stated it was her expectation that the admitting nurse, or member of the nursing management present for an admission, entered a baseline care plan within 48 hours of a new resident's admission. She stated it was important to ensure safe and appropriate care for all residents. The facility provided an acceptable removal action plan on 01/02/2025 at 1:45 PM that read verbatim: Resident #3 discharged from [Facility Name] on 12/1/24. Identification of Residents Affected or Likely to be affected: Residents currently at [Facility Name]. Actions to prevent occurrence/recurrence: 1. An Ad Hoc QAPI meeting was held with DON, Medical Director and ED on 12/20/24 discussing IJ regarding Baseline Care Plans for Medical Director input. (continued on next page)

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	185241	A. Building B. Wing	01/03/2025

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The Director of Clinical Risk Management educated the DON and Nurse Managers on the Baseline Care Plan Policy. Completed 12/20/24 3. The Executive Director, Corporate Clinical Leadership Team, Director of Clinical Risk, DON discussed the Baseline Care Plan policy and the plan for the abatement. Completed 12/20 4. The Director of Clinical Reimbursement and the MDS nurse audited all baseline care plans for completion and accuracy. If the baseline care plan was missed during this time frame, comprehensive care plans from admissions dated 11/1/24 through 12/20/24 have been completed. 12/20/24. 5. Education was provided by DON/Nurse Managers for all nurses and KMAs regarding the Baseline Care Plan policy. Agency nurses are educated prior to their shift by the DON/Nurse Managers. 100% of nurses educated (1 nurse on leave will be educated prior to returning to work by the DON/Nurse Managers.) 6. Starting on 12/26/24 DON/Nurse Managers administer quizzes to nurses and KMAs regarding Baseline Care Plans and report results to the QAPI team weekly. Any nurses/KMAs not receiving a 100% correct will receive 1:1 education provided by the DON/Nurse Managers. 7. Beginning 12/21/24 - DON/Nurse Managers will audit Baseline Care Plan daily 7 days per week in morning clinical meetings. 100% Baseline Care Plans have been completed per policy. 8. DON/Nurse Managers reported results of the audit of baseline care plans, issues that needed resolution and how resolution was achieved to the QAPI committee on 12/27/24 and will continue to report to QAPI weekly for 4 weeks and then every other week until substantial compliance is achieved. 9. QAPI meeting on 12/27/24 was attended by Medical Director, Nurse Practitioner, ED, DON, Diet Tech, Nurse Manager, IP Nurse, Social Worker designee, Director of Facilities, Business Office Manager, MDS nurse, Director of Therapy and Life Enrichment Director. IJ abatement plan audits, results, and follow up were discussed. 10. The next QAPI meeting is scheduled for 1/3/25 and will review Baseline Care Plan completion. Date facility alleges IJ removal: 1/2/2025

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	185241	A. Building B. Wing	01/03/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on interview, record review, and review of the facility's policy, the facility failed to promptly identify and intervene with a significant change in a resident's condition, for the resident to receive treatment and care in accordance with professional standards of practice for 1 of 11 sampled residents, Resident (R) 3. R3 was admitted to the facility on [DATE] with diagnoses to include post-surgical infection of the intrathecal (the space between the spinal cord and the membranes that protect it) pain pump. The resident was to receive two weeks of intravenous (IV) antibiotic therapy by a peripherally inserted central catheter (PICC) line. However, the resident did not receive four of those ordered doses. In addition, the MAR revealed the physician ordered metronidazole (an antibiotic) to be administered orally every eight hours, but R3 did not receive five of those doses. On 12/01/2024, in the early hours of the morning, R3 was observed by Registered Nurse (RN) 2 to have a significant change in mental status. At 7:00 AM, during the shift change, RN2 communicated to Licensed Practical Nurse (LPN) 1 that the resident's mental status had deviated from baseline during the night. However, neither nurse rounded on R3 to assess his condition and failed to notify the physician or provider. On 12/01/2024 at approximately 11:30 AM, R3's family alerted LPN1 that R3 was febrile, unresponsive, and had tremors. The family requested the nurse to call emergency medical services (EMS) for transfer to the local emergency department (ED). The resident was admitted to the hospital with life-threatening deterioration and spent five days in a critical care unit (CCU) and was in the hospital for 12 days. Immediate Jeopardy (IJ) was identified on 12/20/2024 and was determined to exist on 11/26/2024, in the area of 42 CFR S483.25, F684 Quality of Care at a Scope and Severity (S/S) of a J related to KY00044335. The IJ at F684 also constituted Substandard Quality of Care (SQC) at 42 CFR 483.25. The facility was notified of the IJ on 12/20/2024 at 1:20 PM. On 12/20/2024 at 1:20 PM, the facility's Executive Director, Director of Corporate Risk Management, Unit Manager, and Infection Preventionist were provided a copy of the IJ Template and notified that the facility's failure to have an effective system to ensure residents received treatment and care in accordance with professional standards of practice has caused or is likely to cause serious injury, serious harm, or death. The facility provided an acceptable IJ Removal Plan, on 01/02/2025 at 1:45 PM, alleging removal of the IJ on 01/02/2025. The State Survey Agency (SSA) validated the IJ had been removed on 01/02/2025 at 1:45 PM as alleged, after an acceptable Removal Plan was received and further interviews, observations, and record reviews were conducted to verify the immediate corrections. Remaining non-compliance continued at a S/S of a D (no actual harm with a potential for more than minimal harm that is not immediate jeopardy) at F684. Refer to F580, F655, and F760 (continued on next page)

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	185241	A. Building B. Wing	01/03/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The findings include: Review of the facility's policy titled, Provision of Quality of Care, dated 12/20/2024, revealed the facility would ensure residents received treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person centered care plan, and the resident's choice. Further review revealed each resident would be provided care and services to attain or maintain his or her highest practicable physical mental and psychosocial well-being. Additionally, per the policy, all employees were responsible for following established policies and procedures. Closed record review of R3's Face Sheet, located in the resident's electronic medical record (EMR), revealed the facility admitted the resident on 11/26/2024, with diagnoses to include post laminectomy syndrome, post-surgical infection of the intrathecal pain pump, and idiopathic peripheral neuropathy. Review of R3's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/01/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 14 out of 15, which indicated R3 was cognitively intact. Continued review revealed R3 was assessed as having a wound infection and receiving oral and IV antibiotic therapy. Review of R3's Baseline Care Plan, dated 11/26/2024, located in the resident's EMR, revealed there was no documented evidence showing the facility had created a baseline care plan with treatments and interventions to address R3's current infection, antibiotic therapy, care of the PICC line, or physician notification for worsening condition. Review of R3's EMR clinical documentation revealed, from 11/27/2024 at 11:43 AM until 12/01/2024 at 11:52 AM, no nursing progress notes were documented that showed nursing staff had performed clinical assessments per professional standards of practice to evaluate the resident's condition. Review of R3's Physician Orders, located in the resident's electronic medical record (EMR), revealed on 11/26/2024, R3 was ordered cefepime, 2 grams (gm) IV twice daily at 9:00 AM and 9:00 PM for the treatment of infections. Additionally, on the same date, R3 was prescribed metronidazole, 500 milligrams (mg) one oral tablet taken every eight hours for infections. Review of R3's Medication Administration Record (MAR), dated 11/2024, and located in the resident's EMR, revealed the facility failed to administer three doses of ordered cefepime on 11/26/2024 at 9:00 PM; 11/27/2024 at 9:00 AM; and on 11/29/2024 at 9:00 AM. Further review revealed nursing staff administered IV antibiotics to R3 outside the scheduled parameters according to facility policy on four occasions: 1) on 11/27/2024 the 9:00 PM dose was administered on 11/28/2024 at 12:06 AM, resulting in a delay of two hours and six minutes; 2) on 11/29/2024 the 9:00 PM dose was administered at 10:30 PM, resulting in a delay of 30 minutes; 3) on 11/30/2024 the 9:00 AM dose was administered at 12:36 PM, resulting in a delay of two hours and 36 minutes; and 4) on 11/30/2024 the 9:00 PM dose was administered to R3 at 12:04 AM on 12/01/2024, resulting in a delay of two hours and four minutes. Review of R3's MAR, dated 12/2024, revealed the facility failed to administer one dose of ordered cefepime on 12/01/2024 at 9:00 AM. (continued on next page)

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	185241	A. Building B. Wing	01/03/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R3's MAR, dated 11/2024, revealed the facility failed to administer the following four doses of metronidazole: 11/26/2024 at 10:00 PM; 11/27/2024 at 6:00 AM or 2:00 PM; and 11/28/2024 at 2:00 PM. Review of R3's MAR, dated 12/2024, revealed the facility failed to administer one dose of metronidazole on 12/01/2024 at 6:00 AM. Review of R3's Nurse's Note, dated 12/01/2024 at 11:52 AM and authored by LPN1, revealed R3 was transferred to the local ED upon the request of family. LPN1 stated the resident's family alerted staff that R3 was not responding. LPN1 stated upon her assessment, R3 was lethargic, difficult to arouse, and would only respond to painful stimuli. She noted bodily tremors were observed. Review of R3's ED Provider Notes, dated 12/01/2024 at 2:47 PM, found in the local hospital records, revealed R3 presented to the ED in an altered mental status, septic, and in atrial fibrillation with rapid ventricular response (AFib RVR). R3 was febrile. His mental status was noted as somnolent, opened eyes to verbal stimuli, but was not conversant. Further review of the note revealed the physician stated, Upon my evaluation the patient had a high probability of imminent or life-threatening deterioration due to presentation which required my direct attention, intervention, and immediate management. Review of R3's Infectious Disease Progress Note, dated 12/08/2024 at 8:12 AM, found in the local hospital records, revealed R3 was admitted to the hospital and found to have an enterococcus faecium (VRE, a type of bacteria that could cause serious infections) bacteremia (a type of bacteria found in blood). Review of R3's Infectious Disease Progress Note, dated 12/12/2024 at 11:13 AM, found in the local hospital records, revealed R3 presented with a temperature of 102.2 degrees Fahrenheit (F) upon admission to the local hospital. Further review revealed the resident continued on IV and oral antibiotic therapy for an additional six weeks. Review of R3's clinical records, located in the resident's EMR, revealed there was no documentation on 11/30/2024 or 12/01/2024 by RN2 during the 7:00 PM to 7:00 AM shift related to R3's lethargy or change in mental status. Review of R3's Weights and Vitals Summary, dated 11/26/2024 through 11/29/2024, located in the resident's EMR, revealed the last documented completed set of vital signs taken on R3 was on 11/29/2024 at 2:23 PM. Observation and resident interview not conducted due to the resident being discharged from the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Family Member (F) 2 on 12/18/2024 at 12:23 PM, she stated when family came to visit R3 on 12/01/2024 at 11:10 AM, they found R3 unresponsive, feverish, sweaty, and exhibiting seizure like activity. F2 stated the family alerted LPN1 of R3's change in condition (CIC), and they requested LPN1 to call emergency medical services (EMS) for transfer to the local emergency department. F2 stated R3 was admitted to the local hospital's CCU for one week. She stated R3 had returned home and required an additional 10 weeks of IV antibiotic therapy. Additionally, F2 stated LPN1 told the family she was made aware of R3's CIC at 7:00 AM, during the shift change report. However, F2 stated LPN1 told F2 she had not seen R3 or assessed him that morning, and he had not received his 9:00 AM dose of IV antibiotic therapy. During an interview with LPN1 on 12/18/2024 at 11:58 AM, she stated she received a verbal report from RN2 that R3 had been lethargic and had altered mental status overnight, but she stated RN2 stated R3 was fine after aides changed him. LPN1 stated at around 11:00 AM, when the family made her aware of R3's deterioration, she had not seen or assessed the resident and had not given him his 9:00 AM dose of antibiotic. LPN1 stated that particular day (12/01/2024) was busy and got behind on her medication administration. She stated she managed her tasks as best she could. Additionally, LPN1 stated she did not remember if she communicated her need for assistance or asked the unit coordinator (UC) for support. Furthermore, she stated residents should be checked on at least every two hours to ensure their safety, noting that rounding on a resident included entering the resident's room to visually assess their condition. On 12/18/2024 at 11:57 AM and 12/19/2024 at 12:50 PM, the State Survey Agency (SSA) Surveyor left voice messages for RN2 to return the call for an interview. The interview was not conducted because RN2 did not return the calls from the SSA Surveyor. During an interview with RN4 on 12/18/2024 at 12:51 PM, she stated nursing staff should round on every resident every hour. According to RN4, rounding included the nurse laying eyes on the resident, assessing the resident's status, and asking purposeful questions to ensure the resident's needs were met. She stated that hourly rounding was important for the resident's safety and well-being. During a telephone interview with the Medical Director on 12/19/2024 at 12:40 PM, he stated he expected the nursing staff to administer medications as ordered by the medical provider. The Medical Director stated administering antibiotics on time was important to ensure that all bacteria causing the infection were eliminated and to prevent the infection from recurring. Per the interview, the Medical Director stated it was his expectation that staff followed all facility policies to ensure quality of care and the safety of the residents. During an interview with the Interim Director of Nursing (IDON) on 12/18/2024 at 10:06 AM, she stated per policy, RN2 should have notified R3's physician related to the resident's change in mental status and condition. Additionally, the IDON stated RN2 should have completed an assessment of R3's condition, which included all vital signs, and documented her findings in the resident's EMR. Furthermore, the IDON stated that LPN1 should have assessed R3 immediately after she received report from RN2. The IDON stated nursing staff should check on every resident every hour. She stated clinical rounding involved the nurse visually assessing the resident's condition and asking intentional questions to ensure that the resident's needs were being met. She stated timely assessments, notification of a change in condition, documentation, and hourly rounding were all crucial for the safety and well-being of the residents. The IDON stated her expectation was for nursing staff to follow clinical guidelines and policies and provide quality care according to current nursing care standards. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Executive Director (ED) on 12/19/2024 at 1:08 PM, she stated it was her expectation that staff followed the facility's policy related to quality of care. She stated it was her expectation that the facility's staff provided care according to current nursing care standards. The ED stated it was important to ensure safe and appropriate care for all residents. The facility provided an acceptable removal action plan on 01/02/2025 at 1:45 PM that read verbatim: Resident #3 discharged from [Facility Name] on 12/1/24 Identification of Residents Affected or Likely to be affected: Residents currently at [Facility Name]. Actions to prevent occurrence/recurrence: 1 .An Ad Hoc QAPI meeting was held with DON, Medical Director and ED on 12/20/24 to discuss quality of care related to Medication Administration, Baseline Care Plans, and Notification of Changes in Resident Condition for Medical Director input. Completed 12/20/24 2. Notification of Changes Policy The Baseline Care Plan Policy and the Medication Administration Policy were reviewed immediately for accuracy by the Director of Clinical Risk Management. Completed 12/20/24 3. The Executive Director, Corporate Clinical Team and DON discussed the Notification of Changes in Condition, Medication Administration, and Baseline Care Plan policies and the plan for abatement. Completed 12/20/24 4. The Executive Director, Corporate Clinical Team and DON discussed the Provision of Quality Care policy. Completed 12/20/24 5. The Director of Clinical Risk Management educated the DON, Nurse Managers and ED regarding Baseline Care Plans, Medication Administration and Notification of Changes in Resident Condition and Provision of Quality Care policies. Completed 12/20/24 6. The DON/Nurse Managers provided education for all nurses and KMAs regarding Notification of Changes, Baseline Care Plan, and Medication Administration policies and provisions of the Quality of Care policy prior to their next shift. Agency nurses received education prior to their shift by DON/Nurse Managers. 100% completion of active staff, 1 nurse on leave will be educated by the DON/Nurse Manager prior to returning to work. Completed 12/20/24. 7. Going forward all newly hired nurses and all agency staff will be educated by the DON/Nurse Managers on the Notification of Changes, Baseline Care Plan, Medication Administration, Provision of Quality Care policies and the Nurse Clinical Binder. 8. On 12/20/24 DON/Nurse Managers completed an audit of all progress notes 11/26/24 through current immediately for changes in condition of identified residents and proper notification of MD and Responsible Party as appropriate. Completed 12/20/24 (continued on next page)

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Madonna Manor	2344 Amsterdam Road Villa Hills, KY 41017

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. STNAs, Housekeepers and Dining staff received information via text regarding: if they notice a change in a residents' condition that they should report it to the nurse immediately. Completed 12/20/24 10. Director of Clinical Risk Management/DON audited all missed meds for identified residents using the Medication Administration Audit Report. Completed 12/20/24 11. DON notified the Medical Director of results of the Medication Admin Audit report and asked for any new orders. No new orders given. DON notified responsible parties of any current affected residents. Completed 12/20/24 12. The Director of Clinical Reimbursement and MDS nurse audited baseline care plans for admissions 11/1/24 through 12/20/24 for completion and accuracy. If incomplete or inaccurate, comprehensive care plans have been completed by the Director of Clinical Reimbursement/MOS nurse. Completed 12/20/24 13. Beginning on 12/21/24 in morning clinical meeting- DON/Nurse Managers review 24 hour report sheet and 24 hour summary report in PCC daily 7 times per week for appropriate notification of changes in resident condition. The DON reported results of the audit to the QAPI committee on 12/27/24 and will continue to report audit results to QAPI weekly for 4 weeks then every other week until substantial compliance is achieved. 1. Beginning on 12/21/24 - The Medication Admin Audit Report in PCC is completed daily 7 days per week by DON/Nurse Managers. Missed medications will be reported to the MD and responsible party immediately as per policy by the DON/Nurse Manager. Report audit results to QAPI weekly for 4 weeks then every other week until substantial compliance is achieved. 2. Starting on 12/21 Nurse Managers provide daily 1:1 Nurse/KMA coaching to ensure medication administration per MD orders and following the nursing process to assure quality care. 14. Beginning on 12/21/24 - Audit of baseline care plans will be by the DON/Nurse Managers daily 7 days per week with immediate follow up. 100% compliance has been achieved to date. DON reported results to QAPI committee on 12/27/24 and will continue to report audit results to QAPI weekly for 4 weeks then every other week until substantial compliance is achieved. 15. QAPI meeting on 12/27/24 was attended by Medical Director, Nurse Practitioner, ED, DON, Diet Tech, Nurse Manager, IP Nurse, Social Worker designee, Director of Facilities, Business Office Manager, MOS nurse, Director of Therapy and Life Enrichment Director. IJ abatement plan audits, results, and follow up were discussed. 16. Next QAPI meeting scheduled for 1/3/25 (1/3/25).

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on interview, record review, and review of the facility's policies, the facility failed to provide services to prevent pressure ulcers for 1 of 11 sampled residents, Resident (R) 2. On 10/18/2024 an unstageable wound to R2's left bottom heel was found by Physical Therapy (PT) staff. The nursing staff was notified; however, they failed to put interventions in place to care for the wound and prevent further worsening. In addition, the facility failed to include interventions to address R2's need to ensure pressure off-loading boots were on the resident and to off-load the wound while in the bed or up in the wheelchair. The findings include: Review of the facility's policy titled, Pressure Injury Prevention Guidelines, revised 11/23/2022, revealed measures would be taken to prevent avoidable pressure injuries and to promote the healing of existing ones. Per the policy, the facility would implement evidence-based interventions for all residents assessed as being at risk or who currently had a pressure injury. The policy stated these interventions would be resident-centered and carried out according to physician orders. Review of the facility's policy titled, Wound Treatment Management, revised 11/23/2022, revealed wound treatments would be provided by physician orders and were based on the etiology (cause) of the wound, characteristics, location, and the preferences of the resident or their representative. Additionally, the policy stated all treatments would be recorded in the treatment administration record (TAR). The effectiveness of treatments would be monitored through ongoing assessments of the wound. Closed Record Review of R2's Face Sheet, located in the resident's electronic health record (EHR), revealed the facility admitted the resident on 10/09/2024 with diagnoses to include idiopathic hydrocephalus, peripheral vascular disease, and atherosclerosis of native arteries of left leg with ulceration of calf. Review of the pre-admission to the facility local hospital's Wound Care Note, dated 10/07/2024 at 11:23 AM, found in the EHR, revealed R2 had a stage 3 pressure injury to the left calf area (Achilles) that was red, yellow, moist, and with full-thickness skin loss. Per the note, the wound was complicated by poor vascular status. Additionally, the note stated there was an open laceration/cut in skin on the left lateral heel, and the remainder of the left heel was red and blanchable. Review of the local hospital's Discharge Summary, dated 10/09/2024 at 12:14 PM, found in the EHR, revealed R2 was admitted with an arterial occlusion (restriction of arterial blood flow) of the lower extremity and atherosclerosis of native artery of left lower extremity with ulceration (a sore in the skin or mucous membrane) of calf. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R2's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 10/14/2024 and found in the EHR, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of nine out of 15, which indicated R2 was moderately cognitively impaired. Continued review revealed R2 was assessed as being at risk for pressure ulcer development; however, the facility did not assess the resident as having current skin breakdown, current venous and arterial ulcers, or other skin problems. Furthermore, the facility assessed the resident as needing substantial/maximal assistance (helper did more than half the effort) for bed mobility and transferring. Review of R2's Baseline Care Plan [BCP], initiated 10/09/2024 and last updated 11/04/2024, found in the EHR, revealed the facility identified the resident was at risk for pressure ulcer development and included interventions such as assisting and encouraging the resident to reposition routinely and as needed. Further review revealed the facility noted in the interventions to administer treatments as ordered, monitor for effectiveness, and provide a pressure reducing cushion and mattress. However, the facility failed to include resident-centered interventions to off-load the wound while in the bed or up in the wheelchair. Continued review revealed the facility failed to include interventions to address the need to ensure pressure off-loading boots were on the resident. Review of R2's Physician Orders, dated 10/2024 and found in the EHR, revealed an order for weekly skin assessments to be done every Thursday evening beginning 10/10/2024 at 7:00 PM. Review of R2's TAR, dated 10/2024, found in the EHR, revealed only one skin assessment was performed, on 10/10/2024, during her admission to the facility. Skin assessments scheduled for 10/17/2024 and 10/24/2024 were not documented as being completed. Review of R2's PCC Skin & Wound - Total Body Skin Assessment, dated 10/10/2024 at 11:51 PM, found in the EHR, revealed R2 was assessed as having 0 wounds. Her skin was assessed as having good elasticity, normal color, warm temperature, and normal moisture and condition. Review of R2's provider's Progress Note, dated 10/10/2024 at 2:38 PM, found in the EHR, revealed the Advanced Practice Registered Nurse (APRN) documented an ulcer to left Achilles and a lateral heel laceration with skin breakdown. The note stated to encourage off-loading pressure and to monitor for signs and symptoms of infection. R2's TAR and BCP were not revised to add these nursing care measures. Review of R2's CHI Skilled/Episodic Note - V.5, dated 10/12/2024 at 5:26 PM, found in the EHR, revealed Licensed Practical Nurse (LPN) 4 documented R2 had no skin abnormalities, and her skin was intact. Review of R2's provider's Progress Note, dated 10/14/2024 at 11:32 AM, found in the EHR, revealed the APRN documented an ulcer to left Achilles and a lateral heel laceration with skin breakdown. Per the progress note, there were no signs or symptoms of infection. The APRN wrote to encourage off-loading pressure and to monitor for s/s of infection. The TAR and BCP were not revised to add these nursing care measures. Review of R2's provider's Progress Note, dated 10/16/2024 at 3:59 PM, found in the EHR, revealed the Infection Preventionist/Wound Care Nurse (IP/WCN) documented R2 was seen by the Wound Care Physician, and the area to the posterior left lower extremity (Achilles area) was healed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R2's Physical Therapy Treatment Encounter Notes, dated 10/18/2024, found in the EHR, revealed the physical therapist noted an unstageable wound to the left heal. According to the note, the therapy staff notified nursing staff of the wound and educated them to float heels when in bed. Review of R2's CHI Skilled/Episodic Note - V.5, dated 10/20/2024 at 3:53 PM, found in the EHR, revealed Registered Nurse (RN) 7 documented R2's skin integrity was not intact and an impaired skin condition is noted. No further details were provided. Review of R2's Progress Note, dated 10/22/2024 at 10:42 AM, from the EHR, revealed RN3 completed R2's skin assessment and documented that R2 had an open area and a blister on her left heel. Per the note, the open area measured approximately 3.0 inches by 2.0 inches. The wound was observed to have clear drainage accompanied by a slight odor. It was noted that new treatment orders were received. Review of R2's CHI Skilled/Episodic Note - V.5, dated 10/23/2024 at 1:12 PM, found in the EHR, revealed LPN5 documented R2's skin integrity was not intact and an impaired skin condition is noted. No further details were provided. It was noted that R2 was compliant with skin interventions. Review of R2's provider's Progress Note, dated 10/23/2024, found in the EHR, revealed the APRN documented an unstageable ulcer to left heel. Per the progress note, she stated there was a blister on left heel, 3 x 2, clear drainage with foul odor. Per the note, the APRN consulted with the Wound Care Physician who was in the building. Review of R2's Progress Notes, on 10/23/2024 at 1:22 PM, found in the EHR, revealed the IP/WCN documented R2 was seen by the Wound Care Physician for a wound on the left heel. Per the note, new orders were given, including the initiation of oral antibiotic therapy to treat the wound infection. Review of R2's Wound Evaluation and Management Summary, dated 10/23/2024 at 2:32 PM, found in the EHR, revealed the Wound Care Physician was referred by the facility to assesses R2's wound. Per his assessment, he noted the resident had an unstageable DTI from pressure to her left bottom heal measuring (length (L) x width (W) x depth (D)): 5.0 L x 8.0 W x 0.1 D centimeters (cm), with moderate serous exudate (bloody drainage). Further review revealed the wound care provider wrote orders to cleanse the wound with saline at the time of dressing change, off-load the wound, use pressure boot, and start on oral antibiotic therapy. Per the note, the physician stated the updated plan of care was discussed with the resident, the assigned nurse, and a nursing staff member. Review of R2's CHI Skilled/Episodic Note - V.5, dated 10/24/2024 at 7:10 PM, found in the EMR, revealed LPN6 documented R2's skin integrity was intact and without abnormalities. Review of R2's Discharge (return anticipated) MDS, dated [DATE], revealed the facility identified the resident as having an unstageable DTI to the left heel that was not present on admission. Review of R2's Progress Note, dated 10/25/2024 at 2:33 PM, found in the EHR, revealed R2 was discharged from the facility at the family's request, but it did not specify the facility to which the family was taking the resident. According to the note, R2's family was given the resident's order summary. Observation and interview of R2 could not be conducted due to R2 being discharged from the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During interview with Family Member (F) 1 on 12/16/2024 at 9:26 AM, she stated R2 had currently received treatment at a local hospital for an unstageable pressure ulcer (PU) on her left heel, which she developed while at the facility. F1 expressed concern that the nursing staff and former Director of Nursing (DON) did not listen to the family's concerns or notify the medical provider when the Physical Therapist discovered the pressure ulcer. According to F1, on 10/14/2024, during a care conference held with the former Director of Nursing (DON), it was agreed that R2's leg would remain elevated to prevent further pressure wounds. However, she stated this agreement had not been honored. F1 stated despite repeated requests, the staff failed to off-load pressure on R2's left heel or place pressure relieving boots on when up and in bed. During interview with the former DON on 12/16/2024 at 1:45 PM, she stated R2 had not been at the facility very long. She stated the resident developed a wound on her left heel during her stay and was evaluated by the Wound Care team. Following this assessment, she stated the facility physician prescribed oral antibiotic therapy. However, the former DON could not recall the timeline regarding when the wound was first noticed, when the physician was notified, or when the resident first received the oral antibiotics. Additionally, she stated while heel boots had been ordered for the resident, R2 repeatedly kicked them off. The former DON stated she was unable to remember if the nursing staff had documented the resident's non-compliance with this care. During interview with the PT Manager on 12/17/2024 at 10:55 AM, she stated during a physical therapy session on 10/18/2024 with R2, she observed a change in the resident's heel. The PT Manager stated the wound was closed and had a slight discoloration to the skin, but the area was red and blanchable. She stated she collaborated with the nursing staff to offload pressure and apply boots to both feet. According to the PT Manager, the wound status changed significantly from Friday (the 18th) to Monday (the 21st). She stated on 10/21/2024 the area on R2's left heel was an open blister, and R2 could not complete her therapy session due to pain in her left foot. She stated she requested nursing staff to assess R2's left heel wound. Upon assessment, she stated the wound had grown in size and was secreting blood and drainage. During interview with RN4 (also a Unit Manager) on 12/18/2024 at 12:51 PM, she stated nursing should document findings and assessments in the nursing progress notes and communicate concerns on the 24-hour report. RN4 stated nurses should document treatments in the TAR when completed. During interview with the Interim Director of Nursing (IDON) on 12/18/2024 at 10:06 AM, she stated it was her expectation for nursing staff to document all their assessments and treatments. She stated record-keeping was crucial in demonstrating that care was provided. She also stated it was important for nursing staff to have initiated pressure wound interventions and followed treatment orders for R2 to wear bilateral pressure boots and off-loaded the extremity to prevent a pressure ulcer from developing or worsening. She further stated it was her expectation that nursing staff followed facility policies and protocols to prevent pressure ulcers, as this was important for the safety and well-being of the resident and to prevent further harm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During interview with the Infection Preventionist/Wound Care Nurse (IP/WCN) on 12/19/2024 at 10:17 AM, she stated she became aware of R2's heel wound on 10/21/2024. At that time, she stated she communicated with the Wound Care Physician. On 10/22/2024, she stated she conducted a skin assessment on R2 and discovered an open area on the resident's left heel. The IP/WCN stated she informed the Wound Care Physician, who then issued new treatment orders. She stated the admitting nurse should have performed a comprehensive head-to-toe assessment of the resident to check for any skin breakdown and document the findings in the resident's EHR. She stated any areas of concern should be communicated to the healthcare provider. The IP/WCN stated she did not know why nursing staff did not inform her of R2's newly developed wound on 10/18/2024. Additionally, the IP/WCN stated R2's care plan should have included interventions to prevent further deterioration of the wound or the development of new wounds. During telephone interview with the Wound Care Physician on 12/19/2024 at 12:06 PM, she stated on 10/23/2024, she examined R2's wound and found R2 had an unstageable deep tissue injury (DTI) on the left heel caused by pressure. She stated she ordered a new treatment regimen and prescribed an oral antibiotic. Additionally, she stated she instructed the nursing staff to have the resident wear pressure-relieving boots and to ensure the wound was offloaded. During interview with the APRN on 12/20/2024 at 1:00 PM, she stated she was made aware of R2's new wound on her left heel by nursing staff on 10/21/2024. She stated she provided new orders for the resident to wear pressure boots on bilateral lower extremities at night and a new wound treatment. She stated on 10/23/2024, she examined the resident and collaborated with the Wound Care Physician, recommending R2 start oral antibiotics. She stated the decision to initiate the antibiotic treatment course was made after the Wound Care Physician assessed the resident later the same day. She stated it was her expectation that nursing staff followed the medical provider's orders and provided services to prevent pressure ulcers from developing or worsening. She stated it was important to ensure safe and appropriate care for all residents. During interview with the Executive Director on 12/19/2024 at 1:08 PM, she stated it was her expectation that staff followed the facility's policies and protocols for resident care. She stated it was her expectation that nursing staff provided services to prevent pressure ulcers. She stated it was important to ensure safe and appropriate care for all residents.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on interview, record review, and review of the facility's policy, the facility failed to have an effective system in place to ensure residents were free from significant medication errors for 1 of 2 sampled residents receiving intravenous (IV) antibiotic therapy, Resident (R) 3. On 11/26/2024, the facility admitted R3 with diagnoses to include post laminectomy syndrome (chronic pain following back surgery; a laminectomy was removing part or all of the bony arch that covered the spinal cord) and post-surgical infection of the intrathecal (the space between the spinal cord and the membranes that protect it) pain pump. The resident was scheduled to receive two weeks of intravenous (IV) antibiotic therapy while at the facility. Review of R3's Medication Administration Record [MAR] revealed the physician had ordered cefepime (an antibiotic given for infection) to be administered IV twice daily, but he did not receive four of those ordered doses. In addition, the MAR revealed the physician ordered metronidazole (an antibiotic) to be administered orally every eight hours, but he did not receive five of those doses. On 12/01/2024 at approximately 11:30 AM, R3's family alerted Licensed Practical Nurse (LPN) 1 that R3 was febrile, unresponsive, and had tremors. The family requested the nurse to call emergency medical services (EMS) for transfer to the local emergency department (ED). R3 presented to the ED in an altered mental status, septic, and in atrial fibrillation with rapid ventricular response (AFib RVR). R3 spent five days in a critical care unit (CCU) and was in the hospital for 12 days. Immediate Jeopardy (IJ) was identified on 12/20/2024 and was determined to exist on 11/26/2024, in the area of 42 CFR S483.45, F760 Free of Significant Medication Errors at a Scope and Severity (S/S) of a J related to KY00044335. The IJ at F760 also constituted Substandard Quality of Care (SQC) at 42 CFR 483. 45. The facility was notified of the IJ on 12/20/2024 at 1:15 PM. On 12/20/2024 at 1:15 PM, the facility's Executive Director, Unit Manager, and Infection Preventionist were provided a copy of the IJ Template and notified that the facility failed to have a system to ensure R3's medications were administered as ordered and verified. This failure is likely to cause serious injury, impairment, or death. The facility provided an acceptable IJ Removal Plan, on 01/02/2025 at 1:45 PM, alleging removal of the IJ on 01/02/2025. The State Survey Agency (SSA) validated the IJ had been removed on 01/02/2025 at 1:45 PM, after an acceptable Removal Plan was received and further interviews, observations, and record reviews were conducted to verify the immediate corrections. Remaining non-compliance continued at a S/S of a D (no actual harm with a potential for more than minimal harm that is not immediate jeopardy) at F760. Refer to F655 and F684 The findings include: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Medication Administration, undated, revealed medications were administered as prescribed by the physician and in accordance with established professional standards of practice. Further review revealed the facility upheld the rights related to medication administration, which included ensuring medications were given at the appropriate times. Per the policy, all medications should be administered within 60 minutes prior to or after the scheduled time. Closed Record Review of R3's Face Sheet, located in the resident's electronic medical record (EMR), revealed the facility admitted the resident on 11/26/2024 with diagnoses to include post laminectomy syndrome, post-surgical infection of the intrathecal pain pump, and idiopathic peripheral neuropathy. Review of R3's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/01/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 14 out of 15, which indicated R3 was cognitively intact. Review of R3's Physician Orders, located in the resident's electronic medical record (EMR), revealed on 11/26/2024, R3 was ordered cefepime, 2 grams (gm) IV twice daily at 9:00 AM and 9:00 PM for the treatment of infections. Additionally, on the same date, R3 was prescribed metronidazole, 500 milligrams (mg) one oral tablet taken every eight hours for infections. Review of R3's MAR, dated 11/2024, and located in the resident's EMR, revealed the facility failed to administer three doses of ordered cefepime on 11/26/2024 at 9:00 PM; 11/27/2024 at 9:00 AM; and on 11/29/2024 at 9:00 AM. Further review revealed nursing staff administered IV antibiotics to R3 outside the scheduled parameters according to facility policy on four occasions: 1) on 11/27/2024 the 9:00 PM dose was administered on 11/28/2024 at 12:06 AM, resulting in a delay of two hours and six minutes; 2) on 11/29/2024 the 9:00 PM dose was administered at 10:30 PM, resulting in a delay of 30 minutes; 3) on 11/30/2024 the 9:00 AM dose was administered at 12:36 PM, resulting in a delay of two hours and 36 minutes; and 4) on 11/30/2024 the 9:00 PM dose was administered to R3 at 12:04 AM on 12/01/2024, resulting in a delay of two hours and four minutes. Review of R3's MAR, dated 12/2024, revealed the facility failed to administer one dose of ordered cefepime on 12/01/2024 at 9:00 AM. Review of R3's MAR, dated 11/2024, revealed the facility failed to administer the following four doses of metronidazole: 11/26/2024 at 10:00 PM; 11/27/2024 at 6:00 AM or 2:00 PM; and 11/28/2024 at 2:00 PM. Review of R3's MAR, dated 12/2024, revealed the facility failed to administer one dose of metronidazole on 12/01/2024 at 6:00 AM. Review of R3's Nurse's Note, dated 12/01/2024 at 11:52 AM and authored by LPN1, revealed R3 was transferred to the local ED. LPN1 stated R3's family alerted staff that R3 was not responding. LPN1 stated upon assessment, R3 was lethargic, difficult to arouse, and would only respond to painful stimuli. She noted bodily tremors were observed. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R3's ED Provider Notes, dated 12/01/2024, revealed R3 presented to the ED in an altered mental status, septic, and in atrial fibrillation with rapid ventricular response (AFib RVR). R3 was febrile. His mental status was noted as somnolent, opened eyes to verbal stimuli, but was not conversant. Further review of the note revealed the physician stated, Upon my evaluation the patient [resident] had a high probability of imminent or life-threatening deterioration due to presentation which required my direct attention, intervention, and immediate management. During an interview with Family Member (F) 2 on 12/18/2024 at 12:23 PM, she stated when family came to visit R3 on 12/01/2024 at 11:10 AM, they found R3 unresponsive, feverish, sweaty, and exhibiting seizure like activity. F2 stated the family alerted LPN1 of R3's change in condition (CIC), and they requested LPN1 to call emergency medical services (EMS) for transfer to the local emergency department. F2 stated R3 was admitted to the local hospital's critical care unit (CCU) for several weeks. She stated R3 had returned home and required an additional 10 weeks of intravenous [IV] antibiotic therapy. During an interview with LPN1 on 12/18/2024 at 11:58 AM, she stated at the time the family made her aware of R3's CIC at around 11:00 AM, she had not seen R3 and had not given him his 9:00 AM dose of IV antibiotics. LPN1 stated that all medications should be given as ordered. During further interview, LPN1 stated that on 12/01/2024, it was a particularly busy day, and she had fallen behind on her assessments and medication administration. She stated she had tried her best to manage her tasks. Additionally, LPN1 stated she did not recall if she communicated her need for assistance or asked the unit coordinator (UC) for support. During an interview with the Advanced Practice Registered Nurse (APRN) on 12/20/2024 at 1:15 PM, she stated she expected the nursing staff to administer medication as ordered by the medical provider. She stated administering medication on time, every time, was important to ensure that all bacteria causing the infection were eliminated. She stated this was also the best approach to prevent the infection from recurring. During a telephone interview with the Medical Director on 12/19/2024 at 12:40 PM, he stated he expected the nursing staff to administer medication as ordered by the medical provider. The Medical Director stated administering antibiotics on time was important to ensure that all bacteria causing the infection were eliminated and to prevent the infection from recurring. Per the interview, the Medical Director stated it was his expectation that staff followed all facility policies to ensure quality of care and the safety of the residents. During an interview with Registered Nurse (RN) 4/Unit Manager (RN/UM) on 12/18/2024 at 12:51 PM, she stated nursing staff should administer antibiotic medication as ordered to treat and prevent the infection from recurring. She stated that administering medication timely was important for the resident's safety and well-being. During an interview with the Interim Director of Nursing (IDON) on 12/18/2024 at 10:06 AM, she stated the unit managers were responsible for auditing medication administration on their units; however, there was no formal documentation of those audits. The IDON stated it was her expectation that licensed staff should administer antibiotics as prescribed and timely to ensure the infection was treated and to prevent recurrence. She further stated that timely medication administration was crucial for the resident's safety and well-being. (continued on next page)

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	185241	A. Building B. Wing	01/03/2025

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Executive Director (ED) on 12/19/2024 at 1:08 PM, she stated it was her expectation that staff adhered to the facility's medication administration policy. The ED stated following the medical provider's orders was crucial for ensuring safe and appropriate care for all residents. The facility provided an acceptable removal action plan on 01/02/2025 at 1:45 PM that read verbatim: Resident #3 was discharged from [Facility Name] on 12/1/24. Identification of Residents Affected or Likely to be affected: Residents currently at [Facility Name]. Actions to prevent occurrence/recurrence: l. An Ad Hoc QAPI meeting was held with DON, Medical Director and ED on 12/20/24 discussed IJ regarding Medication Administration for Medical Director input. 2. The Corporate Clinical team, VP of Operations, Executive Director and DON discussed the Medication Administration policy and the plan for abatement. 12/20/24 3. The Director of Clinical Risk Management reviewed the Medication Administration policy. Completed 12/20/24. 4. The Director of Clinical Risk Management educated the DON and Nurse Managers regarding the Medication Administration policy. Completed 12/20/24 5. The Director of Clinical Risk Management and the DON audited all missed meds using the Medication Admin Audit Report in PCC and communicated with MD and responsible party as needed. Completed 12/20/24 6. The DON/Nurse Managers provided education for all nurses and KMAs regarding Medication Administration policy and the Nurse Clinical Binder. Agency Nurses are educated prior to their shift. 100% complete with 1 nurse on leave who will be educated prior to her return to work. 7. Nurses were educated by the DON/Nurse Managers on the Nurse Clinical Binder that includes information on Daily Nurse Expectations, pharmacy cut off times, admission/readmission orders, what to do when a medication is unavailable, what to do when someone admits to the facility, what to do when a resident receives new orders, what to do when sending someone to the hospital, what to do when you receive medications from the pharmacy and Medication Administration Special Considerations. Education was initially completed by the DON on [DATE]th and [DATE]th at the Monthly All Staff Clinical Meeting. Beginning 12/21 the DON/Nurse Managers started referencing the Nurse Clinical Binder as education on step by step guides for nurses and KMAs. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. DON/Nurse Managers administer quizzes to nurses and KMAs regarding Medication Administration. DON/Nurse Managers follow up with Nurse/KMA if a question is missed and reports results to QAPI team weekly. 9. Starting 12/21/24, DON/Nurse Manager completes audit daily 7 days per week using Medication Admin Audit Report in PCC. DON/ Nurse Managers address issues immediately with appropriate nurse or KMA and assures follow up regarding notification policy. 10. Starting on 12/21 Nurse Managers provided daily 1:1 Nurse/KMA coaching to ensure medication administration per MD orders. 11. Starting with admissions on or after 1/1/25 DON/Nurse Managers compare the hospital discharge summary to the MD orders in PCC for all new admissions, within 12 hours of admission, to assure accuracy and timeliness of medication administration. Results of the audits will be reported to the QAPI committee weekly for 4 weeks and every other week until substantial compliance is achieved. 12. DON/Nurse Manager reported results of audits, follow up, and trends to QAPI committee on 12/27/24 and will continue to report data to QAPI weekly for 4 weeks and then every other week until we are in substantial compliance. 13. QAPI meeting on 12/27/24 was attended by Medical Director, Nurse Practitioner, ED, DON, Diet Tech, Nurse Manager, IP Nurse, Social Worker designee, Director of Facilities, Business Office Manager, MDS nurse, Director of Therapy and Life Enrichment Director. IP abatement plan audits, results, and follow up were discussed. 14. The next QAPI meeting is scheduled for 1/3/25. Date facility alleges IJ removal: 1/2/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44001 Based on interview, record review, and facility policy review, the facility failed to ensure drugs and biologicals were stored according to professional standards for 1 of 3 medication carts where an opened pharmacy delivery tote with medications was left unattended. The findings include: Review of the facility's policy titled, Storage of Medications, undated, revealed drugs and biologicals stored in the facility were kept in locked compartments, accessible only to authorized personnel. According to the policy, nursing staff was responsible for managing medication storage. Per the policy, compartments containing drugs and biologicals must be locked when not in use, and any unlocked medications should not be left unattended. Observation of a medication cart in the Household B Hall on 12/12/2024 at 10:31 AM, revealed an opened pharmacy delivery tote full of medications. The delivery tote was left opened, unsecured, and unattended out in the open as residents and staff walked by. The tote contained two boxes of multiple single dose albuterol (bronchodilator) inhalation solution packets for nebulizer treatments, several intravenous (IV) fluid bags containing normal saline, multiple heparin (an anticoagulant) flush injections, and two 100-milliliter (mL) bags of IV ceftriaxone (an antibiotic). During interview with Licensed Practical Nurse (LPN) 1 on 12/12/2024 at 10:38 AM, she stated the pharmacy had just delivered the medication, and she had not had a chance yet to place the storage tote in the medication storage room. She stated she had stepped away from the cart to administer medication to a resident and was going to place the contents of the tote in the medication cart. LPN1 stated facility protocol was to place medication in the medication storage room or in the designated medication cart when inventory was received from the pharmacy. During interview with Registered Nurse (RN) 3 on 12/12/2024 at 10:45 AM, she stated medication inventory should be stored in the medication room when it was received from the pharmacy and should never be left unlocked and unattended. She stated leaving medication out could pose a risk to residents. During interview with the Interim Director of Nursing (IDON) on 12/12/2024 at 10:32 AM, she stated when inventory was received from the pharmacy, it should be put away in its correct location, either in the medication room or in the medication cart. She stated not ensuring medication was stored properly and locked when unattended could pose a safety risk to residents. She stated nursing staff was responsible for the medication cart, and medication should not be left unattended. The IDON further stated storing medications appropriately prevented the diversion of drugs by other staff members or visitors. During interview with the Executive Director on 12/19/2024 at 1:08 PM, she stated it was her expectation that staff followed the facility's policy. She stated it was her expectation that staff properly stored and locked medication when it arrived from the pharmacy. She further stated it was important to ensure safe and appropriate care for all residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, review of the manufacturer's instructions for use, and review of the facility's policies, 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 for 2 of 11 sampled residents, Residents (R) 4 and R8. 1. Observation on 12/12/2024 of R4's room revealed the resident was under contact isolation precautions. However, staff was observed in the room without wearing the appropriate personal protective equipment (PPE). Further observation on 12/12/2024 revealed another staff member entered R4's room and did not don (put on) PPE. 2. Observation and interview on 12/12/2024 with Licensed Practical Nurse (LPN) 1 revealed she carried a contaminated glucometer (blood sugar measuring device), without wearing gloves, across the common area and placed it on the medication cart without first placing a barrier down. Further observation on 12/18/2024 revealed LPN1 failed to clean the glucometer according to the Environmental Protection Agency (EPA) registered disinfectant manufacturer's instructions. The findings include: Review of the CDC's Guidelines, provided by the facility, titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 09/10/2021, revealed reusable medical equipment should be cleaned and disinfected according to manufacturer's instructions or the facility's policies before and after use. The guidelines stated facilities should maintain separation between clean and soiled equipment to prevent cross-contamination. Further review of the guidelines revealed staff should be trained in the correct steps for cleaning and disinfection of shared equipment. Review of the facility's policy titled, Infection Prevention and Control Program [IPCP], dated 10/24/2022, revealed the facility maintained 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 per accepted national standards and guidelines. Continued review revealed all staff was responsible for following policies and procedures related to the IPCP program to include transmission based precautions. Furthermore, the policy stated all staff should use personal protective equipment (PPE) according to established facility policy governing the use of PPE. Review of the facility's policy titled, Cleaning and Disinfection of Resident Care Equipment, dated 03/01/2023, revealed shared reusable equipment could be a source of indirect transmission of pathogens. The policy stated resident care equipment would be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection, and staff would clean and disinfectant in accordance with manufacturers' recommendations. Furthermore, per the policy, staff would clean and disinfect reusable equipment after each use. (continued on next page)

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	185241	A. Building B. Wing	01/03/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the cleaning and disinfecting instructions for the Assure Prism Multi-Blood Glucose Monitoring System, no date, revealed to minimize the risk of transmitting bloodborne pathogens, the exterior of the glucometer should be cleaned of all dirt, blood, and bodily fluids before performing the disinfection procedure, which would prevent the transmission of bloodborne pathogens. Per the instructions, the exterior of the glucometer should remain wet for the appropriate dwell time (time a surface must remain visibly wet after the application of a disinfectant) according to the disinfectant's instructions. Review of the cleaning and disinfecting instructions for Medline's MicroKill One (blue lid) container revealed for cleaning to use one or more wipes as necessary to wet surfaces sufficiently and to thoroughly clean the surface. Then, the instructions stated to use a second wipe as necessary to thoroughly wet all surfaces to be treated. According to the instructions, all surfaces must remain visibly wet for a one minute dwell time to assure complete disinfection of all pathogens. 1. Review of R4's Face Sheet, located in the resident's electronic health record (EHR), revealed the facility admitted the resident on 12/11/2024 with diagnoses to include pyogenic arthritis right knee, cellulitis of right lower limb, Sjogren syndrome (disorder of the immune system), and history of multidrug-resistant organisms (MDRO). Review of R4's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/12/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, which indicated R4 was cognitively intact. Review of R4's Discharge Summary, from the resident's previous facility, dated 12/11/2024, located in the resident's EHR, revealed the resident had an infection of the right knee which was positive for staph pseudointermedius and streptococcus mitis, and there was an order for contact isolation precautions. Observation on 12/12/2024 at 10:33 AM of R4's room, a contact isolation room, revealed the Advanced Practice Registered Nurse (APRN) was in the room sitting on the resident's unmade bed while she talked with the resident. The APRN did not wear a gown or gloves during her time in R4's room. During interview with the APRN on 12/12/2024 at 10:33 AM, she stated she had entered the room to check on the resident. She stated it was the facility's policy to wear a gown and gloves at all times while in a contact precaution room to protect both the resident and staff from the spread of infection. She further stated it was not appropriate to sit on the bed, and sitting on a resident's bed could facilitate the spread of infection. The APRN stated she had completed multiple education modules related to IPCP training. Continued observation on 12/12/2024 at 10:35 AM, revealed Registered Nurse (RN) 3 was standing inside R4's room at the end of the bed without wearing a gown and gloves. During interview with RN3 on 12/12/2024 at 10:50 AM, she stated she was in R4's room just to say hello and did not don (put on) PPE because she was not providing care. When asked by the State Survey Agency (SSA) Surveyor what was required before entering a contact precaution isolation room, RN3 stated gloves and a gown must be worn. She stated transmission-based precautions were important to prevent the spread of infection to other staff and residents. RN3 stated she had received IPCP education upon hire and had multiple in-services related to infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of R8's Face Sheet, located in the resident's EHR, revealed the facility admitted the resident on 11/28/2024 with diagnoses to include left hemiplegia and hemiparesis following cerebral infarction (stroke), type 2 diabetes mellitus, and chronic obstructive pulmonary disease (COPD). Review of R8's admission MDS, with an ARD of 12/02/2024, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, which indicated R8 was cognitively intact. Observation on 12/12/2024 at 10:35 AM revealed LPN1, without wearing gloves, brought a glucometer out of R8's room, walked across the common area to the medication cart sitting outside of room [ROOM NUMBER], and then placed the glucometer on the medication cart without using a barrier. During interview with LPN 1 on 12/12/2024 at 10:38 AM, she stated she had just performed a blood glucose fingerstick on R8 and was coming back to the cart to clean and disinfect the glucometer (because it was contaminated after R8's blood glucose fingerstick). When asked what the process for cleaning the glucometer after use on a resident, she stated it should be cleaned immediately with disinfectant wipes. She further stated she knew not to put it down on the cart without a barrier but added she was nervous due to the SSA Surveyor's presence. LPN1 stated she had received IPCP education upon hire and had also received education through in-service trainings provided by the Infection Preventionist/Wound Care Nurse (IP/WCN) and the Interim Director of Nursing (IDON) related to infection control. Observation on 12/18/2024 at 12:47 PM revealed LPN1 performed a blood glucose fingerstick on R8. The LPN took the glucometer to the medication cart and placed it on top of the cart without first placing a protective barrier down. LPN1 took a disinfectant wipe out of the MicroKill One Wipes container and wiped the glucometer for 10 seconds. She then placed the glucometer in the top drawer of the medication cart. During additional interview with LPN1 on 12/18/2024 at 12:47 PM, she stated she was educated to place the glucometer on a barrier and clean and disinfect it with the MicroKill One Wipes. When asked what the dwell time for the wipes was, she stated, One minute. When asked to discuss the facility's protocol for cleaning and disinfecting the shared glucometer, LPN1 could not articulate what the kill time meant and was unable to correctly list the steps for cleaning the glucometer. During interview with the IP/WCN on 12/17/2024 at 11:15 AM, she stated the facility followed CDC guidelines and recommendations related to IPCP. She stated she provided education to all staff related to IPCP, and all staff was trained on the use of PPE and isolation precautions to include contact precautions. She stated gowns and gloves must be worn whenever staff entered a contact precaution room. Per the interview, the IP/WCN stated she and other nurse leaders had not observed any concerns related to staff's failure to follow infection control or transmission-based precautions protocols. She stated it was her expectation that all staff followed infection prevention control practices. The IP/WCN stated it was important for the safety of residents and staff and to prevent the spread of infection. She also stated nursing staff was trained to clean and disinfect the glucometer after each use using the blue topped MicroKill One Wipes cleaning and disinfectant wipes with a one minute dwell time. She stated contaminated glucometers should be placed on a barrier cloth to prevent the spread of infection and cleaned, then disinfected for the appropriate time and stored separately to keep clean. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with the IDON on 12/18/2024 at 1:19 PM, she stated all staff received IPCP training upon hire and periodically throughout the year. In addition, the IDON stated staff was updated on current CDC guidelines when they changed. She stated nursing leadership audited staff for compliance. However, she stated there was no documentation of staff IPCP audits. Per interview, it was the IDON's expectation that all staff maintained IPCP guidelines at all times to decrease the potential spread of infection. During interview with the Executive Director on 12/19/2024 at 1:08 PM, she stated it was her expectation that staff followed the facility's IPCP policies and procedures to prevent the spread of infection to residents and staff.