

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2025
NAME OF PROVIDER OR SUPPLIER Madonna Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 Amsterdam Road Villa Hills, KY 41017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the website www.weather.gov, and review of the facility's policies, the facility failed to have an effective system in place to ensure each resident received the electronic monitoring devices to prevent unsafe wandering and elopement, for 1 of 18 sampled residents, Resident (R) 1. Review of R1's Investigation Report revealed R1 was found by State Tested Nurse Aide (STNA) 2 outside the building, approximately 84 feet from the employee entrance/exit, on 08/07/2025 at 11:10 PM as she was getting out of her car from the back parking lot of Household B. Per the report, STNA2 brought R1, who appeared to be confused and was unstable with ambulation, back into the facility to get warm. During interviews conducted with facility staff who were on duty during the time of the 08/07/2025 elopement, they stated they had last seen the resident at approximately 9:30 PM and were unaware R1 left the building unsupervised until they received notice from Registered Nurse (RN) 1. The facility's failure to have an effective system in place to ensure residents' safety is likely to cause serious injury, impairment, or death, if immediate action is not taken. Immediate Jeopardy (IJ) was identified on 08/21/2025 and was determined to exist on 08/07/2025 in the area of 42 CFR 483.25. Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care, F689. The facility was notified of IJ on 08/21/2025. The facility provided an acceptable Immediate Jeopardy Removal Plan, on 08/22/2025, alleging removal of the IJ on 08/23/2025. The State Survey Agency (SSA) validated the IJ was removed on 08/23/2025, prior to exit. Remaining non-compliance continues at a Scope and Severity of a D while the facility develops and implements a Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: Review of the facility's policy titled, Elopements and Wandering Residents, dated 08/12/2022, revealed the facility must establish and utilize a systematic approach to monitoring and managing residents at risk for elopement and or unsafe wandering, including identification and assessment risk, evaluation and analysis of hazards and risk, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. The policy also stated the IDT (Interdisciplinary Team) would evaluate the unique factors contributing to risk in order to develop a person-centered care plan, including if a resident should wear a Wander Gard bracelet. Review of R1's admission Record, located in the resident's electronic medical record (EMR), revealed the facility admitted the Resident on 07/23/2025 with diagnoses which included cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, other sequelae following unspecified cerebrovascular disease, and Alzheimer's disease with late onset. Review of R1's Comprehensive Care (CCP), dated 07/25/2025, located in the resident's EMR, revealed the Resident was an elopement risk/wanderer related to impaired safety awareness and wandered aimlessly. The goal stated the resident would not leave the facility unattended. Interventions included: engage resident in purposeful activity and schedule regular walks and appropriate activity. Review of R1's Elopement Assessment, completed on admission on [DATE], revealed R1 had a history of elopement or an attempted elopement while at home as communicated by her family. Per the assessment, R1, having a history of elopement and R1's wandering behaviors were likely to affect the safety or wellbeing of self/others and was determined to be at high risk. Review of R1's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 07/25/2025, located in the resident's EMR, revealed the facility assessed R1 to have a Brief Interview for Mental Status [BIMS] score of three out of 15, which indicated she had severe cognitive impairment. Review of R1's Facility Investigation, 08/07/2025, revealed on 08/07/2025 at approximately 11:10 PM as State Trained Nurse Aide (STNA) 2 was getting out of her car to walk into the back door entrance of Household B, she found R1 sitting alone in the grass near a tree. STNA2 approached R1 and asked R1 if she was okay and did she need any help. STNA2 stated R1 appeared to be confused because R1 stated she did not know where she was. STNA2 stated she told R1 she would be okay, and she was going to take her inside so she could get warm. STNA2 assisted R1 into the building, holding her close as R1 was unstable when walking. Per the investigation, STNA2 asked R1 if she was hurt anywhere, and R1 stated she did not know. STNA2 stated once she got inside the building, she asked staff, including the DON (who was working at the time), why R1 was outside, and no one knew how or why R1 was outside the building. Review of the website www.weather.gov revealed the temperature at the facility on the evening of 08/07/2025 was 78 degrees Fahrenheit with clear skies. Review of the distance taken by R1 when she exited the facility on 08/07/2025 in a measurement taken by a measuring wheel on		