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	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Manor	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49267 Based on interview, record review, and review of the facility's policy, the facility failed to ensure each resident was treated with respect and dignity and cared for in a manner and in an environment that promoted the maintenance or enhancement of his/her quality of life. The facility failed to ensure residents had a right to communicate with and had access to persons and services inside and outside the facility for 2 of 22 sampled and supplemental residents, Resident (R) 7 and R10. R7's representative and R10's representative stated they were unsuccessful when they attempted multiple times to communicate with the facility via telephone. The findings include: Review of the facility's policy titled, Resident Rights, dated 10/24/2022, revealed the resident had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 1. Review of R7's Admission Record revealed the facility admitted the resident on 08/08/2013 with diagnoses of vascular dementia, hereditary and idiopathic neuropathy, and cerebrovascular disease. Review of R7's, Minimum Data Set (MDS), with an assessment reference date (ARD) of 08/02/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of a facility written communication document provided to residents and families on 08/08/2024 revealed a listing of updated numbers for Household (the facility's nursing units) floor phones and nurse cell phones. During an interview with family member (F) 5 on 08/20/2024 at 2:55 PM, she stated R7 developed COVID a few weeks ago, and she was unable to reach anyone at the facility to check on his condition. She further stated each time she called the facility, the phone rang and went straight to voicemail; however, the voice mailbox was full. F5 stated since that time, she learned from the Director of Nursing (DON) the facility had new telephone numbers that became effective a couple of months earlier. F5 further stated she did not receive information related to the new telephone numbers. F5 stated she was very upset and worried when she was unable to reach the facility to check on her father's condition. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/2024 at 8:54 AM with Licensed Practical Nurse (LPN) 2, she stated she had difficulty reaching the Households when she called from outside the facility, and her calls went straight to voicemail. LPN2 stated possible reasons phones were not answered included the location in the building at the time, phones were on silent, or the nurse laid the phone down unattended. During an interview with the Maintenance Director on 08/22/2024 at 10:45 AM, he stated no recent changes were made to the facility's phone system. He further stated incoming calls after hours were rolled over to staff cell phones. During an interview with the DON on 08/23/2024 at 11:05 AM, she stated incoming phone calls went to the Receptionist until around 7:00 PM, and then calls were diverted to the Households. She further stated, if calls were not answered at the Household landline, they were forwarded to the nurses' cell phones, and messages could be left on any of the phones. The DON stated any staff member could check phone messages, and that responsibility was not assigned to a single individual. She stated family members also had the ability to directly dial the nurses' cell phones. The DON stated there were family members that complained to her they were unable to reach the facility, and the facility determined they had incorrect phone numbers. The DON offered no explanation as to why residents' family members had incorrect numbers. On 08/23/2024 at 6:37 AM, the State Survey Agency (SSA) Surveyor attempted a call to the Household A floor phone. The phone rang, no one answered, and it went straight to voicemail. The voice mailbox was full, and the SSA Surveyor was unable to leave a message. 2. Review of R10's Admission Record revealed the facility admitted the resident on 08/01/2022 with diagnoses of congestive heart failure (CHF) and chronic kidney disease (CKD). Review of R10's MDS, with an ARD of 07/31/2024, revealed the resident had a BIMS score of four out of 15, which indicated the resident was severely cognitively impaired. During an interview on 08/22/2024 at 1:55 PM with F4, he voiced concerns about staff response to telephone calls. He further stated he observed on multiple occasions the facility cell phones lying unattended on the dining tables in Household A. F4 stated the call lights were tied to the cell phones, and the nurses often silenced the phones. F4 stated he visited his mother daily, Monday through Friday, but still called her every morning on her cell phone. F4 stated two Sundays ago he called R10's cell phone numerous times, but she failed to answer. He further stated he then called the Household nurse's cell phone, and it went straight to voicemail, but the mailbox was full. F4 stated at that point he called the main number to the reception desk. He stated he heard a recording with several options that included one that directed him to leave a message. F4 stated he chose that option but was not given the opportunity to leave a message. F4 stated he hung up, called back, pressed the option for the physician line, and still no one answered. F4 stated at that point he was concerned and drove to the facility to check on his mother. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Receptionist on 08/23/2024 at 8:31 AM, she stated a Receptionist was at the front desk from 6:00 AM to 8:00 PM. She stated when a call came in, she initially told the caller not to hang up during the transfer process, and if for some reason the call was disconnected, they should call back. The Receptionist further stated she then transferred the call to the appropriate extension, and if no answer, it bounced back to her if the caller stayed on the line. The Receptionist stated she then tried to track down the intended recipient, and if unsuccessful, she took a message. The Receptionist stated there were individual phones on each of the Households as well as cell phones the nurses carried. She further stated, after hours calls rerouted somewhere else, but she was not exactly sure where they went. During an interview with F7 on 08/23/2024 at 8:50 AM, she stated she visited R10 every Sunday, took her to Mass, lunch, and usually a drive in the car. F7 stated on 08/04/2024 she arrived at the facility around 10:30 AM and was surprised to find her brother there because he typically visited Monday through Friday. She further stated her brother informed her he tried unsuccessfully to reach both the resident and the facility multiple times that morning and was concerned, so he drove to the facility. F7 stated one of the nurses on duty at the time told her the phone must have been turned off, and she did not hear it. F7 was unable to identify the nurse. During an interview with the Administrator on 08/23/2024 at 11:44 AM, she stated the phones the nurses carried were cell phones, and they were also tied to the call light system. She further stated each Household had a floor phone and a nurse cell phone, and outside callers were able to leave voicemail messages on the phones. Additionally, she stated no one person was designated to check and return voicemail messages. The Administrator stated the facility sent a list of updated numbers for both Household phones and cell phones to residents and family. The Administrator stated it was her expectation outside callers were able to reach staff and/or family members when they called the facility.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 49267 Based on interview, record review, and review of the facility's policies, the facility failed to ensure each resident had the right to be informed of and participate in his or her treatment for 1 of 22 sampled and supplemental residents, Resident (R) 10. Staff refused to administer a COVID-19 test to R10 when requested by the resident. The findings include: Review of the facility's policy titled, Resident Rights, dated 10/24/2022, revealed the resident had the right to be informed of, and participate in, his or her treatment, including the right to request, refuse, and/or discontinue treatment. Review of the facility's policy titled, Coronavirus Testing, revised 09/26/2022, revealed anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible. Further review revealed the facility would obtain an order for COVID-19 testing from the physician, physician assistant, nurse practitioner, or clinical nurse specialist to provide or obtain laboratory services for a resident. Additional review revealed the facility would document the resident's test results in the medical record in accordance with the standard for protected health information. Review of R10's Admission Record revealed the facility admitted the resident on 08/01/2022 with diagnoses of congestive heart failure (CHF) and chronic kidney disease (CKD). Review of R10's Annual Minimum Data Set (MDS), with an assessment reference date (ARD) of 07/31/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated the resident was severely cognitively impaired. Review of R10's August 2024 Orders revealed no open or completed orders for COVID testing. Review of R10's August 2024 Progress Notes revealed no documented COVID testing or results. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with family member (F) 7 on 08/23/2024 at 8:50 AM, she stated on 08/04/2024 she arrived at the facility around 10:30 AM, and before they left for lunch, she overheard a staff member yell not to let a particular resident out of his room because he had COVID. F7 stated she took her mother out for lunch and a drive and returned to the facility about two hours later. F7 stated a short time later she noticed R10 had a slight cough that was new, and the resident asked for a tissue because of a mild runny nose. F7 stated she requested a COVID test for her mother from one of the nurses. F7 did not identify the nurse. F7 stated the nurse refused and said it was not necessary because the facility had no positive COVID cases. F7 further stated the nurse turned around and left the room. F7 stated she approached another nurse (that she did not wish to identify) and begged for a COVID test for her mother. F7 stated the nurse agreed to the test and walked away. F7 stated she assumed the test was administered after she left, but when she requested the result, the facility was unable to provide that information. F7 stated she had a scheduled appointment with the Director of Nursing (DON) today to discuss this and other concerns, but the DON contacted her today to reschedule and told her she was not working today. During an interview on 08/22/2024 at 1:55 PM with F4, he stated the facility failed to administer a COVID test to R10 when requested. F4 stated when his sister visited R10 a couple of weekends ago, she requested a COVID test, and staff refused to administer one. He further stated nursing staff told R10 and his sister she did not need one because there was no COVID in the building. During an interview with the Infection Preventionist (IP) Nurse on 08/23/2024 at 9:52 AM, she stated the facility's current COVID testing guidelines were based on exposure and/or presence of symptoms. The IP Nurse stated COVID testing administration and results were documented in residents' progress notes. She further stated a resident could request a COVID test at any time regardless of symptoms or exposure, and there was no reason a resident would be denied a COVID test. During an interview with the DON on 08/23/2024 at 11:05 AM, she stated COVID testing was available for residents at any time, and there was not a reason to ever tell residents they could not have a test. She further stated COVID testing and test results were documented in progress notes. The DON stated it was important for staff to follow the facility's infection prevention and control policies and procedures to prevent the spread of infections. During an interview with the Administrator on 08/23/2024 at 11:44 AM, she stated the facility would never deny a resident a COVID test if one was requested. She further stated it was her expectation staff followed facility infection prevention guidelines to prevent the spread of infection and to protect residents.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 49267 Based on interview, record review, and review of the facility's policy, the facility failed to ensure that the resident's medical record included documentation that indicated the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal for 1 of 5 sampled residents, Resident (R) 43. A review of R43's immunization record revealed the absence of documentation confirming the administration or refusal of the influenza vaccine for 2023-2024. The findings include: Review of the facility's policy titled, Infection Prevention and Control Program, dated 10/24/2022, revealed residents would be offered the influenza vaccine each year between October 1 and March 31. Further review revealed documentation would reflect the education provided and details regarding whether the resident received the immunization. Review of R43's Admission Record revealed the facility admitted the resident on 11/19/2023 with diagnoses of chronic obstructive pulmonary disease (COPD) and Alzheimer's disease. Review of R43's, Minimum Data Set (MDS), with an assessment reference date (ARD) of 08/16/2024, revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident was severely cognitively impaired. Review of R43's immunization record revealed the absence of documented evidence of administration or refusal of an influenza immunization for 2023-2024. The State Survey Agency (SSA) Surveyor requested verification of R43's administration or refusal of the influenza vaccine for 2023-2024 from the facility on 08/21/2024 at 5:00 PM; however, verification of documentation was not provided. During an interview with the Infection Preventionist (IP) Nurse on 08/23/2024 at 9:52 AM, she stated residents received educational information related to the benefits versus the side effects of vaccines prior to administration. She further stated educational information was also included in the admission packets. The IP Nurse stated immunization education and administration or refusal of administration were documented in the residents' charts under their immunization record. During an interview with the Director of Nursing (DON) on 08/23/2024 at 11:05 AM, she stated residents and/or family were educated verbally and consented for immunizations prior to administration. She further stated administration of immunizations or refusals of immunizations were documented in a resident's chart. The DON stated it was important for staff to follow the facility's policies and procedures for infection prevention and control to prevent the spread of infections. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 08/23/2024 at 11:44 AM, she stated she expected a resident's medical record to reflect documentation of either administration or refusal of immunizations. She further stated it was her expectation staff followed the facility's infection prevention guidelines to prevent the spread of infection and to protect residents.