

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

PRINTED: 04/10/2015
FORM APPROVED
OMB NO. 0938-0391

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 03/27/2015
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 000 INITIAL COMMENTS

A Recertification Survey was initiated on 03/24/15 and concluded on 03/27/15, with deficiencies cited at the highest Scope and Severity of an "F"

F 155 483.10(b)(4) RIGHT TO REFUSE; FORMULATE SS=D: ADVANCE DIRECTIVES

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

The facility must comply with the requirements specified in subpart 1 of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and a review of the facility's policy, it was determined the facility failed to ensure residents' medical records reflected the resident's Advanced Directives or wishes regarding the provision or withholding of

F 000

The completion and submission of this plan of correction does not constitute an admission that the facility agrees with the cited deficiencies as stated in the 2567. The facility is completing the plan of correction because it is required by state and federal law.

F 155

The facility alleges compliance as of 5/12/2015.

F 155 Right to Refuse; Formulate Advance Directives

All current resident charts as of 4/23/15 were audited by the Social Service Director (SSD). Audit was to verify that each resident has an accurate order for Advanced Directives and that the order was placed in the chart per facility policy. The SSD also verified that all advanced directive care plans are a reflection of each resident's wishes.

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BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director* (X6) DATE *4-16-15*

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.

J. Pennington RN, BSN Director of Nursing 5-12-15

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cardiopulmonary resuscitation for three (3) of fifteen (15) sampled residents (Residents #2, #4, and #13).

The findings include:

A review of the facility's "Do Not Resuscitate (DNR) Policy & Procedure", dated 07/31/2014, revealed the facility would not perform CPR on a resident who had DNR status in effect. Continued review revealed DNR orders were to be signed by the Physician and maintained with the resident's medical record.

1. Review of the medical record for Resident #13 revealed the facility admitted the resident on 07/15/13, and readmitted the resident on 08/08/13, with diagnoses which included Hypertension, Status Post Cardiovascular Accident (Stroke), Hemiplegia, and Cognitive Deficit. Continued review of the medical record revealed an active Physician's order for Full Code status, which was noted on the inside front cover of the chart. Further review of the medical record revealed no documented evidence an Advanced Directives form had been completed for Resident #13.

Review of the Annual Minimum Data Set (MDS), dated 08/15/14, revealed the facility assessed Resident #13 to have a Brief Interview of Mental Status (BIMS) score of nine (9) out of fifteen (15), which indicated the resident was interviewable.

Interview with Resident #13, on 03/26/15 at 1:30 PM, revealed he/she had a Living Will (Advanced Directives), and did not want cardiopulmonary resuscitation (CPR) performed if his/her heart stopped or if he/she stopped breathing.

F 155

All new residents and /or POA will be interviewed by the SSD or designee on admission to obtain the wishes of the resident in regards to advanced directives. The SSD will also verify that a written physician order is in place matching the residents' wishes. The facilities DRN policy (attachment 1) was also reviewed and updated on 4/17/2015 by the facilities Quality Assurance Committee. The Quality Assurance Committee is made up of the Medical Director, Director of Nurses, Administrator, Pharmacist, Therapy Manager, Director of Dining, Facility Manager, MDS Nurse, Assistant Director of Nursing and Social Worker.

Medical Recorders Clerk will audit 10 charts per month to verify that the SSD is compliant with this practice. Audits will be turned into the Director of Nurses (DON) The DON will have oversight for compliance of facilities DNR policy. All Advance Directives will be reviewed at least

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Interview with Social Services (SS) staff, on 03/27/15 at 2:00 PM, revealed she did not know if the resident had a living will or that he/she did not want CPR. She stated she had tried to contact the resident's daughter/Power of Attorney (POA), without success.

2. Review of the medical record revealed the facility admitted Resident #4 on 06/21/13 with diagnoses which included Alzheimer's Disease and Coronary Artery Disease. Continued review of the medical record revealed the resident's POA indicated the resident's desire for Do Not Resuscitate (DNR) status on the Advanced Directives form completed on admission. Continued review of the medical record revealed the resident's chart was labeled Full Code inside the front cover, and a Physician's order dated 03/15, for Full Code status was in place.

3. Review of the medical record revealed the facility admitted Resident #2 on 02/24/15, with diagnoses which included Closed Fracture of the Femur (broken leg), Cardiovascular Disease, Depression, and Hypertension.

Review of Resident #2's Advanced Directives form completed on admission revealed the resident was Full Code status upon admission to the facility. Contradictorily, review of the Physician's order, dated 02/26/15, revealed the resident requested a DNR status.

Interview on 03/27/15 at 3:20 PM, with the Director of Nursing (DON), revealed the Social Service Director was responsible for completing the Advanced Directives form with residents and their families during the admission process.

F 155

quarterly with the resident and or POA to reflect the wishes of the resident. Any changes requested during the review will be addressed with that residents MD to obtain orders, and place in chart per facility policy. The nurses were educated on the DNR policy and on the facilities procedures, on 4/20/15 by the Social Service Director

Resident #2 has been safely discharged to his /her home on 4/5/2015

Resident #13 resident remains in the facility the resident has been interviewed for a new BIMS Score on 4/13/15. The BIMS Score was 14. The resident POA was contacted to verify code status. A care conference was held when the Social Service Director re-interviewed the resident to find out his code status wishes. The resident stated that he was unclear as to what advance directives that he had. The daughter (POA) verified that the resident does not have a living will. The resident and POA decided that resident wanted to stay a "Full Code". Resident # 13's care plan was updated to reflect the residents' wishes. The order and chart were verified for accuracy.

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Continued interview revealed she could not say why the facility had not followed its policies related to Advanced Directives.

An interview, on 03/27/15 at 3:30 PM, with the Social Service Director, revealed she was responsible for discussing an established code status with residents and family members on admission and was to complete the Advance Directive form. She stated when a resident requested a DNR, she would give the information to the nurses to obtain the order. Continued interview revealed once she received the Physician's Order, she would update the medical record.

An interview with the Administrator, on 03/27/15 at 4:04 PM, revealed the Advanced Directive form should have been completed on admission for each resident.

F 155
Resident # 4 resident remains in the facility. Resident was interviewed and for a new BIMS score. The BIMS score was 5. The POA was contacted to verify the resident's wishes at this time are to be a DNR. DNR documents and orders are in place in the residents chart per facility policy. Resident # 4 care plan for advanced directives was updated to reflect resident's wishes.

Compliance date 5/12/2015

F 279 SS=E 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under

F 279
F279 Developing Comprehensive Care Plan's
All current resident charts as of 4/20/2015 were audited by the Social Service Director (SSD) to verify that all residents have an accurate care plan for Advanced Directives. Care Plans for advanced directives for new

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§483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on interview, record review and a review of the facility's policy, it was determined the facility failed to develop a Comprehensive Care Plan which addressed each resident's wishes regarding Advanced Directives and the provision or withholding of cardiopulmonary resuscitation (CPR) for twelve (12) of fifteen (15) sampled residents (Residents #2, #4, #5, #6, #7, #9, #10, #11, #12, #13, #14 and #15).

The findings include:

- A review of the facility's "Do Not Resuscitate (DNR) Policy & Procedure", dated 07/31/2014, revealed the facility would not perform CPR on a resident who had DNR status in effect.
- Continued review revealed DNR orders were to be signed by the Physician and maintained with the resident's medical record.
- Review of the facility's "Comprehensive Care Planning" policy, dated 02/2014, revealed the facility would develop an individualized Comprehensive Care Plan for each resident, in order to meet the resident's medical, physical, mental and psychological needs.

1. Review of the medical record revealed the facility admitted Resident #2 on 02/24/15, with diagnoses which included Closed Fracture of the

F 279 residents will be completed by the SSD as part of the new admission process. The SSD and or designee (Admissions & Marketing Director or the MDS nurse) will continue to interview the residents and /or POA on admission to obtain the wishes of the resident for advance directives and care planning. The SSD designee's were educated on the advance directives policy & procedure on 4/20/15 by the Social Service Director. Medical Records will audit 5 charts per month to verify that the SSD is in compliance with this practice. These audits will continue monthly times 4 months, unless the QA committee decides to continue the audits longer. Audits will be turned into the Director of Nurses (DON) The DON will have oversight for compliance. All Advance Directives will be reviewed at least quarterly with the resident and or POA to reflect the wishes of the resident. Any changes requested during the review will be addressed with that residents MD to obtain orders, and place in chart per facility policy. The facilities DNR policy (attachment 1) was also reviewed and updated on 4/10/2015 by the facilities Quality Assurance Committee. The Quality Assurance Committee is made up of the Medical Director, Director of Nurses, Administrator, Pharmacist, Therapy Manager, Director of Dining, Facility Manager, MDS Nurse, Assistant Director of Nursing and Social Worker. The Facilities Comprehensive Care Plan Policy (attachment #2) was also reviewed and updated on 4/10/2015 by the facilities Quality Assurance Committee to reflect the facilities practice.

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Femur (broken leg), Cardiovascular Disease, Depression, and Hypertension.

Review of Resident #2's Advanced Directives form revealed the resident was Full Code status (Full Code status means life-saving measures, including cardiopulmonary resuscitation will be performed in the event the resident ceases to have respiratory or cardiac function) upon admission to the facility. Contradictorily, review of the Physician's order, dated 02/26/15, revealed the resident requested a DNR status.

Review of the Comprehensive Care Plan for Resident #2, revealed no documented evidence the facility had developed a care plan to address the resident's code status.

2. Review of the medical record revealed the facility admitted Resident #4 on 06/21/13 with diagnoses which included Alzheimer's Disease and Coronary Artery Disease. Continued review of the medical record revealed the resident's Power of Attorney (POA) indicated the resident's desire for DNR status on the Advanced Directives form.

Review of Resident #4's Comprehensive Care Plan, with no clear initiation date, revealed no documented evidence the facility had developed a care plan to address the resident's code status/Advanced Directives.

3. Review of the medical record for Resident #5 revealed the facility admitted the resident on 02/04/15, with diagnoses which included Status Post Cerebral Vascular Accident (CVA/Stroke). Continued review of the medical record revealed a signed Advanced Directives form which

F 279 Resident #15 has been discharged from the facility.

Resident #14 has been discharged from the facility.

Resident #13 Care Plan for advance directives was initiated to reflect the wishes of the resident.

Resident #12 Care Plan for advance directives was initiated to reflect the wishes of the resident.

Resident #11 Care Plan for advance directives was initiated to reflect the wishes of the resident.

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documented the resident's wish to have Full Code status. Continued review revealed the resident's chart was labeled "Full Code" inside the front cover. In addition, review of the Physicians orders revealed Resident #5 was designated as Full Code status.

Review of the Comprehensive Care Plan for Resident #5, dated 02/28/15, revealed no documented evidence the facility had developed a care plan to address the resident's code status/Advanced Directives.

4. Review of the medical record revealed the facility admitted Resident #6 on 09/05/14 with diagnoses which included Hypertension, Esophageal Reflux, Chronic Kidney Disease, Atrial Fibrillation, and Cerebrovascular Disease. Continued review of the medical record revealed the resident's desire for Do Not Resuscitate (DNR) status on the Advanced Directive Form.

Review of Resident #6's Comprehensive Care Plan, with no clear initiation date, revealed no documented evidence the facility developed a care plan to address the resident's Advanced Directives to ensure staff honored the resident's wishes.

5. Review of the medical record revealed the facility admitted Resident #7 on 07/01/13, and re-admitted the resident on 07/30/14, with diagnoses which included Senile Dementia, Diabetes, Chronic Pain Syndrome, and Hypertension. Review of the signed Advanced Directives form revealed the resident's wishes for DNR status. Continued review of the resident's medical record revealed a Physician's order for DNR status. In addition, the resident's chart was

F 279

Resident # 10 Care Plan for advance directives was initiated to reflect the wishes of the resident.

Resident #9 Care Plan for advance directives was initiated to reflect the wishes of the resident.

Resident #7 Care Plan for advance directives was initiated to reflect the wishes of the resident.

Resident #6 Care Plan for advance directives was initiated to reflect the wishes of the resident.

Resident #5 Care Plan for advance directives was initiated to reflect the wishes of the resident.

Resident #4 Care Plan for advance directives was initiated to reflect the wishes of the resident.

Resident # 2 was discharged from the facility.

Date of compliance 5/12/2015.

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marked DNR on the front cover

F 279

Review of Resident #7's Comprehensive Care Plan, with no clear date of initiation, revealed no documented evidence the facility had developed a care plan to address the resident's code status/Advanced Directives.

6. Review of the medical record revealed the facility admitted Resident #9 on 10/03/13 with a diagnoses, which included Atrial Fibrillation, Hypertension, Osteoporosis, Dementia, Anxiety Depression and Chronic Obstructive Airway Disease. Review of Resident #9's Advanced Directive dated 10/07/13, revealed the resident's daughter signed the DNR form as POA. Review of the Physician Order Summary Sheet, dated 10/07/13, revealed an order for a DNR code status.

Review of Resident #9's Comprehensive Care Plan, with no clear date of initiation, revealed no documented evidence the facility had developed a care plan to address the resident's code status/Advanced Directives.

7. Review of the medical record revealed Resident #10 was admitted by the facility on 07/15/14, and readmitted on 07/17/14, with diagnoses which included Esophageal Reflux and Hypertension. Further review of the medical record revealed the resident's Advanced Directives form indicated a DNR status, which was consistent with the Physician's order. Continued review revealed the resident's DNR status was indicated on the inside front cover of the chart.

Review of Resident #10's Comprehensive Care

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Plan, with no clear date of initiation, revealed no documented evidence the facility had developed a care plan to address the resident's code status/Advanced Directives.

8. Review of the medical record revealed the facility admitted Resident #11 on 09/07/12 with a diagnoses, which included Dementia, Hypertension, Glaucoma, Depression, and Diabetes Type II. Review of Resident #11's Advanced Directives dated 09/07/12, revealed a DNR form signed by the resident. Review of the Physician order summary sheet dated 09/07/12 revealed an order for a DNR code status.

Review of Resident #11's Comprehensive Care Plan, with no clear date of initiation, revealed no documented evidence the facility had developed a care plan to address the resident's code status/Advanced Directives.

9. Review of the medical record revealed the facility admitted Resident #12 on 03/05/15 with diagnoses which included Coronary Artery Disease, Esophageal Reflux and Atrial Fibrillation. Continued review of the medical record revealed the resident's desire for DNR status on the Advanced Directives Form.

Review of Resident #12's Comprehensive Care Plan, with no clear initiation date, revealed no documented evidence the facility developed a care plan to address the resident's Advanced Directive to ensure staff honored the resident's wishes.

10. Review of the medical record for Resident #13, revealed the facility admitted the resident on 07/15/13, and readmitted the resident on

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F 279	<p>Continued From page 9</p> <p>08/08/13, with diagnoses which included Hypertension, Status Post CVA, Hemiplegia, and Cognitive Deficit. Continued review of the medical record revealed the resident's code status was Full Code, consistent with the Physician's order, and so noted on the inside front cover of the chart. Further review revealed no documented evidence an Advanced Directives form had been completed for Resident #13.</p> <p>Review of the Annual Minimum Data Set (MDS), dated 08/15/14 revealed the facility assessed the resident with a Brief Interview of Mental Status (BIMS) of nine (9) out of fifteen (15) indicating the resident was interviewable. Interview with Resident #13, on 03/26/15 at 1:30 PM, revealed he/she had a Living Will (Advanced Directives), and did not want cardiopulmonary resuscitation (CPR) performed if his/her heart stopped or if he/she stopped breathing.</p> <p>Interview with Resident #13, on 03/26/15 at 1:30 PM, revealed he/she had a Living Will (Advanced Directives), and did not want CPR performed if his/her heart stopped or if they stopped breathing.</p> <p>Review of the Comprehensive Care Plan for Resident #13 revealed no documented evidence the facility had developed a care plan to address the resident's code status/Advanced Directives</p> <p>11. Review of the closed medical record for Resident #14 revealed the facility admitted the resident on 02/09/15 with diagnoses which included Hypertension, (High Blood Pressure) Atrial Fibrillation (Irregular Heart Rate) and Dyspnea (Difficulty Breathing). Further review of the medical record revealed Resident #14's Full Code status, evidenced by the Physician's order.</p>	F 279	

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Review of Resident #14's Comprehensive Care Plan, with no clear date of initiation, revealed no documented evidence the facility developed a care plan to address the resident's code status to ensure the resident's wishes would be honored by staff in the event of a code situation.

12. Review of the medical record revealed the facility admitted Resident #15 on 06/06/14 with diagnoses which included Anxiety, Chronic Fatigue Syndrome, Muscle Weakness, and Pneumonia. Further review of the medical record revealed a signed Advanced Directives form indicating the resident's desire for DNR status. Continued review revealed a Physician's order for DNR status, and the inside front cover of the chart indicated DNR status.

However, review of Resident #15's Comprehensive Care Plan, with no clear initiation date, revealed no documented evidence the facility develop a care plan to address the resident's code status to ensure the resident's wishes would be honored by staff in the event the resident's heart stopped or respirations ceased.

An interview on 03/27/15 at 3:10 PM, with the MDS nurse revealed she was new to the position and was not aware it was her responsibility to care plan the Advanced Directives. Continued interview revealed the Advanced Directives should have been care planned.

An interview on 03/27/15 at 3:20 PM, with the Director of Nursing (DON), revealed the Social Services Director was responsible for completing the Advanced Directives form with residents and their families during the admission process and

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NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
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F 279 Continued From page 11
was responsible for care planning the code status. Continued interview revealed she did not realize the facility was not following their policy related to care planning the Advanced Directives. She stated it was necessary to have a completed record of the resident's care.

F 279

An interview on 03/27/15 at 3:30 PM with the Social Service Director revealed she was responsible to establish the code status with residents and family members on admission. She stated when the resident requested a DNR, she would give the information to the nurses. Continued interview revealed once she received the Physician's order, she would update the information in point click care. She revealed the code status should be care planned and it was her responsibility.

An interview on 03/27/15 at 4:04 PM with the Administrator revealed the Advanced Directives should have been completed for every resident upon admission, and individualized care plans developed for each resident. Continued interview revealed the Advanced Directives should always be care planned.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS
SS=D

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined the facility failed to ensure the nurse notified the Physician to obtain

F281 Services Provided Meet Professional Standards

A Teaching Moment on following the facilities policy and procedures (attachment #4) care planning was done by the Director of Nurses (DON) on April 13, 2015 for the nursing staff. Charts were reviewed on all current residents having a foley catheter (or other type). Charts were reviewed for the countenance of orders, diagnosis, and care plan. It is the facilities practice to review all residents on a daily basis. Any new orders for foley catheters will be reviewed for completion of obtaining orders for foley catheter care per the facilities catheter care policy. Any newly admitted or readmitted resident will have a chart review after admission to review catheter care orders and care plans are in place. The Assistant Director of Nursing (ADON) and DON will continue to audit resident charts and 24 hour report sheets for any new orders for foley catheter. The ADON or DON will then

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F 281 Continued From page 12
pertinent orders and failed to implement care planning related to an indwelling urinary catheter, for one (1) of fifteen (15) sampled residents (Resident #8).

The findings include:

Review of the facility's policy titled "Comprehensive Care Planning Policy and Procedure", updated February 2014, revealed the facility would develop an individualized comprehensive care plan for each individual resident. Continued review revealed an acute care plan would be initiated as needed based on the nurses' judgment.

Review of the facility's policy titled "Catheter Care Policy and Procedure", updated 02/28/14, revealed the facility would attempt to prevent catheter-related urinary tract infections, and would provide care based on individual resident need. Continued policy review revealed interventions related to care of the resident with an indwelling catheter included monitoring of the catheter system by nursing staff, changing of the catheter as needed, and the provision of catheter (hygiene) care daily.

Medical record review revealed Resident #8 was admitted by the facility on 03/23/15 with diagnoses which included Urinary Tract Infection, Diabetes, Chronic Kidney Disease, and Hypertension.

Interview with Resident #8, on 03/25/15 at 3:30 PM, revealed he/she was new to the facility. The resident reported being admitted with an indwelling urinary catheter, which made it easier for the resident since he/she was unable to get to

F 28 verify that diagnosis, orders, and care plans have been initiated. If a nurse has been noted to have missed any of the required steps needed for a catheter, that nurse will be educated on the importance of the facilities process. The Catheter Care policy (attachment #3) has been reviewed on 4/10/2015 by the facilities Quality Assurance Committee. The Quality Assurance Committee is made up of the Medical Director, Director of Nurses, Administrator, Pharmacist, Therapy Manager, Director of Dining, Facility Manager, MDS Nurse, Assistant Director of Nursing and Social Worker. RN #1 and LPN #2 were specifically educated on the facilities catheter care policy by the DON.

Resident #8 remains in the facility. Resident #8's chart was reviewed the physician was notified and orders for catheter care were in put into place. An acute care plan was updated for resident # 8. The DON assessed resident #8 on 3/27/15 for signs or symptoms of a urinary tract infection. The resident's physician also reassessed resident # 8 on 3/27/15

Date of compliance 5/12/2015.

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the bathroom.

Review of the Admission Physician's Orders revealed no orders related to Resident #8's urinary catheter.

Review of the Interim (initial) Plan of Care, dated 03/23/15, revealed no interventions related to Resident #8's urinary catheter were in place.

Interview with Registered Nurse (RN) #1, on 03/26/15 at 2:10 PM, revealed she was aware Resident #8 was admitted with a urinary catheter, and acknowledged no care plan to address the catheter was enacted upon admission. She stated the initial Care Plan should have included interventions related to the catheter. Continued interview revealed RN #1 did not check the resident's chart to determine if the Physician had provided any orders regarding the catheter.

Interview with Licensed Practical Nurse (LPN) #1, on 03/26/15 at 2:34 PM, revealed she was the admitting nurse for Resident #8, and she was aware the resident was admitted with a urinary catheter in place. LPN #1 stated upon a resident's admission to the facility, she was responsible to develop an initial care plan which addressed assessed risks, such as a risk for falls, and the presence of pain. She further stated a "specialized" care plan was to be developed for specific needs, which included the need for interventions related to caring for a resident with a catheter. Continued interview revealed she did not complete a "specialized" care plan for Resident #8's catheter, but acknowledged she should have done so. In addition, LPN #1 stated she was responsible to review the Physician's orders upon admission. She further stated she

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F 281 : Continued From page 14
did not contact the Physician for orders related to Resident #8's catheter, but affirmed she should have.

Interview with the Assistant Director of Nursing (ADON), on 03/26/15 at 2:00 PM, revealed LPN #1 should have called the Physician to obtain orders related to Resident #8's catheter, and should have included interventions to guide care of the catheter on the care plan.

Interview with the Director of Nursing (DON), on 03/27/15 at 3:20 PM, revealed it was her expectation that a care plan reflecting the care needs of the resident be developed upon admission. She stated it was important because the care plan guides the care of each resident. Continued interview revealed the admitting nurse should obtain necessary orders to address the care needs of the resident.

Interview with the Executive Director, on 03/27/15 at 4:00 PM, revealed it was his expectation for each resident to have a care plan initiated upon admission to address the resident's current status, including the presence of a urinary catheter. Continued interview revealed the nurse should have verified the admission Physician's orders for Resident #8, and ensured all necessary orders to care for the resident were obtained.

F 371 483.35(i) FOOD PROCURE,
SS=F STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and

F 281 :

F371 Food Procedure, store/prepare/Serve- Sanitary
The Director of Dining (DOD) will conduct a staff meeting on 4/21/15 to re-educate dietary staff on the facilities policy and procedure on proper food procedures and storage. The DOD is doing an in-service for the nursing staff on the facilities procedures on the storage of food items on the kitchenettes on 4/24/15. The DOD has completed audits on all food storage. All new dietary staff will be educated on the facilities food procedure and storage policy as part of orientation.

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F 371 Continued From page 15
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the proper labeling, dating, monitoring and storage of refrigerated and frozen foods in the main kitchen and on the A Household kitchenette.

The findings include:
Review of the facility's "Food Dating" policy, dated 06/01/2012, revealed all food containers were to be labeled with the "open date" upon opening. Continued review revealed, based on the "open date", all non-perishable foods were to be discarded after one (1) week, and perishable foods were to be discarded after three (3) days. Further policy review revealed all food sent from the main kitchen to the household kitchenettes would be labeled and dated by the Dietary staff, and the Certified Nursing Assistants (CNAs) who received the food on the Household kitchenettes were responsible to track the labeling, dating, and covering of food items to maintain good quality food which was safe for consumption. In addition, all loose food items were to be dated individually or placed in labeled and dated containers for storage.

Observation during the initial kitchen tour, on

F 371
A Quality Assurance & Performance Improvement (QAPI) committee is being started to review and educate staff on the importance of following facilitates policy for the storage and handling of foods. The QAPI committee will meet on 4/22/15. Members of the committee will include the Chef, Household team leaders, up to two dietary staff and the Registered Dietician (RD). The QAPI committee will meet at least monthly. The purpose of the QAPI will be to focus on continued education and to look for ways to improve safety and storage of food. The household team leader will be responsible for checking the labels and dates of stored food daily. The DOD or designee will be responsible for auditing each of the kitchenettes at least twice a week checking dates and labels on stored foods, and the RD will audit one household each week. All audits will be turned into the Quality Assurance Committee. Immediate action will be taken if any area falls outside of the audit guidelines. The food dating policy (see attachment 5) was reviewed by the facilities Quality Improvement Committee on 4/10/15, to review needed

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03/24/15 at 7:08 PM, revealed multiple food items stored in the refrigerators in the main kitchen which were not covered, labeled, and/or dated: a container of pureed chicken was undated; ten (10) cooked hamburger patties were stored on a tray, unlabeled and undated; an open bottle of A1 sauce was not labeled with the date opened; a container of forty (40) slices of bacon was not labeled or dated; one (1) bunch of green onion was unlabeled, undated and uncovered; and a container of grapes was not covered. Continued observation revealed containers holding mushrooms, onions, carrots, cauliflower, and cooked chicken were unlabeled and undated.

Interview with the front-line cook in the main kitchen, on 03/24/15 at 7:15 PM, revealed all food which was opened should be covered, labeled and dated. The cook was unable to explain why the food in the refrigerator was not covered, labeled, and/or dated, and stated only trained dietary staff had access to the refrigerator and knew the procedure for handling opened food items.

Observation on the A Household kitchenette, on 03/24/15 at 7:50 PM, revealed eight (8) undated ice cream bars in the freezer, two (2) undated pieces of cheese in a covered container in the refrigerator, and a scoop of strawberry ice cream in the freezer was uncovered, and was not labeled or dated.

Interview with State Registered Nursing Assistant (SRNA) #1, on 03/24/15 at 7:50 PM, revealed the standard dietary practice in the household kitchenettes was for all food which arrived from the main kitchen to be covered and labeled with the resident's name and the date. Continued

F 371

changes. The policy was updated on 4/17/15. The Quality Assurance Committee is made up of the Medical Director, Director of Nurses, Administrator, Pharmacist, Therapy Manager, Director of Dining, Facility Manager, MDS Nurse, Assistant Director of Nursing and Social Worker. Audits will continue for three months and then as directed by the Quality Assurance and QAPI committees over site for this plan will be the DOD.

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interview revealed if a resident declined to eat a particular food at mealtime but wanted to save it for later, it was to be returned to the refrigerator and covered with a clean sheet of saran wrap and labeled with the resident's name and date. She stated she did not know how the ice cream came to be placed in the refrigerator without being covered or labeled, or why the ice cream bars and the cheese was not labeled and dated.

F 371

Interview with the Head Chef, on 03/24/15 at 8:10 PM, revealed it was facility policy for all opened, refrigerated food to be covered, labeled and dated. He stated the food was to be disposed of after three (3) if it remained unused. He stated he periodically conducted audits of the refrigerators in the main kitchen and on the household kitchenettes to ensure all refrigerated food was stored and labeled correctly to prevent spoilage or contamination of the food. He further stated he could not say why the observed foods were not covered and/or dated properly according to facility policy.

F 520 483.75(o)(1) QAA
SS=E COMMITTEE-MEMBERS/MEET
QUARTERLY/PLANS

F 520

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary, and

F520 QAA Committee Members/meet quarterly /Plans

The Director of Dining (DOD) conducted a staff meeting on 4/21/15 to re-educate dietary staff on the facilities policy and

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develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and review of facility policy, it was determined the facility failed to develop and implement an appropriate plan of action to correct an identified quality deficiency, as evidenced by a repeat deficiency related to the proper storage of food items. Review of the Statement of Deficiency (SOD) from the prior survey of 05/15/14 revealed the facility was cited at F-371 for its failure to ensure proper storage, labeling and dating of food items. According to the facility's Plan of Correction for the 05/15/14 survey, corrective actions included re-education of staff and weekly audits to determine compliance. Observations in the main kitchen and on the A Household, on 03/24/15, revealed multiple food items were improperly stored and/or undated.

The findings include:

Review of the Quality Assurance (QA) Prevention Initiative Policy, updated 01/18/2014, revealed the

F 520

procedure on proper food procedures and storage. The DOD is conducting an in-service for the nursing staff on the facilities procedures on the storage of food items on the kitchenettes. This will be held on 4/24/15. The DOD has completed audits on all food storage. All new dietary staff will be educated on the facilities food procedure and storage policy as part of orientation. A Quality Assurance & Performance Improvement (QAPI) committee is being started to review and educate staff on the importance of following facilitates policy for the storage and handling of foods. The QAPI committee will meet on 4/22/15. Members of the committee will include the Chef, Household team leaders, up to two dietary staff and the Registered Dietician (RD). The QAPI committee will meet at least monthly. The purpose of the QAPI will be to focus on continued education and to look for ways to improve safety and storage of food. The household team leader will be responsible for checking the labels and dates of stored food daily. The DOD or

See attachment

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facility would maintain a Quality Assurance Committee and monitoring program, with the stated goal to keep facility systems functioning satisfactorily and consistently, including the maintenance of current practice standards. Continued review revealed the QA Committee would meet monthly to discuss concerns, would audit for effectiveness of policies in facility, would review audits and determine which audits should continue or needed to be changed, would discuss facility concerns or issues and determine if changes were needed, and would identify educational needs of the staff.

Review of the Statement of Deficiency for the 05/15/14 survey revealed deficient practice was identified at F-371 when the facility failed to ensure all stored foods were properly labeled and dated.

Review of the facility's Plan of Correction (POC) for the deficient practice revealed the facility would re-educate the dietary and nursing staff regarding the proper storage, labeling and dating of all refrigerated food items. Continued review of the POC revealed a Kitchen Preventive Maintenance Check-off Sheet was developed, and dietary managers would conduct walk-through audits in the kitchen and kitchenettes to monitor for compliance.

Observation in the main kitchen, on 03/24/15 at 7:08 PM, revealed multiple food items stored in the refrigerators were not properly covered, labeled, and/or dated. The improperly stored items included pureed chicken, hamburger patties, steak sauce, sliced bacon, and various fruits and vegetables.

F 520

designee will be responsible for auditing each of the kitchenettes at least twice a week, checking dates and labels on stored foods, and the RD will audit one household each week. All audits will be turned into the Quality Assurance Committee. Imitate action will be taken if any area falls outside of the audit guidelines. The food dating policy (see attachment 5 has been reviewed for needed changes by the facilities Quality Improvement Committee. The policy was updated on 4/17/15. The Quality Assurance Committee is made up of the Medical Director, Director of Nurses, Administrator, Pharmacist, Therapy Manager, Director of Dining, Facility Manager, MDS Nurse, Assistant Director of Nursing and Social Worker. Audits will continue for three months and then as directed by the Quality Assurance and QAPI committees over site for this plan will be the DOD.

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5/17/15

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Observation on the A Household kitchenette, on 03/24/15 at 7:50 PM, revealed undated cheese in the refrigerator, and undated ice cream bars and a scoop of uncovered ice cream in the freezer.

Interview with the Sous Chef, on 03/27/15 at 2:00 PM, revealed the Dietary Managers conducted informal walk-throughs in the kitchen and kitchenettes on a weekly basis, and spoke to staff on an individually if concerns were identified. The Sous Chef stated overall things were improving; however, he acknowledged periodic problems indicated the need for additional re-education.

Interview with the Head Chef, on 03/24/15 at 8:10 PM, revealed it is the facility policy for all food items to be covered, labeled and dated for storage. He stated he periodically conducted audits of stored food in the refrigerators of the main kitchen and the household kitchenettes to ensure all foods were stored and labeled correctly. He further stated the facility had been trying to address the issue since the last survey, and reported things were improving; however, he acknowledged re-education was still needed, especially when there was staff turnover.

Interview with the Director of Nursing (DON), on 03/27/15 at 11:30 AM, revealed she was Chairman of the Quality Assurance Committee. She stated the Dietary Department had been re-educating their staff related to the importance of labeling and dating all refrigerated food items, and the Head Chef had been conducting audits on a weekly basis. The DON further stated, based on State Agency findings during the current survey, the facility needed to re-evaluate and critically analyze the previous POC in an attempt to develop a root cause for its failure. Continued

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NAME OF PROVIDER OR SUPPLIER MADONNA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 520 Continued From page 21
interview revealed the facility, through its QA process, would develop a new POC to achieve and maintain compliance related to the proper storage, labeling, and dating of food.

F 520

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

PRINTED: 04/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2015
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NAME OF PROVIDER OR SUPPLIER MADONNA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017
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K 000 INITIAL COMMENTS

K 000

CFR: 42 CFR §483.70 (a)

BUILDING: 02

PLAN APPROVAL: 04/06/2010

SURVEY UNDER: 2000 New

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURES: One (1) story, Type V (111)

SMOKE COMPARTMENTS: Four (4) smoke compartments.

FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.

FIRE ALARM: Complete automatic fire alarm system with heat and smoke detectors.

SPRINKLER SYSTEM: Complete automatic (wet and dry) sprinkler system. The dry sprinkler system covers the exterior canopies.

GENERATOR: Type II generator, fuel source is diesel.

A standard Life Safety Code survey was conducted on 03/25/15. Madonna Manor was found to be in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et. seq. (Life Safety from Fire). Requirements for Participation in Medicare and Medicaid. The facility is licensed



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director* (X6) DATE *4-19-15*

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

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K 000	Continued From page 1 for sixty (60) beds with a census of fifty-seven (57) on the day of the survey.	K 000	