

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

PRINTED: 01/04/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>01/04/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD</b> <b>VILLA HILLS, KY 41017</b>		
(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	
{F 000}	INITIAL COMMENTS  An offsite revisit was conducted, and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance on 12/17/15 as alleged.	{F 000}			

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

TITLE

(X6) DATE

12/17/2015

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.

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

PRINTED: 11/05/2015  
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  C 10/23/2015
--	--	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000 INITIAL COMMENTS

An Abbreviated Survey investigating Complaint KY#00023928 and Complaint KY#00023946 was initiated on 10/22/15 and concluded on 10/23/15. Complaint KY#00023928 and Complaint KY#00023946 were substantiated and deficiencies were cited with the highest scope and severity of a "D".

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

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, review of the facility "Medication Administration" Policy, and review of the "Kentucky Board of Nursing Advisory Opinion Statement" (AOS) #14 Patient Care Orders, revised October 2010, it was determined the facility failed to ensure services provided by the facility meet professional standards of quality for one (1) of seven (7) sampled residents (Resident #3).

Observation on 10/22/15, revealed Resident #3 was left unattended with medication in a cup, on the left hand side of his/her plate at the lunch table.

The findings include:

Review of the facility "Medication Administration" Policy, revised 12/2012, revealed nurses were to observe medication consumption by residents.

F 000

The completion and submission of this plan of correction does not constitute 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. The facility alleges compliance as of 12/18/2015.

F 281

F281 483.20 (k) (3) The services provided or arranged by the facility must meet professional standards of quality.

Surveyors Allegation: The requirement is not met as evidenced by the facility failed to ensure services provided by the facility meet professional standards of quality for one (1) of seven (7) sampled residents (Resident #3).

1. The alleged noncompliance was corrected for the resident affected (Resident #3) by the deficient practice by ensuring the resident did consume the medications herself, per interview of this alert and oriented resident. And educating the nurse directly involved in the deficient practice on the facility policy for medication administration which includes that she will observe resident's consumption of medications.

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

TITLE

(X6) DATE

*Kanya [Signature]*

*Executive Director*

*12/17/15*

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.

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

PRINTED: 11/05/2015  
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  C 10/23/2015
--	--	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 281 Continued From page 1

Review of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14 Patient Care Orders, revised October 2010, revealed Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) were responsible for the administration of medication treatment as authorized by a Physician, Physician Assistant, or Advanced Practice Registered Nurse (APRN). Review revealed components of medication administration included, but were not limited to, preparing and giving medication in the prescribed dose, route and frequency.

Review of Resident #3's clinical record revealed the facility admitted the resident on 09/19/14, with diagnoses which included Osteoporosis, Epilepsy, Idiopathic Neuropathy, Essential Hypertension and Heart Disease. Review of Resident #3's Annual Minimum Data Set (MDS) Assessment, dated 09/27/15 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of fifteen (15) out of fifteen (15) indicating he/she was not cognitively impaired.

Review of Resident #3's Physician's Orders dated October 2015, revealed orders for Neurontin Capsule 300 milligrams one (1) time a day and Clonidine HCL (anti-hypertensive medication) 0.1 milligrams three (3) times a day.

Review of Resident #3's Medication Administration Record (MAR) dated October 2015, revealed the Neurontin Capsule 300 milligrams was scheduled to be administered at noon daily, and Clonidine HCL 0.1 milligrams was scheduled to be administered three (3) times a day at 8:00 AM, 12:00 Noon, and 8:00 PM.

F 281

2. The facility will identify other residents/ patients having the potential to be affected by the same deficient practice by observing medication administration practice of the consistently assigned nurses on the same unit to ensure compliance with professional standards of quality outlined in the facility policy for medication administration.
3. The facility will ensure that the deficient practice does not recur by conducting in-service training to all nurses regarding the professional standards of quality outlined in the facility policy for medication administration. The Director of Nursing and administrative nursing team will oversee, and present the education of the nurses which began on 10/23/15 and will be concluded by 12/17/15. The facility does not utilize Certified Medication Technicians nor agency staffing. The new hires will receive the education as part of their orientation. Any PRN staff who have not completed the education by 12/17/15, will not be scheduled to work until they have completed the education.

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

PRINTED: 11/05/2015  
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  C 10/23/2015
--	--	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 281 Continued From page 2

Observation on 10/22/15 at 12:20 PM, revealed Resident #3 had two (2) pills, in a cup, on the left hand side of his/her place, at the lunch table.

Interview with Resident #3, on 10/22/15 at 12:20 PM, revealed nurses routinely left medication with him/her, especially morning medications, per his/her request. Continued interview revealed he/she had numerous morning medications and would fill up on fluids to take them and would not have "any room in my stomach left to eat breakfast" so he/she took them later. Further interview revealed the resident identified the two (2) medications in the cup as Neurontin, and Clonidine.

Review of Resident #6's medical record revealed the facility admitted the resident on 03/14/13 with diagnoses including Parkinson's Disease and Dysphagia. Review of the resident's Quarterly MDS Assessment dated 07/27/15 revealed the facility assessed the resident as having a BIMS score of twelve (12) out of fifteen (15) indicating the resident was cognitively intact. Interview with Resident #6 on 10/23/15 at 1:55 PM, revealed nurses occasionally, maybe one (1) or two (2) times a week, left medication with him/her to take later.

Interview with State Registered Nurse Aide (SRNA) #3, on 10/22/15 at 12:30 PM, revealed she had never observed a nurse leave any medication with a resident. Continued interview revealed medications should not be left with residents.

Interview with SRNA #4, on 10/22/15 at 12:35 PM, revealed medication should not be left with the residents but Licensed Practical Nurse (LPN

F 281 4. The facility plans to monitor its performance to ensure the solutions are sustained by conducting medication pass observations of one nurse per week for a period of four weeks and then at least one nurse per month for two months, then at the direction of the Director of Nursing. Medication pass audits will observe two to three residents for each medication pass. The medication pass observations will be conducted by the Director of Nursing and the nursing management team as delegated. The results of the monitoring will be discussed as part of the Quality Management program ongoing.

The facility alleges compliance as of 12/18/15.

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

PRINTED: 11/05/2015  
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  C 10/23/2015
--	--	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 281 Continued From page 3

F 281

#1) routinely left medication with certain residents. Further interview with SRNA #4 indicated LPN #1 routinely left medication with Resident #3, Resident #5 and Resident #6.

Interview with SRNA #5, on 10/22/15 at 12:45 PM, revealed medication should not be left with the residents but the nurses say it's all right to leave the medication with residents who were alert and oriented. Further interview with SRNA #5 indicated she usually noticed medication being left with residents at the dinner table more than in the resident rooms.

Interview with LPN #1, on 10/22/15 at 1:05 PM, who was assigned to Resident #3, revealed she had been taught in nursing school, medications were not to be left with residents. However, she further stated, when she came to work at the facility about three (3) years ago, she was told they were striving for a more home like environment and it would be all right to leave medication with a resident if they were alert and oriented. Continued interview revealed LPN #1 would routinely leave medication with Resident #3 and Resident #7 because they were alert and oriented.

Resident #7 was not able to be interviewed due to illness.

Interview with the Director of Nursing (DON), on 10/23/15 at 1:45 PM, revealed since she had only been hired about a month ago, she was unable to speak to anything staff may have been told before she was hired. Continued interview revealed she was unaware nurses were leaving medication with residents. She stated, per the facility policy, nurses were to observe resident

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

PRINTED: 11/05/2015  
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  C 10/23/2015
--	--	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 281 Continued From page 4  
consumption of medication at the time of administration. She stated it was her expectation for staff to follow facility policy. Further interview revealed the facility did have a medication self administration policy; however, it was not being implemented at this time.

F 281

F 465 483.70(h)  
SS=E SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

F 465

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

F 465 483.70 (h) The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by.

Based on observation and interview, it was determined the facility failed to provide a safe, and sanitary environment. Observation of the Household Kitchenettes revealed soiled and sticky cabinet drawers, soiled dish cabinets and cabinet shelves, soiled ice machine exteriors and there was no access knobs on the covers of the ice machines. Also, the steam tables were left with food and debris.

Surveyors Allegation: The requirement is not met as evidenced by observation of the Household Kitchenettes revealed soiled and sticky cabinet drawers, soiled dish cabinets and cabinet shelves, soiled ice machine exteriors and there were no access knobs on the covers of the ice machines. Also, the steam tables were left with food and debris.

The findings include:

Observation of Household "A" kitchenette area, on 10/22/15 at 9:00 AM, revealed the silverware tray was soiled, and the drawer the silverware tray was in, had granule particles in it. Also, the lips of the drawers under the juice machine had a sticky substance on them, and there was a sticky substance in the drawers. The cabinets above the counter top that held plates, cups, and saucers had a stain, the cabinet shelves over the

1. The alleged noncompliance was corrected on 10/24/15 for the residents affected by the deficient practice by conducting detailed cleaning of each Household Kitchenette by STNA staff at the direction of the Director of Nursing. The cleaning was audited for completeness by the DON.

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

PRINTED: 11/05/2015  
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  C 10/23/2015
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 465 Continued From page 5

microwave had debris and dust like particles on them, and the top shelf lip had a dime sized yellow food substance on it. The ice machine exterior was covered with dust like particles and a sticky substance and there was no access knob on the cover of the ice machine. Also, the steamtable well had a piece of floating bread in the water.

Observation of Households "B" kitchenette area on 10/22/15 at 9:12 AM, revealed the silverware tray and drawer was soiled. The inside of the drawers under the juice machine was covered with a sticky substance, and the dish cabinets and ice machine had a build up of dust like particles. Also, there was no access knob on the cover of the ice machine.

Observation of Household "C" kitchenette on 10/22/15 at 9:17 AM, revealed the silverware tray and drawer holding the tray was soiled, the inside of the drawers under the juice machine were soiled with a sticky substance and the dish cabinets and ice machine had a build up of dust like particles. In addition, Household "C"'s kitchenette steamtable well had a piece of plastic floating in it.

Interview with State Registered Nurse Aide (SRNA) #1, on 10/22/15 at 9:17 AM, revealed it was the SRNA's responsibility to ensure the kitchenettes were cleaned up after each meal, much as a kitchen at home would be cleaned up after a meal to include wiping up spills and sweeping and mopping the floor. Further interview revealed the Dietary staff came up once a month and de-limed the dishwasher and steamtable wells and deep cleaned the floors, walls and cabinets.

F 465

2. The facility will identify other residents/patients having the potential to be affected by the same deficient practice by observing Household cleanliness rounds one household per week. This will be conducted by the members of the interdisciplinary team at the direction of the Director of Nursing.
3. The facility will ensure that the deficient practice does not recur by conducting in-service training to all STNA regarding the standards for cleanliness within the kitchenettes, for which they are responsible for cleaning. This in-service training will be conducted using the internet based staff training system overseen by the human resource director for completeness. This in-service training was begun on 10/23/15 and will be completed 12/17/15. The training will be provided to new hires, the facility does not use agency staff. Any PRN Staff who have not completed the education by 12/17/15 will not be scheduled to work until the education is completed.

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

PRINTED: 11/05/2015  
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  C 10/23/2015
--	--	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 465 Continued From page 6

F 465

Interview with the Director of Nursing (DON), on 10/23/15 at 1:45 PM, revealed during walking rounds on 10/13/15, the general cleanliness of the facility kitchenettes did not meet her expectations. Continued interview revealed, as soon as information gathering/discussions were completed and processes and procedures were developed and completed, staff education would be instituted on general kitchenette cleanliness.

- The facility plans to monitor its performance to ensure the solutions are sustained by conducting Household Kitchenette cleanliness audits once per week x 4 weeks on each Household, then one Household per week ongoing at the direction of the Director of Nursing. The audits will be conducted by members of the administrative interdisciplinary team at the direction of the Administrator. The audits will be conducted using visual inspection to determine that the criteria for cleanliness is met and will be checked off on an audit tool. The audits will begin the week of Nov 22-28, 2015. The results of the monitoring will be discussed as part of the Quality Management program ongoing.

The facility alleges compliance by 12/18/15.