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 _____	R 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA MANOR	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	{F 000}		

Based on the acceptable Plan of Correction (POC) received on 04/12/21 and the on-site revisit survey conducted on 05/06/21, it was determined the facility was in compliance as alleged on 04/13/21.

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

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.

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100268	A. BUILDING: _____ B. WING _____	R 05/06/2021

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{N 000}	Initial Comments Based on the acceptable Plan of Correction (POC) received on 04/12/21 and the on-site revisit survey conducted on 05/06/21, it was determined the facility was in compliance as alleged on 04/13/21.	{N 000}		

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

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

2ND POC acceptable 4/22/2021 (SAn) administrator notified by e-mail 4/22/2021

PRINTED: 04/26/2021
FORM APPROVED
OMB NO. 0938-0391

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 ______	03/04/2021

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 03/01/2021 and concluded on 03/04/2021. The facility was found not to be in compliance with 42 CFR 483.80 infection control regulations and had not implemented the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Deficient practice was identified at the highest scope and severity of an "E." Total census was 44.	F 000	Received 4/12/2021 c attachments (2) (SAn)	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of Material Safety Data Sheets (MSDS),	F 689	F689- Free of Accident Hazards/Supervision/Devices	3/29/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/29/2021

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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F 689	Continued From page 1	F 689		

and review of the facility's policies, it was determined the facility failed to maintain an environment that remained as free of accident hazards as possible.

Observation, on 03/01/2021 at 3:17 PM, revealed a housekeeping cart, on Household C, not secured with hazardous chemicals within. Per interview, the cart had no key to secure it.

Observation, on 03/01/2021 at 3:23 PM, revealed a medication cart, on Household C, not secured, with the nurse away from the cart. Another observation, on 03/02/2021 at 11:55 AM, revealed a medication cart, on Household B, not secured, with the nurse away from the cart.

The findings include:

Review of a facility list of residents assessed to be at risk for wandering, provided by the Director of Nursing (DON), revealed seven (7) residents on Household C were considered wanding risk, cognitively impaired and potentially at a high risk due to unlocked medication carts or unlocked housekeeping carts. Three (3) of the residents listed were determined, on review of the Minimum Data Set (MDS), to be potentially at a higher risk due to cognitive impairment: Resident #10, Resident #11, and Resident #13.

Review of Resident #10's medical record revealed the facility admitted the resident, on 04/01/2020, with diagnoses that included Dementia without Behavioral Disturbance, Insomnia Unspecified, and Difficulty in Walking Not Elsewhere Classified.

Review of the 12/31/2020 Quarterly Minimum

Education:
1A. Education with staff given by Director of Housekeeping and Director of Nursing on facility policy "Safety, Precautions, General", which discussed the general safety precautions as established by the facility. Furthermore, this discussed manufactures guidelines when using chemicals, equipment's, and other supplies at facility all staff in-service on 3/11/21
1B. Individual education with HHC housekeeper #1 regarding policy of locking housekeeping cart done immediately by Director of Housekeeping on 3/1/21.
1C. . Education given from Director of Housekeeping to all HK staff at Housekeeping Staff Meeting on 3/8/21.
2A. Education to all nurses on policy "Storage of Medications", done by Director of Nursing. This policy covered/included the process of storing medications and ensuring all carts with any type of medication/cream/powder remains locked when away from cart. Education occurred at facility all staff on 3/11/21.
2B/3A. Individual education with LPN #1, LPN #2, LPN #4 completed on 3/1/21 & 3/2/21 related to Facility policy "storage of medication" and ensuring cart is locked when not in use by Director of Nursing. Individual education with LPN #1 by DON related to ensuring no loose medications are anywhere in resident area on 3/1/21.
Immediate Action Taken:
1A. All housekeeping carts immediately removed from unit on 3/1/21. all carts relocked and rekeyed by Director of

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F 689	Continued From page 2	F 689		

Data Set (MDS) Assessment revealed the facility assessed Resident #10 as moderately cognitively impaired. In addition, the Assessment revealed the resident required, on the unit, supervision with ambulation and assist of one (1) staff; off the unit, the resident required supervision with ambulation and setup assist only.

Review of Resident #11's medical record revealed the facility admitted the resident, on 05/26/2016, with diagnoses that included Dementia in Other Diseases Classified Elsewhere with Behavioral Disturbance, Difficulty in Walking Not Elsewhere Classified, and Repeated Falls. The facility assessed Resident #11, in a 02/22/2021 Quarterly MDS Assessment, as severely cognitively impaired, requiring supervision and assist of one (1) staff for ambulation.

Review of Resident #13's medical record revealed the facility admitted the resident on 06/24/2020, with diagnoses that included Alzheimer's Disease with Late Onset, Difficulty in Walking Not Elsewhere Classified, and Other Symptoms and Signs Involving Cognitive Functions and Awareness. The facility assessed Resident #13, in a 06/27/2020 Admission MDS Assessment, as moderately cognitively impaired and required limited supervision and assist of one (1) staff for ambulation on the unit.

1. Review of the facility's policy titled, "Safety Precautions, General," revised November 2009, revealed all staff were required to follow general safety precautions as established by the facility. Further, the policy stated staff was to follow manufacturers' guidelines when using chemicals, equipment, and other supplies.

Facility Maintenance on 3/2/21
2B/3A. Audit of all medication carts done by Director of Nursing to ensure locked carts on 3/1/21. Audit of all units done by DON on 3/1/21 to ensure no loose medications on/near medications carts.
Resident Observation/Assessment:
1A. Resident #10, #11, and #13 whom are a wandering risk, assessed by licensed nurse for any potential adverse reaction related to observation with both housekeeping cart, and medication cart unlocked.
2B/3A. Resident #11 and #12 whom were nearby at time of unlocked cart, assessed for any adverse reaction by DON.
Ongoing Assessment:
Audits for tags F761 and F689 will be done by Director of Nursing and Director of Housekeeping weekly x'4, monthly x'3 and quarterly x's 4 to ensure all treatment/medication and housekeeping carts are locked. The results will reported to the Facility QAPI Committee at monthly QAPI meeting.

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F 689	Continued From page 3	F 689		

Observation, on 03/01/2021 at 3:17 PM, revealed Housekeeper #1's housekeeping cart, on Household C, was unlocked with hazardous chemicals inside, including Ecolution Pro Glass Cleaner; Ecolution Odor Remover Crisp Linen; GBC-34, a germicidal detergent and deodorant; NDC Morning Fresh Disinfectant Cleaner; D-Story Morning Fresh; and Triple Quick Lavender Meadow.

Review of a Material Safety Data Sheet (MSDS) for Ecolution Pro Glass Cleaner revealed it was an eye and skin irritant, with low toxicity risk to vulnerable populations. Further, the MSDS revealed the chemical should be stored locked up.

Review of the MSDS for Ecolution Odor Remover Crisp Linen revealed it was an eye irritant and skin irritant that should be stored in a dry place.

Review of the MSDS for GBC-34, a germicidal detergent and deodorant, revealed it was capable of causing serious eye damage, severe skin burns, and to avoid breathing chemical vapors. The MSDS further revealed GBC-34 contained toxic chemicals and should be stored locked up.

Review of the MSDS for NDC Morning Fresh Disinfectant Cleaner revealed the product caused severe skin burns and eye damage; was harmful if inhaled or swallowed; and was to be stored in a dry place and locked up. First aid measures included contacting a poison center if swallowed.

Review of the MSDS for D-Story Morning Fresh revealed the product caused skin and eye

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F 689	Continued From page 4	F 689		

irritation; was harmful if swallowed; and was to be stored in a dry place and locked up. First aid measures included contacting a poison center, if swallowed.

Review of the MSDS for Triple Quick Lavender Meadow revealed it was a skin and eye irritant that could be harmful if swallowed. Further review revealed the product contained toxic chemicals and should be stored in a dry place and locked up.

Interview with Housekeeper #1, as she returned to the housekeeping cart, on 03/01/2021 at 3:17 PM, revealed when she opened the cart to show compartments within her cart, it was not locked. When asked if the cart should be locked, Housekeeper #1 stated it should be, but, there were no keys to match the cart. She also stated she had been unable to lock it since it had been assigned to her. Further, when asked if there had been any training regarding storage of items in the housekeeping cart, she stated she had received training, and the cart should always be secured.

Interview with the Housekeeping Supervisor, on 03/02/2021 at 2:05 PM, revealed Housekeeper #1 had worked in the facility for under a year and had been working Household C for about six (6) months. She stated Housekeeper #1 had one (1) of the carts with a missing key, and when she started working as Supervisor, she discovered several housekeeping carts used on residential units had missing keys. Per interview, the Supervisor stated the original plan was to have all housekeeping carts keyed with the same key, which was on a list of things to be done, but unfortunately, had not been done. When

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F 689	Continued From page 5	F 689		

interviewed about the importance of having carts locked, she stated staff was trained to keep an eye on housekeeping carts and to shut carts when in a resident's room. She stated she was not aware that any resident had ever bothered the housekeeping carts. Furthermore, the Supervisor stated, based on her experience, an unlocked cart would not be a risk to residents on Household C, as none had ever shown any interest in the housekeeping cart.

Interview with the DON, on 03/02/2021 at 3:44 PM, revealed housekeeping carts should be secured when the housekeeper stepped away and at all times. The DON stated the danger of an unsecured housekeeping cart was a confused resident, or any resident could try to consume or use chemicals inside the cart.

Interview with the Administrator, on 03/02/2021 at 3:44 PM, revealed housekeeping staff, including the Supervisor of Housekeeping, did not understand the urgency of having secured housekeeping carts, and she was unaware there were housekeeping carts that were not secured, prior to 03/01/2021. The Administrator stated it was a resident safety issue because any resident could get a harmful chemical and possibly spill or ingest it.

2. Review of the facility's policy titled, "Storage of Medications," revised April 2007, revealed all drugs and biologicals were to be stored in a safe, secure, and orderly manner. Further review revealed compartments containing drugs and biologicals were to be locked, when not in use, and medication carts should not be left unattended, if opened or potentially available to others.

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F 689	Continued From page 6	F 689		

Observation, on 03/01/2021 at 3:22 PM, revealed an unlocked medication cart on Household C. Observation of the area revealed two (2) residents in the television area near the medication cart, Resident #11 and Resident #12. Further observation revealed Resident #6 wheeled past the cart while it was unlocked.

Interview with Licensed Practical Nurse (LPN) #1, on 03/01/2021 at 3:23 PM, revealed she left her medication cart briefly to put some Med Pass (a nutritional supplement used during medication administration) in the unit refrigerator, as she had completed medication administration to residents. She stated she locked her cart, when she was away from it, and should have done so when refrigerating the Med Pass because leaving it unlocked could pose a danger to residents. In addition, she stated someone could take medications from it or get into other supplies stored there, such as blood sugar supplies or insulin supplies stored in the medication cart. While interviewing LPN #1, a loose pill was noted under the medication cart, which was later determined to be an eighty-one (81) milligram (mg) aspirin tablet. LPN #1 stated she did not know what the loose medication was but stated someone else might have dropped it and not noticed it. She stated she did not believe anyone had missed medications, and she disposed of the loose pill in the sharps container. Furthermore, LPN #1 stated all Household C residents had medications in the medication cart.

Interview with the DON, on 03/01/2021 at 5:00 PM, revealed the facility just switched to medication carts recently, on 02/26/2021.

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F 689	Continued From page 7	F 689		

Additional observation on Household B, on 03/02/2021 at 11:54 AM, revealed LPN #2 left the medication cart unlocked when performing glucometer testing of an unsampled resident. Three (3) nurse aides were observed nearby in the unit kitchen area.

Interview with LPN #2, on 03/02/2021 at 11:55 AM, revealed she usually locked her cart, and should have done so, when doing glucometer checks on residents, because a confused resident, or any resident, could potentially get into the cart and grab medications. In addition, she stated the facility just started using medication carts.

Follow up interview with LPN #1, on 03/03/2021 at 3:46 PM, revealed the facility just started using medication carts, possibly on 02/26/2021, or on 03/01/2021. She again stated medications for all residents on Household C were in the cart on 03/01/2021. She stated she was away from the cart for possibly thirty (30) seconds when the State Survey Agency (SSA)Surveyor noted the unlocked medication cart. LPN #1 stated it was important to keep the medication cart locked when she was not present, as a confused resident, or any resident, could get into the cart and take medications or get sharps that were in the medication cart and harm himself/herself.

Interview with LPN #4, of Household B, on 03/03/2021 at 3:22 PM, revealed there had been no formal education at the facility regarding medication cart usage, although she had been a nurse long enough she did not feel there was a need for formal education. She stated it was standard practice to lock the medication cart, when away from it, because there could be a

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F 689	Continued From page 8 danger of residents taking medications, leading to severe negative physical consequences. Interview with the DON, on 03/02/2021 at 3:44 PM, revealed medication carts should be locked anytime the nurse stepped away from them. The DON stated a dropped medication, including an 81 mg aspirin tablet, could pose a danger of adverse consequences to a resident. Interview with the Administrator, on 03/02/2021 at 3:44 PM, revealed medication carts should not be left unlocked. She revealed this had been the facility's second day using medication carts, and they needed to be kept secured for resident safety.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		3/29/21

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the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure drugs and biologicals were stored in locked compartments with only authorized personnel permitted access.

Observation, on 03/02/2021 at 11:54 AM, revealed State Registered Nurse Aide (SRNA) #5 accessed a medication cart, then secured the medication cart, after Licensed Practical Nurse (LPN) #2 asked for an alcohol pad to clean a glucometer prior to usage.

The findings include:

Review of the facility's policy titled, "Storage of Medications," revised April 2007, revealed compartments containing drugs and biologicals, including medication carts, were to be locked when not in use and should not be left unattended or potentially available to others. The policy further stated only persons authorized to prepare and administer medications should have access to the medication room, including any keys.

Observation, on 03/02/2021 at 11:54 AM,

F761- Label/Store Drugs and Biologicals
Education:
1A. Education to SRNA #5 and LPN #2 related to ensuring medication cart is always locked was provided by DON on 3.2.21 . Education provided to to SRNA #5 on the only person who should access the medication cart is the licensed nurse who has keys for specific cart by Director of Nursing . Policy related to tag F761 is the same policy/education give F689.
2A. Education to all nurses on policy "Storage of Medications", done by Director of Nursing. This policy covered/included the process of storing medications and ensuring all carts with any type of medication/cream/powder remains locked when away from cart. Education occurred at facility all staff on 3/11/21.
3A. Individual education with LPN #1, LPN #2, LPN #4 completed on 3/1/21 & 3/2/21 related to Facility policy "storage of medication" and ensuring cart is locked when not in use by Director of Nursing. Individual education with LPN #1 by DON related to ensuring no loose medications

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F 761	Continued From page 10 revealed LPN #2 left her medication cart unlocked in the common area and out of sight while entering a resident's room to conduct a glucometer check. Once the LPN put on appropriate personal protective equipment (PPE), to include gown, gloves, mask, and face shield, she realized she did not have an alcohol prep pad to sanitize the glucometer, prior to its usage. LPN #2 proceeded to call out for someone to get her an alcohol prep pad. Continued observation revealed SRNA #5 left the nearby kitchen area, proceeded to the medication cart, withdrew an alcohol prep pad from the cart, secured the cart, and then met LPN #2 in the doorway to the room with the alcohol prep pad. SRNA #5 then returned to his duties. Interview with LPN #2, on 03/02/2021 at 11:55 AM, revealed she should have locked her cart but did not consider it an issue to ask an aide to get an alcohol wipe from the medication cart. Interview with the Director of Nursing (DON), on 03/02/2021 at 3:44 PM, revealed medication carts should be locked whenever the nurse stepped from the cart so no one else had access to the cart. Interview with the Administrator, on 03/02/2021 at 3:44 PM, revealed LPN #2 should not have left her medication cart unlocked, and SRNA #5 should not have gotten anything from the cart, and only the nurse responsible for the cart should have access to the cart. In addition, she stated alcohol prep pads could be accessed by aides in the supply room on the unit.	F 761	are anywhere in resident area on 3/1/21. Immediate Action taken : DON completed audit of med cart to ensure no medication missing on 3.2.21 Ongoing assessment: DON/designee will conduct audits to ensure that med cart remain locked and only the nursing professional assigned to the cart may access it. Audits will occur weekly x's4, monthly x'3 and quarterly x's 4. Results will be reported to the Facility QAPI committee at Monthly QAPI meeting.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		4/10/21

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F 880	Continued From page 11	F 880		

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:

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F 880	Continued From page 12 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies, it was determined the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections, such as COVID-19.	F 880	F880- Infection Prevention & Control Education Education given to all staff on policy Infection Prevention and Control Policy COVID19 Basic Policy Version 3. All staff signed off on receiving and understanding of policy. Education provided by DON at Facility All Staff on 3.11.21 1A. Education given to Infection	

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F 880	Continued From page 13 1. Observation, on 03/01/2021 at 1:37 PM, noted six (6) rooms, on Household B, and one (1) room, on Household A, with isolation carts in front of doors, without signage indicating the nature of the isolation. 2. Observation, on 03/01/2021 at 3:15 PM, on Household C, revealed residents not social distancing and not wearing masks. Observation on 03/02/2021 at 8:18 AM, on Household A, revealed multiple residents seated around tables in the dining area, not socially distanced. 3. Observation, on 03/01/2021 at 3:17 PM, on Household C, revealed a pile of loose gloves on top of a soiled housekeeping cart. Further observation revealed a housekeeper donned a pair of the gloves and placed the other gloves in a clean storage container. The findings include: Review of the facility's policy titled, "Infection Prevention and Control Policy COVID-19, Basic Policy VERSION-3," revised 02/23/2021, revealed communal dining would be permitted, however, social distancing would remain in effect. Further review revealed residents who were in isolation would have a sign posted "Please see a nurse before entering." Review of the facility's policy titled, "Infection Prevention and Control Policy SARS-CoV-2, Coronavirus Disease 2019 (COVID-19) VERSION 12," revealed if unable to use dedicated or disposable equipment, equipment used should be disinfected and cleaned according to manufacturer's guidelines. Further review of the policy revealed core principles to	F 880	Preventionist as well as nursing staff regarding signage posted indicating which type of isolation each resident is in. Education given by DON on 3.2.21 1B. Audit done to ensure signage posted on all isolation rooms to accurately reflect what type of isolation resident was in. Rooms 166, 168, 169, 170, 173, 154 and 177 immediately fixed with proper signage. Audit completed by DON on 3.2.21. 2A. Education given to all staff related to socially distancing while in common areas and encouraging the use of face masks with all residents. Education provided by DON at Facility All staff on 3.11.21 2B. Audit done of resident□s cognition status to comply with masks and/or socially distancing. Care plans updated to reflect any limitations of proper masking or socially distancing. 2C. Residents visualized not social distancing audited- all residents had zero COVID symptoms, negative COVID tests, and had not triggered on any respiratory assessment completed by licensed nurse. Residents were not in contact with any COVID positive people. 3A. Education given to housekeeping by Director of HK regarding making sure all gloves on carts are in the storage box for gloves at housekeeping departmental meeting on 3.8.21 3B. Audit done of all housekeeping carts to ensure no loose gloves by Director of Housekeeping on 3.1.21 3C. No residents were in immediate harm with the loose gloves on housekeeping cart.	

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reduce the risk of COVID-19 transmission included the use of face coverings or masks and social distancing of at least six (6) feet between persons.

1. Observation, during the initial tour, on 03/01/2021 at 1:37 PM, on Household B, revealed six (6) rooms with personal protective equipment (PPE) storage outside of the rooms with no signage on the doors or near the rooms indicating the nature of the isolation precautions (Rooms 166, 168, 169, 170, 173, and 177). Another room (Room 154) was observed, on Household A, with PPE storage outside, yet no signage on the door or near the room. Continued observation of these areas revealed staff donned full PPE (gowns, face masks, eye protection, gloves), prior to entering rooms, with PPE storage outside.

Interview with the Infection Preventionist (IP), on 03/01/2021 at 9:40 AM, and again at 6:20 PM, revealed she knew the Director of Nursing (DON) had been in contact with the Corporate Office regarding signage, prior to the State Survey Agency (SSA) Surveyor noting the lack of signage. She further stated all residents with PPE by their doors were either new admissions, readmissions, or residents who had been out for appointments. She stated all of those residents were considered to be on Droplet Precautions; but, if the facility was not enforcing use of Droplet Precautions for all residents, signage would be important to prevent potential staff exposure.

Interview with State Registered Nurse Aide (SRNA) #5, on 03/02/2021 at 5:54 PM, revealed aides were not always informed of the nature of precautions residents were on; however, staff

Ongoing Assessment
Audits will be completed by DON/ Desginee to ensure gloves are secured properly on housekeeping carts, proper signage is located on doors of residents in isolation correctly reflects the type of isolation the resident is in. Audits will be completed by DON/designee on the proper masking and social distancing on units by the residents. Results of Audits will be reported to the Facility QAPI Committee at the Facility Monthly QAPI meeting.

Facility will complete the Directed Plan of Correction developed by the OIG.
Directed Plan of Correction to include:
a. Module 1: Infection Prevention and Control Program
b. Module 6A: Principles of Standard Precautions
c. Module 6B: Principles of Transmission Based Precautions

Clean Hands: Combat COVID-19!
https://www.youtube.com/watch?v=xmYMUly7qiE

Use Personal Protective Equipment (PPE) correctly for COVID-19
https://www.youtube.com/watch?v=YYTATw9yav4

Facility will also complete a Root Cause Analysis of the areas indicated in the 2567.

See ATTACHMENTS 1 & 2 JAH

compliance date 04/13/2021 JAH

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was told to treat everyone in precautions as if on Droplet Precautions, utilizing full PPE. He stated, although nursing staff would not necessarily say residents were isolated due to COVID-19 and there was no signage to indicate the type of precaution, the assumption would be any resident in isolation was due to COVID-19.

Interview with Licensed Practical Nurse (LPN) #1, on 03/03/2021 at 3:46 PM, revealed most new admits were on her unit (Household B). She stated she was informed during report, at shift change, the nature of the residents' isolation precautions. Per interview, she stated all residents on any type of isolation had isolation carts outside of their doors with full PPE available to staff. In addition, LPN #1 stated when aides saw the isolation carts, they typically asked nurses about the nature of the isolation.

Interview with the Director of Nursing (DON), on 03/01/2021 at 5:00 PM, revealed she was uncertain about the specifics on signage to be posted outside of residents' rooms. The DON stated she had contacted the Corporate Office regarding this, on 02/26/2021, but had not received clarification. She stated she was uncertain what type of signage needed to be posted, but all residents on any type of isolation currently were treated as if on Droplet Precautions, which required staff to wear full PPE when caring for those residents.

Interview with the Administrator, on 03/04/2021 at 1:59 PM, revealed she expected the facility to have signage posted in accordance with the Centers for Medicare and Medicaid Services (CMS) regulations.

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2. Observation, on 03/01/2021 at 3:15 PM, on Household C, revealed two (2) incidents of residents in the television area not socially distanced (Resident #11 and Resident #12; Resident #1 and an unsampled resident) and not wearing masks. Further, masks were visible hanging off one (1) resident and hanging on the wheelchair of a second resident. Further observation, during the time period observed, revealed staff was not encouraging, promoting social distancing amongst the residents.

Observation, on 03/02/2021 at 8:18 AM, on Household A, revealed residents seated around dining tables awaiting breakfast. Further, observation revealed five (5) residents were seated around two (2) tables pushed together, not social distancing; four (4) residents were seated around one (1) table, not social distancing; four (4) residents were seated around two (2) tables pushed together, with two (2) social distancing and two (2) others within three (3) feet of each other; and three (3) residents were seated at one (1) table, not socially distanced.

Interview with the IP, on 03/02/2021 at 9:40 AM, and again at 6:20 PM, revealed there was not a lot of space on Household A for residents to social distance, although masks were encouraged until meal service was about to begin, for those that would listen. She stated it was a struggle to keep residents socially distanced and to utilize masks. The IP stated residents ate better and were less depressed when they had communal dining. She stated she would love to be able to ensure residents maintained a six (6) foot distance, but it was difficult with wanderers, and during meals, as residents desired to sit near their friends. Further

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interview reveled this had been more difficult lately for Household C, following recovery from a recent isolation due to a COVID-19 outbreak. She stated she expected staff to encourage mask use among residents and to try to keep residents separated from wandering residents who refused to wear masks. The IP stated Resident #11 was particularly difficult to social distance, as he/she always wanted to spend time near others.

Interview with State Registered Nurse Aide (SRNA) #2, on 03/02/2021 at 10:22 AM, revealed most cognitively impaired residents removed their masks and threw them on the floor, and it was a challenge for staff to keep their masks on them. She stated staff reiterated the need to wear masks, and most residents wore masks or kept them on their wheelchairs when not wearing them. She further revealed staff were trained to keep residents six (6) feet apart, but it could be hard to do, especially at meal time.

Interview with SRNA #9, on 03/03/2021 at 9:59 AM, revealed she worked on Household B. She stated there were more residents with Dementia on Household C who refused to wear masks, and staff did the best they could to encourage residents to keep masks on or to put masks back on.

Interview with LPN #3 from Household A, on 03/03/2021 at 3:02 PM, revealed staff tried to keep residents apart and encouraged mask use. She revealed not all residents were compliant with wearing masks, and staff was more vigilant about maintaining social distancing with those residents. LPN #3 also revealed, if a resident refused to use a mask, she would try and approach him/her later to again encourage mask

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use. She stated there was a danger of transmitting COVID-19, or any virus, if residents did not wear masks and did not socially distance.

Interview with LPN #4, on 03/03/2021 at 3:22 PM, revealed she worked on various units. She revealed residents were encouraged to socially distance when outside of their rooms and to wear masks. Per interview, alert and oriented residents were generally compliant with these requirements. However, LPN #4 stated it was more challenging for residents with Dementia, who required frequent redirection by staff, and staff did the best they could to ensure these residents were compliant with wearing masks and social distancing.

Interview with LPN #1 of Household B (used to be Household C), on 03/03/2021 at 3:46 PM, revealed about one-half (1/2) of the residents on the unit were cognitively impaired and about one-third (1/3) required feeding encouragement or assistance. She revealed staff encouraged residents to keep masks on, although many would remove them. Further, LPN #1 stated staff had to keep encouraging residents to put masks back on and would place masks on their wheelchairs when residents refused to wear them. She stated staff tried to keep residents socially distanced.

Interview with SRNA #12 of Household A, on 03/04/2021 at 10:35 AM, revealed a few residents with Dementia either would not wear masks or would not keep them on. She revealed staff focused more to encourage wandering residents to mask up, as they came in contact with other residents.

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Interview with the DON, on 03/02/2021 at 3:44 PM, revealed staff had been educated on residents to maintain social distancing and to encourage residents to wear masks when out of their rooms; however, it could be difficult to achieve compliance with some residents.

Interview with the Administrator, on 03/02/2021 at 3:44, and again, on 03/04/2021 at 1:59 PM, revealed staff had to respect residents' rights and could not force mask usage but did provide masks and encouraged their use. The Administrator stated, although staff were not observed by the SSA Surveyor encouraging social distancing or mask use, they did those things. She stated she expected staff to encourage social distancing and to ensure residents had masks available to them.

3. Observation, on 03/01/2021 at 3:17 PM, on Household C, revealed a pile of gloves sitting on top of the soiled-appearing lid of a housekeeping cart, as Housekeeper #1 returned to the cart.

Interview with Housekeeper #1, on 03/01/2021 at 3:17 PM, revealed someone had placed gloves on the lid of the cart because she had asked staff on the unit for gloves. She stated gloves were usually kept in a box and were stored in the cart, not on top of it. In addition, she stated she had cleaned the housekeeping cart the previous week and did so approximately every other week. During interview related to the gloves being left atop an unclean housekeeping cart, she responded "very probably" that they may be contaminated. Housekeeper # 1 then placed the gloves in a clean storage bag, hanging on the back of the cart, and donned a pair of the gloves before entering a resident's room to clean.

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Interview with the IP, on 03/02/2021 at 9:40 AM, and at 6:20 PM, revealed there would be a danger of cross-contamination for a housekeeper to take gloves from the top a dirty cart and use them. She further stated PPE should be stored in a way to prevent it from becoming soiled, prior to use, and housekeeping carts should be cleaned daily.

Interview with the Housekeeping Supervisor, on 03/02/2021 at 2:05 PM, revealed Housekeeper #1 had worked on Household C for approximately six (6) months. She stated the housekeeping carts were supposed to be wiped down when taken to the storage closet at the end of each shift, but unfortunately, some of the housekeepers were a little messier than others and did not clean their carts as they were supposed to. She stated she expected the carts to be cleaned at the end of each shift with disinfectant cleaner. Per interview, she stated housekeepers were to inform her when they needed supplies, such as gloves, and she would get the supplies. She stated boxes of gloves were sometimes kept on top of housekeeping carts, but they should not be lying loose on top of a cart. In addition, she stated it was unsanitary to store gloves in a pile on top of the housekeeping cart. Further, the Housekeeping Supervisor stated the gloves on top of the housekeeping cart should not have been worn but thrown away.

Interview with the Administrator, on 03/03/2021 at 2:35 PM, and again, on 03/04/2021 at 1:59 PM, revealed she expected housekeeping carts to be clean and gloves to be stored appropriately.

F 886 SS=E	COVID-19 Testing-Residents & Staff	F 886	3/26/21

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F 886	Continued From page 21 CFR(s): 483.80 (h)(1)-(6)	F 886		

§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:

§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not
limited to:
(i) Testing frequency;
(ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;
(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and

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MADONNA MANOR	2344 AMSTERDAM ROAD VILLA HILLS, KY 41017

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F 886	Continued From page 22 (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident ' s testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the COVID-19 test user manual, review of the Centers for Disease Control and Infection Prevention (CDC) guidelines and website, and review of the facility's policy, it was determined the facility failed to conduct testing in a manner that was consistent with current standards of practice for COVID-19 tests. Two (2) observation, on 03/02/2021, revealed the Infection Preventionist not donning a gown prior to conducting in-room nasal swabbing of Resident #15 and Resident #16.	F 886	F886- COVID19 Testing Residents & Staff Education: Immediate education given to IP and all nurses on the policy "Infection Prevention and Control Policy SARS-COV2, Coronavirus Disease 2019 V12". Education provided by DON at facility all staff dated 3.11.21. This education included during specimen collection, facilities must maintain proper infection control and use recommended PPE, to include and N95 (or higher), facemask, eye protection, gloves, and a	

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The findings include:

Review of the facility's policy titled, "Infection Prevention and Control Policy SARS-CoV2, Coronavirus Disease 2019 (COVID-19) VERSION 12," last revised 10/27/2020, revealed, during specimen collection, facilities must maintain proper infection control and use recommended personal protective equipment (PPE), to include an N95 or higher-level respirator or facemask, eye protection, gloves, and a gown.

Review of the Abbott BinaxNOW COVID-19 Ag Card User Manual for conducting on-site COVID-19 testing revealed, under the section on specimen collecting and handling, to refer to CDC Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19). The manual then provided a web address, https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html.

Review of the above website, under a section titled, "Collecting and Handling Specimens Safely," the following was documented: "For healthcare providers collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown."

Observation, on Household A, on 03/02/2021 at 8:05 AM, revealed the Infection Preventionist (IP) gown while performing and COVID specimen collection. Director of Nursing immediately educated Infection Preventionist, LPN #4, LPN #1, LPN #3, on 3.2.21
Immediate Action: Education to above employees and all staff on Infection Prevention and Control Policy SARS-COV2, Coronavirus Disease 2019 V12" by DON at Facility All Staff meeting dated 3.11.21 Audit/rounding of COVID specimen collection to ensure that gown was observed being worn per policy completed by DON on 3.2.21
Resident Assessment: Residents #15, #16, #2 all directed by observation of specimen collection being done without proper PPE (gown not on). Per policy, residents assessed every 12 hours for any COVID symptoms by Current Charge Nurse through assessments in Electron Medical Record. , Residents did not triggered for any symptoms that would be alarming to the potential spread due to a gown not being worn. Scheduled assessments ongoing per policy and reviewed by Director of Nursing to ensure residents did not develop any signs or symptoms of COVID19.

Ongoing Assessment
Director of Nursing / Designee will audit Covid testing to ensure policy is being followed when conducting Covid tests. Audits will be completed weekly x's4, monthly x's 3 and quarterly x'4. Results will be reported to the Facility QAPI Committee at the monthly QAPI meeting

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F 886	Continued From page 24	F 886		

already masked and wearing a face shield, donned gloves, prior to entering Resident #15's room, and performed a nasal swab for COVID-19 testing. The IP was then observed to seal and label the sample following collection, prior to disposal of gloves and sanitation of hands.

Second observation, on Household A, on 03/02/2021 at 8:15 AM, revealed the IP, masked and wearing a face shield, donned gloves, prior to entering Resident #16's room, and performed a nasal swab for COVID-19 testing. The IP was then observed to seal and label the sample following collection, prior to disposal of gloves and sanitation of hands.

Interview with the IP, on 03/02/2021 at 9:40 AM and at 6:20 PM, as well as on 03/04/2021 at 9:36 AM, revealed none of the collected samples tested positive. She stated she had been trained by the Director of Nursing (DON) on how to conduct testing. The IP stated she was not aware of the need to wear a gown when collecting specimens. To her knowledge, floor staff was also unaware of the need to wear a gown when collecting specimens. She stated she did not think the collection process would aerosolize, unless a resident sneezed or coughed as a result of the collection process. During further interview, the IP stated for staff COVID-19 testing, staff collected their own specimens, under supervision by the HR staff or other staff, who also did not wear a gown while observing collection. The IP stated the potential dangers of not wearing the appropriate PPE when collecting specimens could lead to staff exposure and possible infection.

Interview with State Registered Nurse Aide

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(SRNA) #2, on 03/02/2021 at 10:22 AM, revealed she self-swabbed for COVID-19 testing and got results from the rapid test within fifteen (15) minutes. She revealed staff could self-swab, or if they did not feel comfortable doing that, nursing staff could swab them.

Interview with Resident #2, on 03/02/2021 at 3:00 PM, revealed he/she was tested last night and observed the nurse to wear a mask, goggles, and gloves, but not a gown. Resident #2 revealed he/she was tested twice weekly and was informed when there were new cases of COVID-19 in the facility.

Interview with SRNA #6, on 03/03/2021 at 8:45 AM, revealed she self-swabbed for facility COVID-19 testing twice weekly. She stated she went to a designated area for testing and was not aware if staff observing the process was wearing a gown.

Interview with Licensed Practical Nurse (LPN) #4, on 03/03/2021 at 3:22 PM, revealed floor nurses did resident COVID-19 testing. She stated, when testing residents, she wore masks, face shield or goggles, and gloves. She revealed she had never worn a gown while conducting resident COVID-19 testing and had not been educated to do so.

Interview with LPN #1, on 03/03/2021 at 3:46 PM, revealed when she tested residents for COVID-19, she wore a gown, gloves, an N 95 mask with a surgical mask over it, and goggles. She stated that was something she knew to do from her experience and training as a nurse and was not aware other staff was not wearing a gown for testing of residents.

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F 886	Continued From page 26	F 886		

Interview with LPN #3, on 03/04/2021 at 9:17 AM, revealed she did not wear a gown when collecting resident nasal swab specimens for COVID-19 testing. She stated she was given instruction on the collection process, but it did not include education on the need to wear a gown when collecting specimens. Per interview, she stated, when staff conducted self-swabbing for COVID-19 testing, they were observed by management staff, sometimes HR or one (1) of the secretaries. In addition, she stated staff typically wore scrubs, when monitoring self-swabbing, with masks, goggles, and gloves on, but no gown.

Interview with SRNA #12, on 03/04/2021 at 10:35 AM, revealed she collected her own samples for COVID-19 testing, and staff was always present observing, wearing gloves, goggles, and a mask. She stated she had not observed staff wearing gowns while observing and assisting in specimen collection.

Interview with the DON, on 03/02/2021 at 3:44 PM, revealed she was not aware staff needed to wear gowns when collecting nasal swabs from residents or when observing staff self- swabbing. She revealed the danger of not wearing appropriate PPE when collecting samples would be the potential for staff to become infected.

Interview with the Administrator, on 03/02/2021 at 3:44 PM, and again, on 03/04/2021 at 1:59 PM, revealed when staff self-swabbed for COVID-19 testing, he/she was observed by management staff, although they were unaware staff needed to wear gowns while collecting specimens. The Administrator stated, without wearing proper

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F 886	Continued From page 27 PPE, there was a possibility staff involved in the collection process would become infected.	F 886		

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 03/01/2021 and concluded on 03/04/2021. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6). Total census was 44.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

TITLE

(X6) DATE: 03/29/2021

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.

ATTACHMENT 1 F880
from e-PoC

April 16, 2021

Madonna Manor

Directed Plan of Correction

All staff will completed the 3 modules of Nursing Home Infection Preventionist Training:

1. Module A Infection prevention and control program
2. Module 6a: Principles of Standard Precaution
3. Module 6b: Principles of Transmission Based Precaution

Clean hands: you tube video

Use of Protective Equipment PPE correctly for Covid19

Training is offered by DON via Zoom meeting through April 12th. Any staff failing to complete training on or before April 12th will be removed from the schedule until verified completion of the education is provided.

ATTACHMENT 2 F880
from e-POC

Madonna Manor:

4.2.21

Root Cause Analysis F880

1. Proper signage not posted
    a. Corporate Infection Control Policy / Covid-19 Policy did not include verbiage addressing signage
        i. Correction – Policy updated to reflect required signage verbiage
2. Residents not socially distant in common space
    a. Many staff are assisted feeds that require residents to sit closer together
        i. Correction: Dining area increased to reflect 6' social distancing and rearrange seating chart to observe social distance
3. Residents not wearing Masks
    a. Residents with decreased cognition are non-compliant with masking
        i. Correction: reassessed resident's cognition level, masks made available by placing on wheelchairs. Updated Care Plans on non complaint residents. Educated staff on non-compliance and techniques for overcoming non-compliance.