



**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF INSPECTOR GENERAL**

**Andy Beshear  
Governor**

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**Eric C. Friedlander  
Acting Secretary**

Adam Mather  
Inspector General

April 24, 2020

Ms. Gretchen Aichele, Administrator  
Madonna Manor  
2344 Amsterdam Road  
Villa Hills, KY 41017-3799  
gaichele@chilivingcomm.org

**SUBJECT: Survey Results  
CMS Certification Number: 185241**

Dear Ms. Aichele:

**SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES**

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit <https://www.cms.gov/files/document/qso-20-20-allpdf.pdf>.

**SURVEY RESULTS**

On April 3, 2020, the Division of Health Care completed COVID-19 Focused Survey at Madonna Manor to determine if your facility was in compliance with Federal requirements related to implementing proper

infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that no deficiencies were cited. A copy of the CMS Form 2567 is attached.

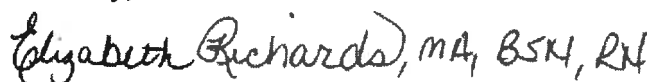
### **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <https://qioprogram.org/covid-19>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <https://qioprogram.org/locate-your-qio>.

### **CONTACT INFORMATION**

If you have any questions regarding the Focused Infection Control Survey results, please contact Elizabeth Richards, MA, BSN, RN at 859-285-4299.

Sincerely,



Elizabeth Richards, MA, BSN, RN  
Branch Manager

cc: Jill Lander-Yorns – CMS Atlanta State Team Coordinator  
State Medicaid Agency  
Stephanie M. Davis, LTC– Enforcement Branch Manager  
Jill Jones, LTC- Survey Branch Manager

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

PRINTED: 04/24/2020  
FORM APPROVED  
OMB NO. 0938-0391

|   |   |   |   |                      |   |
|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185241</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>04/03/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MADONNA MANOR</b>              |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2344 AMSTERDAM ROAD<br/>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<br><br>A COVID-19 Focused Infection Control Survey was initiated on 04/02/2020 and concluded on 04/03/2020. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 55. | F 000   |   |                      |   |
| 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>MADONNA MANOR</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2344 AMSTERDAM ROAD<br/>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 |   |
| E 000  | Initial Comments<br><br>A COVID-19 Focused Emergency Preparedness Survey was initiated on 04/02/2020 and concluded on 04/03/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6). | E 000   |   |                      |   |

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>100268</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>04/03/2020</b> |
|--|---|---|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MADONNA MANOR</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2344 AMSTERDAM ROAD<br/>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) COMPLETE DATE |
|--------------------|---|---------------|---|--------------------|
| N 000              | <p>Initial Comments</p> <p>A COVID-19 Focused Infection Control Survey was initiated on 04/02/2020 and concluded on 04/03/2020. The facility was found to be in compliance pursuant to 42 CFR §483.80 infection control regulations and has implemented the Centers for Medicare &amp; Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 55.</p> | N 000         |   |                    |

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