

05-19-'10 11:51 FROM-

T-745 P005 F-287

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

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  04/22/2010
NAME OF PROVIDER OR SUPPLIER  MADONNA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(X4) ID PREFIX TAG F 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 225 SS-D	<p><b>INITIAL COMMENTS</b></p> <p>A Recertification Survey and an Abbreviated Survey investigating ARO #KY00013679, ARO #KY00014556, ARO #KY00014583 and ARO #KY00014564 was conducted through 04/20/10 -04/22/10. A Life Safety Code Survey was conducted on 04/21/10. Deficiencies were cited with the highest Scope and Severity being an "F".</p> <p>ARO #KY00013679 and ARO #KY00014583 were substantiated with no deficiencies identified. ARO #KY00014556 was substantiated with deficiencies identified and ARO #KY00014564 was unsubstantiated with no deficient practice.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) <b>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b></p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p>		<p>Madonna Manor recognizes the importance of reporting suspected abuse immediately, including injuries of unknown origin. The appropriate interventions are initiated and a report is completed for all reports of suspected abuse. As of 4/28/2010, DON/ADON reviewed all prior incidents reported for suspected abuse, including injuries of unknown origins the prior 90 days. No resident was found to have suffered neglect, mistreatment or abuse.</p> <p>Resident #1: This was an isolated event. The allegation of verbal abuse by a nurse (LPN) occurred on 2/17/2010, the nursing staff did not</p>	

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F 225  
MAY 21 2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Maxine Dun* TITLE: *EXECUTIVE DIRECTOR* (X6) DATE: *5-21-10*

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

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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD VILLA HILLS, KY 41017</b>
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F 225	<p>Continued From page 1</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined staff failed to immediately report an allegation of verbal abuse to the Administrator. An incident involving Resident #1 occurred on 02/17/10 in which a nurse was alleged to have been verbally abusive to the resident. However, a nurse's aide who witnessed the incident failed to report the allegation to the Administrator until 02/26/10.</p> <p>The findings include:</p> <p>Review of Resident #1's clinical record revealed diagnoses which included Arthritis. Record review revealed on on 02/17/10, SRNA #8 witnessed the following: Resident #1 required assistance in getting up from bed. When the alleged perpetrator (LPN #8) reported to the resident's room to assist, a verbal altercation occurred between the resident and the LPN (Licensed Practical Nurse) in which the LPN told</p>	F 225	<p>report the incident to the DON until 2/26/2010. The resident was evaluated by the DON 2/26/2010 for the incident which occurred on 2/17/2010. It was determined that resident #1 did not sustain any further problems associated with this alleged verbal abuse. Madonna Manor is aware of the importance of initiating an investigation immediately with the report of suspected abuse or injuries of unknown origin. The DON/ADON also recognizes the significance of interviewing any staff, family or visitors who may have witnessed the incident. Madonna Manor is aware of the importance of reporting to the appropriate authorities if abuse is determined. To prevent a reoccurrence, the DON/ADON will evaluate each incident reported including injury of unknown origin within 24 hours. The DON/ADON will initiate an investigation and appropriate actions will be taken. Madonna Manor also provides in-services on Elder Abuse bi-annually to all staff conducted by our ombudsman. The last in-service was held on March 16<sup>th</sup> 2010; Connie</p>	
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05-19-'10 11:51 FROM-

T-745 P007 F-287

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

REVISION 03/01/2010  
FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  #85244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/22/2010
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F 225	<p>Continued From page 2</p> <p>the resident she "hated her" and that the resident was "the devil". It was further alleged the LPN continued to "baggler" the resident, causing the resident to cry.</p> <p>Per the facility report on the morning of 02/28/10, SRNA #8 contacted the Director of Nursing (RN #1), reporting the allegation of verbal abuse which had occurred on 02/17/10. When asked why she had delayed in reporting the allegation, the Aide reportedly stated she thought the nurse (LPN #8) was "just having a bad night"; however, because the nurse continued to yell ("holler") at the resident, something had to be done.</p> <p>The facility, after learning of the allegation, responded by suspending LPN #8, notifying all pertinent parties in timely fashion, and initiating an internal investigation. The facility concluded that verbal abuse had occurred. During an interview with the Director of Nursing on 04/22/10, LPN #8 continued to be under suspension. She stated that, although she understood that Adult Protective Services (APS) had substantiated the allegation, the LPN would not be terminated until the facility received written notice of the ruling for APS.</p> <p>On 04/22/10 at 9:00 AM, during an interview with SRNA #8, stated "I didn't report right away since I just thought she was having a bad day and because it would have just been her (i.e., the LPN's) word against mine. When I did report, I was told I should have reported it much earlier". When asked if she considered the LPN's actions against Resident #1 to constitute verbal abuse, she responded "Yes".</p> <p>Review of the facility's abuse/neglect policy</p>	F 225	<p>Murphy (see attached sign in sheet for in-service held 3/16/2010) was the speaker. The next Elder Abuse in-service will be held again August 11<sup>th</sup> 2010. All new hires will review Madonna Manors Policy and Procedures for recognizing and reporting abuse during orientation as well as be required to attend the bi-annual Elder Abuse in-services as scheduled.</p> <p>An all staff in-service was held on 5/5/2010. Attendance required and 100% attendance was achieved (see attached in-service sign in sheet dated 5/5/2010.)</p> <p>Areas of focus: reporting suspected abuse immediately to the supervisor but within 24 hours of the occurrence, review of Madonna Manors Policy and Procedure for reporting abuse: who to report the suspected abuse to, staffs' involvement and their roles, the notifications of agencies involved and their roles. All staff was tested on these areas and received an average score of 95-100% on completion (see test attached).</p>	
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In-service on: Elder Abuse, Dining Experience  
And ADLS/ROM

N110 p. 4  
F225

ELDER ABUSE

1. What are some signs of elder abuse?
  1. The person seems very quiet or withdrawn
  2. The person seems fearful anxious or agitated
  3. The person does don't seem to want to talk or answer questions
  4. All the above.
2. The intentional mistreatment or harm of another person is:
  1. Assault
  2. Abuse
  3. Defamation
  4. Battery
3. Who do you report suspected abuse to?
  1. Immediate supervisor
  2. Co-worker
  3. Administrator
  4. Anyone as long as it is reported
4. All suspected abuse should be reported \_\_\_\_\_.
  1. The next day as long as it is not your day off, if so just wait until the employees next scheduled day and talk to them in person.
  2. Immediately to the supervisor, but not in excess of 24 hours after the discovery of the incident.
  3. By leaving a message for the DON to call you the next day she works, but please don't call early I sleep in the morning.
  4. Anytime as long as I say something to someone
5. All reported abuse must be investigated within \_\_\_\_\_ after the discovery of the incident by the DON and Administrator in a confidential manner.
  1. Five days
  2. Within 2 weeks
  3. 30 days
  4. 24 hours
6. All allegations are reported to
  1. Office of Licensing/Regulations
  2. Adult Protective Services
  3. Northern Kentucky Ombudsman
  4. Kentucky Board of Nursing ( If RN/LPN involved)
  5. All the above
7. All allegations are reported to the above agency/agencies as soon as possible but not in excess of \_\_\_\_\_.
  1. 1 week
  2. 1 month
  3. 24 hours
  4. 48 hours
8. The results of the investigation will be reported to a/all the agency/agencies within \_\_\_\_\_.
  1. 5 days
  2. 24 hours
  3. 1 month
  4. 48 hours

NAME \_\_\_\_\_ DATE \_\_\_\_\_

## Dining Experience

1. We may not offer more fluids after the tray has come out.
  - True
  - False
2. Anyone may feed the residents as long as they know them
  - True
  - False
3. All non certified staff member must complete an 8 hour course before they can feed a resident.
  - True
  - False
4. Always wash your hands between serving trays
  - True
  - False
5. Our residents should be sitting up straight while being fed and not slumping down in their chair or leaning to one side or another.
  - True
  - False
6. All resident do better drinking liquids through a straw
  - True
  - False
7. As long as staff is comfortable in regards to room temperature the residents don't mind.
  - True
  - False
8. Resident have a right to refuse
  - True
  - False

N110 p<sup>5</sup>

F225

**ADL'S/ROM**

- N110 pg  
F225
1. A resident's rehabilitation begins with preventing
    - a) Angry feelings
    - b) Contractures and pressure ulcers
    - c) Illness and injury
    - d) Loss of self-esteem
  2. The movements that occur when the CNA is bathing, dressing or grooming a resident is considered:
    - a) A blessing we can still move their arms and legs
    - b) A Restorative Nursing Program
    - c) A maintenance program of range of motion
    - d) Nothing at all just doing my job
  3. When you walk a resident to the bathroom or shower room this is :
    - a) A hassle
    - b) Time consuming
    - c) My job
    - d) A maintenance program for ambulation
  4. A Formal Restorative Program is provided by:
    - a) Any staff member
    - b) A CNA with additional training in therapy terms and programs
    - c) Licensed staff
    - d) Therapist.
  5. To be on a maintenance program means:
    - a) The staff delivers the program with the resident everyday ADL's, such as bathing, dressing, grooming, ambulation or eating.
    - b) A specially trained person has to do my care
    - c) A maintenance employee is involved or has to be present for my care.
    - d) All the above
  6. Restorative nursing is a program which requires an MD order for:
    - a) True
    - b) False
  7. Therapy can discharge someone from therapy and place them on a Formal Restorative Program or refer them to a maintenance program.
    - a) True
    - b) False
  8. Restorative nursing/maintenance programs are not required
    - a) True
    - b) False

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F 225	Continued From page 3 revealed "All employees are to report any signs of abuse, neglect or misappropriation of resident personal property to their immediate supervisor. The supervisor is responsible to report this to the Director of Nursing and Administrator immediately when any allegations are believed to have occurred".	F 225		
F 241 SS-E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to promote care for residents in a manner which enhanced or maintained each resident's dignity. Observations revealed residents seated on the extended dining room terrace were required to wait forty-five (45) minutes for their meal trays after the residents in the main dining room had been served. Observations revealed residents seated in the main dining room were offered drinking beverages prior to the meal, however, residents seated in the extended dining room terrace were not offered beverages prior to the meal. In addition, four residents were observed in the terrace dining area with the room thermostat reading of sixty-four (64) degrees Fahrenheit for twenty-two (22) minutes.  The findings include:  Observations on 04/20/10 at 5:00 PM revealed	F 241	F 241  Madonna Manor strives to care for each resident in concert with our mission and values that honor and respects each individual. The evening meal referred to in N 113 failed to meet the resident's needs and embrace our values.  Prior to making any changes in the dining area and procedures, there was discussion at the monthly nursing staff meeting with the purpose of seeking input from the direct care staff. Managers were also asked to observe a meal function and make recommendations from this observation for a better, quieter, calmer dining experience for our residents.  Based on the information received, a process was developed and shared with staff through department meetings. Although it looked good	

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F 241	<p>Continued From page 4</p> <p>ten (10) residents were seated in the main dining room and were being offered their choice of beverages prior to serving the evening meal trays. Continued observation revealed the dining staff began to serve meal trays to the residents in the main dining area by 5:00 PM while other residents were being transported through the main dining room to the terrace dining area.</p> <p>Observation on 04/20/10 at 5:46 PM revealed fourteen (14) residents were seated in the extended terrace dining area when the first evening meal tray was served. Continued observation at 6:00 PM revealed two (2) of the fourteen (14) residents had not received their evening meal tray. One of the residents (Resident #5) stated, "I am hungry, all the others are eating supper. I need my food."</p> <p>Interview on 04/20/10 at 6:01 PM with the Dietary Manager and CNA #1 revealed the reason the other two residents had not received their evening meal tray when all the other residents were eating was because there was not enough staff to assist the other two residents.</p> <p>In addition, observation on 04/21/10 at 7:35 AM revealed one unsampled resident sitting in a "Geri" chair in the extended terrace dining area. The resident had a short sleeved shirt and pants, which appeared to be of light weight. The resident did not respond to verbal stimuli from the surveyor. Continued observation revealed the windows were slightly opened and the thermostat on the wall in the extended dining area revealed a reading of sixty-four (64) degrees Fahrenheit (F).</p> <p>Continued observation at 7:45 AM revealed staff transported three other residents per wheelchairs,</p>	F 241	<p>on paper and sounded like it would work, this process fell short of meeting the goals as observed by state surveyors at the evening meal on April 20, 2010.</p> <p>It was critical to bring all departments together to determine what was working and what was not working. This proved very helpful and resulted in a better dining service/experience for our residents. Representatives from every department met on April 28, 2010 to determine the best way to meet the dining needs of our residents.</p> <p>The plan that emerged and has been implemented as detailed in attachment.</p> <p>Managers in-serviced the staff in their departments to this new dining procedure on the following dates: nursing, 5-10-10; activities, 5-13-10; dietary, 5-13-10; housekeeping talked individually to each employee from April 29 – May 7, 2010.</p> <p>A program was initiated to train staff members to become certified as feeding assistants. The first training was held on Monday, May 10, 2010.</p>	
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F 241	Continued From page 5 into the extended terrace dining area. One of the residents yelled, "It's cold, get me out of here...it's the coldest place I have ever been...turn on the heat".  Observation at 7:57 AM revealed the extended terrace dining area thermostat reading was seventy-two (72) degrees (F).  Interview on 04/22/10 at 12:40 PM with the Director of Nursing (DON) revealed the independent residents were served in the main dining room first and then the dependent residents, who required assistance with feeding were served on the attached extended terrace dining area. She stated the facility's dining program had recently been revised and she was unaware the residents who were assigned to the terrace dining area for meals, were having to wait forty-five (45) minutes for their meal trays after having seen the other residents eating in the main dining room. The DON stated she was unaware all the residents were not being fed at the same time. The DON indicated she was not aware the thermostat reading on the extended terrace dining room was sixty-four (64) degree F. She indicated the management team which included the department heads and the nursing staff had been monitoring the dining program since the program had been revised and she was unaware of any concerns.  The facility was unable to provide a policy related to Dining. 483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS  The facility must provide comfortable and safe temperature levels. Facilities initially certified	F 241	A second session is scheduled for May 24, 2010. Fourteen staff members from activities, dietary and housekeeping departments participated in the initial training. The anticipated goal is that these extra, trained hands will be available to assist residents as needed so that no residents have to wait to have assistance at mealtime.  The ADON will monitor the effectiveness of this program. A breakfast, lunch and dinner meal will be observed weekly for the next month. Any change will be communicated to all departments and implemented immediately. If the dining experience is positive at the end of the month, no formal monitoring will continue. If there is evidence that concerns continue on the dining experience, a formal review with the departmental representatives who met in April will reconvene. They will review the expressed concerns and develop procedures. After communicating with all staff, it will be implemented and monitored with weekly	
F 257 SS=E		F 257		

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ON  
NEXT PAGE

F-241 (CONTINUED)

observations at a breakfast, lunch and dinner by the ADON for a month. This process will continue until the meal functions provide a pleasant environment and service to our residents.

Madonna Manor recognizes the importance to the well-being of our residents of a comfortable dining experience. An environment that is either too cold or too hot certainly does not meet this criteria. Contact was made on May 10, 2010 with Arc Electric for professional advice on how best to insure a comfortable environment in the River Room. Their written recommendations have not been received to date. When these are received, we will implement the most effective to meet the comfort of our residents. A programmable thermostat will however be installed by our staff by Friday, May 21, 2010. This will bring the room up to a comfortable temperature before the residents come for breakfast; keep the room at a comfortable temperature during the day and through the evening meal.

The Director of Facilities will monitor the temperatures at various times each week for the next month. If the temperatures are at a comfortable level for this month, a monthly check will be deemed sufficient to monitor this area.

If at any time the temperature during this first month is not at a comfortable level, additional guidance will be sought from outside resources. Their recommendation will be implemented and then monitored weekly again for the next

month. If the temperatures are at a comfortable level for this month, a monthly check will be deemed sufficient to monitor this area.

N113 -1

F241

## Dining Experience

April 2010

Updated based on April 28, 2010 Interdisciplinary Meeting

**Goals:** A pleasant dining experience. Although this means different things to everyone, overall the environment needs to be calm, smooth and recognize this is not only a physical function but also social and may be the only interaction with the "larger world" for some of our residents.

### Process

All tables are washed prior to setting of the tables by the dietary staff

Tables are set with napkins and tray tickets by the dietary staff

A hostess greets the residents and offers drinks as residents are seated (note: the entire table does not have to all be seated before drinks are served)

Note: this will usually be a dietary staff member

When all residents at one table are seated, the hostess gathers the tray tickets and presents to the dietary staff.

**NOTE CHANGE:** Condiments will be in the dining areas for ease of service to the resident's needs.

Note: a hostess at this point will be nurse aide, dietary or activity staff member

Dietary staff "plates" each of these residents meal and the hostess serves the meal, assisting where needed, making sure all needs are met.

**Feeding Assistant Tables:** Again once when all the residents are seated and a dining assistant aide is able to assist, the process begins with gathering the tray tickets and presenting to the dietary staff for "traying the meal".

**NOTE CHANGE:** The hostess will monitor and insure service is provided to each table as soon as possible when all residents are seated at one table. This means service will vary between the dining areas. This process should help in everyone getting meals served in a timely manner.

During the meal the dietary hostess will offer refills on coffee or water, walking through to make sure all needs are met but not disturbing the eating/visiting at the tables.

As residents finish their meal and the entire table is empty, the hostess can begin to complete the tray tickets (noting the amount of food that was eaten)

Note: nursing train the dietary hostesses on the process needed for this

N-113 -2

F 241

To clean the dining room, think restaurant not institution! Dishes will be gathered from each table, like a restaurant (Brian will determine how this will be done), garbage will be disposed properly (again a large garbage can not be in the dining room). With this method, tables can be cleaned as residents leave the dining room.

All tables are washed and sanitized, entire floor is swept and mopped  
Chairs are placed neatly at the tables.

River Room: All spills are cleaned, carpet is vacuumed and chairs are placed neatly at the tables.

Any extra items are removed from the dining areas and taken to the nursing stations or place where they belong.

Over-all: the dining experience needs to be calming, relaxing and enjoyable. We can make a difference for the residents. If we work together, keep our voices and stress down we can offer a good eating/visiting environment.

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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2844 AMSTERDAM ROAD VILLA HILLS, KY 41017</b>
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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 257	<p>Continued From page 6</p> <p>after October 1, 1980 must maintain a temperature range of 71 - 81° F</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a comfortable and safe temperature level for the extended terrace dining room.</p> <p>The findings include:</p> <p>Interview on 04/20/10 at 2:15 PM with a resident's family member revealed the extended terrace dining area was cold during meal times.</p> <p>Observation on 04/21/10 at 7:35 AM revealed the extended terrace dining room had multiple large windows with the windows on the left side of the room slightly opened. The thermostat on the right entrance wall revealed a reading of sixty-four (64) degrees Fahrenheit (F). Further observation revealed four residents were observed to be in the terrace dining room from 7:35 AM to 7:56 AM when the room thermostat had a reading of sixty-four (64) degrees F. One of the residents yelled, "It's cold, get me out of here...it's the coldest place I have ever been...turn on the heat".</p> <p>Observation at 7:57 AM revealed the extended terrace dining area thermostat reading was seventy-two (72) degrees (F).</p> <p>Interview on 04/22/10 at 12:40 PM with the Director of Nursing revealed she was unaware of the temperature reading in the extended terrace dining area was sixty-four (64)degrees. She indicated the room temperature should be higher.</p>	F 257	<p>F 257</p> <p>Madonna Manor desires to provide comfortable and safe temperature levels. A room that is 64 degrees does not meet this standard. Arc Electric was contacted to address the temperature concerns in the terrace room. Attached are their recommendations and the timetable for implementation.</p> <p>The Director of Facilities will monitor the temperatures at various times each week for the next month. If the temperatures are at a comfortable level for this month, a monthly check will be deemed sufficient to monitor this area.</p> <p>If at any time the temperature during this first month is not at a comfortable level, additional guidance will be sought from outside resources. Their recommendation will be implemented and then monitored weekly again for the next month. If the temperatures are at a comfortable level for this month, a monthly check will be deemed sufficient to monitor this area.</p>	
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05-19-'10 11:53 FROM-

T-745 P012 F-287

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

PRINTED: 05/21/2010  
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 04/22/2010
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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 281 SS=D	<p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure Physician's orders were carried out related to range of motion for one (1) of sixteen (16) sampled residents (Resident #12).</p> <p>The findings include:</p> <p>Review of the clinical record revealed Resident #12 was admitted with diagnoses which included Debility, Insulin Dependent Diabetes Mellitus, Chronic Venous Stasis and a History of Deep Vein Thrombosis.</p> <p>Review of the Significant Change Minimum Data Set (MDS) dated 04/02/10 and the Resident assessment Protocol Summary (RAPS) dated 04/02/10 revealed the facility assessed the resident as being severely impaired in decision-making skills and as being totally dependent in activities of daily living (ADL).</p> <p>Review of the monthly Physician's Orders dated March, 2010 and April, 2010, revealed an order for passive range of motion (PROM) to the bilateral lower extremities.</p> <p>Review of the Treatment Administration Records (TARs) dated March, 2010 and April, 2010, revealed the PROM to bilateral lower extremities had been discontinued. Further review revealed</p>	F 281	<p>F 281</p> <p>It is the policy of Madonna Manor that all physician orders regarding treatments/medications, including routine and PRN administered to a resident are carried out properly and documented immediately on the MAR/TAR's after being administered.</p> <p>All residents had the potential to be affected by this deficiency. As of 4/28/10, the DON/ADON and professional nursing staff reviewed all resident treatment orders and records to assure physician orders were appropriately recorded. It was determined that no other residents were found to be affected by this deficiency. Resident #12 had no negative outcome from this isolated deficiency.</p> <p>To prevent further occurrences, the DON/ADON will for the next 2 months will check at least 15% of the resident's treatment records to ensure physician orders are carried forward and implemented from month to month. Errors will be brought to the staff's attention and if necessary appropriate counseling will occur.</p>	
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05-19-'10 11:53 FROM-

T-745 P013 F-287

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

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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>C</b> <b>04/22/2010</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 281	<p>Continued From page 8</p> <p>no documented evidence the facility provided the PROM to the bilateral lower extremities for the month of March, 2010 and April, 2010.</p> <p>Interview on 04/22/10 at 3:40 PM with Licensed Practical Nurse (LPN) #2 revealed she was assigned to the unit where Resident #12 resided. She stated the resident's Physician's Order for PROM to bilateral lower extremities had not been discontinued and she was unsure why the TAR indicated the PROM had been discontinued. She stated since March, 2010, the PROM was a current order and the Restorative Nursing Assistant (RNA) should have been performing the range of motion per the Physician's order.</p> <p>Review of the Formal Restorative Nursing Program form dated April, 2010 revealed Resident #12's plan included Passive Range of Motion (PROM) to bilateral upper and lower extremities with ten (10) repetitions in all planes every day. However, continued review revealed Resident #12 received the PROM eight (8) of twenty-two (22) days. Record review revealed no documented evidence Resident #12 received PROM to bilateral lower extremities for March, 2010.</p> <p>Interview on 04/22/10 at 12:01 PM with the Restorative Nursing Assistant (RNA) revealed she was the only Certified Nursing Assistant (CNA) assigned to perform the Restorative Nursing. She indicated she worked a five (5) day a week schedule. She stated she hadn't documented any of the restorative activities since she had been in the Restorative Nursing Assistant Position until the past week or so of April, 2010.</p>	F 281			

05-19-'10 11:53 FROM-

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

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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 04/22/2010
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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 281	Continued From page 9 Joint interview on 04/21/10 at 1:50 PM with the Director of Nursing (DON) and the Assistant DON revealed they were responsible for the Restorative Nursing Program. The DON stated the facility had never had a formal Restorative Nursing Program until April 1, 2010. The DON indicated a formal Restorative Nursing Program included the resident having either a Physician's order or a referral from Therapy Department. She stated the Restorative Program that was implemented on April 1, 2010 did not include a formal program for ROM. She stated Resident #12 was just placed on the facility's Restorative Program.	F 281		
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE  Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure residents' abilities in activities of daily living did not diminish unless circumstances of the individuals' clinical condition demonstrated the diminution was unavoidable for one (1) of sixteen (16) sampled residents (Resident #1).  The findings include:	F 310	F 310  Madonna Manor understands its responsibility to care for residents in a manner that maintains their dignity and is respectful of them as individuals. Promoting and maintaining the dignity and independence of our residents is of major importance to all staff.  Resident #1 has a diagnosis of a metastatic lesion in the liver reportedly a possible neuroendocrine tumor. She is being treated symptomatically with no further workup or treatments in regards to her condition. She was initially residing on the Personal Care unit of Madonna Manor upon initial admission. She was hospitalized in	

05-19-'10 11:54 FROM-

T-745 P015 F-287

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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD VILLA HILLS, KY 41017</b>
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F 310	<p>Continued From page 10</p> <p>Review of the clinical record revealed Resident #1 was admitted to the facility on 12/11/10 with diagnoses which included Advanced Arthritis, Irritable Bowel Syndrome, Neuroendocrine Tumor, Depression and Anxiety.</p> <p>Review of the Admission Minimum Data Set (MDS) dated 12/19/10 revealed the facility assessed Resident #1 as having modified independence in cognitive skills for daily decision making and required extensive assistance with ambulation and transfers. The Resident Assessment Protocol Summary (RAPS) dated 12/19/10 revealed the facility noted the resident received Physical Therapy to increase strength and mobility and showed motivation to increase mobility skills. Continued review of the RAPS revealed the facility assessed the resident as having an unsteady gait, utilized a walker for transfers and ambulation and as having discharge plans to return to the resident's previous Personal Care room.</p> <p>Review of the Physical Therapy Notes dated 01/15/10 revealed Physical Therapist #1 discharged Resident #1 on 01/18/10 to Restorative Nursing for ambulation due to making excellent progress toward the goal of ambulating five hundred (500) feet. In addition, the referral to Restorative Nursing included treatment consisting of gait training, transfer training and therapeutic exercise all four (4) extremities.</p> <p>Review of the Comprehensive Care Plan, revised on 04/12/10, revealed the facility assessed Resident #1 as having impaired mobility. Interventions included providing extensive assistance with all transfers each shift. The Care</p>	F 310	<p>December 2009 with chronic diarrhea (result of cancerous condition) and C-diff. The effects of this hospitalization caused significant decline in her functional and cognitive status. She was admitted onto the skilled nursing wing of the facility to attempt to get her back to baseline.</p> <p>Madonna Manor recognizes the comprehensive care plan is an important aspect of the providing quality care to all residents. The facility staff recognizes the need to address all resident issues and concerns through the comprehensive plan of care to ensure that all staff "consistently and thoroughly" meets the resident's needs. The facility recognizes its responsibilities to follow the plan of care developed by the interdisciplinary team and to review, revise and update the plan of care as needed. All residents have a plan of care and as such all residents had the potential to be affected by this deficiency. A review of plans of care, treatment records, and restorative nursing records was conducted by the DON/ADON as of April 30, 2010. Five plans of care</p>	

05-19-'10 11:54 FROM-

T-745 P016 F-287

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

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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>04/22/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD 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 310	<p>Continued From page 11</p> <p>Plan failed to include interventions for Restorative Nursing or for treatment consisting of gait training, transfer training and therapeutic exercise of all four (4) extremities.</p> <p>Record review revealed no documented evidence Resident #1 received Restorative Nursing for ambulation, transfer and gait training and therapeutic exercises for all four (4) extremities from 01/18/10 to 04/22/10. The review failed to reveal documented evidence the facility addressed the resident's functional ambulating ability.</p> <p>Interviews on 04/22/10 at 12:01 and 2:00 PM with the Restorative Nursing Aid (RNA) revealed she was the only Certified Nursing Assistant (CNA) responsible for providing the facility's Restorative Nursing Program. She indicated she never receives written documentation on any of the Therapy referrals to Restorative Nursing. She stated she had received "just a verbal from the Therapist to keep the resident as mobile as I could." The RNA indicated she never documented the Restorative Nursing for Resident #1 and stated the resident was not currently receiving Restorative Nursing. The RNA indicated when she was told by the Therapist to keep the resident as mobile as possible, the resident was able to walk the full length of the main hallway which included the length of twelve resident rooms. She went on to say the resident now walked about twenty five (25) feet which included the length of two (2) resident rooms. The RNA indicated she did not document any of the Restorative Nursing services for Resident #1 until the past two weeks. She stated she was the person who decided to stop the resident's Restorative Nursing because the resident refused</p>	F 310	<p>required updating and changes were made and communicated to staff and the restorative nursing assistant (restorative care plans put into place as needed; see attached care plan samples). Resident #1 care plan was updated and revised as of May 5, 2010 to reflect her current treatment modality, in order to meet her needs (see attached).</p> <p>Professional nurses will be responsible to update each resident's plan of care whenever new treatment orders are initiated, a treatment modality is changed or the problem has been resolved, in order to assure ongoing compliance. An in-service was held on 4-28-10 for nursing staff, at which time the importance of reviewing, revising and updating each residents plan of care to assure consistent quality care and services are provided (see attached).</p>	

05-19-'10 11:54 FROM-

T-745 P017 F-287

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

FORM APPROVED  
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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 310	<p>Continued From page 12</p> <p>to participate and/or became combative. The RNA could not remember when the resident's Restorative Nursing services were stopped and stated she did not document the resident's discharge from Restorative Nursing. She indicated that, when she decided to stop Resident #1's Restorative Nursing, she thought she told the nurse but, couldn't recall which nurse she had told. She indicated she was the person who was responsible for deciding if a resident was discharged from Restorative Nursing up until about two (2) weeks ago however now the Director of Nursing (DON) did this. The RNA stated she had been the facility's RNA for two years, and the only training she had received since she had been in the position was when the DON spoke to her about two weeks ago about the new form for documenting Restorative Nursing services.</p> <p>Interview on 04/22/10 at 11:00 AM with the Director of Nursing revealed the facility had never had a formal Restorative Program. She stated the facility initiated a formal Restorative Program on April 1, 2010 to include documentation of the Restorative services provided to the residents. She indicated the only person who had been in-serviced regarding Restorative Nursing was the Restorative Aide and that only included how to complete the new flow sheet.</p> <p>Review of the facility's policy entitled "Restorative Nursing Policy", undated, revealed a resident would be evaluated and placed into a restorative program appropriate to meet their needs. In addition, the policy revealed when the Therapist discontinued a resident to Restorative Nursing, a plan of care would be provided to include each program the resident would receive. The policy</p>	F 310	<p>To prevent a reoccurrence of this deficient practice, ongoing monitoring began April 26, 2010 to assure continued compliance. The DON/ADON will review 10% of the records for new or altered orders to assure these have been documented on resident care plans. The review will be done weekly, for one month, and then monthly for six months. If problems arise, further corrective action will be initiated per DON.</p>	

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T-745 P018 F-287

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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD VILLA HILLS, KY 41017</b>
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F 310	Continued From page 13 revealed before the RNA began the Restorative services, the plan of care must be signed by the RNA, DON and Assistant DON. Further review revealed that, if at any time a resident was referred to Restorative Nursing after receiving skilled therapy was noted to have a decline or improvement, therapy would be notified. The policy revealed when a program was discontinued, the date it was discontinued and the person who discontinued the program would be documented.	F 310		
F 318 SS-E	<p><b>483.26(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</b></p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for three (3) of sixteen (16) sampled residents (Resident #1, #5, and #6).</p> <p>The findings include:</p> <p>1. Review of the clinical record revealed Resident #1 was admitted to the facility on 12/11/10 with diagnoses which included Advanced Arthritis.</p>	F 318	<p>F 318</p> <p>The importance of conducting a comprehensive assessment utilizing the RAI to identify residents at risk for functional and cognitive decline is understood by the MDS Coordinator. By utilizing the RAI and reviewing the RAPS, residents at risk for decline are identified and appropriate measures are initiated.</p> <p>For residents #1, 5, and 6, as of 5/3/10, all residents have been reviewed by the DON/ADON to determine if their status suffered due to lack of restorative nursing and documentation. It was determined that two residents (#1, 6) showed evidence of decline in their functional abilities; specifically in relation to ambulation; resident #5 remained without change.</p>	

N202 - 1  
F31D

MADONNA MANOR  
CARE PLAN FOR RESTORATIVE NURSE PROGRAM

DATE	PROBLEM/NEED POTENTIAL PROBLEM/ STRENGTH	GOALS	APPROACHES	DISCIPLINE	REVIEW DATE
	CURRENTLY RECEIVING A FORMAL RESTORATIVE NURSING PROGRAM:  RANGE OF MOTION: PASSIVE  ACTIVE  ACTIVE ASSIST  WHAT AREAS:  RIGHT UPPER EXTREMITY  LEFT UPPER EXTREMITY  RIGHT LOWER EXTREMITY  LEFT LOWER EXTREMITY	WILL MAINTAIN CURRENT FUNCTIONAL STATUS OF JOINT THRU NEXT REVIEW  WILL HAVE NO FURTHER CONTRACTURES THRU NEXT REVIEW  SKIN WILL REMAIN INTACT THRU NEXT REVIEW	PROGRAM/PROGRAMS AS WRITTEN  OBSERVE FOR IMPROVEMENTS /DECLINES AND REPORT TO APPROPRIATE DISCIPLINES IF CHANGES ARE OBSERVED  REFER TO THERAPY PRN  SCREENS ARE COMPLETED AS INDICATED AND WITH THE MDS PROCESS  RNA TO OBSERVE SKIN AND REPORT TO NURSING ANY RED/OPEN AREAS  PROGRAMS ARE: 3-6 TIMES WEEKLY  REFER TO RESTORATIVE BOOK FOR INDIVIDUAL PROGRAMS  WEEKLY NOTES/PRN	NSG  NSG  NSG  NSG  NSG  NSG  NSG  NSG	

RESIDENT NAME: \_\_\_\_\_

N202 -2  
F310

MADONNA MANOR

CARE PLAN FOR RESTORATIVE NURSE PROGRAM

DATE	PROBLEM/NEED POTENTIAL PROBLEM/ STRENGTH	GOALS	APPROACHES	DISCIPLINE	REVIEW DATE
	<p>CURRENTLY RECEIVING A FORMAL RESTORATIVE NURSING PROGRAM:</p> <p>AMBULATION PROGRAM:</p> <p>FEET AMBULATING:</p> <p>_____</p> <p>_____</p> <p>FREQUENCY:</p> <p>DAILY</p> <p>3 TIMES WEEKLY</p> <p>OTHER:</p> <p>_____</p> <p>_____</p> <p>ASSISTIVE DEVICES:</p> <p>WALKER:</p> <p>ROLLING</p> <p>STANDARD</p>	<p>WILL MAINTAIN CURRENT FUNCTIONAL STATUS OF AMBULATING _____ FEET Q _____ THRU NEXT REVIEW</p>	<p>PROGRAM/ PROGRAMS AS WRITTEN</p> <p>OBSERVE FOR IMPROVEMENTS /DECLINES AND REPORT TO APPROPRIATE DISCIPLINES IF CHANGES ARE OBSERVED</p> <p>REFER TO THERAPY PRN</p> <p>SCREENS ARE COMPLETED AS INDICATED AND WITH THE MDS PROCESS</p> <p>RNA TO OBSERVE SKIN AND REPORT TO NURSING ANY RED/OPEN AREAS</p> <p>PROGRAMS ARE: 3-6 TIMES WEEKLY</p> <p>REFER TO RESTORATIVE BOOK FOR INDIVIDUAL PROGRAMS</p> <p>WEEKLY NOTES/PRN</p>	<p>NSG</p> <p>NSG</p> <p>NSG</p> <p>NSG</p> <p>NSG</p> <p>NSG</p> <p>NSG</p> <p>NSG</p> <p>NSG</p>	

RESIDENT NAME: \_\_\_\_\_

N202 -3  
F310

MADONNA MANOR  
CARE PLAN FOR RESTORATIVE NURSE PROGRAM

DATE	PROBLEM/NEED POTENTIAL PROBLEM/ STRENGTH	GOALS	APPROACHES	DISCIPLINE	REVIEW DATE
	CURRENTLY RECEIVING A FORMAL RESTORATIVE NURSING PROGRAM:  STRETCHING:  WHAT AREAS:  RIGHT UPPER EXTREMITY  LEFT UPPER EXTREMITY  RIGHT LOWER EXTREMITY  LEFT LOWER EXTREMITY	WILL MAINTAIN CURRENT FUNCTIONAL STATUS OF JOINT THRU NEXT REVIEW  WILL HAVE NO FURTHER CONTRACTURES THRU NEXT REVIEW  SKIN WILL REMAIN INTACT THRU NEXT REVIEW	PROGRAM/ PROGRAMS AS WRITTEN  OBSERVE FOR IMPROVEMENTS /DECLINES AND REPORT TO APPROPRIATE DISCIPLINES IF CHANGES ARE OBSERVED  REFER TO THERAPY PRN  SCREENS ARE COMPLETED AS INDICATED AND WITH THE MDS PROCESS  RNA TO OBSERVE SKIN AND REPORT TO NURSING ANY RED/OPEN AREAS  PROGRAMS ARE: 3-6 TIMES WEEKLY  REFER TO RESTORATIVE BOOK FOR INDIVIDUAL PROGRAMS  WEEKLY NOTES/PRN	NSG  NSG  NSG  NSG  NSG  NSG  NSG  NSG	

RESIDENT NAME: \_\_\_\_\_

RESIDENT: [REDACTED]

CHART#: 809 PG. 4

CONFERENCE DATE: 4/12/10

TARGET DATE: 7/12/10

N202-4

F310

## APPROACH:

5. NA monitor resident each shift during performance of her care needs and throughout the day for signs of increased agitation and verbal negative remarks. Continue to attempt reality orientation and verbal cueing as to her whereabouts and current physical status; as she is able to understand. Explain to resident what you are doing prior to carrying out the tasks; allow her to do it her way, if she insists. Attempt to inform resident that she requires staff with all her care needs; as she is able to understand and accept. Monitor for health issues associated with agitation; i.e. increased shortness of breath, shakiness, ?UTI. Report to the LPN/RN on duty for evaluation of the resident. PCP contact if needed. Continue to dispense medications as ordered per neurologist; consult with facility psychiatrist if friend in agreement for other options. (friend does not desire any other physician intervention with medications other than residents neurologist).

*u*

## PROBLEM #6:

6. Impaired mobility; impaired transfers and ambulation; impatient awaiting staff arrival to assist with transfers (resident ideation of time frame is confused; she thinks "I have waited 4 hours"); verbal remarks "I will sit on the floor and you can't stop me"; continued risk for falls, despite safety measures being in place (we feel she knows what she is doing by placing herself on the floor).

## GOAL:

- 6. Resident will not sustain a fall this quarter that requires hospital intervention.
- 6. Resident will not sustain more than 2-3 falls this quarter (she puts herself on the floor on purpose).

## APPROACH:

6. 1-2 NA provide extensive assist with all transfers each shift; explain to resident the importance of waiting for staff assist with transfers; as she agrees to listen and understand. Monitor at least q2hrs when in bed; remove from her bed if she is showing signs of wanting to get up. Continue use of low bed; she continues to remove herself from this also. Initiate the use of more protective devices; if needed. Allow resident to voice her concerns when she attempts to walk without assist or place herself onto the floor. Reinforce the positive and negative results of her actions as she is able to understand and listen. Consult with psychiatrist for other options; PCP contact if needed for other options. Continue use of alarms to alert staff of unassisted transfers.

*u*  
5/3/10 Continue to attempt to ambulate resident during the transfer process, as she accepts & agrees; use walker as she agrees.

*Markus*  
5/3/10

05-19-'10 11:55 FROM-

T-745 P019 F-287

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

PRINTED: 05/01/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/22/2010
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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)	(X6) COMPLETION DATE
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F 318	<p>Continued From page 14</p> <p>Review of the Admission Minimum Data Set dated 12/19/10 revealed the facility assessed Resident #1 as having modified independence in cognitive skills for daily decision making.</p> <p>The Resident Assessment Protocol Summary (RAPS) dated 12/19/10 revealed the facility assessed Resident #1 as receiving Physical Therapy to increase strength and mobility and as showing motivation to increase skills in mobility. Continued review of the RAPS revealed the facility indicated the resident had discharge plans to return to his/her previous Personal Care room.</p> <p>Review of the Physical Therapy Notes dated 01/15/10 revealed the Physical Therapist discharged Resident #1 on 01/18/10 to Restorative Nursing for ambulation, gait training, transfer training and therapeutic exercise of all four (4) extremities.</p> <p>Interview on 04/22/10 at 12:01 and 2:00 PM with Restorative Nursing Aid (RNA) revealed she was the only Certified Nursing Assistant (CNA) responsible for providing the facility's Restorative Nursing Program. She stated Resident #1 was not currently receiving Restorative Nursing. The RNA stated when Resident #1 was referred to Restorative Nursing, the Therapist told her to "keep the resident as mobile as you can". She indicated she never received written documentation on any of the Restorative Nursing referrals from Therapy. The RNA stated she was the person who decided to stop the resident's Restorative Nursing, but could not remember when. She stated she thought she had told the nurse, but could not remember which nurse she told. The RNA indicated she had stopped the</p>	F 318	<p>Resident #1 exhibited the ability to move all extremities without difficulty. Evaluation of ambulatory status revealed she was able to walk approximately 10-15ft with direct assist of two nurse assistants (chronic peripheral edema impeded further ambulation). Continued evaluation of resident, revealed she was transferring herself without assist from her wheelchair to her recliner, at least 1-2 times weekly and that she has no evidence of difficulty propelling her wheelchair throughout the facility (propels herself using her legs to the Personal care wing and the length of the nursing hallway without problems).</p> <p>Resident #6 exhibited the ability to move all extremities without difficulty; she voiced no discomfort when weight bearing. Evaluation of ambulatory status revealed she was able to weight bear and take approximately 8 steps with support of two nursing assistants (she informed staff "sit me down now"). Resident has no difficulty propelling herself up and down the nursing hallway; approximately 100-125ft at least 2-3 times daily (she uses both arms and legs to accomplish this task).</p>	
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05-19-'10 11:55 FROM-

T-745 P020 F-287

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

PRINTED: 05/06/2010  
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 04/22/2010
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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 318	<p>Continued From page 15</p> <p>resident's Restorative Nursing because the resident became combative and/or refused the therapy.</p> <p>Record review revealed no documented evidence Resident #1 received Restorative Nursing related to ambulation, transfers, gait training and/or therapeutic exercises for all four (4) extremities from 01/18/10 to 04/22/10.</p> <p>Interview on 04/22/10 at 11:00 AM with the Director of Nursing revealed the facility had been working on initiating a Restorative Program since April 1, 2010 because the facility had never had a formal Restorative Program.</p> <p>2. Review of the clinical record revealed Resident #6 was admitted to the facility on 02/01/09 with diagnoses which included Syncope, Status Post Pacemaker and Hypertension.</p> <p>Review of the Annual Minimum Data Set (MDS) dated 02/01/10 revealed the facility assessed the resident as being independent in cognitive skills for daily decision making and as requiring extensive assistance with all transfers. The facility assessed the resident as having an unsteady gait and requiring partial physical support for balance while standing.</p> <p>The Resident Assessment Protocol Summary (RAPS) dated 02/01/10 revealed the facility noted Resident #6 had "stiffness" in the lower extremities and received Restorative Nursing to increase strength, mobility and ambulation.</p> <p>The Comprehensive Care Plan dated 02/01/10 revealed the facility identified Resident #6 as</p>	F 318	<p>Resident #5 exhibited the ability to move her right arm and leg without difficulty. She has had no movement of the left arm and leg since initial admission (she suffered a CVA in September 2009, resulting in left sided hemiparesis). Miscoding of section "G" of the MDS 2.0 assessments completed prior to 3/14/10, triggered evidence of decline in the functional status of her left arm (no change since admission).</p> <p>As of 5/3/10, restorative programs have been developed and instituted for all involved residents (see attached). This information was also communicated to the nursing staff and the restorative nursing assistant; care plans developed and placed in residents charts.</p> <p>Since all residents residing on the nursing wing could have been affected by this deficient practice, as of 5/5/10, DON/ADON evaluated all residents currently residing on the nursing wing. No negative outcomes were noted and appropriate interventions were initiated as needed.</p>	
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05-19-'10 11:55 FROM-

T-745 P021 F-287

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

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 04/22/2010
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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)	(X6) COMPLETION DATE
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F 318	<p>Continued From page 18</p> <p>being at risk for falls due to a history of syncope and unsteady gait. Interventions included continue working with Restorative Nursing Aide (RNA) to increase ambulation, mobility and strength.</p> <p>Observations on 04/20/10 at 4:40 PM revealed Resident #8 sitting in a wheelchair in preparation for the evening meal. Further observation on 04/21/10 at 7:30 AM revealed the resident sitting in a wheelchair in the dining room awaiting breakfast.</p> <p>Interview on 04/22/10 at 12:01 PM with the Restorative Nursing Aide (RNA) revealed she was the Certified Nursing Assistant responsible for providing Restorative Nursing services. She stated Resident #8 was not receiving Restorative Nursing services. The RNA indicated when the resident was first admitted to the facility, the resident used to walk about half the length of the hall which included the length of six (6) resident rooms. She stated, "Now the resident can't walk". Further interview revealed the RNA never documented any Restorative services for Resident #8.</p> <p>Record review failed to reveal documented evidence the facility provided Restorative Nursing services for increasing Resident #8's ambulation, mobility and strength.</p> <p>Interview on 04/22/10 at 11:00 AM with the Director of Nursing (DON) revealed she was the person responsible for the facility's Restorative Program. She stated she was also the person responsible for the residents plan of care. She indicated she was unaware Resident #8 was not on the Restorative Nursing Program. The DON</p>	F 318	<p>To prevent reoccurrence of this deficient practice, the DON/ADON will monitor current residents in the restorative program no less than weekly for evidence of decline; appropriate interventions will be initiated. Beginning, 5/10/10, for the next 30 days, all newly admitted residents and residents requiring an annual or significant change in status assessment will be reviewed by the DON/ADON to assure residents are receiving appropriate restorative nursing when needed. This will be an ongoing process.</p>	
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05-19-'10 11:56 FROM-

T-745 P022 F-287

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

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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 04/22/2010
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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)	(X6) COMPLETION DATE
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F 318	<p>Continued From page 17</p> <p>stated she was supposed to be made aware when a resident was discharged from Restorative Nursing.</p> <p>3. Review of the clinical record revealed Resident #5 was admitted to the facility 10/17/09 with diagnoses which included Cerebral Vascular Accident with Left Sided Hemiparesis and a History of Transient Ischemic Accidents.</p> <p>Review of the Significant Change Minimum Data Set (MDS) dated 03/14/10 revealed the facility assessed the resident as having moderate impairment in cognitive skills for daily decision making and as having a full loss in ROM to one side. Review of the Resident Assessment Protocol Summary (RAPS) dated 03/14/10 revealed the facility assessed the resident as having no movement of the left side.</p> <p>The Comprehensive Care Plan dated 03/14/10 revealed the facility assessed the resident as having severely impaired mobility with Left Sided Hemiparesis. Interventions included to verbally direct the resident to lift left leg when attempting to walk.</p> <p>Interview on 4/21/10 at 10:20 AM with the Director of Nursing (DON) indicated she was responsible for completing Minimum Data Sets (MDSs). The DON stated, "If there is an indication of change with a resident such as a decline in range of motion (ROM), I would refer the resident to the Physical Therapy Department."</p> <p>Interview on 4/21/10 at 1:15 PM with License Practical Nurse (LPN) #1, stated "When PT (Physical Therapy) was discontinued, restorative nursing program was not needed related to the</p>	F 318		
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05-19-'10 11:56 FROM-

T-745 P023 F-287

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

PRINTED: 05/05/2010  
FORM APPROVED  
OMB NO. 0938-0391

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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 318	<p>Continued From page 18</p> <p>left upper extremity was flaccid and the goals were met. LPN #1 indicated the resident gets range of motion (ROM) with dressing and grooming daily with certified nursing assistant (CNA) raising arm to put in clothing and out of clothing two times a day".</p> <p>Review of the facility's policy entitled "Restorative Nursing Policy", undated, revealed residents would be evaluated and placed into a Restorative Program appropriate to meet their needs. The policy revealed the facility was responsible to provide the necessary care and services to residents so that they may attain the highest quality of life.</p> <p>Review of the facility's policy entitled "Restorative Nursing Policy", undated, revealed a resident would be evaluated and placed into a restorative program appropriate to meet their needs. The policy revealed when the Therapist discontinued a resident to Restorative Nursing, a plan of care would be provided to include each program the resident would receive. The policy revealed before the RNA began the Restorative services, the plan of care must be signed by the RNA, DON and Assistant DON. Further review revealed if at any time a resident that has been referred to Restorative Nursing after receiving skilled therapy was noted to have a decline or improvement, therapy would be notified. The policy revealed when a program was discontinued, the date it was discontinued and the person who discontinued the program would be documented.</p>	F 318		
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05-19-'10 11:56 FROM-

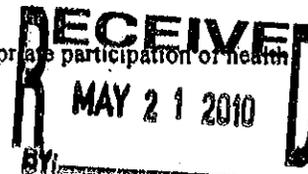
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F-287

CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNPs AND NPs	PROVIDER # <b>185241</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>4/22/2010</b>
NAME OF PROVIDER OR SUPPLIER <b>MADONNA MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD VILLA HILLS, KY</b>	
ID PREFIX TAO	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 278</b>	<p><b>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</b></p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the accuracy of an assessment for one (1) of sixteen (16) residents (Resident #5).</p> <p>The findings include:</p> <p>Record review revealed Resident #5 was admitted to the facility on 10/17/09 with diagnoses which included Cerebral Vascular Accident with Left Hemiparesis.</p> <p>Review of the Admission Minimum Data Set (MDS) dated 10/21/09 revealed the facility assessed the resident as having voluntary partial loss in range of motion (ROM) to one side. However, review of the Resident Assessment Protocol Summary (RAPS) dated 10/21/09 revealed the facility assessed the resident as having no movement of the left side.</p> <p>Review of the Significant Change Minimum Data Set (MDS) dated 03/14/10 revealed the facility assessed the resident as having full loss in ROM to one side. The RAPS dated 03/14/10 revealed the facility assessed the resident as having no movement of the left side.</p> <p>Interview on 04/21/10 at 10:20 AM with the Director of Nursing (DON) revealed she was responsible for completion of Resident #5's MDS. She indicated Resident #5 did not have a decline in ROM. She stated the resident had always had full loss of one side since the resident had been admitted. The DON indicated she</p>		



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

The above isolated deficiencies pose no actual harm to the residents

05-19-'10 11:56 FROM-

T-745 P025 F-287

"A" FORM

## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNIPs AND NPs	PROVIDER # <b>185241</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>4/22/2010</b>
NAME OF PROVIDER OR SUPPLIER <b>MADONNA MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD VILLA HILLS, KY</b>		
ID PREFIX TAG <b>F 278</b>	SUMMARY STATEMENT OF DEFICIENCIES		
	<p>Continued From Page 1</p> <p>did not know why she coded the resident as having a partial loss in ROM on 10/21/09. She went on to indicate if she had identified a change in ROM she would have referred the resident to the Therapy Department.</p> <p><b>F 278</b></p> <p>The MDS Coordinator is aware of appropriate coding techniques regarding the MDS 2.0 in order to identify residents at risk for potential issues.</p> <p>As of 4/23/10, the MDS Coordinator has reviewed section "G" of the MDS 2.0 User' Manuel regarding Physical Functioning and Structural Problems and proper coding. The MDS Coordinator is knowledgeable regarding appropriate coding techniques.</p> <p>Since all residents on the nursing wing could have been affected by this deficient practice, as of 4/26/10, the DON/ADON reviewed 12 resident records in regards to section "G" coding. The DON determined that no resident was affected by this isolated deficient practice involving appropriate coding of the MDS assessment tool.</p> <p>To prevent this deficient practice from reoccurring, beginning 5/3/10, for the next 30 days, all newly admitted resident and those residents discharged to the hospital with return anticipated, will be reviewed by the DON/ADON to ensure proper coding. Thereafter, one annual/significant change in status and new admission assessment will be reviewed monthly for three months to ensure proper and accurate coding of the MDS assessment reflecting the resident's status.</p>		

05-19-'10 11:56 FROM-

T-745 P025

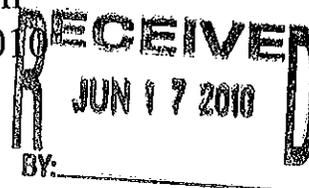
F-287

CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 185241	MULTIPLE CONSTRUCTION A: BUILDING B: WING	DATE SURVEY COMPLETE 4/22/2010
NAME OF PROVIDER OR SUPPLIER <b>MADONNA MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD VILLA HILLS, KY</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 278	<p>Continued From Page 1</p> <p>did not know why she coded the resident as having a partial loss in ROM on 10/21/09. She went on to indicate if she had identified a change in ROM she would have referred the resident to the Therapy Department.</p> <p>F 278</p> <p>The MDS Coordinator is aware of appropriate coding techniques regarding the MDS 2.0 in order to identify residents at risk for potential issues.</p> <p>As of 4/23/10, the MDS Coordinator has reviewed section "G" of the MDS 2.0 User' Manuel regarding Physical Functioning and Structural Problems and proper coding. The MDS Coordinator is knowledgeable regarding appropriate coding techniques.</p> <p>Since all residents on the nursing wing could have been affected by this deficient practice, as of 4/26/10, the DON/ADON reviewed 12 resident records in regards to section "G" coding. The DON determined that no resident was affected by this isolated deficient practice involving appropriate coding of the MDS assessment tool.</p> <p>To prevent this deficient practice from reoccurring, beginning 5/3/10, for the next 30 days, all newly admitted resident and those residents discharged to the hospital with return anticipated, will be reviewed by the DON/ADON to ensure proper coding. Thereafter, one annual/significant change in status and new admission assessment will be reviewed monthly for three months to ensure proper and accurate coding of the MDS assessment reflecting the resident's status.</p>		

Madonna Manor  
Addendum to Plan of Correction  
Abbreviated Survey, April 22, 2010



Dates of compliance

F-225; pg. 2-19: As of 5/5/10, residents capable of conversing were interviewed per DON/ADON in regards to "any concerns" they had in regards to performance of their care needs and overall attitude of staff and if there were issues on how they are being treated. Those residents incapable of conversation were evaluated for injuries of unknown origin. It was determined that no resident suffered from this deficient practice.

F-225: the elder abuse test was added to the orientation package for all newly hired employees as of 5/5/10.

**DATE OF COMPLIANCE:** **May 6, 2010**

F-241: explained that weekly monitoring of meals did occur weekly for one month. It was explained that if issues arise, the DON/ADON would monitor each meal daily until issues are resolved.

**DATE OF COMPLIANCE:** **May 28, 2010**

F-257: Temperatures will be monitored for by the Facility Manager at various times each week for a month. At the end of the month, these checks revealed a safe and comfortable temperature.

**DATE OF COMPLIANCE:** **May 28, 2010**

F-281: The DON/ADON monitors the accuracy of noting and transcribing physician orders/MARS and TARS.

**DATE OF COMPLIANCE:** **May 28, 2010**

F-310: The in-service on 4/28/10, was conducted per DON/ADON (signatures at bottom of in-service sign in sheet).

**DATE OF COMPLIANCE:** **May 6, 2010**

F-318: All newly admitted residents evaluated upon admission and residents requiring an annual or significant change assessment will be reviewed by DON/ADON.

**DATE OF COMPLIANCE:** **May 11, 2010**

F-278: Complete review completed on May 3, 2010 with monthly reviews for 90 days.

**DATE OF COMPLIANCE:** **June 3, 2010**

K 022: Signs Posted

**DATE OF COMPLIANCE:** **May 28, 2010**

K 048: In-service held; all staff informed on the Locations of the Evacuation Plan

**DATE OF COMPLIANCE:** **May 28, 2010**

K 070: All portable heaters removed from all offices.

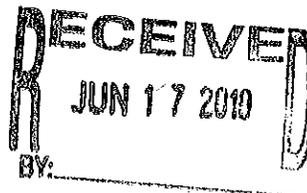
**DATE OF COMPLIANCE:** **April 30, 2010**

K 074: All non-flame resistant curtains removed.

**DATE OF COMPLIANCE:** **April 30, 2010**

K 144: Weekly and monthly generator checks performed.

**DATE OF COMPLIANCE:** **May 28, 2010**



**Madonna Manor**  
**Addendum to Plan of Correction**  
**Abbreviated Survey, April 22, 2010**

The following indicates the date of compliance for the Life Safety Code items identified as deficient.

K 022: Signs Posted

**DATE OF COMPLIANCE:** **May 28, 2010**

K 048: In-service held; all staff informed on the Locations of the Evacuation Plan

**DATE OF COMPLIANCE:** **May 28, 2010**

K 050: Fire Drills will be held monthly on a different day and shift

**DATE OF COMPLIANCE:** **May 31, 2010**

K 070: All portable heaters removed from all offices.

**DATE OF COMPLIANCE:** **April 30, 2010**

K 074: All non-flame resistant curtains removed.

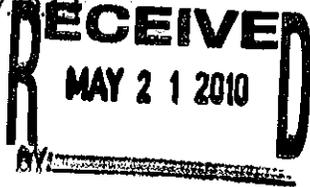
**DATE OF COMPLIANCE:** **April 30, 2010**

K 144: Weekly and monthly generator checks performed.

**DATE OF COMPLIANCE:** **May 28, 2010**

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

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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 01 B. WING		(X3) DATE SURVEY COMPLETED  04/21/2010
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	
K 000	INITIAL COMMENTS	K 000			
K 022 SS=E	<p>A Life safety Code Survey was initiated and concluded on 04-21-2010 for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at an "F".</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.8.1</p> <div style="text-align: center;">  </div> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exits according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 04-21-2010 at 1:00 PM revealed the doors in the dining area could be confused as exits, as the doors were not marked in that area to identify exits.</p> <p>On 04-21-2010 at 1:00 PM during interview with the Administrator it was revealed that he was unaware of the requirements for the door</p>	K 022	<p>K 022 Madonna Manor recognizes the importance of having all exits properly marked. It is just as important to mark doors that may appear to be an exit (that are not exits as described in NFPA 101 Life Safety Code Standard) with NO EXIT signage to protect residents, staff, visitors from potential harm.</p> <p>Madonna Manor is aware that this deficient practice could have potentially affected all residents.</p> <p>To remedy this deficiency, temporary NO EXIT signs meeting the size and location as described in NFPA 101.7.10.8.1* have been posted on the doors in the nursing dining rooms which were identified as no exit doors as of May 20, 2010. Permanent signs were ordered from Art &amp; Sign Studio Corporation, Florence, KY on May 20, 2010 and will be installed on or before Friday, May 28, 2010.</p>		

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

TITLE

(X6) DATE

*Maureen [Signature]*

*EXECUTIVE DIRECTOR*

5-21-10

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  04/21/2010
NAME OF PROVIDER OR SUPPLIER  MADONNA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2944 AMSTERDAM ROAD VILLA HILLS, KY 41017		
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K 022	Continued From page 1 marking.  Actual NFPA Standard: NFPA 101 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.  NFPA 101 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approve existing signs. Based on observation and interview, it was determined the facility failed to maintain exits according to NFPA standards.	K 022			
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1	K 048			

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K 048	Continued From page 2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have a written plan for the evacuation of residents in the event of an emergency.  The findings include:  On 04-21-2010 at 2:00 PM during record review with the Administrator it was determined that no documented evidence of an evacuation plan could be found. Interview with the Facility Manager revealed that he had not been able to find all the records from the previous Facility Manager. The Facility Manager stated that he knew they had a plan, but he was unable to find a record of it. Review of the facility's maintenance records on 04-21-2010 at 2:30 PM with the Administrator reveals no evidence of an evacuation plan. The Administrator stated that they did have a plan, but the records must have been misplaced by the previous facility's director.  Actual NFPA Standard: 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone	K 048	K 048 Evacuation plans are basic to providing safety to residents, staff and visitors. Madonna Manor has a comprehensive evacuation plan (copy attached). Madonna Manor acknowledges that a plan not readily available does little to insure the safety of our residents, staff and visitors.  Madonna Manor is aware that this deficient practice could have potentially affected all residents.  To rectify this deficiency, a copy of the Disaster and Evacuation Plan has been placed in the nursing station, the mailroom and the business office in addition to the nursing and personal care nursing stations. A copy of the plan will also be held by the Executive Director, the DON, the Safety Committee Chair and the Director of Facilities. An in-service to review the evacuation plan and the location of said plan will be held on June 9, 2010. An in-service on fire, disaster and evacuation was last held on		

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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD VILLA HILLS, KY 41017</b>		
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K 048	Continued From page 3 operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. <b>19.7.1.2*</b> Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. <b>19.7.1.3</b> Employees of health care occupancies shall be instructed in life safety procedures and devices. <b>19.7.2 Procedure in Case of Fire.</b> <b>19.7.2.1*</b> For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy ' s fire safety plan. <b>19.7.2.2</b> A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms	K 048	9-04-09 (copy attached). As further evidence of Madonna Manor's commitment to resident's safety, the chairman of the safety committee and five additional staff members attended the Emergency Preparedness in LTC, sponsored by Northern Kentucky Region 7 HPP/LTC on May 5, 2010. The day included training on the components and importance of a comprehensive evacuation plan (copy of agenda attached).		

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K 048	Continued From page 4 (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan.	K 048			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050	K 050 Madonna Manor recognizes the value of fire drills, hoping that they are never needed but being prepared is necessary to prevent harm to any resident, staff or visitor. It is also recognized that fire drills should be performed at various times during the month.  Madonna Manor is aware that this deficient practice could have potentially affected all residents.		

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K 050	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a written record of fire drills.</p> <p>The findings include:</p> <p>On 04-21-2010 at 1:50 PM during record review, the Facility Manager was only able to find records of fire drills held on 12-31-09 and 03-31-10. During interview with the Facility Manager he stated he had not been able to find any other fire drill records from the previous facility manager.</p> <p>On 04-21-2010 at 2:30 PM, during interview with Administrator, he revealed that no other records were found. The Administrator stated the previous facility manager must have misplaced the records.</p> <p>Actual NFPA Standard: 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.</p>	K 050	<p>The Chair of the Safety Committee, currently the Director of Facilities, is aware of NFPA 101 Life Safety Code Standard to hold fire drills at least quarterly on each shift and to vary the day, time and month that fire drills occur throughout each quarter.</p> <p>On April 4, 2010, the first fire drill of the second quarter took place on the 11- 7 shift (copy attached).</p> <p>To assure continued compliance, the safety committee chair submitted a confidential written plan for the remainder of the year identifying a calendar for when fire drills will occur to the Executive Director (copy attached). This will be monitored by the Executive Director monthly. Failure to comply with the submitted plan will result in disciplinary action as described in the Madonna Manor Employee Handbook.</p>	
K 070 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable space heating devices are prohibited in</p>	K 070		

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K 070	Continued From page 6 all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that portable heating units used in non-sleeping areas have a heating element that did not exceed 212° F (degrees Fahrenheit).  The findings include:  Observation on 04/21/2010 at 12:20 PM revealed two (2) space heaters were found in the office area. Interview with the Facility Manager revealed he did not know there was a standard for the heaters. He further stated he would take care of the problem.  Actual NFPA Standard; 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070	K 070 In order to be in compliance with NFPA 101 Life Safety Code Standard, all non compliant portable heaters have been removed from staff offices.  No new portable personal heaters will be purchased for staff offices without meeting the standard of the "heating elements not exceeds 212 degrees F". All such heaters will be tagged, signed and dated as approved by  the Facility Manager signifying compliance with the standard.		
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for	K 074			

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K 074	<p>Continued From page 7</p> <p>the installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4. 19.7.5.3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure curtains were flame resistant.</p> <p>The findings include:</p> <p>Observation on 04/21/2010 at 12:50 AM revealed the curtains hanging in the dining area were not flame resistant. Observation of the curtains revealed no label could be found on the curtains that stated they were flame resistant. Interview with the Facility Manager revealed he did not have any documented evidence that the curtains were flame resistant.</p> <p>Actual NFPA Standard: 10.3.1* Where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in</p>	K 074	<p>K 074 Madonna Manor is aware that this deficient practice could have potentially affected all residents.</p> <p>To ensure compliance with NFPA 101 Life Safety Code Standard 10.3.1, the curtains in the nursing dining room have been removed. All new curtains will meet the flame resistant standard either through the manufacturing progress documented by the manufacturer's label or by treating any curtains with Flamex PF, Fire Resistant Spray and documenting when this treatment was applied and/or reapplied as required.</p>	

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K 074	Continued From page 8	K 074			
K 144 SS=E	<p>accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to inspect generators weekly and exercise under load for thirty (30)minutes per month.</p> <p>The findings include:</p> <p>On 04/21/2010 at 2:20 PM during record review it was discovered the Facility Manager could not produce a record for the generator. During interview with the Facility manager he stated there was no weekly inspection of the generator, nor was it ran monthly under load for thirty (30) minutes a month. He further stated that the generator was started weekly to make sure it starts.</p> <p>Actual NFPA Standard: NFPA 99, 3.4.4.1 Record keeping, A written record of inspection, performance, exercising period, and repairs shall be regularly</p>	K 144	<p>K 144</p> <p>The recent weather crisis (the wind storm and the ice storm) which affected our state has certainly been proven the importance of an operational generator at all times.</p> <p>Madonna Manor is aware that this deficient practice could have potentially affected all residents.</p> <p>One way to protect our residents from any negative impact from loss of power is a routine check on the emergency generator. Madonna Manor recognizes the standards set in NFPA Life Safety Code Standard 99.3.4.4.1</p> <p>To maintain compliance with this standard, the facility manager will perform a weekly check on the generator. This check includes fuel, oil and coolant levels, examining belts/hoses and overall mechanical condition and documenting this on a "Madonna Manor Emergency Generator" log (copy attached).</p>		

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K 144	Continued From page 9 maintained and available for inspection by the authority having jurisdiction,	K 144	<p>In addition, the facility contracted with On-Site Maintenance Company for a routine check (copy of service provided attached).</p> <p>To comply with the standards of "exercise under load for thirty minutes per month", Arc Electric, Inc (Wilder, KY) will train the Maintenance Department employees in the proper procedures necessary to perform this monthly procedure the week of May 24, 2010. A log will be developed and implemented by the Director of Facilities to track compliance.</p> <p>Reports on both the weekly checks and the monthly check will be submitted to the Executive Director weekly for the next month and monthly for the next three months to validate on-going compliance. Failure to submit report or to do the routine checks will result in disciplinary action according to the Madonna Manor Employee Handbook.</p>	