

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

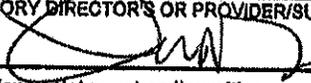
PRINTED: 04/19/2011
FORM APPROVED
OMB NO. 0938-0391

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 04/06/2011
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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
F 000	INITIAL COMMENTS	F 000	The following Plan of Correction will serve as Madonna Manor's credible allegation that substantial compliance will be achieved by May 9, 2011. The submission of this Plan of Correction does not necessarily constitute an agreement on the part of Madonna Manor as to the accuracy of the surveyor's findings. Rather, it is being submitted as required by law.	
F 225 SS=D	<p>483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</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>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</p>	F 225	<p>A criminal background check for Employee #5 was completed on April 4, 2011 and the supporting documentation placed in her employee file.</p> <p>To ensure that criminal background checks and the Nurse Aide Abuse Registry have been checked for other staff, employee files for current, active employees will be audited by the Human Resources Coordinator or designee using an audit tool (Exhibit B). Criminal background checks and/or Nurse Aide Abuse Registry searches will be performed for any active employees identified with missing documentation of either in their files. Employees lacking evidence of these screens will not be permitted to work until they have been obtained and with acceptable findings.</p> <p>To prevent a reoccurrence, criminal background checks and the Nurse Aide Abuse Registry will be checked for newly hired employees prior to them commencing work. To ensure ongoing</p>	5/9/11

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EXECUTIVE DIRECTOR	(X6) DATE 4/28/11
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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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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 225	<p>Continued From page 1</p> <p>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 view it was determined the facility failed to ensure background checks were completed prior to employment for two (2) of five (5) sampled employees. Review of Employee #5's record revealed no evidence of a criminal background check or Nurse Aide Abuse Registry Check completed prior to the employee being hired. Review of Employee #3's record revealed no evidence of the Nurse Aide Abuse Registry Check completed prior to the employee being hired.</p> <p>The findings include:</p> <p>A review of the Facility's Policy titled "Protection of residents from abuse, neglect or misappropriation of personal property", last updated 10/07/07, revealed that prior to employment the Human Resources Director will: Request by mail a state of KY criminal background check; Contact the KY Abuse Registry to assure the applicant has not had a charge filed in the past.</p> <p>1. A review of Employee # 5's personnel filed revealed the employee was hired on 02/07/11. The facility could provide no evidence a criminal</p>	F 225	<p>compliance, the Human Resources Coordinator or designee will audit employee files for new hires weekly for eight (8) weeks using an audit tool (Exhibit C).</p> <p>Any future deficient practices noted will be referred to the Madonna Manor Quality Assurance Committee for corrective action.</p>	

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F 225	Continued From page 2 background check had been performed prior to employment. In addition record review revealed the Nurse Aide Abuse Registry Check was no completed until 02/11/11, four (4) days after hire. 2. A review of Employee #3's personnel file revealed the employee was hired 02/03/11. Further review revealed the Nurse Aide Abuse Registry Check was not completed until 02/11/2011, eight (8) days after hire. An interview with the Human Resources Coordinator on 04/06/11 at 10:00 AM revealed the process followed was to obtain the criminal background check and the Nurse Aide Abuse Registry Check prior to employment. She stated Employee #5 was hired first and a criminal background check was performed after hire. She was not aware this document was not in the file. Further interview revealed the Nurse Aide Abuse Registry Check for Employee #3 was completed after hire. She acknowledged Employee #3's Nurse Aide Abuse Registry check was not completed until after hire and stated she was new at her position and was still learning the process.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to develop and implement policies and procedures for the	F 226	The referenced employee (C.N.A. #1) was terminated December 9, 2010. To ensure that other staff has received training on the Madonna Manor policy regarding abuse, neglect, and misappropriation, employee files for current, active employees will be audited by the Human Resources Coordinator or designee using an audit tool (Exhibit D). Any employees	5/9/11

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F 226	<p>Continued From page 3</p> <p>screening and training of employees to protect residents from abuse, neglect, mistreatment and misappropriation of property. There was no evidence the facility had provided abuse, neglect, mistreatment and misappropriation of property training for Certified Nursing Assistant (CNA) #1.</p> <p>The findings include:</p> <p>Review of the facility's Policies/Procedures regarding the protection of residents from abuse, neglect or misappropriation of personal property revealed "The facility provides annual in-service education for all employees in regard to resident rights, abuse, neglect and misappropriation of personal property, and dealing effectively with resident behavioral issues. Newly hired employees receive this information during their initial orientation in the form of videos and written materials."</p> <p>Review of Certified Nursing Assistant (CNA) #1's employee file revealed a hire date of 11/09/10. Continued review revealed no documented evidence the facility had provided education on abuse, neglect, and misappropriation for the CNA during initial orientation nor at any other time during her employment at the facility.</p> <p>Interview with the Human Resources (HR) Coordinator on 4/5/11 at 10:30 AM revealed there was no evidence of abuse training for CNA #1 in the CNA's employee file. The HR Coordinator explained this training had probably been provided, at least during the employee's orientation, but there had been numerous people in the HR position in the year before she was hired and the files were inconsistent in their documentation and contents.</p>	F 226	<p>whose files lack documentation verifying they have received training on the abuse policy will be in- serviced by the Social Worker or designee.</p> <p>To prevent a reoccurrence, the Madonna Manor policy regarding abuse, neglect and misappropriation will be presented to newly hired employees at orientation and prior to them working in their assigned areas or otherwise having interaction with residents. To ensure ongoing compliance, the Human Resources Coordinator or designee will audit employee files of new hires weekly for eight (8) weeks using an audit tool (Exhibit E).</p> <p>Any future deficient practices noted will be referred to the Madonna Manor Quality Assurance Committee for corrective action.</p>	

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F 226	Continued From page 4	F 226			
F 371 SS=F	<p>Interview with the Director of Nursing (DON) on 4/5/11 at 3:00 PM revealed abuse training is always provided for new employees and on a regular basis. The DON could not account for the lack of evidence of the training in CNA #1's employee file.</p> <p>483.36(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store, prepare and distribute food under sanitary conditions as evidenced by equipment in the food preparation area stored dirty, numerous stored food items that were opened and undated, improper storage of utensils, an uncovered garbage can in the food area, and a dented can in the dry food storage.</p> <p>The findings include:</p> <p>1. Observation during tour of the kitchen on 04/03/11 at 1:45 AM revealed equipment in the food preparation area was not clean and sanitary. Observation revealed the base of the blender had corrosive material of an undetermined nature.</p>	F 371	<p>The base of the blender was cleaned and removed of corrosive material and the juice dispenser was cleaned. The floor fan and exhaust fan were both cleaned and removed of dust. The mixer was cleaned and the whisk and inner bowl surfaces removed of food particles. The toaster was cleaned and removed of bread crumbs. The tray holding condiments was cleaned.</p> <p>The open, undated cooking spices, jar of garlic, grape jelly, jar of maraschino cherries, and jar of bacon bits in the walk- in refrigerator were all discarded. The open, undated bag of pizza rolls, pumpkin rolls, and box of Danish pastries in the walk- in freezer were all discarded. The open, undated jar of honey and bottle of balsamic vinegar near the stove were both discarded. The open, undated bag of cooking oil and bottle of Marsala wine in the dry storage room were discarded.</p> <p>The undated bags containing bread and rolls and mixed frozen vegetables in the walk- in freezer were all discarded.</p>	5/9/11	

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F 371	<p>Continued From page 5</p> <p>Observation of the juice dispenser revealed dried and sticky juices that had not been removed after use. Dust was found on the wire cage around the blades of the large floor fan standing in the food preparation area. Dust was found on blades and surfaces of the exhaust fan in the wall of the food preparation area. The large mixer was found to have food particles on the whisk and inner surfaces of the mixer. Observation inside the 4-slice toaster revealed an accumulation of bread crumbs. Observation of the tray holding cooking condiments was revealed to be scattered with food particles and other unknown debris.</p> <p>Interview with the Cook's Aide on 04/03/11 at 2:30 PM revealed it was their policy for all these items to be clean and sanitary. She did not know the nature of the corrosion on the blender base. She revealed the sticky juice spouts, the crumbs in the toaster, and the condiment tray should have been cleaned. The Cook said the floor fan and the exhaust fan were not currently being used but should have been cleaned at least quarterly.</p> <p>2. Observation on 04/03/11 at 2:00 PM revealed cooking spices at the stove were not dated when opened for use. Chopped garlic in a plastic jar in the walk-in refrigerator was not dated when opened for use. Grape jelly in the reach-in refrigerator was not dated when opened for use. A jar of maraschino cherries was not dated when opened for use. A jar of bacon bits in the walk-in refrigerator was not dated when opened for use. A bag of pizza rolls in the walk-in freezer was not dated when opened for use. A jar of honey at the stove was not dated when opened for use in cooking. A bottle of balsamic vinegar at the stove was not dated when opened for use in cooking. A</p>	F 371	<p>The undated blocks of American cheese were discarded.</p> <p>The utensils stored in the drawers in the food preparation area were cleaned and placed in the drawers with all handles facing out.</p> <p>The lid for the large plastic garbage can in the food preparation area has been placed over the garbage can when not in use.</p> <p>The dented can of tomato soup in the dry storage room was discarded.</p> <p>The dietary staff were in- serviced by the Executive Chef/ foodservice director on April 11, 2011 on the proper procedures for cleaning, dating of open food items, storing of utensils, covering of garbage cans, and disposal of dented food cans (Exhibit F).</p> <p>To prevent a reoccurrence of these issues, the Executive Chef/ foodservice director or designee will inspect the kitchen, walk- in freezer and refrigerators, and dry storage room daily for eight (8) weeks using an audit tool (Exhibit G) and corrections made as necessary.</p> <p>Any future deficient practices noted will be referred to the Madonna Manor Quality Assurance Committee for corrective action.</p>	
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F 371	<p>Continued From page 6</p> <p>plastic bag of liquid cooking oil in a box was not dated when opened for use in the dry storage room. A box of pumpkin rolls and a box of Danish pastry in the walk-in freezer were not dated when opened. A bottle of Marsala wine in the dry storage room was not dated when opened.</p> <p>Interview with the Executive Chef on 04/03/2011 at 2:30 PM revealed that it was facility policy for all food items to be dated when they were opened for use. The Chef revealed that he instructs his staff to follow this procedure and follows it himself with all food or condiments used in the kitchen. His explanation for the undated items was that he had taken several vacation days immediately prior to the survey and had been unavailable to make sure staff was following procedures</p> <p>3. Observation and interview on tour of the kitchen on 04/03/2011 at 1:45 PM revealed several food items were not dated when received into stock.</p> <p>Three (3) clear plastic bags of bread and rolls in the walk-in freezer revealed no date when they were received into stock. Four (4) blocks of American cheese wrapped in clear plastic revealed no date as to when it was received into stock in the walk-in refrigerator. Three (3) bags of frozen mixed vegetables in the walk-in freezer were not dated when received into stock.</p> <p>Interview with the Head Chef on tour on 04/03/11 at 2:30 PM revealed it is the facility's policy to write dates on all foods when they are received into stock. Explanation for why these items were not dated was revealed to be staff oversight.</p> <p>4. Observation and interview on tour of the kitchen on 04/03/2011 at 1:45 PM revealed</p>	F 371			

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F 371	Continued From page 7 utensils in two drawers in the food preparation area were not all turned with the handles facing out. Interview with the Cook's Aide on 04/03/2011 at 2:00 PM revealed that it was the facility's policy to turn all utensils in drawers in the same direction, with the handles facing out, but explained the deficiency was due to staff oversight. 5. Observation and interview on tour of the kitchen on 04/03/2011 at 1:45 PM revealed a large plastic garbage can in the food preparation area to be uncovered. Interview with the Cook's Aide on 04/03/2011 at 1:50 PM revealed it was their policy to cover all garbage cans in the food preparation area but explained that someone had been using it and neglected to recover the can after use. 6. Observation and interview on 04/03/2011 at 1:55 PM in the dry storage room revealed a large can of tomato soup with a dent in the side of the can. Interview with the Cook's Aide on 04/03/2011 at 1:55 PM revealed it was the facility's policy to remove dented cans from the storage rack and send them back to the supplier. She said, "I don't know why we have it" when asked about the dented can.	F 371		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514	The Medication Administration Record (MAR) for unsampled Resident #1 has been corrected to reflect the current physician order for Calcium with	5/9/11

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F 514	<p>Continued From page 8 accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</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 the clinical record was maintained for one (1) unsampled resident (unsampled Resident #1). The unsampled resident's Medication Administration Record (MAR) was not corrected when Vitamin D was added to the Calcium on 03/31/11.</p> <p>The findings include:</p> <p>Review of the clinical record for unsampled Resident #1 revealed, the facility admitted the resident with diagnoses which included Muscular Dystrophy and Osteoporosis. Per pharmacy recommendations on 03/09/11, the original calcium order was changed to Calcium with Vitamin D for increased absorption.</p> <p>Observation of the medication pass on 04/05/11 at 9:00 AM, revealed the original Calcium order written on 02/07/11 had not been discontinued from the Medication Administration Record (MAR). However, the new order for Calcium with Vitamin D had been transcribed to the MAR and the resident was receiving the correct medication.</p>	F 514	<p>Vitamin D and this resident continues to receive it as ordered. No negative outcomes occurred for this resident.</p> <p>The Director of Nursing and Assistant Director of Nursing reviewed the MAR's of each of the other NF residents on April 8, 2011 to ensure that appropriate medications and treatments were being administered and documented. No other errors were noted.</p> <p>Licensed nursing staff were in-serviced by the Director of Nursing on April 8, 2011 regarding the transcription and discontinuation of physician orders (Exhibit H).</p> <p>To prevent future occurrences, the DON or designee will monitor physician orders weekly for six (6) weeks using an audit tool (Exhibit I) to ensure they are carried out properly.</p> <p>Any future deficient practices noted will be referred to the Madonna Manor Quality Assurance Committee for corrective action.</p>	

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F 514	Continued From page 9	F 514			
F 520 SS=D	<p>Interview with Licensed Practical Nurse (LPN) #1 on 04/05/11 at 9:00 AM, revealed the original Calcium order without Vitamin D had not been discontinued from the MAR.</p> <p>Interview with LPN #3 on 04/05/11 at 11:30 AM, who was responsible for discontinuing the Calcium, revealed it was an oversight on her part and the original Calcium order without Vitamin D should have been discontinued from the MAR.</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p>	F 520	<p>A criminal background check for Employee #5 was completed on April 4, 2011 and the supporting documentation placed in her employee file.</p> <p>To ensure that criminal background checks and the Nurse Aide Abuse Registry have been checked for other staff, employee files for current, active employees will be audited by the Human Resources Coordinator or designee using an audit tool (Exhibit B). Criminal background checks and/or the Nurse Aide Abuse Registry searches will immediately be performed for any active employees with missing documentation of either in their files. Employees lacking evidence of these screens will not be permitted to work until they have been obtained and with acceptable findings.</p>	5/9/11	

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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 04/06/2011
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to have an effective Quality Assessment and Assurance process to develop and implement appropriate plans of actions to correct quality deficiencies to ensure compliance with F225. This was evidenced by repeat deficiencies for F225 related to the facility's failure to perform criminal background checks and/or State Nurse Aide Registry Checks for employees prior to their hire.</p> <p>The findings include:</p> <p>Based on interview and record review, during the survey completed on 04/06/11, it was revealed the facility failed to perform criminal background checks and/or State Nurse Aide Registry for employees prior to their employment. This was a repeat deficiency for F225 as the facility was cited 04/22/10 for deficiencies related to the failure to report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property.</p> <p>Review of the facility's policy titled "Protection of residents from abuse, neglect or misappropriation of personal property", last updated 10/07/07, revealed that prior to employment the Human Resources Director would: Request by mail a criminal background check; Contact the KY Nurse Aide Abuse Registry to assure the applicant has not had a charge filed in the past.</p> <p>Review of Employee #5's personnel file revealed the employee was hired on 02/07/11. The facility</p>	F 520	<p>To prevent a reoccurrence, criminal background checks and the Nurse Aide Abuse Registry will be checked for newly hired employees prior to them commencing work. To ensure ongoing compliance, the Human Resources Coordinator or designee will audit employee files for new hires weekly for eight (8) weeks using an audit tool (Exhibit C).</p> <p>The facility has an active Quality Assurance committee comprised of the Administrator, Director of Nursing, Department Managers, Medical Director, and Pharmacy Consultant that meets quarterly.</p> <p>This deficiency will be referred to the Quality Assurance committee at its next meeting, scheduled for May 6, 2011. The Quality Assurance committee will then monitor facility practices to ensure ongoing compliance of the requirements of F225. Other cited deficiencies, including F226, F371, and F514 will also be monitored to ensure ongoing compliance and prevent repeat deficiencies.</p>		

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F 520	<p>Continued From page 11</p> <p>could provide no documented evidence that a criminal background check had been performed prior to employment. In addition, record review revealed the Nurse Aide Abuse Registry check was not completed until 02/11/11, four (4) days after hire.</p> <p>Review of Employee #3's personnel file revealed this employee was hired 02/03/11. Further review revealed the Nurse Aide Abuse Registry check was not completed until 02/11/11, eight (8) days after hire.</p> <p>Interview with the Human Resources Coordinator (HRC) on 04/05/11 at 10:00 AM revealed the process followed was to obtain the criminal background check and the Nurse Aide Abuse Registry check prior to employment. She stated Employee #5 was hired first and a criminal background check was performed after hire. The HRC was not aware this document was not in Employee #5's file. Further interview revealed the Nurse Aide Abuse Registry Check for Employee#5 was completed after hire. She acknowledged Employee#3's Nurse Aide Registry Check was completed eight (8) days after hire because it had not been done prior to hire. The Coordinator stated she was new to the position and was still learning the process at that time. In addition, it was revealed prior to her being hired, no one was assigned to this position for approximately three (3) months and multiple persons had filled this position during the past year. She further stated when reviewing employee files, who had been hired during 2010, it appeared there was no consistent process to ensure the criminal background checks, State Nurse Aide Registry checks and orientation had been performed for new employees.</p>	F 520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188241	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/05/2011
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NAME OF PROVIDER OR SUPPLIER MADONNA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017
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K 000	INITIAL COMMENTS K3 Building: 0101 K6 Plan Approval: 1986 K7 Survey under: 2000 existing K8 Hospital Type of structure: one (1) story TYPE III (200). Full automatic sprinkler system. A Life Safety Code survey was initiated and concluded on 04/05/2011 for compliance with Title 42, Code of Federal Regulations, 483.70, and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 edition. The highest deficiency was a " F " level. The following findings demonstrate noncompliance.	K 000	The following Plan of Correction will serve as Madonna Manor's credible allegation that substantial compliance will be achieved by May 9, 2011. The submission of this Plan of Correction does not necessarily constitute an agreement on the part of Madonna Manor as to the accuracy of the surveyor's findings. Rather, it is being submitted as required by law.	
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that candles used in the facility were under continuous supervision. The deficiency has the potential to affect one (1) smoke compartment, thirty five (35) residents, staff and visitors. The census the day of the Life Safety Code survey was thirty four (34). The findings include: Observation on 04/05/2011 at 11:48 AM, With the Facility Manager, revealed a candle burning in the	K 130	This candle, located in the sanctuary area of the facility chapel, was extinguished and replaced with a battery operated lighting device. The facility and chapel were inspected for other continuous burning candles and none were identified. To prevent a reoccurrence, the chapel area will be inspected daily by the Facility Manager or designee for eight (8) weeks using an audit tool (Exhibit A) to ensure that candles are not lit and left burning while unsupervised.	5/9/11

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APR 28 2011
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EXECUTIVE DIRECTOR	(X6) DATE 4/28/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 130	<p>Continued From page 1</p> <p>Chapel area. The candle was not being supervised by facility staff at the time of discovery. The observation was confirmed with the Facility Manager.</p> <p>Interview on 04/05/2011 at 11:48 AM, with the Facility Manager, revealed the candle is used for religious purpose and is in continuous use. Further interview, with the Facility Manager, revealed the only time the candle would be under supervision would be during religious services held daily from 11:00 AM till 11:30 AM and during Lent. When the Facility Manager was showed a Survey and Certification letter from the Center for Medicaid and Medicare regarding the proper use of candles in nursing homes, the Facility Manager agreed the facility was not meeting the requirements for candle use.</p> <p>Reference: Survey and Certification Letter 07-07</p>	K 130	Any future deficient practices noted will be referred to the Madonna Manor Quality Assurance Committee for corrective action.	