

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

PRINTED: 11/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

12/14 Acceptable POC date of copy 11/16/11

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185241 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>11/04/2011 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>MADONNA MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2344 AMSTERDAM ROAD<br>VILLA HILLS, KY 41017 |
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| F 000<br><br>F 225<br>SS=E | <p><b>INITIAL COMMENTS</b></p> <p>An Abbreviated Survey Investigating ARO#KY00017272 and ARO#KY00017274 was initiated on 11/01/11 and concluded on 11/04/11. ARO#KY00017272 was substantiated with deficiencies cited. ARO#KY00017274 was substantiated with no deficiency cited. The highest scope and severity was a "E".</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)<br/>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> | F 000<br><br>F 225 | <p>DISCLAIMER: THE COMPLETION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE CITED DEFICIENCIES AS STATED IN THE 2567 INCLUDING ANY DETERMINATIONS OF SCOPE AND SEVERITY OF THE ALLEGED DEFICIENCIES. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY DISAGREES AND DISPUTES THE DEFICIENCIES STATED IN THE 2567.</p> <p>The facility alleges compliance as of 11/16/11.</p> <p style="text-align: center;">RECEIVED<br/>DEC - 9 2011</p> |  |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><br><i>[Signature]</i> | TITLE<br>Executive Director | (X6) DATE<br>12/8/11 |
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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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| F 225  | <p>Continued From page 1</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:<br/>Based on interview, record review, review of facility "Protection of Residents from Abuse, Neglect, or Misappropriation of Personal Property" Policy, and facility investigation, it was determined the facility failed to have an effective system to ensure all alleged violations involving abuse were reported immediately to the Administrator of the facility and to State Agencies in accordance with state law. In addition, the facility failed to have an effective system to ensure residents were protected after an allegation of abuse for four (4) of five (5) sampled residents (Resident #19, #20, #21, and #22).</p> <p>Allegations of abuse involving Residents #19, #20, #21, and #21 were not reported immediately to the Administrator of the facility, and therefore not reported immediately to State Agencies. This delay in notification of the alleged abuse prevented the facility from protecting the residents from further potential abuse while the investigation was in progress.</p> <p>The findings include:<br/><br/>Review of the "Protection of Residents from</p> | F 225   | <p>The community has policies implement so allegations of abuse are reported timely. The facility takes seriously its responsibility to protect residents from abuse, neglect or misappropriation.</p> <p>1. The facility's policies and procedures for implementation have been reviewed and follow regulatory standard. Residents #19, 20, 21 and 22 were assessed by licensed nursing staff on 10/11/11 and no injuries were evident. The Social Worker interviewed and provided support to resident #20 on 10/13/11 and 10/14/11 Residents # 21, 22 and 19 were unable to be interviewed due to advanced dementia, and these residents understanding of events was not able to be assessed. Family and doctor were made aware of the incident, conclusions and outcomes for residents #19, 20, 21 and 22.</p> | 11/16/11             |   |

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| F 225   | <p>Continued From page 2</p> <p>Abuse, Neglect, or Misappropriation of Personal Property" Policy, revised 03/31/01, revealed all employees were to report any signs of abuse to their immediate supervisor. Further review revealed the supervisor was responsible to report to the Director of Nursing (DON) and Administrator immediately when any allegations are believed to have occurred.</p> <p>1. Review of Resident #20's medical record revealed diagnosis which included Parkinson's Disease and Depression. Review of the Quarterly Minimum Data Set (MDS) dated 10/06/11 revealed the facility assessed the resident as cognitively intact and as requiring limited to extensive assistance with Activities of Daily Living (ADL's).</p> <p>Review of the Comprehensive Plan of Care date 09/16/11 revealed the resident had a diagnosis of Psychosis and symptoms were manifested by poor impulse control, unable to control anger, and resistive to care at times.</p> <p>Review of the facility investigation revealed LPN #20 reported that CNA #17 and CNA#18 had witnessed CNA #15 screaming at Resident #20. CNA #18 was interviewed and stated CNA #15 was screaming at Resident #20 yesterday. CNA #18 stated she could hear CNA #15 yelling at Resident #20 from down the hall and as she got closer to the resident's room heard CNA #15 state "you are not going to bark orders to me, you treat us like dogs, but I am not going to take it". Further review revealed Resident #20 asked for CNA#15's name and CNA #15 replied, "you do not need to know my name". Further review revealed CNA #17 was with CNA #18 at the time</p> | F 225  | <p>2. The other residents in the assignment on 10/11/11-10/13/11 covered by the CNA with this allegation of abuse were checked for injuries by the Assistant Director of Nursing and no skin injuries were identified. A unit meeting was held with nursing staff by RN Nursing Consultant on 10/14/11 to determine if other staff had any knowledge of other incidents to bring forward, with no new information obtained. A review of incidents has been completed to identify any other potential abuse issues or patterns of staff behavioral with no patterns or issues identified. The Social Worker conducts informal interviews of residents 1-2 times per week and includes questions concerning potential abuse/neglect. Social Service Director presents any issues to Executive Director and other Department Leaders when appropriate. Resident Council monthly meeting minutes have been reviewed with no identified concerns for abuse. In-services were completed with staff on 10/13-10/15/11 by Director of Nursing (DON) and other Department Heads on the abuse policy and reporting abuse timely. Additional in-servicing on the abuse policy was completed on 11/9/11 by DON and Executive Director.</p> |   |

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| F 225   | <p>Continued From page 3 and also heard CNA #15 yelling at the resident.</p> <p>Further review of the facility investigation revealed CNA #17 was interviewed separately and stated she was walking into Resident #20's room when she heard CNA #15 state, " I can't do one thing without you barking orders at me". CNA #17 also stated CNA #15 was making a motion with her hands like she was wringing the resident's neck but no actual physical contact occurred.</p> <p>The conclusion of the investigation revealed CNA #15's actions were inappropriate, discourteous, and not respectful to the resident and it was determined that most likely verbal abuse occurred.</p> <p>Interview with CNA #18 on 11/04/11 at 1:50 PM verified she had observed CNA #15 yelling at Resident #20 as she came down the hall. She stated she observed CNA #15 in the resident's face and telling the resident that she/he could not keep barking orders. Continued interview revealed Resident #20 asked CNA #15 her name and CNA #15 refused. She stated she did not report this the same day to Administration because CNA #15 "is crazy" and she was afraid of her. She stated she was off work the next day and reported it the following day (two (2) days later).</p> <p>Interview on 11/02/11 at 3:00 PM with CNA #17 revealed CNA #15 was rough and screaming at Resident #20. She stated she entered Resident #20's room and witnessed CNA #15 to make a choking gesture behind the resident; however, did not touch the resident. She further stated CNA</p> | F 225  | <p>The inservicing reinforced the policies regarding the appropriate treatment of all residents with dignity and respect at all times.<br/>CNA#17 and 18 were in-serviced on timely reporting of abuse by DON when incident was reported.</p> <p>3. An abuse questionnaire will be given to 5 staff members each week for the next 4 weeks that includes timeliness of reporting by DON, Assistant Director of Nursing (ADON), MDS Nurse, and/or Nurse Consultant.</p> <p>4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments.<br/>The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy.<br/>The Quality Assurance (QA) committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of quizzes will be reported to QA monthly for review and recommendations.</p> |   |

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| F 225  | <p>Continued From page 4</p> <p>#15 stated, "no wonder nobody wants to take care of you, your demanding.</p> <p>Interview on 11/04/11 at 4:47 PM with Resident #20 revealed a caregiver had been rough with her/him and the caregiver would not give her name. She stated the CNA had accused her/him of "barking orders at her/him. Further Interview revealed the CNA had talked to her/him in a loud and rough tone and if she/he knew the CNA's name she would have reported her.</p> <p>2. Review of Resident #22's medical record revealed diagnosis which included Senile Dementia, Deafness, Depressive Disorder, and Anxiety. Review of the Quarterly Minimum Data Set (MDS) dated 09/19/11 revealed the facility assessed the resident as having severe impairment in cognitive skills and as requiring total assistance with all Activities of Daily Living (ADL's).</p> <p>Review of the Comprehensive Plan of Care dated 09/16/11 revealed the resident had a diagnosis of end stage Alzheimer's Disease with symptoms manifested by impaired decision making, poor impulse control, poor ability to control anger, and resistive to care.</p> <p>Review of the facility investigation revealed a complaint was received from CNA #17 that she had witnessed CNA #15 to place her hand over Resident #22's mouth and tell the resident to "shut up". Further review revealed the incident occurred during a pivot transfer of the resident by CNA #17 and CNA#15. The conclusion of the investigation revealed it could be substantiated via staff eye witness report that CNA #15 was</p> | F 225   |   |                      |   |

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| F 225   | <p>Continued From page 5</p> <p>abusive in a physical manner with Resident #22 by placing her hand over the resident's mouth and in a verbal manner by telling the resident to "shut up". Per the investigation Resident #22 was not interviewable.</p> <p>Interview was attempted on 11/04/11 at 4:30 PM and the resident was only able to make mumbling sounds.</p> <p>Interview on 11/02/11 at 3:00 PM with CNA #17 revealed Resident #22 hollered out and CNA #15 placed her hand over the resident's mouth and told the resident to stand up using foul language. She stated she reported it to LPN #20 and the DON took her statement. She stated this happened the same day as the incident with Resident #21, but she was unsure of the date.</p> <p>Interview on 11/04/11 at 12:00 PM with CNA #16 revealed she had witnessed CNA #15 to place her hand over the resident's mouth and tell her/him to shut up. She stated she waited about a week to report it to the DON because she was scared of CNA #15. She further stated abuse should be reported immediately.</p> <p>Interview with LPN #20 on 11/04/11 at 2:30 PM revealed CNA #16, #17, and #18 all came to her at the same time and reported CNA #15 was verbally and physically abusive to Resident #20 and #22 the prior day. She stated she notified the DON immediately.</p> <p>3. Review of Resident #21's medical record revealed diagnoses which included Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 10/15/11, revealed</p> | F 225  |   |                      |   |

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| F 225   | <p>Continued From page 6</p> <p>the facility assessed the resident as having severe impairment in cognitive skills for decision making and as requiring total assistance in Activities of Daily Living (ADL's).</p> <p>Review of the facility investigation revealed a complaint was received by CNA #17 that she witnessed CNA #15 to place her hand over Resident #22's mouth and this occurred during a pivot transfer of the resident with CNA #15 and CNA #17 assisting. The conclusion of the investigation revealed it could be substantiated via staff eye witness report that CNA #15 was abusive in a physical manner with resident by placing her hand over the resident's mouth.</p> <p>Interview was attempted on 11/14/11 at 4:55 PM with Resident #21; however, was unsuccessful.</p> <p>Interview on 11/02/11 at 3:00 PM with CNA #17 revealed they were transferring Resident #21 and the resident kept repeating the same thing over and over that she/he was cold. She stated CNA #15 took her hand and covered the resident's mouth and told the resident to "shut up". She stated she was unsure of the date this occurred. She stated this was the second instance of abuse she had witnessed by CNA #15 on this day and the first instance was with Resident #20. She stated the DON may not have been notified of the incident with Resident #20 prior to the incident with Resident #20 occurring because CNA #15 was still on the floor working.</p> <p>4. Review of Resident #19's medical record revealed diagnoses which included Dementia and Agitation. Review of the Admission Minimum</p> | F 225  |   |                      |   |

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| F 225              | <p>Continued From page 7</p> <p>Data Set (MDS) Assessment, dated 09/14/11, revealed the facility assessed the resident as having severe impairment in cognitive skills for decision making and as requiring extensive to total assistance in Activities of Daily Living (ADL's).</p> <p>Review of the Comprehensive Plan of Care, dated 09/20/11, revealed the resident had the potential for behavioral disturbance related to the diagnosis of Dementia. The goal stated the resident would be free of abnormal behavior as evidenced by no combativeness and no anxiety. The interventions included avoiding interactions when the resident was over stimulated, if resistive to care or upset, and attempt to calm and re-direct. If unsuccessful leave alone and attempt to provide care after twenty (20) minutes have passed.</p> <p>Review of the facility investigation, dated 10/18/11, revealed a complaint was received from Certified Nursing Assistant (CNA) #18 that she witnessed CNA #15 use a jerking motion when assisting Resident #19 to get up out of her chair to walk. CNA #18 stated she heard CNA #15 state "I never wanted to let someone hit the floor and break something as much as I do now". The conclusion of the facility investigation stated it could be substantiated via staff eye witness report that CNA #15 was likely abusive in a physical manner with the resident when assisting her/him to get out of her/his chair and very inappropriate in her verbal comments while ambulating the resident.</p> <p>Interview, on 11/04/11 at 4:10 PM, was attempted with Resident #19 and was unsuccessful.</p> | F 225         |   |                      |

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| F 225   | <p>Continued From page 8</p> <p>Interview, on 11/04/11 at 1:50 PM, with CNA #18 revealed Resident #19 became anxious at times and stood up setting off her/his chair alarm. She further stated CNA #15 told the resident if she/he wanted to stand up they would walk her/him and assisted the resident to stand up jerking the resident. She further stated CNA #15 starting walking the resident and the resident wanted to sit. She stated she told CNA #15 to let the resident sit and grabbed the wheelchair to place behind the resident. She further stated CNA #15 then said, " I never wanted to let a resident fall so bad". She stated she did not report the incident the day that it happened, but reported it two (2) days later because CNA #15 was known to slam cabinets and slam dishes in the dining area, and "was crazy" and she was worried for her own safety.</p> <p>Interview with CNA #15 on 11/04/11 at 6:30 PM revealed she denied all allegations. She stated she was suspended on 10/13/11 at 11:30 AM and terminated on 10/14/11.</p> <p>Further review of the investigation revealed all the allegations of abuse were reported to Administration on 10/13/11 and State Agencies were notified on 10/14/11. However, interviews with LPN #20, CNA #16 and #17 revealed the allegations were not reported to immediately to Administration.</p> <p>The DON was unable to be interviewed due to absence.</p> <p>Interview, on 11/04/11 at 9:00 AM, with the Administrator revealed staff were inserviced on</p> | F 225  |   |                      |   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185241</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>C<br><b>11/04/2011</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MADONNA MANOR</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2344 AMSTERDAM ROAD<br/>VILLA HILLS, KY 41017</b>                   |  |
| (X4) ID PREFIX TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE                                     |
| F 225  | Continued From page 9<br>abuse training three (3) times since 07/11. He further stated that through the investigation the facility had identified the allegations of abuse against CNA #15 were not reported immediately to Administration and Administration was not aware of the incidents until 10/13/11. He stated CNA #15 was suspended on 10/14/11 after Administration became aware of the allegations. This was verified by the time clock reading. He further stated another abuse inservice was provided since this investigation related to this deficient practice. | F 225   |   |  |