

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

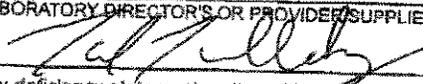
PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

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 09/07/2012
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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 000	INITIAL COMMENTS	F 000		
F 164 SS=D	<p>An Abbreviated Survey Investigating KY#00019005 was initiated on 09/06/12 and concluded on 09/07/12. KY#00019005 was unsubstantiated; however, deficient practice was identified. A deficiency was cited with the highest scope and severity of a "D".</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>	F 164	<p>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.</p> <p>The facility is completing the plan of correction because it is required by state and federal law.</p> <p>The facility alleges compliance as of 9/14/2012.</p> <p>F164 Privacy/Confidentiality of Records Resident # 1 has a common name. The photo taken July of 2011 as well as the corresponding face book comments does not reveal the facility name, location or that the common name used was the same name as a resident that happens to be a reside in this facility.</p> <p>No personal or clinical information was shared in any of the comments.</p> <p>The ADON that was mentioned in the complaint as being aware of this matter was not even employed at the time this photo was taken. Resident # 1 with the common name as the name in the face book posting remains in the facility and personal and clinical information remain protected.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 9-27-12
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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 30 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 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's Employee Handbook, it was determined the facility failed to ensure the personal privacy of residents for one (1) of three (3) sampled residents (Resident #1). On 07/19/11, Resident #1 was identified on the website facebook by facility employees; therefore, the facility violated Resident #1's right to privacy.</p> <p>The findings include:</p> <p>A Review of the facility's Employee Handbook, revised 01/01/11, revealed "personal phones are not allowed to be on or used while employees are working. . . except at lunch or break and in approved areas". Further review of the Employee Handbook revealed residents have the right to personal privacy, and "information about the resident's care, treatment and condition is kept confidential."</p> <p>Record review revealed the facility admitted Resident #1 on 10/02/08 with diagnoses which included Alzheimer's Disease, Hypertension, and Depression. Resident #1 was not capable of accurately responding to interview questions.</p> <p>Interview conducted on 09/06/12 at 10:15 AM with Certified Nursing Assistant (CNA) #1 revealed on 07/19/11, during third shift, CNA #1 was trying to "lighten the mood." She reported several organizational and environmental changes were taking place in the facility, and stress levels were high. CNA #1 stated she picked a fictitious name for herself and that</p>	F 164	<p>Facility staff were re-educated on the facilities social media policy. This policy is also covered in orientation of all new staff. (See attachment 1 copy of facility policy)</p> <p>The QA committee reviews all alleged violations of Resident Rights and Privacy violations in a timely manner.</p>	9-14-12

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F 164	<p>Continued From page 2</p> <p>another staff member, whom she could not recall, took a photo of her on their phone and she (CNA #1) posted it to facebook. CNA #1 stated she was wearing a gown over her clothing and ambulating with a walker and a stooped posture in the photo. CNA #1 stated the walker was facility property, as was the gown as it was an unclaimed donation. Further interview with CNA #1 at that time revealed, of the names mentioned by others on her facebook page, only the name of Resident #1 was an actual resident name.</p> <p>Review of a printout of CNA #1's facebook page, dated 07/19/11, revealed the name of Resident #1 was mentioned by a former employee which could not be reached during the course of the investigation. Further review revealed no negative comments were made regarding Resident #1, nor were any attributes alluded to.</p> <p>interview with the Assistant Director of Nursing (ADON), on 09/06/12 at 11:40 AM, revealed she was not aware of the facebook page until August 2012, when she received information from the Kentucky Board of Nursing. The ADON acknowledged Resident #1 was a resident of the facility at the time of the incident, and was currently a resident of the facility. The ADON further revealed staff was not allowed to use phones in the facility during work hours.</p>	F 164		