STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185241	A. BUILDING _____ B. WING _____	R-C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA MANOR	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 000}	INITIAL COMMENTS A Revisit Survey was initiated on 02/25/2025 and concluded on 02/27/2025. It was determined the facility had corrected the deficiencies on 02/01/2025 as alleged by implementing the acceptable Plan of Correction received via ePOC on 02/05/2025.	{F 000}		

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

Electronically Signed

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185241	A. BUILDING _____ B. WING _____	C 02/27/2025

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F 000	INITIAL COMMENTS	F 000		

An Abbreviated Survey was concluded on 02/27/2025. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.

Deficiencies were issued related to KY00044811 at F604 and F607.
No deficiencies were issued related to KY00044985 and KY00044510.

The facility provided an acceptable Plan of Correction (POC) on 01/31/2025 alleging past noncompliance. The State Survey Agency (SSA) team validated the deficient practice was corrected on 02/01/2025, following the facility's implementation of the acceptable POC and before the start of the survey.

Survey Dates: 02/25/2025 to 02/27/2025
Survey Census: 47
Sample Size: 5
Supplemental Residents: 42

F 604 SS=D — Right to be Free from Physical Restraints — CFR(s): 483.10(e)(1), 483.12(a)(2) — F 604

§483.10(e) Respect and Dignity.
The resident has a right to be treated with respect and dignity, including:

§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).

§483.12
The resident has the right to be free from abuse,

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

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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 604	Continued From page 1 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies, the facility failed to ensure each resident had the right to be free from restraint for 1 of 5 sampled residents, Resident (R) 15. On 01/13/2025 at approximately 2:00 PM, a Dining Aide (DA) 1 tied a washcloth around one wheel of R15's wheelchair. Activity Assistant 2 saw R15 on the floor around 3:00 PM. At that time, Activity Assistant 2 notified State Trained Nurse Aide/Kentucky Medical Aide (STNA/KMA) 14 who was in the hall and STNA15. The facility provided an acceptable Plan of Correction (POC) on 01/31/2025 alleging past noncompliance. The State Survey Agency (SSA) survey team validated the deficient practice was corrected on 02/01/2025, following the facility's	F 604	Past noncompliance: no plan of correction required.	

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F 604	Continued From page 2	F 604		

implementation of the acceptable POC and before the start of the survey.

The findings include:

Review of the facility's policy titled, "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation," effective 10/24/2022 and reviewed 02/26/2025, revealed staff was to immediately report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property, immediately to the Administrator of the facility. It also stated the Administrator would then report to the appropriate agencies in accordance with current state and federal regulations within prescribed timeframes.

Review of the facility's policy titled, "Resident Rights," effective 10/24/2022 and reviewed 02/11/2025, revealed residents had a right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. Per the policy, the resident had a right to be treated with respect and dignity, including: the right to be free from physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

Review of R15's "Face Sheet" revealed the facility admitted the resident on 03/17/2022 with diagnoses of dementia, cognitive communication deficit, and disorientation.

Review of R15's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 12/24/2024, revealed the facility

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F 604	Continued From page 3	F 604		

assessed the resident to have a "Brief Interview for Mental Status (BIMS)" score of eight of 15, indicating she had moderate cognitive impairment. This assessment also revealed R15 was ambulatory and self-propelling for mobility when she used a manual wheelchair.

Review of R15's "Comprehensive Care Plan (CCP)," created on 03/21/2022, revealed R15 was at risk for falls related to impaired mobility, risk for pain, hospice admission, weakness, diagnosis, and being totally dependent on physical assist of one to two staff members with performing activities of daily living (ADL).

Review of the facility's "Falls List," dated 11/01/2024 to 01/26/2025, revealed R15 had two falls, one on 01/10/2025 and one on 01/13/2025. Per the list, R15 had no injuries from either fall.

Review of DA1's employment file revealed his hire date was 08/21/2024. Further review revealed his abuse/criminal abuse check was completed on 08/07/2024, and the results showed there were no prior abuse or criminal convictions.

Review of the facility's "Investigation Report," dated 01/13/2025, revealed DA1 admitted in a written statement he tied a washcloth on the wheel of R15's wheelchair to keep an eye on her due her wandering around Household A. Further review revealed STNA13 witnessed DA1 place the washcloth on the wheel of R15's wheelchair and failed to report the incident.

In an interview with STNA13 on 02/27/2025 at 3:51 PM, she stated the incident happened after lunchtime, and she witnessed DA1 tie a

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F 604	Continued From page 4	F 604		

washcloth to one of the wheels of R15's wheelchair. STNA13 stated she was unsure if the tying of the washcloth to the resident's wheelchair was a restraint. STNA13 stated she did not report it to anyone at the facility.

In an interview with the Administrator on 02/27/2025 at 9:52 AM, she stated she was informed of the incident regarding DA1 tying a washcloth to the wheel of R15's wheelchair after R15 was found lying on the ground. The Administrator stated she immediately opened an investigation on how R15 fell, as she would on any fall that took place in the facility. The Administrator stated R15 had a habit and was care planned for getting out of her wheelchair and lying on the floor with a blanket over her head. The Administrator stated she had Nurse 8 and the Scheduler/Former STNA16 help assess R15 and get her back into her wheelchair. The Administrator stated Nurse 8 assessed R15 to have no physical wounds, abrasions, or bleeding, and R15 responded appropriately to the questions being asked. The Administrator stated Nurse 8 found the washcloth tied to the to the wheel of the wheelchair. The Administrator stated tying a washcloth to a wheel or any resident to keep them from moving freely inside the facility was a form of physically restraining a resident and was not a standard for quality care.

The facility provided an acceptable Plan of Correction on 01/31/2025 alleging past non-compliance of the deficient practice and a date of compliance of 02/01/2025 with corrective actions as follows verbatim:

1. Corrective actions for identified resident(s) affected by the deficient practice.

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F 604	Continued From page 5 Review of document titled, "Restraints" used educate staff on Physical and Chemical Restraints. Review of document titled; "Alzheimer's Association" used to educate staff on Wandering. Review of the facility's, "CHI Skin One Time Observation," dated for 01/13/2025 revealed R15 had no abnormalities and her skin was intact. Review of the disciplinary action/termination of the Dining Aid1 revealed his was terminated on 01/13/2025. Review of the disciplinary action/termination of the STNA13 revealed she was terminated on 01/15/2025. Review of the facility staff training log dated 01/14/2025 revealed every employee within the facility signed stating they received training on Resident Abuse, Reporting and Restraints.	F 604		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at	F 607		

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F 607	Continued From page 6 paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, the facility failed to implement the abuse policy for 1 of 5 sampled residents, Resident (R) 15. A Dining Aide (DA) 1 tied a washcloth around one wheel of R15's wheelchair around 2:00 PM on 01/13/2025. State Trained Nurse Aide (STNA) 13 witnessed DA1 tie the washcloth to the wheel of R15's wheelchair, but failed to report the incident, and R15 fell from her wheelchair. The facility provided an acceptable Plan of Correction (POC) on 01/31/2025 alleging past noncompliance. The State Survey Agency (SSA) survey team validated the deficient practice was corrected on 02/01/2025, following the facility's implementation of the acceptable POC and before the start of the survey.	F 607	Past noncompliance: no plan of correction required.	

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F 607	Continued From page 7	F 607		

The findings include:

Review of the facility's Abuse policy titled, "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation," effective 10/24/2022, revealed the facility reported all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property. Per the policy, staff was to immediately report any of those incidents to the Administrator of the facility, and the Administrator would report to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes.

Review of R15's "Face Sheet" revealed the facility admitted the resident on 03/17/2022 with diagnoses of dementia, cognitive communication deficit, and disorientation.

Review of R15's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 12/24/2024, revealed the facility assessed the resident to have a "Brief Interview for Mental Status (BIMS)" score of eight of 15, indicating she was moderately cognitively impaired. This assessment also revealed R15 was ambulatory, self-propelling for mobility, and used a manual wheelchair.

Review of R15's "Comprehensive Care Plan (CCP)," created on 03/21/2022, revealed R15 was at risk for falls related to impaired mobility, risk for pain, hospice admission, weakness, diagnosis, and being totally dependent on physical assist of one to two staff members with performing activities of daily living (ADL).

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F 607	Continued From page 8	F 607		

Review of the facility's "Investigation Report," dated 01/13/2025, revealed DA1 admitted in a written statement he tied a washcloth on the wheel of R15's wheelchair to keep an eye on her due her wandering around Household A. The report also revealed STNA13 witnessed the DA1 place the washcloth on the wheel of R15's wheelchair and failed to report the incident.

In an interview with Nurse 8 on 02/27/2025 at 11:13 AM, she stated she was called to Household A to assess R15 who was lying on the floor. R15 was located on the floor underneath a table with her head propped up with a pillow. Nurse 8 stated R15 had no physical wounds, abrasions, or bleeding. Nurse 8 stated R15 answered all her questions that she had asked. Nurse 8 stated she and Kentucky Medication Aide 14 looked down and saw what appeared to be a washcloth tied to the wheel of the wheelchair making the wheelchair stationary and unable to be moved.

During an interview with STNA13 on 02/27/2025 at 3:51 PM, she stated the incident happened after lunchtime, and she witnessed DA1 tie a washcloth to the wheel of R15's wheelchair. STNA13 stated she was unsure if tying the washcloth to the resident's wheelchair was a restraint. STNA13 stated she did not report it to anyone at the facility where she was employed. STNA13 stated after R15 fell from her wheelchair she left the building.

Review of the facility's documented phone call to STNA13 from Human Resources (HR) on 01/15/2025 at 4:55 PM, she stated she was aware DA1 placed a restraint on the wheelchair

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F 607	Continued From page 9	F 607		

of R15. Per the document, STNA13 was asked by HR what she should have done based on the information she received from the restraint and abuse training and test which was done the prior Tuesday and Wednesday. The document revealed STNA13 stated she should have removed the restraint and reported it.

During an interview with the Administrator on 02/27/2025 at 9:52 AM, she stated she was informed of the incident regarding DA1 tying a washcloth to the wheel of R15's wheelchair after R15 was found lying on the ground. The Administrator stated she immediately opened an investigation on how R15 fell as she would on any fall that took place in the facility. The Administrator Stated Nurse 8 found the washcloth tied to the to the wheel of R15's wheelchair. The Administrator stated tying a washcloth to a wheel or any resident to keep them from moving freely inside the facility was a form of physically restraining a resident and was not a standard for quality care. The Administrator stated the facility provided in-services and Relias (online) training on physical and chemical restraints and Abuse and Reporting for all employees. The Administrator stated STNA13 should have reported DA1 immediately to her Unit Nurse if she was unsure or had any question of the DA1 tying the washcloth to the wheel of R15's wheelchair. The Administrator stated STNA13 failing to report the incident conflicted with the facility's policy on reporting abuse. The Administrator stated any allegations of abuse should be reported immediately.

The facility provided an acceptable Plan of Correction on 01/31/2025 alleging past non-compliance of the deficient practice and a

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F 607	Continued From page 10 date of compliance of 02/01/2025 with corrective actions as follows verbatim: 1. Corrective actions for identified resident(s) affected by the deficient practice. Review of document titled, "Restraints" used educate staff on Physical and Chemical Restraints. Review of document titled; "Alzheimer's Association" used to educate staff on Wandering. Review of the facility's, "CHI Skin One Time Observation," dated for 01/13/2025 revealed R15 had no abnormalities and her skin was intact. Review of the disciplinary action/termination of the STNA13 revealed she was terminated on 01/15/2025. Review of the facility staff training log dated 01/14/2025 revealed every employee within the facility signed stating they received training on Resident Abuse, Reporting and Restraints.	F 607		