STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185241	A. BUILDING 02 - MAIN BUILDING 2... B. WING	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Manor	2344 Amsterdam Road , Villa Hills, Kentucky, 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
K0000 Bldg. 02	INITIAL COMMENTS Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 04/02/2026, it was determined the facility had achieved substantial compliance with Life Safety Code on 03/27/2026.	K0000		03/27/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Manor	**2344 Amsterdam Road , Villa Hills, Kentucky, 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
F0000	INITIAL COMMENTS Based upon the off-site Revisit Survey and implementation of the acceptable Plan of Correction, the facility corrected the deficiencies on 01/19/2026, as alleged.	F0000		01/19/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING 2... B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Manor	2344 Amsterdam Road , Villa Hills, Kentucky, 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
K0000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 2010 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: One (1) story (2010), Type V (111), protected combustible construction with four (4) smoke compartments and a complete automatic wet and dry sprinkler system. A Life Safety Code On-site Revisit Survey was conducted on 02/26/2026, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities. During this Revisit Survey, Madonna Manor was found to be in continued noncompliance with the Requirements for Participation in Medicare and Medicaid. The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:	K0000		03/27/2026
K0363 SS = D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.	K0363	No resident was harmed by this practice. All residents have the potential to be affected by this practice. The door on room 155 was fixed and no longer needs use of prop to remain open. The extension cord was removed from room 155 and the family was contacted by the director of social services to educate on the concern and safety hazard. Letters were sent to families two times since the resurvey, informing them of the safety hazard related to propping doors and extension cords. Letters are dated February 26, 2026 and March 9, 2026. On February 26, 2026, staff immediately removed door props and extension cords from resident rooms. Daily	03/27/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING 2... B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

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K0363 SS = D	Continued from page 1 Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain doors protecting corridors in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) corridor door, staff, and two (2) residents. The facility had the capacity for 60 beds with a census of 52 on the day of the survey. The findings include: Observation, during the building inspection tour on 02/26/2026 at 11:52 AM, revealed the corridor door to Resident Room 155 was being held open by a door wedge. Interview, on 02/26/2026 at 11:53 AM with the Director of Nursing, revealed the facility was not aware of the door being manually held open. The finding was verified by the Director of Nursing at the time of observation and at the exit conference on 02/26/2026. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.3.6.3* Corridor Doors.19.3.6.3.1 * Doors, including doors or panels to nurse servers and pass-through openings, protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist	K0363	Continued from page 1 monitoring has been completed by administrative staff including director of facilities, director of nursing, director of social services, director of dietary and nurse managers. A checklist has been created specifically for extension cords and door props to be completed 5 times per week for 2 weeks, 3 times per week for 2 weeks and then weekly for 3 months starting March 23, 2026 to maintain compliance. The checklist will be completed by Director of Facilities or his maintenance/housekeeping staff. Administrative Staff and Directors all met on February 27th to review CMS Safety standards related to door props and extension cords. The plan was put in place for these staff to immediately begin monitoring rooms. All issues found during monitoring were resolved immediately with help and maintenance staff and documented TELS. All staff are being educated on an ongoing basis related to health safety of the building to assist in monitoring specific to electric cords and door props to be completed by March 27, 2026.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING 2... B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

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Madonna Manor	2344 Amsterdam Road , Villa Hills, Kentucky, 41017

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K0363 SS = D	Continued from page 2 the passage of smoke and shall be constructed of materials such as the following:1. 13/ 4 in. thick, solid-bonded wood core2. Material that resists fire for a minimum of 20 minutes.19.3.6.3.5 * Doors shall be provided with a means for keeping the door closed, and the following requirements also shall apply:1. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door.2. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7.	K0363		
K0920 SS = D Bldg. 02	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain extension cords in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) room, staff, and two (2) residents. The facility had the capacity for 60 beds with a census of 52 on the day of the survey. The findings include: Observation, during the building inspection tour on 02/26/2026 at 11:50 AM, revealed an ungrounded	K0920	No resident was harmed by this practice. All residents have the potential to be affected by this practice. The door on room 155 was fixed and no longer needs use of prop to remain open. The extension cord was removed from room 155 and the family was contacted by the director of social services to educate on the concern and safety hazard. Letters were sent to families two times since the resurvey, informing them of the safety hazard related to propping doors and extension cords. Letters are dated February 26, 2026 and March 9, 2026. On February 26, 2026, staff immediately removed door props and extension cords from resident rooms. Daily monitoring has been completed by administrative staff including director of facilities, director of nursing, director of social services, director of dietary and nurse managers. A checklist has been created specifically for extension cords and door props to be completed 5 times per week for 2 weeks, 3 times per week for 2 weeks and then weekly for 3 months starting March 23, 2026 to maintain compliance. The checklist will be completed by Director of Facilities or his maintenance/housekeeping staff. Administrative Staff and Directors all met on February 27th to review CMS Safety standards related to door props and extension cords. The plan was put in place for these staff to immediately begin monitoring rooms. All issues found during monitoring were resolved immediately with help and maintenance staff and documented TELS. All staff are being educated on an ongoing basis	03/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING 2... B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

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K0920 SS = D Bldg. 02	Continued from page 3 extension cord being used, as a substitute for the fixed wiring of a structure, for personal electronics inside the patient care vicinity in Resident Room 155. Interview, on 02/26/2026 at 11:51 AM with the Director of Nursing, revealed the facility had removed the extension cord from the room and was not aware of the extension cord being used again. The finding was verified by the Director of Nursing at the time of observation and at the exit conference on 02/26/2026. Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012) 10.2.4 Adapters and Extension Cords. 10.2.4.1 Three-prong to two-prong adapters shall not be permitted. 10.2.4.2 Adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. 10.2.4.2.1 All adapters shall be listed for the purpose. 10.2.4.2.2 Attachment plugs and fittings shall be listed for the purpose. 10.2.4.2.3 The cabling shall comply with 10.2.3 10.2.3.2 Grounding Conductor. 10.2.3.2.1 Each electric appliance shall be provided with a grounding conductor in its power cord. Actual NFPA Standard: NFPA 70 National Electrical Code, (2011) 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings 4) Where attached to building surfaces	K0920	Continued from page 3 related to health safety of the building to assist in monitoring specific to electric cords and door props to be completed by March 27, 2026.	

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K0920 SS = D Bldg. 02	Continued from page 4 Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage	K0920		

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F0000	INITIAL COMMENTS A Recertification and Abbreviated Survey was concluded on 12/05/2025. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. No deficiencies were issued related to 2677990 and 2641294. Survey Dates: 09/30/2025 to 10/01/2025, with exit due to government shutdown. Resumption of survey: 12/03/2025 to 12/05/2025. Survey Census: 53 Sample Size: 16 Supplemental Residents: 6	F0000		01/19/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food	F0812	Immediate Corrective Action. Director of Dietary and Chef completed cleaning of dry storage including cleaned walls, shelves, and floor; reorganized shelves, checked all dates and dated any items without dates. Completed 12/10/2025 Confirmed all sanitizer rags observed to be in red sanitation buckets on 12/17/2025 by the Director of Dietary Services. Completed 12/17/2025. Director of Dietary attached trash can lids to each dietary trash can in the main kitchen on 12/04/2025. Completed 12/04/2025. No residents were harmed by this practice. Identification of other residents having the potential to be affected was accomplished by: All residents have the potential to be affected. The immediate interventions resolved the concerns noted.	01/19/2026

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F0812 SS = F	Continued from page 1 service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of the facility's policies, the facility failed to store and prepare foods under sanitary conditions. Observations on 09/30/2025, 10/01/2025, and 12/03/2025 included cleaning cloths lying on the counter and not in the sanitizer bucket, trash cans without lids in the food production area, and foods in the dry storage area not labeled, dated, and expired. This deficient practice had the potential to affect all 53 current residents. The findings include: Review of the facility's policy titled, "Food Safety Guidelines," not dated, revealed cross-contamination could be biological, chemical, and physical. Review of the facility's policy titled, "Food Preparation," not dated, revealed wiping cloth buckets should be assigned an area, stored off the floor and away from food and food contact surfaces. Per the policy, wiping cloths shall be stored in sanitizer solution off the floor and away from food and food contact surfaces, and wiping cloths shall be stored in sanitizer solution when not in-use. The policy stated food products shall be labeled and must include the following: date opened or created date to be consumed or discarded, with a maximum of seven days. Review of the facility's policy titled, "Wiping Cloths," not dated, revealed wet wiping cloths shall be stored in an approved sanitizing solution. Per the policy, wiping cloths shall be changed frequently to prevent cross-contamination. Observation during the initial Kitchen tour on 09/30/2025 at 10:40 AM revealed, upon entering the kitchen, there were two cleaning cloths not in the sanitizer buckets and lying on the food production counters. The large gray trash can was open in the food production area. The dry storage area had several foods not labeled and dated. There was a one-half bag of opened marshmallows with no date; three bags of dry cereal with one which had been opened and taped closed; all dry cereal packages had no date or label; four gelatin mixes had no date; walnuts in clear packaging was taped closed without date or label; one clear package of vanilla wafers on the shelf had no date or label, and the side of the vanilla wafer package had a round hole and was opened; a variety of gravy mixes had no date; and 12 packages wrapped closed with powdered	F0812	Continued from page 1 Completed 12/17/2025. Actions taken/systems put into place to reduce the risk of future occurrence include: Education provided by the Director of Dietary to dining services staff related to use and importance of trash can lids in the production area to prevent cross contamination. Completed 12/17/2025. Education provided by the Director of Dietary to dining services staff related to rags to be stored in a red sanitation bucket on the lower shelf and the bucket should be refreshed before each meal. Completed 12/17/2025. Education provided by the Director of Dietary to dining services staff related to stock rotation, labeling and dating, proper wrapping of open containers. Completed 12/17/2025. Any staff member unable to be present for education will have education before their next scheduled shift and this education will be completed by the director of dietary or chef. The Director of Dietary and/or Chef will administer quizzes to all dietary staff. The Director of Dietary and/or Chef will follow up with staff members if a question was answered incorrectly and education provided immediately. Completed 01/02/2026 or by their next scheduled shift. Actions to monitor the solution is sustained: The Director of Dietary Services will monitor trash can lid use, sanitizer bucket compliance, and stock dating, labeling and rotation using a "dining observation sheet 12/2025." This will be completed starting the week of 12/29/2025 daily for 2 weeks, 3 times a week for 2 weeks, and weekly for 3 months. All observations will be reported in monthly QAPI for 4 months or until substantial compliance is achieved. New hires will receive education on trash can lid use,	

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F0812 SS = F	Continued from page 2 sugar had no label or date. Additional observation of the kitchen on 10/01/2025 at 8:30 AM revealed numerous food items in dry storage not labeled or dated on the shelves. The vanilla wafers bag was still on the shelf within view and continued to have a visible hole in the package. A vanilla wafer had fallen out of the package onto the shelf. Further observation revealed a cleaning cloth on the counter and not in the sanitizer bucket. Further observation revealed two open large trash cans in the food production area of the kitchen, and one of them was near the stand mixer while it was in food production. Additional observation of the kitchen dry storage on 12/03/2025 at 10:10 AM revealed several food items taken out of their box and lying on the shelf without a date. Also observed was a cornmeal package with a use-by-date of 04/22/2023; one opened assorted pasta in a clear package with no date; five assorted pasta in a clear package with no date; one pasta of colored rotini was opened and undated; 12 cornstarch packages had no dates; several gravy mix packages on the shelf with no date; eight powdered sugar packages with no date; two large chip bags on the top shelf with no date; and four yellow cake mixes out of the box with no date. In an interview with the Dietary Manager on 12/03/2025 at 10:59 AM, he stated dry storage food products needed to be dated if taken out of the box. He stated the food was stocked and rotated by Dietary staff. He stated the cleaning cloth was kept in the sanitizer bucket when not in use, and the sanitizer bucket was changed every four hours or with the appearance of a soiled solution. He stated the open trash receptacle could not be kept beside the stand mixer because it could cause cross contamination. In an interview with the Director of Nursing (DON) on 12/04/2025 at 10:08 AM, she stated staff should follow all the food service policies: trash receptacles should have lids, proper labeling and dating of food should occur; and cleaning cloths should be kept in the sanitizing solution when not in use. She stated the food in dry storage should be rotated correctly. In an interview with the Administrator on 12/05/2025 at 8:52 AM, she stated she expected staff to follow all state and federal sanitation regulations.	F0812	Continued from page 2 sanitizer bucket compliance, and stock dating, labeling and rotation in orientation by the staff development nurse, dietary technician, chef or director of dietary. Starting 12/29/2025. A QAPI with the Medical Director, Director of Social Services, DON, and Executive Director, Director of Dietary, Staff Development Nurse, Director of Therapy was completed on 12/23/2025 to review the finalized QAPI plan created on 12/19/2025. Medical Director agreeable to QAPI plan. The Director of Dietary will report results of the “dining observation sheet 12/2025,” follow up and trends to the QAPI committee on 01/02/2026 and will continue to report data to QAPI monthly for 4 months or until we are in substantial compliance. QAPI meetings have taken place on 12/12/2025, 12/19/2025, 12/23/2025, and 12/26/2025. Plan of Correction completion date: __01/19/2026_____.	
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880	Immediate Corrective Action. The Director of Nursing and Nurse Managers confirmed	01/19/2026

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F0880 SS = D	Continued from page 3 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with	F0880	Continued from page 3 all signage outside of the residents room accurate of isolation precautions needed. Completed 12/12/2025. The Director of Nursing ordered a mobile vital signs machine on 12/5/2025 to allow for easier cleaning and mobility for household B. The machine arrived and assembled 12/12/2025. Completed 12/12/2025. Identification of other residents having the potential to be affected was accomplished by: No residents were harmed by this practice. All residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: Director of Nursing and/or Nurse Managers completed education to nursing staff regarding isolation precautions, appropriate PPE, and cleaning equipment between use. Completed 01/07/2026. Any staff member unable to be present for education will have education before their next scheduled shift and this education will be completed by the Director of Nursing or nurse managers. The Director of Nursing and/or nurse managers will administer quizzes to all clinical staff on households. The Director of Nursing and/or nurse managers will follow up with staff members if a question was answered incorrectly and education provided immediately. Completed 01/07/2026 or by their next scheduled shift. Actions to monitor the solution is sustained: Director of Nursing and/or nurse managers will monitor PPE use, isolation precautions, equipment use and handwashing using the “Rounding Tool POC 12/2025” This will be completed starting week of 12/29/2025 5x per week for 2 weeks, 3 times per week for 2 weeks, and weekly for 3 months. All observations will be reported in monthly QAPI for 4 months or until substantial	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Manor	**2344 Amsterdam Road , Villa Hills, Kentucky, 41017**

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F0880 SS = D	Continued from page 4 residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, review of a disinfectant label, and review of the facility's policies, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases by ensuring staff involved in direct resident contact followed hand hygiene procedures and wore required personal protective equipment (PPE) for 1 of 16 sampled residents, Resident (R) 20. In addition, the facility failed to ensure a barrier was used to protect an enhanced barrier precautions (EBP) supply cart from a blood pressure cuff that had not been sanitized. The findings include: Review of the facility's policy titled, "Infection Prevention and Control Program," dated 08/30/2022, last revised date 10/07/2025, revealed the program was designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections and that all staff were responsible for following all policies and procedures related to the program. Per the policy, Transmission-based precautions were placed on residents based on current Centers for Disease Control and Prevention (CDC) guidelines for infection or communicable disease. The policy stated all reusable	F0880	Continued from page 4 compliance is achieved. New hires will receive education on PPE use, isolation precautions, equipment use and handwashing in orientation by the director of nursing or nurse managers. Starting 12/29/2025. A QAPI with the Medical Director, Director of Social Services, DON, and Executive Director, Director of Dietary, Staff Development Nurse, Director of Therapy was completed on 12/23/2025 to review the finalized QAPI plan created on 12/19/2025. Medical Director agreeable to QAPI plan. The Director of Nursing or Nurse Managers will report results of "Rounding Tool POC 12/2025," follow up and trends to QAPI committee on 01/02/2026 and will continue to report data to QAPI monthly for 4 months or until we are in substantial compliance. QAPI meetings have taken place on 12/12/2025, 12/19/2025, 12/23/2025, and 12/26/2025. Plan of Correction completion date: __01/19/2026_____.	

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F0880 SS = D	Continued from page 5 items that had potential for contamination with infectious materials should be placed in an impervious clear plastic bag, labeled “contaminated,” and placed in the soiled utility room for pickup and processing. Review of the facility’s policy titled, “Hand Hygiene,” dated 05/10/2023, last revised 09/16/2025, revealed all staff working in all locations within the facility would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Further review revealed hand hygiene was required after handling contaminated objects, before and after providing care to residents in isolation, and after handling items potentially contaminated with blood, body fluids, secretions, or excretions. Review of the facility’s policy titled, “Infection Surveillance,” dated 08/30/2022, last revised date 05/22/2025, revealed the purpose was to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent spread of infection. The policy stated surveillance activities were to be monitored facility-wide using a combination of processes and outcome measures through data collection, identification of ineffective practices through observation of staff, rounding observation data, skills validation for hand hygiene, PPE, and communication to staff information related to infection rates and outcomes. Review of the facility’s policy titled, “Personal Protective Equipment [PPE],” dated 03/02/2023, revealed the guidelines and compliance included all staff having contact with residents and/or their environment, and they must wear PPE appropriate for care activities and any time that exposure to body fluids was likely. Per the policy, indications/considerations included performing hand hygiene before donning (to put on) and after doffing (to take off) PPE. It stated staff would receive training on why, what, and how PPE was used upon hire, annually, when any new product was introduced, and as needed. Review of the facility’s policy titled, “Transmission-Based (Isolation) Precautions [TBP],” dated 08/30/2022, revealed “Contact Precautions” were defined as measures intended to prevent transmission of infectious agents spread by indirect contact with the resident or the resident’s environment, and the category determined the type of PPE to be used. The policy stated signage that included instructions for use of specific PPE, would be placed in a conspicuous location outside the resident’s room, PPE would be	F0880		

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F0880 SS = D	Continued from page 6 readily available near the entrance of the room, and staff would don appropriate PPE before or upon entry in the room. Review of an attachment titled, “Recommendations for Personal Protective Equipment (PPE),” revealed for contact isolation gloves should be donned upon entry to the room whenever touching the resident’s skin or surfaces and articles in close proximity to the resident was anticipated. It also stated gowns should be donned upon entry to the room whenever staff members anticipated their clothing would have direct contact with a resident or potentially contaminated environmental surfaces or equipment in close proximity. Review of the label for Micro-Kill One (a fast-acting disinfectant bleach wipe with a one-minute kill time for most pathogens, including Tuberculosis (TB), Norovirus, and other bacteria/viruses) revealed surfaces must stay visibly wet for that duration to effectively clean and disinfect hard, nonporous surfaces like medical equipment and countertops. Review of R20’s “Admission Record” revealed the facility admitted the resident on 03/04/2024 with relevant diagnoses of cognitive communication disorder, chronic kidney disease, and acute kidney failure. Review of R20’s quarterly “Minimum Data Set [MDS],” with an Assessment Reference Date (ARD)” of 09/08/2025, revealed a “Brief Interview for Mental Status [BIMS]” score of 12 out of 15, indicative of moderate cognitive impairment. The bladder and bowel assessment revealed occasional incontinence of bladder and always incontinent of bowel. The functional abilities assessment revealed a functional limitation in range of motion on both sides of lower extremities, requiring partial/moderate assistance with toileting hygiene, shower/bathing. Review of R20’s “Order Entry,” dated 09/27/2025, revealed an order placed for meropenem, an antibiotic, to be administered intravenously (IV) every eight hours for seven days, to treat Extended-Spectrum Beta-Lactamase-producing bacteria (ESBL), a complex bacterium easily spread, resulting in serious infections. Further review revealed an order placed for “Contact Isolation related to ESBL in urine” was placed on 10/01/2025. 1. Observation on 09/30/2025 at 10:25 AM revealed R20’s room had a sign posted outside the door titled, “Contact Isolation.” Further observation revealed a three-drawer plastic bin outside the room entrance. Continued observation revealed at 10:29 AM the call	F0880		

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F0880 SS = D	Continued from page 7 light for the resident's room activated, and at 10:30 AM, a staff person was observed entering the room, while the door remained open. Continued observation made of the staff person standing by the resident at the bedside revealed the staff member picked up and held a cup without wearing a gown, gloves, or other PPE. At 10:32 AM, the staff member exited the room, carrying the cup. Further observation revealed she walked to the kitchenette area on the unit, opened the partial door, and sat the cup in a plastic bin. Further observation revealed she walked to the medication cart, touched the computer keyboard, and then used a hand sanitizing gel attached to the wall. In an interview with Licensed Practical Nurse (LPN) 1 on 09/30/2025 at 10:49 AM, she stated she had been the staff person observed entering and exiting R20's room, and she had not donned any PPE prior to or while in the room. LPN1 stated she was aware that R20 had orders for "Contact Isolation" due to ESBL in the urine, but he did not realize she had forgotten to don PPE until she was already standing in the room. She stated proper signage was in place, PPE was available outside of the room, and she should have been wearing gloves and a gown before entering the room. She stated it was important to follow the posted TBPs to prevent R20 from being exposed to any germs potentially being carried into the room and to prevent germs being carried to other residents. LPN1 stated she used hand sanitizer gel after placing the cup in the kitchen area, and she did not recall touching any other items before doing so. She stated, in hindsight, since she had not worn gloves, she should have washed her hands with soap and water. She stated she had received annual training on infection prevention and control policies and guidelines, hand washing, and how to don and doff PPE. However, she stated she had been busy and forgot to follow the guidelines. In an interview with the Administrator on 12/05/2025 at 10:10 AM, she stated she expected all staff to follow the required isolation procedures for the assigned contact precautions. She stated signs were placed outside the resident's door, PPE was readily available for staff, the facility provided all needed education and re-education for updates and as reminders. Therefore, she stated there would be no reason for staff not to follow the guidelines. She also stated the posted signage informed staff what PPE was required. 2. Observation on 09/30/2025 at 11:15 AM revealed the red top wipes product, Micro-Kill One, was on the floor next to the enhanced barrier precaution (EBP) box by Room 174. Further observation revealed Registered Nurse	F0880		

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F0880 SS = D	Continued from page 8 (RN) 1 entered Room 170 with gloves on and closed the door to assist the resident, who was not on EBP. He then exited the room without wearing the gloves and picked up the blood pressure (BP) wrist cuff from inside the treatment cart. He brought the BP wrist cuff monitor back out of the room, with his bare hands, and laid it down on the top of the EBP box, without use of a barrier. He used the red top wipe to sanitize the BP wrist cuff, with one hand, and talked on his phone with his other hand. In an interview with RN 1 on 09/30/2025 at 2:52 PM, he stated he used the pink/red top sanitizer wipes to sanitize the BP monitor/wrist cuff. He stated the kill time was about two minutes. He stated a barrier was needed on the top of the EBP box to prevent cross contamination of equipment between residents, and if the equipment was wet while used on the resident, it could cause skin irritation. In an interview with the Director of Nursing (DON) on 12/04/2025 at 10:27 AM, she stated the BP cuff should be cleaned between residents and a barrier put down if setting the BP cuff on top of the EBP box between the EBP box and the BP cuff. In an interview with the Staff Development Coordinator (SDC) on 12/04/2025 at 11:51 AM, she stated she provided the in-person orientation for all new hire employees. She stated it included instruction and return demonstrations of handwashing, donning, and doffing of PPE. In an interview with the Infection Preventionist (IP) on 12/04/2025 at 3:26 PM, she stated all staff received training at new hire orientation provided by the SDC on the different types of TBP, handwashing, and donning and doffing of PPE. In addition to the new hire orientation, she stated annual trainings on Infection Prevention and Control were assigned to staff through web-based training and were mandatory. She stated she performed routine observations of staff on all units for hand hygiene, cough etiquette, and proper donning/doffing of PPE based on TBP type. She stated if observations were made of staff not performing correctly, then direct education was provided at the time of the observation. The IP stated she did audits to confirm correct orders for the required type of TBP were in place. She stated she then followed up with an observation that the correct signage was posted at the room, and PPE was readily available outside of the isolation door. She stated the expectation was for all staff to follow the level of required PPE at all times and in all situations. She stated staff must follow	F0880		

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F0880 SS = D	Continued from page 9 handwashing and hand sanitizing policies and guidelines as written in the facility's policy. She stated per the facility's policy, any staff in contact with a resident in contact isolation was expected to wear a gown and gloves and to wash hands after leaving the room. In an additional interview with the DON on 12/04/2025 at 4:45 PM, she stated all staff received the required training concerning hand washing, proper donning/doffing of PPE, and infection prevention and control. She stated she expected all staff to follow the protocols that were in place for the resident's level of isolation. In an additional interview with the Administrator on 12/05/2025 at 8:58 AM, she stated she expected all staff to follow sanitation and infection control polices.	F0880		

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K0000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 2010 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: One (1) story (2010), Type V (111), protected combustible construction with four (4) smoke compartments and a complete automatic wet and dry sprinkler system. A Life Safety Code Recertification Survey was initiated on 10/01/2025 and concluded on 10/01/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, Madonna Manor was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:	K0000		01/31/2026
K0211 SS = D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined	K0211	No resident was harmed by this practice. The items blocking egress were removed immediately. Staff members were counseled immediately by the Nurse Manager. All residents have the potential to be harmed by this practice. Further education is provided by Executive Director/DON during All Staff Meetings 1/19, 1/21 and 1/23. Nurse Managers/Manager On Duty will monitor all means of egress during their rounds daily. Nurse managers/DON will report to QAPI weekly for 4 weeks and then monthly for 2 months and then quarterly for 3 quarters.	02/16/2026

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 reverse for further 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.

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

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K0211 SS = D	Continued from page 1 the facility failed to maintain the path of egress in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) path of egress, staff, and 10 residents. The facility had the capacity for 60 beds with a census of 54 on the day of the survey. The findings include: Observation, during the building inspection tour on 10/01/2025 at 2:41 PM, revealed a medication cart, a folding table, and a chair stored directly in front of the delayed egress door access in the Household C path of egress. Interview, on 10/01/2025 at 2:42 PM with the Director of Facilities, revealed the facility was not aware the path of egress was blocked, but was aware of a resident who frequently pushes items in front of the door blocking the path of egress. The finding was verified by the Director of Facilities at the time of observation and the Executive Director at the exit conference on 10/01/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.2 Means of Egress Requirements. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. 7.1.10 Means of Egress Reliability. 7.1.10.1* General. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K0211		
K0353 SS = D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K0353	No resident was harmed by this practice. All residents have the potential to be affected by this practice. All maintenance staff were educated by the Director of Facilities on the preventative maintenance program and importance of regular checks on 2/9/2026. The sprinkler was fixed by replacing the ring and placing the cup back on in December 2025. All sprinklers on Household A, Household B, and Household C	02/16/2026

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K0353 SS = D	Continued from page 2 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a complete automatic sprinkler system in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) sprinkler, staff, and three (3) residents. The facility had the capacity for 60 beds with a census of 54 on the day of the survey. The findings include: Observation, during the building inspection tour on 10/01/2025 at 2:05 PM, revealed one (1) sprinkler missing the escutcheon located in the corridor of Household B outside of Room 174. Interview, on 10/01/2025 at 2:06 PM with the Director of Facilities, revealed the facility was not aware the sprinkler was missing the escutcheon. The finding was verified by the Director of Facilities at the time of observation and the Executive Director at the exit conference on 10/01/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7.1 Automatic Sprinklers. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following:	K0353	Continued from page 2 are part of our preventative maintenance program and will be checked weekly by our Director of Facilities/Household Maintenance employee and reported to QAPI monthly for 3 months.	

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K0353 SS = D	Continued from page 3 (1) NFPA 13, Standard for the Installation of Sprinkler Systems NFPA 13 Standard for Installation of Sprinkler Systems, (2010) 6.2.7 Escutcheons and Cover Plates. 6.2.7.1 Plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. 6.2.7.2* Escutcheons used with recessed, flush-type, or concealed sprinklers shall be part of a listed sprinkler assembly.	K0353		
K0363 SS = D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K0363	No resident was harmed by this practice. All residents have the potential to be affected by this practice. The door was fixed immediately during the survey. All maintenance staff were educated by the Director of Facilities on the preventative maintenance program and importance of regular checks on 2/9/2026. All doors will be checked weekly as part of the Preventative Maintenance program by the Director of Facilities/ Household Maintenance employee and reported to QAPI monthly for 3 months.	02/16/2026

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K0363 SS = D	Continued from page 4 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain doors protecting corridors in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) corridor door, staff, and three (3) residents. The facility had the capacity for 60 beds with a census of 54 on the day of the survey. The findings include: Observation, during the building inspection tour on 10/01/2025 at 1:30 PM, revealed the corridor door to the therapy department was equipped with a self-closing device and was being held open by a door wedge. Interview, on 10/01/2025 at 1:31 PM with the Director of Facilities, revealed the facility was not aware of the door being manually held open. The finding was verified by the Director of Facilities at the time of observation and the Executive Director at the exit conference on 10/01/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.3.6.3* Corridor Doors.19.3.6.3.1 * Doors, including doors or panels to nurse servers and pass-through openings, protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following:1. 13/ 4 in. thick, solid-bonded wood core2. Material that resists fire for a minimum of 20 minutes.19.3.6.3.5 * Doors shall be provided with a means for keeping the door closed, and the following requirements also shall apply:1. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door.2. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7.	K0363		
K0916 SS = F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K0916	0916: No resident was harmed by this practice.	01/31/2026

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K0916 SS = F	Continued from page 5 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain a generator annunciator panel in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) of one (1) emergency generator, staff, and all residents. The facility had the capacity for 60 beds with a census of 54 on the day of the survey. The findings include: Observation, during the building inspection tour on 10/01/2025 at 1:37 PM, revealed the remote annunciator panel for the emergency generator that services the facility, located at the Main Nursing Station had no visual warning lights illuminated, or any audible alarms present when tested. Interview, on 10/01/2025 at 1:38 PM with the Director of Facilities, revealed the facility was not aware the annunciator panel was not functioning properly. The finding was verified by the Director of Facilities at the time of observation and the Executive Director at the exit conference on 10/01/2025. Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012) 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the	K0916	Continued from page 5 The alarm annunciator was repaired by Buckeye Power. The alarm will be checked weekly as part of our Preventative Maintenance program by our Director of Facilities/Household Maintenance employee and reported to QAPI monthly for 3 months.	

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K0916 SS = F	Continued from page 6 following: (a) When the emergency or auxiliary power source is operating to supply power to load (b) When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine generator alarm condition shall indicate the following: (a) Low lubricating oil pressure (b) Low water temperature (below that required in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed 6.4.1.1.17.1* A remote, common audible alarm shall be provided as specified in 6.4.1.1.17.4 that is powered by the storage battery and located outside of the EPS service room at a work site observable by personnel. [110:5.6.6] 6.4.1.1.17.2 An alarm-silencing means shall be provided, and the panel shall include repetitive alarm circuitry so that, after the audible alarm has been silenced, it reactivates after the fault condition has been cleared and has to be restored to its normal position to be silenced again. [110:5.6.6.1] 6.4.1.1.17.3 In lieu of the requirement of 5.6.6.1 of NFPA110, a manual alarm-silencing means shall be permitted that silences the audible alarm after the occurrence of the alarm condition, provided such means do not inhibit any subsequent alarms from sounding the audible alarm again without further manual action. [110:5.6.6.2] 6.4.1.1.17.5 A centralized computer system (e.g., building automation system) shall not be permitted to be substituted for the alarm annunciator in 6.4.1.1.17	K0916		

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K0916 SS = F	Continued from page 7 but shall be permitted to be used to supplement the alarm annunciator.	K0916		
K0920 SS = E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain power strips and extension cords in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect five (5) rooms, staff, and six (6) residents. The facility had the capacity for 60 beds with a census of 54 on the day of the survey. The findings include: 1). Observation, during the building inspection tour on 10/01/2025 at 1:25 PM, revealed a refrigerator plugged into a power strip, overloading the rating located in the Dietary Office. Interview, on 09/01/2025 at 1:26 PM with the Director of Facilities, revealed the facility was not aware of the refrigerator being plugged into the power strip. 2). Observation, during the building inspection tour on 10/01/2025 at 1:28 PM, revealed an ungrounded extension cord being used as a substitute for the fixed wiring of a structure plugged into a power strip located in the	K0920	No resident was harmed by this practice. All residents have the potential to be harmed by this practice. The lights in question were removed from the Salon immediately. The Salon stylist was educated re: appropriate lighting and improper use of power strips the same day that the situation was discovered. All improperly plugged items were plugged into the wall outlets without the use of the power strip included in the dietary office, director of nursing office, assistant director of nursing office, and resident room 155 by the Director of Facilities. Office staff educated regarding improper use of power strips and extension cords by the Director of Facilities/Maintenance. Households and offices are checked weekly by our Director of Facilities/Maintenance employee and reported to QAPI monthly for 3 months and then quarterly for 3 quarters.	02/16/2026

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K0920 SS = E	Continued from page 8 Beauty Salon. Interview, on 10/01/2025 at 1:29 PM with the Director of Facilities, revealed the facility was not aware of the extension cord plugged into a power strip. 3). Observation, during the building inspection tour on 10/01/2025 at 1:30 PM, revealed a coffee maker plugged into a power strip, overloading the rating located in the Director of Nursing Office. Interview, on 10/01/2025 at 1:31 PM with the Director of Facilities, revealed the facility was not aware of the coffee maker being plugged into the power strip. 4). Observation, during the building inspection tour on 10/01/2025 at 1:35 PM, revealed a microwave and a refrigerator plugged into a power strip, overloading the rating located in the Assistant Director of Nursing Office. Interview, on 10/01/2025 at 1:36 PM with the Director of Facilities, revealed the facility was not aware of the microwave or refrigerator being plugged into the power strip. 5). Observation, during the building inspection tour on 10/01/2025 at 2:21 PM, revealed a refrigerator plugged into an extension cord, being used as a substitute for the fixed wiring of a structure located in Resident Room 155. Further observation revealed an extension cord being used as a substitute for the fixed wiring of a structure and being used for personal electronics inside the patient care vicinity in Resident Room 155. Interview, on 10/01/2025 at 2:22 PM with the Director of Facilities, revealed the facility was not aware of the extension cords being used. The findings were verified by the Director of Facilities at the time of observations and the Executive Director at the exit conference on 10/01/2025. Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012) 10.2.4 Adapters and Extension Cords. 10.2.4.1 Three-prong to two-prong adapters shall not be permitted. 10.2.4.2 Adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. 10.2.4.2.1 All adapters shall be listed for the purpose. 10.2.4.2.2 Attachment plugs and fittings shall be	K0920		

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K0920 SS = E	Continued from page 9 listed for the purpose. 10.2.4.2.3 The cabling shall comply with 10.2.3 10.2.3.2 Grounding Conductor. 10.2.3.2.1 Each electric appliance shall be provided with a grounding conductor in its power cord. Actual NFPA Standard: NFPA 70 National Electrical Code, (2011) 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings 4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage	K0920		
K0921 SS = F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates	K0921	No resident was harmed by this practice. All residents have the potential to be affected by this practice. Policies and Procedures were reviewed in the QAPI meeting on 2/6/2026 and implemented 2 policies to cover PCREE titled “Electrical Safety” and “Physical Environment: Electrical Equipment” The policies include testing intervals. During QAPI on 2/6/2026 and Maintenance Meeting on 2/9/2026 the policies were reviewed with the QAPI team and maintenance staff were educated. An outside company provides the service on PCREE. The	02/16/2026

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K0921 SS = F	Continued from page 10 compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to establish policies for the Patient Care Related Electrical Equipment (PCREE) in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect all PCREE, staff, and all residents. The facility had the capacity for 60 beds with a census of 54 on the day of the survey. The findings include: Record review, of the PCREE testing documentation on 10/01/2025 at 12:15 PM, revealed PCREE was in use throughout the facility and there were no policies or protocols for the type of test and intervals of testing for PCREE that the facility owned. Interview, on 12/01/2025 at 12:16 PM with the Director of Facilities, revealed the facility was aware of the PCREE requirements and had the documentation of testing and policies for PCREE testing intervals but was unable to provide any documentation supporting this statement during the survey. The finding was verified by the Director of Facilities at the time of record review and by the Executive Director at the exit conference on 10/01/2025. Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012) 3.3.137 Patient-Care-Related Electrical Equipment. Electrical equipment appliance that is intended to be	K0921	Continued from page 10 Director of Facilities arranges for this service and will have all patient care electrical equipment service completed again before 2/15/2026 to be sure all equipment is in compliance and to have accurate documentation in the facility to meet PCREE guidelines. This documentation will be kept in the Director of Facilities office. Continued annual checks and as needed will be maintained in this file. PCREE compliance will be reported monthly for 3 months and then quarterly for four quarters by the Director of Facilities.	

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K0921 SS = F	Continued from page 11 used for diagnostic, therapeutic, or monitoring purposes in a patient care vicinity. 10.5.2.1 Testing Intervals. 10.5.2.1.1 The facility shall establish policies and protocols for the type of test and intervals of testing for patient care-related electrical equipment.	K0921		
K0923 SS = D Bldg. 02	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.	K0923	0923: No resident was harmed by this practice. The cylinder was placed in the holder immediately. Oxygen and No Smoking signs were placed on the door to the O2 storage room. Monitoring will be done weekly by the Director of Facilities as part of the preventative maintenance program. Results will be reported to QAPI for 3 months.	01/31/2026

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K0923 SS = D Bldg. 02	Continued from page 12 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined the facility failed to provide oxygen storage in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) storage room, staff, and four (4) residents. The facility had the capacity for 60 beds with a census of 54 on the day of the survey. The findings include: 1). Observation, during the building inspection tour on 10/01/2025 at 1:45 PM, revealed the Oxygen Storage Room for the facility was not equipped with a sign including the words CAUTION: OXIDIZING GAS(ES) STORED WITHIN. NO SMOKING. Interview, on 10/01/2025 at 1:46 PM with the Director of Facilities, revealed the facility was not aware the required signage was missing from the oxygen storage room door. 2). Observation, during the building inspection tour on 10/01/2025 at 1:47 PM, revealed the Oxygen Storage Room had one (1) freestanding oxygen E tank unsecured on the floor. Interview, on 10/01/2025 at 1:48 PM with the Director of Facilities, revealed the facility was not aware the E tank was unsecured on the floor. The findings were verified by the Director of Facilities at the time of observations and the Executive Director at the exit conference on 10/01/2025. Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012) 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems	K0923		

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K0923 SS = D Bldg. 02	Continued from page 13 (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour 11.3.2. 4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.3.4 Signs. 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following wording as a minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING 11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures: (1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device. (2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them. (3) Cylinders shall be protected from tampering by unauthorized individuals. (4) Cylinders or cylinder valves shall not be repaired, painted, or altered. (5) Safety relief devices in valves or cylinders shall not be tampered with. (6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water. (7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device.	K0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING 2... B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Manor	2344 Amsterdam Road , Villa Hills, Kentucky, 41017

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K0923 SS = D Bldg. 02	Continued from page 14 (8) Sparks and flame shall be kept away from cylinders. (9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them. (10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. (12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts	K0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Manor	**2344 Amsterdam Road , Villa Hills, Kentucky, 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
E0000	Initial Comments 42 CFR 483.73 Type of Structure: One (1) story (2010), Type V (111), protected combustible construction with four (4) smoke compartments and a complete automatic wet and dry sprinkler system. An Emergency Preparedness Recertification Survey was conducted on 10/01/2025, in accordance with 42 Code of Federal Regulations, Subpart 483.73 (a)(3): (emergency preparedness) Requirements for Long Term Care Facilities. During this Recertification Survey, Madonna Manor was found to be in compliance with the Requirements for Participation in Medicare and Medicaid.	E0000		01/31/2026

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 reverse for further 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.

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