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		

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

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 12/05/2025

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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	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	01/19/2026

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.

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F0812 SS = F	Continued from page 1 food 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	F0812	Continued from page 1 immediate interventions resolved the concerns noted. 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	01/19/2026

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F0812 SS = F	Continued from page 2 date; and 12 packages wrapped closed with powdered 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 use, 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_____.	01/19/2026

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F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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	F0880	Immediate Corrective Action. The Director of Nursing and Nurse Managers confirmed 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	01/19/2026

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F0880 SS = D	Continued from page 4 prohibit employees with a communicable disease or infected skin lesions from direct contact with 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	F0880	Continued from page 4 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 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_____.	01/19/2026

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F0880 SS = D	Continued from page 5 Control and Prevention (CDC) guidelines for infection or communicable disease. The policy stated all reusable 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	F0880		01/19/2026

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F0880 SS = D	Continued from page 6 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 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	F0880		01/19/2026

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F0880 SS = D	Continued from page 7 titled, “Contact Isolation.” Further observation revealed a three-drawer plastic bin outside the room entrance. Continued observation revealed at 10:29 AM the call 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.	F0880		01/19/2026

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F0880 SS = D	Continued from page 8 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 (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	F0880		01/19/2026

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 12/05/2025

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

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F0880 SS = D	Continued from page 9 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 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		01/19/2026