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 08/23/2025

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
F0000	INITIAL COMMENTS An Abbreviated and Partial Extended Survey was conducted on 08/19/2025 to 08/23/2025. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Immediate Jeopardy (IJ) was identified on 08/21/2025 and was determined to exist on 08/07/2025 in the area of 42 CFR 482.25. Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care, F689. The facility was notified of IJ on 08/21/2025. On 08/21/2025 at 11:58 AM and 12:03 PM, the Executive Director and Director of Nursing were provided a copy of the CMS IJ Template and notified that review of Resident (R) 1's "Admission Record" revealed the facility admitted R1 on 07/23/2025 with a diagnosis of Alzheimer's disease with late onset. On 07/23/2025, Registered Nurse (RN) 1 assessed R1 to be a "high risk" for wandering and elopement, however, she did not ensure interventions were in place to provide supervision and monitoring of the resident's whereabouts. On 08/07/2025 R1 exited the facility without staff knowledge. R1 was found approximately 84 feet from the facility exit at 11:10 PM by a staff member reporting to work. The facility provided an acceptable plan for removal of the immediate jeopardy on 08/22/2025. The survey team validated the immediate jeopardy was removed on 08/23/2025 before exit following the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice remained at a "D" (an isolated case of no actual harm with potential for more than minimal harm) scope and severity following the removal of the immediate jeopardy. Deficiencies were cited for 2587085 at F689. No deficiencies were cited for 2561927, 696074, 696075, 696076, and 696081. Survey Dates: 08/19/2025 to 08/23/2025 Survey Census: 57 Sample Size: 5	F0000		09/23/2025

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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F0000	Continued from page 1 Supplemental Residents: 0	F0000		09/23/2025
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, review of the website www.weather.gov, and review of the facility's policies, the facility failed to have an effective system in place to ensure each resident received the electronic monitoring devices to prevent unsafe wandering and elopement, for 1 of 18 sampled residents, Resident (R) 1. Review of R1's "Investigation Report" revealed R1 was found by State Tested Nurse Aide (STNA) 2 outside the building, approximately 84 feet from the employee entrance/exit, on 08/07/2025 at 11:10 PM as she was getting out of her car from the back parking lot of Household B. Per the report, STNA2 brought R1, who appeared to be confused and was unstable with ambulation, back into the facility to get warm. During interviews conducted with facility staff who were on duty during the time of the 08/07/2025 elopement, they stated they had last seen the resident at approximately 9:30 PM and were unaware R1 left the building unsupervised until they received notice from Registered Nurse (RN) 1. The facility's failure to have an effective system in place to ensure residents' safety is likely to cause serious injury, impairment, or death, if immediate action is not taken. Immediate Jeopardy (IJ) was identified on 08/21/2025 and was determined to exist on 08/07/2025 in the area of 42 CFR 483.25. Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care, F689. The facility was notified of IJ on 08/21/2025.	F0689	The facility's IJ Removal Plan verbatim: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: 8/13/2025) • The DON, ADON, SOC, and RN Manager re-evaluated all residents for risk of wandering/elopement using "N Adv - Elopement Evaluation" in Point Click Care. Completed 8/13/2025 • All residents were reassessed using the "N Adv - Elopement Evaluation." 18 residents scored at 1+ on the "N Adv - Elopement Evaluation" as possible elopement/wandering risk. Completed 8/13/2025 • The MDS Coordinator and ADON reviewed and updated care plans for the 18 identified elopement/wandering risk individuals as needed. Completed 8/13/2025 • DON/RN Managers completed an audit to confirm all Wanderguards were functioning properly and in place for all residents care-planned for Wanderguards. Completed 8/13/2025 • DON/RN Managers audit that nurses test the function of the wanderguard daily and placement each shift. Audit results are communicated by the DON/RN Manager at QAPI meetings until substantial compliance is achieved. • All staff on all shifts received education on wandering, elopement, and resident safety from the DON, SOC, RN Manager, and ADON. 169 staff received education. 6 staff are on LOA, 47 staff are on vacation or are PRN and have not worked yet. Any staff on leave, PRN or vacation will receive education on their next scheduled work day by RN Manager/DON/ED. Madonna Manor does not use agency staff. Completed 8/13/2025 or by their next scheduled shift. • DON/Nurse Managers/ED administer quizzes to all	09/23/2025

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F0689 SS = SQC-J	Continued from page 2 The facility provided an acceptable Immediate Jeopardy Removal Plan, on 08/22/2025, alleging removal of the IJ on 08/23/2025. The State Survey Agency (SSA) validated the IJ was removed on 08/23/2025, prior to exit. Remaining non-compliance continues at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: Review of the facility's policy titled, "Elopements and Wandering Residents," dated 08/12/2022, revealed the facility must establish and utilize a systematic approach to monitoring and managing residents at risk for elopement and or unsafe wandering, including identification and assessment risk, evaluation and analysis of hazards and risk, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. The policy also stated the IDT (Interdisciplinary Team) would evaluate the unique factors contributing to risk in order to develop a person-centered care plan, including if a resident should wear a Wander Gard bracelet. Review of R1's "Admission Record," located in the resident's electronic medical record (EMR), revealed the facility admitted the Resident on 07/23/2025 with diagnoses which included cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, other sequelae following unspecified cerebrovascular disease, and Alzheimer's disease with late onset. Review of R1's "Comprehensive Care (CCP)," dated 07/25/2025, located in the resident's EMR, revealed the Resident was an elopement risk/wanderer related to impaired safety awareness and wandered aimlessly. The goal stated the resident would not leave the facility unattended. Interventions included: engage resident in purposeful activity and schedule regular walks and appropriate activity. Review of R1's "Elopement Assessment," completed on admission on 07/23/2025, revealed R1 had a history of elopement or an attempted elopement while at home as communicated by her family. Per the assessment, R1, having a history of elopement and R1's wandering behaviors were likely to affect the safety or wellbeing of self/others and was determined to be at "high risk."	F0689	Continued from page 2 staff. DON/Nurse Managers/ED follow up with all staff if a question was answered incorrectly, education was provided immediately. Completed 8/13/2025 or by their next scheduled shift. • DON/RN Managers provided education for all licensed nurses regarding assessment and developing care plans and interventions for residents who are at risk for elopement. • The Director of Facilities tested the Doors, Locks, & Alarms on both 8/7/2025 and 8/13/2025. All functioning properly. Doors, Locks & Alarms will continue to be tested weekly. • An Elopement Drill was conducted on day shift and night shift on 8/22/2025 to assure staff understanding of proper process during an elopement. Madonna Manor took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: 8/13/2025 • "Elopements and Wandering Residents" policy was reviewed by ED, VP of Operations, and SOC. Completed. No changes were made to the policy. 8/8/2025. • "Elopements and Wandering Residents" policy was reviewed again by ED, VP of Clinical, VP of Operations and DON. No changes were made to the policy. Completed 8/11/2025. • The admitting nurse completes an admission "N Adv - Elopement Evaluation" assessment and places interventions as appropriate. Starting on admission after 8/13/2025. • The DON/Nurse Managers will audit all new admissions for elopement risk and ensure appropriate interventions are in place. Starting with admissions after 8/13/2025 until substantial compliance is achieved. • The DON/Nurse Managers will audit all new admission care plans to ensure it reflects individual needs identified. Starting with new admissions after 8/13/2025 until substantial compliance is achieved. • Newly hired employees will receive education on wandering, elopement, and resident safety by the DON/Nurse Managers in orientation starting 8/13/2025.	09/23/2025

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F0689 SS = SQC-J	Continued from page 3 Review of R1's admission "Minimum Data Set [MDS]," with an Assessment Reference Date (ARD) of 07/25/2025, located in the resident's EMR, revealed the facility assessed R1 to have a "Brief Interview for Mental Status [BIMS]" score of three out of 15, which indicated she had severe cognitive impairment. Review of R1's "Facility Investigation," 08/07/2025, revealed on 08/07/2025 at approximately 11:10 PM as State Trained Nurse Aide (STNA) 2 was getting out of her car to walk into the back door entrance of Household B, she found R1 sitting alone in the grass near a tree. STNA2 approached R1 and asked R1 if she was okay and did she need any help. STNA2 stated R1 appeared to be confused because R1 stated she did not know where she was. STNA2 stated she told R1 she would be okay, and she was going to take her inside so she could get warm. STNA2 assisted R1 into the building, holding her close as R1 was unstable when walking. Per the investigation, STNA2 asked R1 if she was hurt anywhere, and R1 stated she did not know. STNA2 stated once she got inside the building, she asked staff, including the DON (who was working at the time), why R1 was outside, and no one knew how or why R1 was outside the building. Review of the website www.weather.gov revealed the temperature at the facility on the evening of 08/07/2025 was 78 degrees Fahrenheit with clear skies. Review of the distance taken by R1 when she exited the facility on 08/07/2025 in a measurement taken by a measuring wheel on 08/20/2025 at 2:00 PM by the facility's Physical Therapy Assistant 1 and the State Survey Agency (SSA) Surveyor revealed from Household C to the employee entrance/exit door was 18.9 feet. A second measurement taken on 08/20/2025 at 2:58 PM with the same participants revealed, from the tree where STNA2 saw R1 to the building, was 84.4 feet. Review of the facility provided security video with the Executive Director on 08/23/2025 at 12:12 PM revealed on 08/07/2025, time unknown, Security Officer 1 was observed walking to the employee entrance door and pressed the code to unsound the alarm. Further review of the video revealed Security Office 1 did not make any observations outside the facility or complete a perimeter check to verify any resident had left the facility. Observation of R1 on 08/19/2025 at 4:27 PM	F0689	Continued from page 3 • An Adhoc QAPI with Medical Director, Director of Social Services, DON, and Executive Director was completed on 8/13/2025 to review QAPI plan created on 8/8/2025 Medical Director agrees with QAPI plan. • DON/Nurse Managers will report results of audits, follow up and trends to QAPI committee on 8/22/2025 and will continue to report data to QAPI weekly for 4 weeks and then every other week until we are in substantial compliance. • An Elopement Drill was held on 8/22/2025 at approximately 11:30am. • An additional Elopement Drill will be held 8/22/2025 for night shift (after7pm) • An Ad Hoc QAPI meeting is scheduled for 8/22/2025 at 8pm to discuss the results of the Elopement Drills and the IJ Abatement plan progress. Date facility alleges IJ removal: 8/23/2025 Corrective Action completed for R1. The Medical Director over R1 was Dr. Kelash Kumar. Address is 4850 Smith Road, Ste 250, Cincinnati, OH 45212. And Phone number 513-699-9090 R1 was immediately assessed by DON including a new Elopement Evaluation, Skin Check with no identified skin concerns , Neurologic Focused Evaluation with no new abnormalities noted, and a Skilled Evaluation with no concerns for harm. The care plan was updated based on assessment evaluations. Completed 8/8/2025 DON notified the medical director immediately after assessments to report data, that a Wandergard was placed on the resident. . The Medical Director had no new orders for the resident. . Completed 8/8/2025 The resident's responsible party was promptly notified of the incident, the result of the assessments, the medical director's response and the placement of the Wanderguard. . Completed 8/8/2025	09/23/2025

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F0689 SS = SQC-J	Continued from page 4 revealed R1 was sitting in her wheelchair. The Resident showed no acknowledgement of the State Survey Agency (SSA) Surveyor. During an interview with STNA2 on 08/20/2025 at 2:47 PM, she stated on 08/07/2025 she was reporting to work for her shift. She stated after parking her car, she exited the vehicle and started walking toward the facility from the back parking lot of Household B. She stated she saw a person sitting alone under a tree. At first glance, she stated she thought it was an employee; then at second glance, she realized it was an older resident. She stated she had not worked in Household C and had not had a chance to get acquainted with R1, but she instantly knew the person did not belong outside. She stated she asked R1 if she was okay or hurt, and R1 stated she did not know. She stated she was able to get R1 up from the ground; however, R1 was unstable. She stated she held on close to her, hugging her to keep R1 from falling. She stated she entered the building with R1 and asked staff on Household B if they were aware R1 was outside. During an interview with STNA3 on 08/20/2025 at 2:09 PM, she stated she was working on Household C with R1 on 08/07/2025. She stated the last time she saw R1 she was sitting quietly in her wheelchair. She stated during her shift she had not seen R1 wandering or having exit seeking behaviors. STNA3 stated after R1 was found outside and was back on Household C, she got the resident ready for bed, and she stayed in bed all throughout her shift. She stated she kept a closer eye on her that night due to her exiting the facility earlier that evening. Per the interview, she stated when the door alarms sounded, staff checked immediately to see if anyone got out. She stated she did not hear the alarm go off or see a Security Officer come to the unit and turn off an alarm. The STNA stated she checked on residents every two hours to make sure everyone was in the building and did not need anything. She stated a nurse from Household B told her R1 had been outside over on their unit and had no signs of distress except for being cold, so R1 was given a blanket. During an interview with STNA1 on 08/20/2025 at 2:24 PM, she stated R1 was sitting in her wheelchair in the dining area of Household C, and she saw the resident get up to walk. She stated she asked the resident to sit down, and the resident sat down. She stated she went to Household B and came back past the dining room, and the resident was gone. She stated she thought R1's aide had put the resident to bed. She stated she did not hear the alarm and	F0689	Continued from page 4 (We stated this in first dot point) Social Service Designee completed a 1:1 visit, noting no adverse impact. on 8/8/2025. The DON, ADON and MDS Nurse reviewed the updated care plan to ensure no further interventions were necessary related to wandering and elopement risk. Completed 8/13/2025. Resident no longer resides at the facility as of 8/22/2025. Identification of other residents having the potential to be affected was accomplished by: The DON, ADON, SDC, and RN Manager re-evaluated all residents for risk of wandering/elopement using N Adv - Elopement Evaluation in Point Click Care. Completed 8/13/2025 The MDS Coordinator and ADON reviewed and updated care plans for the identified elopement/wandering risk residents as needed. Completed 8/13/2025 DON/RN Managers completed an audit to confirm all Wanderguards were functioning properly and in place for all residents care-planned for Wanderguards. Completed 8/13/2025 Actions taken/systems put into place to reduce the risk of future occurrence include: All staff on all shifts received education on wandering, elopement, and resident safety from the DON, SDC, RN Manager, and ADON. Any staff on leave will receive education on their next scheduled work day. Completed 8/13/2025 or by their next scheduled shift. DON/Nurse Managers/ED administer quizzes to all staff. DON/Nurse Managers/ED follow up with all staff if a question was answered incorrectly, education was provided immediately. Completed	09/23/2025

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F0689 SS = SQC-J	Continued from page 5 never saw a Security Officer come to Household C to turn off an alarm. She stated if a resident tried to open the door, the alarm went off. She stated the alarms only sound if a resident had a Wander Gard. She stated the employee entrance/exit door required a code or badge to enter and exit. She stated all doors were fire doors, so if one held the door handle for 15 seconds, the door would automatically open. During an interview with Security Officer 1 on 08/20/2025 at 6:33 AM, he stated he reviewed the facility's videotape of the incident, the day of R1's elopement. Per interview, he stated 30 minutes prior to the resident getting out, a family member of another resident was trying to get out and triggered the alarm. He stated when he went back 30 minutes after the prior triggered alarm, he did not think a resident had gotten out and that maybe an employee or family member set off the alarm. Security Office 1 stated he reset the alarm by entering the code. He stated he looked out the glass panels of the door, did not see anyone, and left the unit. He stated the exit door employees used to come and go were right outside of the Household C where the resident resided. He stated he reviewed the security video feed after he was informed of the elopement and got the timeline of the events with R1 that night. He stated at 10:08 PM R1 was seen at the exited door, reading the sign that stated if you press on the door handle and hold for 15 seconds the alarm would sound and the door would open. He stated the resident held the door handle for 15 seconds, and she was out of the facility. He stated he had multiple people, family members, and staff who sounded the alarm on the door. He stated R1 was escorted back to Household C at 11:19 PM. He stated he had never had any specific procedures in place for him or the security team when the alarms were triggered. During an interview with Registered Nurse (RN1) on 08/20/2025 at 3:04 PM, she stated she was the admitting nurse the night R1 came to the facility on 07/23/2025. She stated she completed the "Elopement Assessment" on admission on 07/23/2025, and R1 scored as a high risk. She stated if the resident who scored as high risk did not want to be at the facility, they could be confused and wander. She stated she added wandering/elopement to the Resident's Baseline Care Plan, so staff was aware to keep an eye on the resident. She stated with R1 being high risk, the nursing staff would document the resident's whereabouts and put a Wander Gard on the resident. She stated the night of 07/23/2025 with R1, she did	F0689	Continued from page 5 8/13/2025 or by their next scheduled shift. The Director of Facilities tested the Doors, Locks, & Alarms on both 8/7/2025 and 8/13/2025, 8/20/2025, 8/27/2025, 9/4/2025, 9/11/2025, 9/18/2025. All functioning properly. Doors, Locks & Alarms will continue to be tested weekly Elopement drills were completed on 8/22/2025, 08/27/2025, 09/03/2025, 09/04/2025, 09/18/2025. "Elopements and Wandering Residents" policy was reviewed by ED, VP of Operations, and SDC and no changes were made. Completed 8/8/2025. "Elopements and Wandering Residents" policy was reviewed again by ED, VP of Clinical, VP of Operations and DON and no changes were made. Completed 8/11/2025. The admitting nurse completes an admission N Adv - Elopement Evaluation assessment and places interventions as appropriate. Starting on admission after 8/13/2025. Actions to monitor the solution is sustained: The DON/Nurse Managers will audit all new admissions for elopement risk and ensure appropriate interventions are in place. Starting with admissions after 8/13/2025. Audits will continue at 100% until substantial compliance is achieved, then 75% of admissions will be audited for 1 month, then 50% for 1 month and then continued random audits as needed. The DON/Nurse Managers will audit all new admission care plans to ensure it reflects individual needs identified. Starting with new admissions after 8/13/2025. Audits will continue at 100% until substantial compliance is achieved, then 75% of admissions will be audited for 1 month, then 50% for 1 month and then continued random audits as needed. New hires will receive education on wandering, elopement, and resident safety by the DON/Nurse	09/23/2025

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F0689 SS = SQC-J	Continued from page 6 not know why she did not apply the Wander Gard to the resident. She stated it was nighttime, and she figured R1 would just stay in bed. In an interview with the Director of Nursing (DON) on 08/19/2025 at 4:43 PM, she stated the resident was not wearing a Wander Gard at the time she was found outside the facility. She stated due to R1's behaviors and being high risk for wandering and elopement, R1 should have been given a Wander Gard. She stated the resident was last seen by STNA3 on 08/07/2025 at approximately 9:30 PM sitting in her wheelchair in the dining room. The DON stated she was working as an RN for the shift and did not have any recollection of the resident wandering or exit seeking behaviors. She stated the resident was able to exit the building by going out the Household C employee entrance/exit. Per the DON, the Resident was found outside in the parking lot alone sitting under a tree at the back door of Household Entrance B around 11:10 PM. The DON stated there were many system failures by the facility. She stated R1 was not given a personal safety device due to her scoring on the Elopement Assessment on admission. She stated the admitting RN1 had received disciplinary action due to not applying a Wander Gard to R1. She stated Security Officer 1 also received disciplinary action as he was aware the door alarm was going off, cut off the door alarm by entering the code, but failed to do a security check on the perimeter to verify no resident left the facility through the door. She stated anytime an alarm was triggered it needed to be treated as if a resident could have possibly left the facility. During an interview with the Executive Director on 08/22/2025 at 3:03 PM, she stated R1 did get out of Household C where she was residing and exited the employee entrance/exit of the facility. She stated R1 should have been given a Wander Gard bracelet considering her family informed RN1, the admitting nurse, the night of 07/23/2025 that R1 had wandered/eloped from her residence and was assessed to be an elopement risk. She stated under no circumstances was it okay for an admitting nurse to think the resident would just go to bed and ignore facility policy to implement interventions to keep residents safe. The facility's IJ Removal Plan verbatim: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: 8/13/2025)	F0689	Continued from page 6 Managers in orientation with a completed quiz for understanding starting 8/13/2025. An Adhoc QAPI with Medical Director, Director of Social Services, DON, and Executive Director was completed on 8/13/2025 to review QAPI plan created on 8/8/2025 Medical Director agreeable to QAPI plan. DON/Nurse Managers will report results of audits, follow up and trends to QAPI committee on 8/22/2025 and will continue to report data to QAPI weekly for 4 weeks and then every other week until we are in substantial compliance. QAPI meetings have taken place on 8/29/2025, 9/5/2025, 9/12/2025. Director of Facilities/Maintenance staff will coordinate elopement drills at least 4 times per month on random shifts for 3 months and then 2 times per month for 3 months to ensure procedures are followed and substantial compliance is met, then quarterly. Starting 8/22/2025. Director of Facilities/Maintenance staff will report results of elopement drills to QAPI weekly for 4 weeks and then every other week until we are in substantial compliance. Plan of Correction completion date: __9/23/2025_____.	09/23/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 7 • The DON, ADON, SOC, and RN Manager re-evaluated all residents for risk of wandering/elopement using "N Adv - Elopement Evaluation" in Point Click Care. Completed 8/13/2025 • All residents were reassessed using the "N Adv - Elopement Evaluation." 18 residents scored at 1+ on the "N Adv - Elopement Evaluation" as possible elopement/wandering risk. Completed 8/13/2025 • The MOS Coordinator and ADON reviewed and updated care plans for the 18 identified elopement/wandering risk individuals as needed. Completed 8/13/2025 • DON/RN Managers completed an audit to confirm all Wanderguards were functioning properly and in place for all residents care-planned for Wanderguards. Completed 8/13/2025 • DON/RN Managers audit that nurses test the function of the wanderguard daily and placement each shift. Audit results are communicated by the DON/RN Manager at QAPI meetings until substantial compliance is achieved. • All staff on all shifts received education on wandering, elopement, and resident safety from the DON, SOC, RN Manager, and ADON. 169 staff received education. 6 staff are on LOA, 47 staff are on vacation or are PRN and have not worked yet. Any staff on leave, PRN or vacation will receive education on their next scheduled work day by RN Manager/DON/ED. Madonna Manor does not use agency staff. Completed 8/13/2025 or by their next scheduled shift. • DON/Nurse Managers/ED administer quizzes to all staff. DON/Nurse Managers/ED follow up with all staff if a question was answered incorrectly, education was provided immediately. Completed 8/13/2025 or by their next scheduled shift. • DON/RN Managers provided education for all licensed nurses regarding assessment and developing care plans and interventions for residents who are at risk for elopement. • The Director of Facilities tested the Doors, Locks, & Alarms on both 8/7/2025 and 8/13/2025. All functioning properly. Doors, Locks & Alarms will continue to be tested weekly. • An Elopement Drill was conducted on day shift and night shift on 8/22/2025 to assure staff	F0689		09/23/2025

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 08/23/2025

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

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F0689 SS = SQC-J	Continued from page 8 understanding of proper process during an elopement. Madonna Manor took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: 8/13/2025 • "Elopements and Wandering Residents" policy was reviewed by ED, VP of Operations, and SOC. Completed. No changes were made to the policy. 8/8/2025. • "Elopements and Wandering Residents" policy was reviewed again by ED, VP of Clinical, VP of Operations and DON. No changes were made to the policy. Completed 8/11/2025. • The admitting nurse completes an admission "N Adv - Elopement Evaluation" assessment and places interventions as appropriate. Starting on admission after 8/13/2025. • The DON/Nurse Managers will audit all new admissions for elopement risk and ensure appropriate interventions are in place. Starting with admissions after 8/13/2025 until substantial compliance is achieved. • The DON/Nurse Managers will audit all new admission care plans to ensure it reflects individual needs identified. Starting with new admissions after 8/13/2025 until substantial compliance is achieved. • Newly hired employees will receive education on wandering, elopement, and resident safety by the DON/Nurse Managers in orientation starting 8/13/2025. • An Adhoc QAPI with Medical Director, Director of Social Services, DON, and Executive Director was completed on 8/13/2025 to review QAPI plan created on 8/8/2025 Medical Director agrees with QAPI plan. • DON/Nurse Managers will report results of audits, follow up and trends to QAPI committee on 8/22/2025 and will continue to report data to QAPI weekly for 4 weeks and then every other week until we are in substantial compliance. • An Elopement Drill was held on 8/22/2025 at approximately 11:30am. • An additional Elopement Drill will be held 8/22/2025 for night shift (after7pm) • An Ad Hoc QAPI meeting is scheduled for	F0689		09/23/2025

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 08/23/2025

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F0689 SS = SQC-J	Continued from page 9 8/22/2025 at 8pm to discuss the results of the Elopement Drills and the IJ Abatement plan progress. Date facility alleges IJ removal: 8/23/2025	F0689		09/23/2025