

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

PRINTED: 08/17/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/05/2010
NAME OF PROVIDER OR SUPPLIER  ARBOR PLACE OF CLINTON			STREET ADDRESS, CITY, STATE, ZIP CODE 106 PADGETT DRIVE CLINTON, KY 42031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  A recertification survey was conducted 07/27-29/10 and an extended survey was conducted 07/29-08/05/10. Immediate Jeopardy was identified in the areas of 42 CFR 483.13 Resident Behaviors and Facility Practices, 42 CFR 483.25 Quality of Care and 42 CFR 483.75 Administration with the highest scope/severity being a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.13 Resident Behaviors and Facility Practices and 42 CFR 483.25 Quality of Care.  The Immediate Jeopardy was identified on 07/29/10 and determined to exist on 06/17/10. The facility was notified of the Immediate Jeopardy on 07/29/10. An acceptable Allegation of Compliance (AOC) was received on 08/04/10, with the Immediate Jeopardy determined to be removed on 08/05/10, as alleged.	F 000	<b><i>With respect to this Plan of Correction, please note that this POC is submitted without prejudice to the facility's right to argue that the statement of deficiencies has incorrectly stated the facts, that there was no deficiency; that any deficiency was a lower scope and severity than cited by surveyors; that any deficiency was isolated in scope, and that any deficiency was corrected immediately on June 17, 2010. We expressly reserve the right to make any and all such legal arguments, as we believe the facility has acted with all appropriate diligence and quality in caring for the resident in question. Our Plan of Correction is submitted in order to fix the date of compliance as of a date <u>no later than</u> the date of submission of this POC.</i></b>		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225	<b>483.13 (c)(1)(ii)-(iii), (c)(2) - (4) Investigate/Report Allegations/Individuals For the resident affected:</b>  Resident #11 continues to reside on Special Care Unit.  Resident #11 care plan was updated on June 17, 2010 that he/she was not allowed outside in the courtyard or off the unit without direct visual supervision by a staff member. The care plan was updated to reflect this change June 17, 2010.  Nursing staff on duty were re-trained n Resident #11 care plan change by the DON on June 17, 2010.  Resident #11 was placed on 15 minute checks on return to the facility June 17, 2010 and remains ongoing.	8/6/2010	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Handwritten Signature]*

TITLE  
Administrator

DATE  
8/25/10

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to thoroughly investigate a resident elopement from the facility and report the elopement to the State Agency for one (1) of seventeen (17) sampled residents (Resident #11).</p> <p>Resident #11 was assessed as high risk for elopement from the facility. On 06/17/10, the resident exited the facility without staff knowledge and was found off the facility's property "one-fourth (1/4) mile" from the facility. The facility failed to thoroughly investigate the incident and failed to report the incident to the State Agency, as per facility policy.</p>	F 225	<p><b>For residents at risk:</b></p> <p>All residents are screened on admission using the facility Elopement Risk screening tool and are updated quarterly and PRN. All residents whose screening reflects them to be at risk have the potential to be affected.</p> <p>Since June 17, 2010, no other resident in the Nursing Facility has had an elopement.</p> <p><b>The following measures or systemic changes were added/modified to prevent reoccurrence:</b></p> <p>Nursing staff on duty in the Special Care, upon resident's return, were re-trained on Resident #11's updated care plan which specified that Resident #11 is not allowed off the unit without direct visual supervision.</p> <p>All residents are screened on admission using the facility Elopement Risk screening tool which is updated quarterly and PRN by the Social Service Director or a member of the administrative RAI team being one of the MDS Coordinators, the Director of Clinical Services or the Administrator.</p> <p>A copy of the policy regarding safety and security along with supervision of residents is in the new hire packets so that all new hires are trained on the safety and security procedure of the facility.</p> <p>APS provided an in-service for Special Care unit staff on elopement and attempts to elope and recommendations to prevent future elopements on June 23, 2010.</p>	

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F 225	<p>Continued From page 2</p> <p>The facility's failure to investigate the resident's elopement placed residents in the facility at risk for serious injury, harm, impairment or death.</p> <p>The findings include:</p> <p>A review of Resident #11's medical record revealed the resident was admitted to the facility on 10/20/09. According to the medical record the resident had multiple incidents of elopement from nursing facilities prior to admission. A review of a Statement of Deficiencies, dated 03/18/10, revealed Resident #11 had previously exited the current facility, without staff knowledge, on 03/05/10. Further review of the resident's medical record revealed the resident was transferred to the Specialized Care Unit (SCU), a locked unit, on 03/05/10. Review of nursing notes, dated 06/17/10, the facility investigation, dated 06/17/10, and interviews with staff members, on 07/29/10 and 07/30/10, revealed on 06/17/10 Resident #11 was left unsupervised in an enclosed courtyard adjacent to the SCU. The resident exited the enclosed courtyard without staff knowledge and was located "one-fourth (1/4) mile" from the facility.</p> <p>Review of the facility's Abuse Prevention Policy, dated 01/2003, revealed actions to prevent abuse/neglect included a report to the Administrator and "State-specific requirements for reporting such incidents must be followed." The Administrator or designee was to "Report to the appropriate agencies as per state requirement and conduct an immediate and thorough investigation."</p> <p>Interviews with the Administrator on 07/29/10 at 10:12 AM, 11:30 AM, 12:49 PM and 2:25 PM, and</p>	F 225	<p>The facility held a staff meeting June 25, 2010 with training by the Director of Nursing to members of the staff to include the abuse policy and care of resident's with behaviors.</p> <p>The soda machine in the courtyard was removed to improve visualization on July 29, 2010.</p> <p>Blinds have been removed from the windows to the Special Care Unit courtyard for improved visualization as of July 29, 2010 although no resident will be in that courtyard without staff supervision.</p> <p>Licensed staff were instructed on July 30, 2010 and again on August 4, 2010 by the DON, ADON and ADM that any resident who is put on 15 minute checks will not have those ended without instruction by the DON, ADON or ADM with an order from the physician.</p> <p><b>How will the corrective actions be monitored to ensure the deficient practice will not recur?</b></p> <p>Door alarms continue to be checked daily. All have been found in compliance since June 17, 2010.</p> <p>Plant Services will monitor all exit doors on a daily basis. Any problems will be reported to the Plant Services Director, Administrator or Regional Director immediately,</p> <p>All staff will continue to be in-serviced on hire and annually on the elopement policy.</p> <p>Residents who are at risk for elopement have their pictures posted in the break room next to the time clock for all staff to view.</p>		

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F 225	<p>Continued From page 3</p> <p>on 08/03/10 at 3:35 PM, revealed the Administrator was unaware Resident #11 was located "one-fourth (1/4) mile" away from the property on 06/17/10. According to the Administrator, staff had reported to her that even though the resident had exited the enclosed courtyard, he/she was still located on facility property. Further interview revealed the Administrator did not report the incident to the State Agency, because she was unaware the resident had left facility property during the elopement.</p> <p>The Administrator was unable to provide evidence of a thorough investigation of the elopement. A review of the information provided revealed the only investigation conducted included staff interviews and the investigation did not include the location where Resident #11 was found.</p> <p>Additionally, according to the Administrator, the investigation should have included an investigation regarding the method the resident used to exit from the enclosed courtyard, the safety of leaving Resident #11 in the enclosed courtyard without supervision, staff statements concerning the incident, exact location where the resident was found and an analysis of the possible causative factors leading to the elopement with interventions to prevent an elopement in the future. The Administrator was unable to provide any evidence the investigation included all of these factors.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/04/10. The actions taken to verify the removal of Immediate Jeopardy included a review of the in-service records to</p>	F 225	<p>The DON or ADON will be responsible for validating completion of 15 minute checks during daily QA meetings held during regular business days. This will be done on any resident having 15 minute checks completed.</p> <p>An Elopement Investigation Form was developed to be completed on any resident who exits the facility without staff knowledge or consent. This form identifies if the resident was witnessed by anyone exiting the facility and asks detailed questions to determine how the resident exited the facility, where the resident was located and a sketch of the area including where the resident was discovered. It also identifies the reason the resident eloped, notifications made and immediate corrective action to prevent re-occurrence.</p> <p>Elopement risk and safety/security will continue to be addressed at each Safety Committee meeting held at least quarterly.</p>

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F 225	<p>Continued From page 4</p> <p>include elopement, attempts to elope and recommendations to prevent future elopements, the Abuse Prevention policy (which included components required for a thorough investigation, and when to report an incident to the State survey Agency) and care of residents with behaviors, every 15 minutes check protocol, and direct staff supervision (staff member to accompany) while off the SCU.</p> <p>An interview with the Administrator on 07/29/10 at 4:45 PM revealed the Administrator was knowledgeable about the facility abuse policy, the components of a thorough investigation, and when to report incidents to the State Agency. In addition the Administrator stated the facility should have used the investigation to attempt to identify all the circumstances surrounding the elopement, and utilized the information to develop preventative interventions to prevent reoccurrence of the elopement.</p> <p>A record review revealed, on 06/25/10, the Director of Nursing (DON) provided an in-service for all staff regarding the facility's abuse prevention policy, with special focus on the residents residing on the SCU. The in-service included components for prevention, which included reporting and investigation. On 07/29/10, on 07/30/10 and on 08/04/10, additional in-services were provided by the Administrator, DON and/or the Assistant DON, which included a review of the seven components of the abuse prevention policy and procedure, supervision of residents on the SCU, residents identified at risk for elopement and supervision for residents who used the adjacent courtyard.</p> <p>Interviews were conducted, on 08/04/10, with the</p>	F 225			

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F 225	<p>Continued From page 5</p> <p>Administrator, DON and the Social Services Director as well as direct care staff assigned to work the SCU and all demonstrated knowledge of the facility's policy and procedures, to include the Abuse Prevention policy and supervision of residents on the SCU and the courtyard.</p> <p>A review of Resident #11's care plan, dated revised 08/04/10, revealed revised interventions included every 15 minute checks, direct staff supervision at all times when off the secured unit and discontinuation of the Wanderguard as it had been determined an ineffective intervention for Resident #11. Observations revealed the interventions were implemented.</p> <p>A review of exit door daily monitoring sheets revealed consistent implementation. A review of the new hire orientation protocol revealed inclusion of the supervision of residents and coding at the exit doors.</p> <p>Additional record reviews for all residents identified at risk for elopement were conducted with no regulatory violations identified.</p> <p>Staff interviews, on 08/04/10, revealed confirmation of in-services and interventions to provide for residents identified as at risk for elopement.</p> <p>The Immediate Jeopardy was verified removed on 08/05/10, as alleged in the AOC, with the scope/severity lowered to a "D", based on the facility's need to continue to evaluate the implementation of systematic changes and quality of assurance activities.</p>	F 225			
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

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F 323	<p>Continued From page 6</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure supervision to prevent elopement from the facility for one (1) of seventeen (17) sampled residents (Resident #11).</p> <p>Resident #11 had a history of elopements from facilities, with the most recent elopement being on 03/05/10. Although, Resident #11 had been transferred to a secured unit, there was no evidence the facility implemented interventions to ensure Resident #11's safety while in the enclosed courtyard adjacent to the secured unit.</p> <p>On 06/17/10, Resident #11 exited the enclosed courtyard after being left alone and unsupervised. The resident was located on a road "one-fourth (1/4) mile" from the facility.</p> <p>The facility's failure to ensure supervision and safety for Resident #11 placed residents in the facility at risk for serious harm, injury, impairment or death.</p> <p>The findings include:</p> <p>Resident #11 was admitted to the facility, on</p>	F 323	<p><b>483.25(h) Free of Accident Hazards/ Supervision/Devices</b></p> <p>Resident #11 continues to reside on Special Care Unit.</p> <p>Resident #11 care plan was updated on June 17, 2010 that he/she was not allowed outside in the courtyard or off the unit without direct visual supervision by a staff member. The care plan was updated to reflect this change June 17, 2010.</p> <p>Nursing staff on duty were re-trained n Resident #11 care plan change by the DON on June 17, 2010.</p> <p>Resident #11 was placed on 15 minute checks on return to the facility June 17, 2010 and remains ongoing.</p> <p><b>For residents at risk:</b></p> <p>All residents are screened on admission using the facility Elopement Risk screening tool and are updated quarterly and PRN. All residents whose screening reflects them to be at risk have the potential to be affected.</p> <p>Since June 17, 2010, no other resident in the Nursing Facility has had an elopement.</p> <p><b>The following measures or systemic changes were added/modified to prevent reoccurrence:</b></p> <p>Nursing staff on duty in the Special Care, upon resident's return, were re-trained on Resident #11's updated care plan which specified that Resident #11 is not allowed off the unit without direct visual supervision.</p> <p>8/6/2010</p>

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F 323	<p>Continued From page 7</p> <p>10/20/09, with diagnoses to include Alzheimer's Dementia and Bipolar Disorder. Review of the resident's medical record revealed the resident had been adjudicated incompetent and a Guardian appointed. According to the medical record, Resident #11 had a history of elopement from previous facilities.</p> <p>A review of the Minimum Data Set (MDS) assessment, dated 03/25/10 revealed Resident #11 was assessed as exhibiting wandering behaviors that were not easily altered. Further review of the Elopement Risk Screen, dated 03/22/10, revealed the resident was exit seeking, had a history of wandering, made statements that he/she was leaving and displayed behaviors indicating an elopement may be forthcoming. Review of the admission Resident Assessment Protocol, dated 11/02/09 revealed he/she wandered, had behavioral problems prior to admission and had exhibited exit seeking behavior.</p> <p>A review of a Statement of Deficiencies, dated 03/18/10, revealed Resident #11 had exited the current facility, without staff knowledge, on 03/05/10. Review of the Comprehensive Care Plan, dated 11/02/09 and revised 03/05/10, revealed interventions related to the elopement included a Wanderguard bracelet kept by the resident inside his/her pocket, a check of the presence of the Wanderguard every shift and to ensure the resident did not leave the facility without an escort. Review of a Physician's Order, dated 03/05/10, revealed Resident #11 was transferred to the Speciality Care Unit (SCU), a secured unit, on 03/05/10.</p> <p>A review of the investigation report provided by</p>	F 323	<p>All residents are screened on admission using the facility Elopement Risk screening tool which is updated quarterly and PRN by the Social Service Director or a member of the administrative RAI team being one of the MDS Coordinators, the Director of Clinical Services or the Administrator.</p> <p>A copy of the policy regarding safety and security along with supervision of residents is in the new hire packets so that all new hires are trained on the safety and security procedure of the facility.</p> <p>APS provided an in-service for Special Care unit staff on elopement and attempts to elope and recommendations to prevent future elopements on June 23, 2010.</p> <p>The facility held a staff meeting June 25, 2010 with training by the Director of Nursing to members of the staff to include the abuse policy and care of resident's with behaviors.</p> <p>The soda machine in the courtyard was removed to improve visualization on July 29, 2010.</p> <p>Blinds have been removed from the windows to the Special Care Unit courtyard for improved visualization as of July 29, 2010 although no resident will be in that courtyard without staff supervision.</p> <p>Licensed staff were instructed on July 30, 2010 and again on August 4, 2010 by the DON, ADON and ADM that any resident who is put on 15 minute checks will not have those ended without instruction by the DON, ADON or ADM with an order from the physician.</p>		

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F 323	Continued From page 8 the facility, dated 06/17/10, revealed Resident #11 was left unsupervised in an enclosed courtyard adjacent to the secured unit and the resident exited the facility by climbing over the fence in the courtyard.  An interview with State Registered Nurse Aide (SRNA) #1, on 07/29/10 at 12:40 PM, revealed, on 06/17/10, she went to the enclosed courtyard to take a "break" after the breakfast meal service. SRNA #1 stated Resident #11 had "jerked the door open before it closed" and joined the SRNA in the courtyard. The SRNA explained that she re-entered the facility; however, Resident #11 did not want to re-enter the facility with her. She stated since residents from the secured unit were allowed to remain in the enclosed courtyard unsupervised, she left Resident #11 in the courtyard. SRNA #1 explained that unsupervised residents in the enclosed courtyard were monitored by staff periodically looking out the window.  An observation of the secured unit and adjoining enclosed courtyard, on 07/29/10 at 3:30 PM, revealed limited visibility of the courtyard by looking out the window. There was a shrub and a soda machine located outside the window. The entire courtyard was unable to be visualized.  An interview with Licensed Practical Nurse (LPN) #1, on 07/30/10 at 9:45 AM, revealed on 06/17/10, she was administering medications when she was notified Resident #11 had exited the facility. LPN #1 stated Resident #11, "stacked chairs and pushed off the coke machine" over the fence. LPN #1 stated Resident #11 had been allowed to be in the enclosed courtyard without supervision, prior to 06/17/10. According to LPN	F 323	<b>How will the corrective actions be monitored to ensure the deficient practice will not recur?</b>  Door alarms continue to be checked daily. All have been found in compliance since June 17, 2010.  Plant Services will monitor all exit doors on a daily basis. Any problems will be reported to the Plant Services Director, Administrator or Regional Director immediately.  All staff will continue to be in-serviced on hire and annually on the elopement policy.  Residents who are at risk for elopement have their pictures posted in the break room next to the time clock for all staff to view.  The DON or ADON will be responsible for validating completion of 15 minute checks during daily QA meetings held during regular business days. This will be done on any resident having 15 minute checks completed.  An Elopement Investigation Form was developed to be completed on any resident who exits the facility without staff knowledge or consent. This form identifies if the resident was witnessed by anyone exiting the facility and asks detailed questions to determine how the resident exited the facility, where the resident was located and a sketch of the area including where the resident was discovered. It also identifies the reason the resident eloped, notifications made and immediate corrective action to prevent re-occurrence.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/05/2010
NAME OF PROVIDER OR SUPPLIER  ARBOR PLACE OF CLINTON		STREET ADDRESS, CITY, STATE, ZIP CODE 106 PADGETT DRIVE CLINTON, KY 42031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 9</p> <p>#1, when residents were in the courtyard staff were supposed to monitor them by observing the residents through the window. The LPN was unsure whether she had observed Resident #11 on 06/17/10, and stated she would not have been able to see the resident if he had been behind the soda machine.</p> <p>An interview with Resident #11, on 07/29/10 at 12:00 PM, revealed the resident did not like the facility and wanted to leave. The resident stated he/she stacked chairs in the courtyard and used them to climb over the fence. During the interview, Resident #11 stated, "I need to get out of here".</p> <p>An interview with the Activities Director (AD), on 07/29/10 at 10:50 AM, revealed on 06/17/10, she was driving to work and saw Resident #11 walking alone with grass observed on his/her clothing. According to the AD, the resident was approximately 600 feet from the facility property, walking on the road and headed towards the downtown area. The AD stated she stopped her car and attempted to redirect the resident. She called the facility and reported the resident's elopement. The AD explained that she stayed with the resident, walking with him/her, until additional facility staff arrived.</p> <p>An interview with the Maintenance staff #1, on 07/29/10 at 11:30 AM, revealed he received a call to retrieve Resident #11 with the facility van, on the morning of 06/17/10. He stated he drove from the facility, turned right onto the highway and saw the AD's car sitting on the road with emergency blinkers activated, approximately 600 feet from the facility. The Maintenance staff located the AD and Resident #11 and asked the</p>	F 323	Elopement risk and safety/security will continue to be addressed at each Safety Committee meeting held at least quarterly.	

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NAME OF PROVIDER OR SUPPLIER  ARBOR PLACE OF CLINTON			STREET ADDRESS, CITY, STATE, ZIP CODE 106 PADGETT DRIVE CLINTON, KY 42031	
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F 323	<p>Continued From page 10</p> <p>resident if he/she wanted a ride. The resident replied. "No, I'm going to Louisville" and kept walking.</p> <p>An interview with the Director of Nursing (DON), on 07/30/10 at 11:15 AM, revealed she observed Resident #11 on 06/17/10, after the resident had left the facility. The DON stated she observed the resident leaving the facility property and watched the resident continue to walk away from the facility, "crossing diagonally across to a corner house's yard". However, observation from the window, during the interview, revealed the area the DON described when she stated she saw the resident, was not visible to the surveyor.</p> <p>A review of the resident's medical record revealed after the resident was returned to the facility, every 15 minute checks were initiated.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/04/10. The actions taken to verify the removal of Immediate Jeopardy included a review of the in-service records to include elopement, attempts to elope and recommendations to prevent future elopements, the Abuse Prevention policy (which included components required for a thorough investigation, and when to report an incident to the State survey Agency) and care of residents with behaviors, every 15 minutes check protocol, and direct staff supervision (staff member to accompany) while off the SCU.</p> <p>An interview with the Administrator on 07/29/10 at 4:45 PM revealed the Administrator was knowledgeable about the facility abuse policy, the components of a thorough investigation, and when to report incidents to the State Agency. In</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER  ARBOR PLACE OF CLINTON		STREET ADDRESS, CITY, STATE, ZIP CODE 106 PADGETT DRIVE CLINTON, KY 42031		
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F 323	<p>Continued From page 11</p> <p>addition the Administrator stated the facility should have used the investigation to attempt to identify all the circumstances surrounding the elopement, and utilized the information to develop preventative interventions to prevent reoccurrence of the elopement.</p> <p>A record review revealed, on 06/25/10, the Director of Nursing (DON) provided an in-service for all staff regarding the facility's abuse prevention policy, with special focus on the residents residing on the SCU. The in-service included components for prevention, which included reporting and investigation. On 07/29/10, on 07/30/10 and on 08/04/10, additional in-services were provided by the Administrator, DON and/or the Assistant DON, which included a review of the seven components of the abuse prevention policy and procedure, supervision of residents on the SCU, residents identified at risk for elopement and supervision for residents who used the adjacent courtyard.</p> <p>Interviews were conducted, on 08/04/10, with the Administrator, DON and the Social Services Director as well as direct care staff assigned to work the SCU and all demonstrated knowledge of the facility's policy and procedures, to include the Abuse Prevention policy and supervision of residents on the SCU and the courtyard.</p> <p>A review of Resident #11's care plan, dated revised 08/04/10, revealed revised interventions included every 15 minute checks, direct staff supervision at all times when off the secured unit and discontinuation of the Wanderguard as it had been determined an ineffective intervention for Resident #11. Observations revealed the interventions were implemented.</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER  <b>ARBOR PLACE OF CLINTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>106 PADGETT DRIVE CLINTON, KY 42031</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 12  A review of exit door daily monitoring sheets revealed consistent implementation. A review of the new hire orientation protocol revealed inclusion of the supervision of residents and coding at the exit doors.  Additional record reviews for all residents identified at risk for elopement were conducted with no regulatory violations identified.  Staff interviews, on 08/04/10, revealed confirmation of in-services and interventions to provide for residents identified as at risk for elopement.  The Immediate Jeopardy was verified removed on 08/05/10, as alleged in the AOC, with the scope/severity lowered to a "D", based on the facility's need to continue to evaluate the implementation of systematic changes and quality assurance activities.	F 323		8/6/2010	
F 490 SS=J	<b>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</b>  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the Administration of the facility failed to ensure the facility's resources were utilized effectively and efficiently to provide the required care and services to the residents.	F 490	<b>483.75 Effective Administration/ Resident Well-Being</b>  Resident #11 continues to reside on Special Care Unit.  Resident #11 care plan was updated on June 17, 2010 that he/she was not allowed outside in the courtyard or off the unit without direct visual supervision by a staff member. The care plan was updated to reflect this change June 17, 2010.  Nursing staff on duty were re-trained n Resident #11 care plan change by the DON on June 17, 2010.  Resident #11 was placed on 15 minute checks on return to the facility June 17, 2010 and remains ongoing.		

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NAME OF PROVIDER OR SUPPLIER  ARBOR PLACE OF CLINTON			STREET ADDRESS, CITY, STATE, ZIP CODE 106 PADGETT DRIVE CLINTON, KY 42031		
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F 490	Continued From page 13  The facility Administrator failed to ensure Resident #11 had interventions in place to prevent elopement, and failed to ensure staff implemented the interventions to provide supervision for Resident #11 when in the enclosed courtyard. In addition, the Administrator failed to ensure incidents were reported to the State Agency, as required. (Refer to F225 and F323)  Resident #11 was assessed as a high risk for elopement, had exited the facility without staff knowledge on 3/5/10, and was transferred to the facility's secured unit. On 6/17/10, Resident #11 was left unsupervised in an enclosed courtyard adjacent to the secured unit, and exited the facility by climbing over the fence of the courtyard.  The facility Administrator's failure to ensure supervision was provided for Resident #11 in the enclosed courtyard placed residents in the facility at risk for serious injury, harm, impairment or death.  The findings include:  A review of Resident #11's medical record, and review of a Statement of Deficiencies, dated 03/18/10, revealed Resident #11 was assessed as high risk for elopement, and had eloped from the facility on 3/5/10. According to the resident's medical record, the resident was transferred to the secured unit on 03/05/10, following the 03/05/10 elopement. Review of the resident's care plan revealed interventions for a Wanderguard Bracelet to be carried in the resident's pocket, check the Wanderguard placement every shift, and to not allow the	F 490	<b>For residents at risk:</b>  All residents are screened on admission using the facility Elopement Risk screening tool and are updated quarterly and PRN. All residents whose screening reflects them to be at risk have the potential to be affected.  Since June 17, 2010, no other resident in the Nursing Facility has had an elopement.  <b>The following measures or systemic changes were added/modified to prevent recurrence:</b>  Nursing staff on duty in the Special Care, upon resident's return, were re-trained on Resident #11's updated care plan which specified that Resident #11 is not allowed off the unit without direct visual supervision.  All residents are screened on admission using the facility Elopement Risk screening tool which is updated quarterly and PRN by the Social Service Director or a member of the administrative RAI team being one of the MDS Coordinators, the Director of Clinical Services or the Administrator.  A copy of the policy regarding safety and security along with supervision of residents is in the new hire packets so that all new hires are trained on the safety and security procedure of the facility.  APS provided an in-service for Special Care unit staff on elopement and attempts to elope and recommendations to prevent future elopements on June 23, 2010.		

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NAME OF PROVIDER OR SUPPLIER  ARBOR PLACE OF CLINTON			STREET ADDRESS, CITY, STATE, ZIP CODE 106 PADGETT DRIVE CLINTON, KY 42031	
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F 490	<p>Continued From page 14</p> <p>resident to leave the facility without supervision. Review of the facility Investigation Report, dated 03/17/10, revealed Resident #11 exited the facility without staff knowledge after being left in an enclosed courtyard unsupervised. Resident #11 stacked chairs, and utilized them to climb over the fence of the courtyard.</p> <p>Interviews with the facility Administrator, on 07/29/10 at 10:12 AM, 11:30 AM, 12:42 PM and 2:25 PM, and on 8/3/10 at 3:35 PM, revealed the Administrator thought staff were aware Resident #11 was outside, unsupervised, in the courtyard on 06/17/10. According to the Administrator, staff were unaware the resident had climbed over the fence and left facility property. The Administrator stated she thought Resident #11 had been found on facility property after climbing over the fence, and was unaware the resident was found "one-fourth (1/4) mile" away from facility property. The Administrator stated the incident was not reported to the State Agency as she was unaware Resident #11 had exited the facility property. Continued interview with the Administrator revealed Resident #11 had been on every fifteen (15) minute checks after the resident's elopement on 03/05/10, but was unaware of when the checks had been discontinued, as the charge nurse or DON made the decision to initiate and discontinue the checks. The Administrator stated although she attempted to follow up on the resident's elopement, there was no specific policy/protocol to follow regarding investigating these incidents. In addition, the Administrator explained there was no facility policy related to supervision of residents while in the enclosed courtyard.</p> <p>An acceptable Allegation of Compliance (AOC)</p>	F 490	<p>The facility held a staff meeting June 25, 2010 with training by the Director of Nursing to members of the staff to include the abuse policy and care of resident's with behaviors.</p> <p>The soda machine in the courtyard was removed to improve visualization on July 29, 2010.</p> <p>Blinds have been removed from the windows to the Special Care Unit courtyard for improved visualization as of July 29, 2010 although no resident will be in that courtyard without staff supervision.</p> <p>Licensed staff were instructed on July 30, 2010 and again on August 4, 2010 by the DON, ADON and ADM that any resident who is put on 15 minute checks will not have those ended without instruction by the DON, ADON or ADM with an order from the physician.</p> <p><b>How will the corrective actions be monitored to ensure the deficient practice will not recur?</b></p> <p>Door alarms continue to be checked daily. All have been found in compliance since June 17, 2010.</p> <p>Plant Services will monitor all exit doors on a daily basis. Any problems will be reported to the Plant Services Director, Administrator or Regional Director immediately,</p> <p>All staff will continue to be in-serviced on hire and annually on the elopement policy.</p> <p>Residents who are at risk for elopement have their pictures posted in the break room next to the time clock for all staff to view.</p>	

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NAME OF PROVIDER OR SUPPLIER  ARBOR PLACE OF CLINTON		STREET ADDRESS, CITY, STATE, ZIP CODE 106 PADGETT DRIVE CLINTON, KY 42031	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
F 490	<p>Continued From page 15</p> <p>was received on 08/04/10. The actions taken to verify the removal of Immediate Jeopardy included a review of the in-service records to include elopement, attempts to elope and recommendations to prevent future elopements, the Abuse Prevention policy (which included components required for a thorough investigation, and when to report an incident to the State survey Agency) and care of residents with behaviors, every 15 minutes check protocol, and direct staff supervision (staff member to accompany) while off the SCU.</p> <p>An interview with the Administrator on 07/29/10 at 4:45 PM revealed the Administrator was knowledgeable about the facility abuse policy, the components of a thorough investigation, and when to report incidents to the State Agency. In addition the Administrator stated the facility should have used the investigation to attempt to identify all the circumstances surrounding the elopement, and utilized the information to develop preventative interventions to prevent reoccurrence of the elopement.</p> <p>A record review revealed, on 06/25/10, the Director of Nursing (DON) provided an in-service for all staff regarding the facility's abuse prevention policy, with special focus on the residents residing on the SCU. The in-service included components for prevention, which included reporting and investigation. On 07/29/10, on 07/30/10 and on 08/04/10, additional in-services were provided by the Administrator, DON and/or the Assistant DON, which included a review of the seven components of the abuse prevention policy and procedure, supervision of residents on the SCU, residents identified at risk for elopement and supervision for residents who</p>	F 490	<p>The DON or ADON will be responsible for validating completion of 15 minute checks during daily QA meetings held during regular business days. This will be done on any resident having 15 minute checks completed.</p> <p>An Elopement Investigation Form was developed to be completed on any resident who exits the facility without staff knowledge or consent. This form identifies if the resident was witnessed by anyone exiting the facility and asks detailed questions to determine how the resident exited the facility, where the resident was located and a sketch of the area including where the resident was discovered. It also identifies the reason the resident eloped, notifications made and immediate corrective action to prevent re-occurrence.</p> <p>Elopement risk and safety/security will continue to be addressed at each Safety Committee meeting held at least quarterly.</p>

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NAME OF PROVIDER OR SUPPLIER  ARBOR PLACE OF CLINTON	STREET ADDRESS, CITY, STATE, ZIP CODE 106 PADGETT DRIVE CLINTON, KY 42031
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F 490	<p>Continued From page 16 used the adjacent courtyard.</p> <p>Interviews were conducted, on 08/04/10, with the Administrator, DON and the Social Services Director as well as direct care staff assigned to work the SCU and all demonstrated knowledge of the facility's policy and procedures, to include the Abuse Prevention policy and supervision of residents on the SCU and the courtyard.</p> <p>A review of Resident #11's care plan, dated revised 08/04/10, revealed revised interventions included every 15 minute checks, direct staff supervision at all times when off the secured unit and discontinuation of the Wanderguard as it had been determined an ineffective intervention for Resident #11. Observations revealed the interventions were implemented.</p> <p>A review of exit door daily monitoring sheets revealed consistent implementation. A review of the new hire orientation protocol revealed inclusion of the supervision of residents and coding at the exit doors.</p> <p>Additional record reviews for all residents identified at risk for elopement were conducted with no regulatory violations identified.</p> <p>Staff interviews, on 08/04/10, revealed confirmation of in-services and interventions to provide for residents identified as at risk for elopement.</p> <p>The Immediate Jeopardy was verified removed on 08/05/10, as alleged in the AOC, with the scope/severity lowered to a "D", based on the facility's need to continue to evaluate the implementation of systematic changes and quality</p>	F 490		
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NAME OF PROVIDER OR SUPPLIER  ARBOR PLACE OF CLINTON		STREET ADDRESS, CITY, STATE, ZIP CODE 106 PADGETT DRIVE CLINTON, KY 42031		
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F 490	Continued From page 17 of assurance activities.	F 490		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185452</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ARBOR PLACE OF CLINTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>106 PADGETT DRIVE CLINTON, KY 42031</b>	
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K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and conducted on 07/28/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.