

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

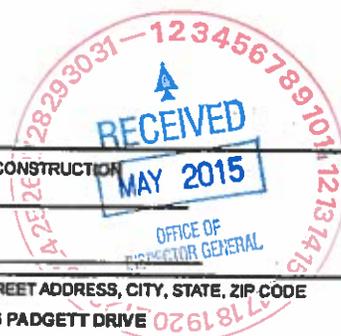
PRINTED: 05/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185469	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 05/15/2015
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 Based upon implementation of the acceptable POC, the deficiencies were deemed to be corrected on 05/15/15, as alleged.	{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X8) 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.

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

PRINTED: 04/16/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185469	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/01/2015
--	--	--	---

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 F 225 SS=D	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating Complaint #23009 was conducted on 03/31/15 through 04/01/15. #KY23009 was found to be substantiated with deficiencies cited at Scope and Severity of a "D".</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and 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</p>	F 000 F 225	<p>Arbor Place of Clinton acknowledges receipt of the Statement of Deficiencies and purposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Arbor Place of Clinton's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor any deficiency is accurate. Further, Arbor Place of Clinton reserves the right to refute any of the deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.</p> <p>All allegations of misappropriation of resident funds and the results of the investigation will be reported to the appropriate state agencies for all residents.</p> <p>All allegations for residents #1, #2, #3, #4, and #5 was investigated.</p> <p>Resident #1 was provided a lock box and care planned to secure personal property/funds to prevent further occurrences.</p> <p>Resident #2 was provided a lock box and care planned to secure personal property/funds to prevent further occurrences.</p> <p>Resident #3 was provided a lock box and care planned to secure personal property/funds to prevent further occurrences.</p> <p>Resident #4 has a lock box and care planned to secure personal property/funds to prevent further occurrences. Resident #4 had a care plan meeting to review keeping personal property/funds in the lock box to prevent further occurrences.</p>	
----------------------------	--	--------------------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMIN	(X5) DATE 4/30/15
---	----------------	----------------------

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185489	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2015
NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF CLINTON			STREET ADDRESS, CITY, STATE, ZIP CODE 108 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 225	<p>Continued From page 1</p> <p>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 observation, interview, record review, review of Customer Concern forms, and review of the facility's policy and procedure it was determined the facility failed to report allegations of misappropriation of resident funds and the results of their investigations to the appropriate state agencies for five (5) of five (5) sampled residents (Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Abuse Policy, dated 03/01/14, revealed it was the policy of the facility to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origins and misappropriation of resident property and to ensure all alleged violations of Federal and State laws which involve mistreatment, neglect, abuse, injuries of unknown origins and misappropriation of residents property were reported immediately to the Administrator of the the facility. Such violations should also be reported to state agencies and law enforcement in accordance with existing state laws. The Administrator was responsible to report the results of all investigations to the state agencies as required by state and federal law.</p>	F 225	<p>All staff will be in serviced by the Administrator or designee that all allegations involving mistreatment, neglect, or abuse, including injuries of unknown origin and 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 the state survey and certification agency.</p> <p>All staff will be in serviced by the Administrator or designee that residents will have lock boxes to secure personal property/funds. All in services began on 4/02/15 and are ongoing to completion date.</p> <p>All other residents having the potential to be affected were interviewed by the Social Service Director and/or the Certified Activities Director on 4/03/15 to assess need for a lock box to secure personal property/funds.</p> <p>Resident Council Meeting held on 4/03/15 to inform residents of availability to obtain a lock box to secure their personal property. Lock boxes were obtained and care planned by the Social Service Director for those residents whom identified a need for a lock box to secure personal property.</p> <p>The facility Administrator is adding to the current Admission Agreement that all new residents upon admission will be educated to the availability of a lock box to secure personal property. The Social Service Director or designee will be responsible for obtaining the lock box for the resident upon admission.</p>		

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

PRINTED: 04/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185469	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2015
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 225	<p>Continued From page 2</p> <p>Review of the Customer Concern Guideline, dated August 2014, revealed the purpose of the guideline is to support each customer's (patients/resident's) right to voice concerns (grievances) and to assure that after receiving a concern, the center actively seeks a resolution and keeps the customer appropriately appraised of its progress toward resolution. The Administrator will ensure a thorough investigation is conducted and will respond to the customer.</p> <p>1. Record review revealed the facility admitted Resident #1 on 02/21/14, with diagnoses which included Diabetes Mellitus Type II and Chronic Airway Obstruction. Review of annual Minimum Data Set (MDS) assessment, dated 02/09/15 revealed the facility assessed Resident #1's cognition as cognitively intact with a Brief Interview of Mental Status (BIMS) score of 13, which indicated the resident was interviewable.</p> <p>Interview with Resident #1, on 03/31/15 at 11:05 AM, revealed the resident was sent to the hospital on 03/10/15 and was admitted. The resident stated he/she left personal effects in the room at the facility when he/she was sent to the emergency room and when she returned there was thirty (30) dollars missing from inside his/her wallet. The resident revealed he/she had obtained the money from the business office prior to getting sick. The resident stated he/she reported the money was missing to the nurse that was at the nurse's desk but no one had talked to him/her directly, and this was the second time money had been missing. The resident further revealed he/she does not have close family members and all his/her money was kept in an account at the facility. The resident further stated he/she talked to the Social Service Director about it and was</p>	F 225	<p>All staff will be in serviced by the Administrator or designee that all allegations involving mistreatment, neglect, or abuse, including injuries of unknown origin and 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 the state survey and certification agency.</p> <p>All staff will be in serviced by the Administrator or designee that residents will have lock boxes to secure personal property/funds.</p> <p>The facility Administrator or designee will review and monitor at the monthly QAPI meeting all allegations of mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriation of resident property for staff compliance with timely reporting to the facility Administrator or designee and facility reporting to state agencies and other officials in accordance with state law and through established procedures including the state survey and certification agency.</p> <p>All concern logs will be audited monthly in the QAPI meeting by the Administrator or designee and the QAPI committee for three months and then per schedule established by the QAPI Committee.</p>	5/15/15	

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

PRINTED: 04/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185469	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2015
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 225	<p>Continued From page 3 told they would check into it.</p> <p>Review of a Customer Concern Form, dated 03/06/15, completed by the Social Services Director and signed by the Administrator on 03/20/15, revealed the resident had returned from the hospital stating someone had taken money from his/her room and he/she was unsure of the exact amount but there was only ten (10) dollars left in the wallet. Further review of the Form revealed the only actions taken by the facility was the Social Services Director interviewed the resident's roommate for possible observation of someone in the resident's room. Further documentation revealed to remind the the resident that he/she needs to leave money with the Business Manager until it was needed and the facility was not responsible for replacing the money. However, further review revealed there was no documented evidence the allegation that the money was taken was reported to the appropriate State agencies.</p> <p>Interview with the Business Office Manager, on 04/01/15 at 8:30 AM, revealed Resident #1 had received thirty (30) dollars from the business office on 03/10/15 and fifty (50) dollars (50) on 03/02/15. Further interview revealed the resident sometimes uses the money to purchase minutes for a personal cell phone, the resident was his/her own responsible party and after he/she signs out the money it belongs to him/her.</p> <p>2. Record review revealed the facility admitted Resident #2 on 10/01/13 with diagnoses which included Diabetes Mellitus and Glaucoma. Review of an Annual MDS assessment, dated 11/18/13 revealed the facility assessed Resident #2's cognition as cognitively intact with a BIMS</p>	F 225			

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

PRINTED: 04/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185469	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2015
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 225	<p>Continued From page 4</p> <p>score of fourteen (14) indicating the resident was interviewable.</p> <p>Interview with Resident #2, on 03/31/15 at 11:00 AM, revealed someone took ten (10) dollars from his/her room approximately six (6) months ago. The resident stated he/she was going out to eat with family and he/she had taken money from the account in the business office. The resident revealed when he/she returned to the room after a walk, he/she realized someone had been in the room and when he/she looked in the wallet the money was missing. The resident stated he/she reported it to everyone and was told there was nothing they could do unless it was witnessed. Further interview revealed he/she was not offered the money back and was told to not keep money in the room.</p> <p>Review of the Customer Concern Form, dated 10/20/14, completed by the Social Services Director and signed by the Administrator on 10/23/15, revealed Resident #1 had concerns that another resident took money from his/her room while he/she was outside walking. Further review of the form revealed the actions taken by the facility were to remind the resident not to keep money or valuables in the room as stated in the resident hand book and the concern was resolved due to the fact the resident revealed he/she does not usually keep money in their room on a regular basis. In addition, the documentation of the form revealed the Administrator offered to replace the money. However, further review revealed there was no documented evidence the allegation that the money was taken was reported to the appropriate State agencies.</p> <p>3. Record review revealed the facility admitted</p>	F 225			

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

PRINTED: 04/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185469	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2015
NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF CLINTON			STREET ADDRESS, CITY, STATE, ZIP CODE 108 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 225	<p>Continued From page 5</p> <p>Resident #3 on 07/23/14 with diagnoses which included Diabetes Type II and Mild Intellect Disability. Review of the Admission MDS assessment, dated 07/31/14, revealed the facility assessed Resident #3's cognition as cognitively intact with a BIMS score of fourteen (14) indicating the resident was interviewable.</p> <p>Interview with Resident #3, on 03/31/15 at 12:45 PM, revealed there are times when his/her money was taken and stated, "sometimes the staff find it and sometimes they don't".</p> <p>Review of handwritten notes, dated 11/23/15 and 11/24/15 provided by the Administrator and the Social Services Director, revealed Resident #3 had multiple complaints of missing money. However, further review revealed there was no formal Customer Concern Forms completed until 03/30/15 after the complaint investigation had begun and no documented evidence the allegation that the money was taken was reported to the appropriate State agencies.</p> <p>4. Record review revealed the facility admitted Resident #4 on 08/23/13 with diagnoses which included Chronic Airway Obstruction. Review of Annual MDS assessment, dated 01/12/15, revealed the facility assessed Resident #4's cognition as cognitively intact with a BIMS score of fifteen (15) indicating the resident was interviewable.</p> <p>Interview with Resident #4, on 3/31/15 at 12:00 PM, revealed he/she had been having problems with money missing at frequent intervals, twenty (20) to thirty dollars(30) at a time. The resident stated that after he/she bought a lock box it all</p>	F 225			

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

PRINTED: 04/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2015
NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF CLINTON			STREET ADDRESS, CITY, STATE, ZIP CODE 108 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 225	<p>Continued From page 6 stopped.</p> <p>Review of a hand written statement by the Social Services Director, dated 09/26/14, revealed the Resident #4 complained that fifteen (15) dollars was taken from his/her room on 09/23/14 and he/she had accused several different residents of taking the money. It was documented on the report the intervention put in place was to have the resident buy a lock box and keep his money inside it. However, further review revealed there was no documented evidence the allegation that the money was taken was reported to the appropriate State agencies.</p> <p>Interview with Business Office Manager, on 04/01/13 at 8:30 AM, revealed Resident # 4 had spent all the money that was in the personal account. She stated the resident only has forty (40) dollars a month and that was spent on cigarettes. She also revealed the resident purchased a lock box several months ago.</p> <p>5. Review of a Closed Record revealed the facility admitted Resident #5 on 11/02/12 with diagnoses which included after care joint replacement, Rehab. Review of Quarterly MDS assessment, dated 12/11/14, revealed the facility assessed Resident #5's cognition as cognitively intact with a BIMS score of fifteen (15) indicating the resident was interviewable. The resident was discharged home on 02/02/15.</p> <p>Review of a Customer Concern Form, dated 10/31/14, revealed the resident accused another staff member of taking money from his/her wallet and the facility notified the police. Review of a report completed by the Administrator on 11/03/15 revealed the incident was investigated</p>	F 225			

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

PRINTED: 04/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185469	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2015
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 225	Continued From page 7 and the facility was unable to substantiate that the resident was ever in possession of the money that he/she claimed to be missing. Further review revealed there was no documented evidence the facility reported this allegation to the appropriate state agencies. Interview with Administrator, on 3/31/15 at 10:30 AM, revealed she was not aware of any complaints related to misappropriation of funds recently. The Administrator stated the facility investigated everything that was reported. Further interview with the Administrator, on 04/01/15 at 2:00 PM, revealed she did not realize that it was necessary to report these allegations of missing money to other state agencies if she had completed an investigation and was unable to substantiate the complaint. She further revealed she had investigated each resident's complaint but was unable to determine if the allegation actually occurred and had not contacted any of the appropriate state agencies related to the abuse allegation made by the residents.	F 225	The facility Administrator will ensure all allegations of mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property are reported immediately to the Administrator. These allegations will also be reported to the state agencies and law enforcement in accordance with the existing state law. The Administrator is responsible for reporting the results of all investigations to the state agencies as required by state and federal law per facility's Abuse/Neglect policy and procedure.		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of Customer Concern forms, and review of	F 226	All allegations of misappropriation of resident funds and the results of the investigation will be reported to the appropriate state agencies for all residents. All allegations for residents #1, #2, #3, #4, and #5 was investigated. Resident #1 was provided a lock box and care planned to secure personal property/funds to prevent further occurrences. Resident #2 was provided a lock box and care planned to secure personal property/funds to prevent further occurrences. Resident #3 was provided a lock box and care planned to secure personal property/funds to prevent further occurrences. Resident #4 has a lock box and care planned to secure personal property/funds to prevent further occurrences. Resident #4 had a care plan meeting to review keeping personal property/funds in the lock box to prevent further occurrences.		

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

PRINTED: 04/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185489	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2015
NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF CLINTON			STREET ADDRESS, CITY, STATE, ZIP CODE 108 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 226	<p>Continued From page 8</p> <p>the facility's Abuse/Neglect policy it was determined the facility failed to implement the facility policy related to reporting allegations of misappropriated of resident money to the appropriate state agencies for five (5) of five (5) sampled residents (Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5).</p> <p>The findings include:</p> <p>Review of the facility's Abuse/Neglect policy and procedure, dated 03/01/2014, revealed the facility should ensure all alleged violations mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property, are reported immediately to the Administrator of the center. Further review revealed these alleged violations should also be reported to state agencies and law enforcement in accordance with existing state law. In addition, the Administrator was responsible to report the results of all investigations to the state agencies as required by state and federal law.</p> <p>Review of Customer Concern forms, dated 03/06/15 for Resident #1, dated 03/31/15 for Resident #2, and dated 10/31/14 for Resident #5; and review of a Social Service Notes, dated 09/26/14 for Resident #4 and dated 11/23/14 for Resident #3 and interviews with Residents #1, #2, #3, and #4 revealed the five (5) residents had reported money was taken from their room. Further record review and interview with staff revealed there was no documented evidence the facility implemented the Abuse/Neglect policy and procedure related to reporting allegations of misappropriated resident funds and the results of the facility's investigation of each allegation.</p>	F 226	<p>All other residents having the potential to be affected were interviewed by the Social Service Director and/or the Certified Activities Director on 4/03/15 to assess need for a lock box to secure personal property/funds.</p> <p>Resident Council Meeting held on 4/03/15 to inform residents of availability to obtain a lock box to secure their personal property. Lock boxes were obtained and care planned by the Social Service Director for those residents whom identified a need for a lock box to secure personal property.</p> <p>The facility Administrator is adding to the current Admission Agreement that all new residents upon admission will be educated to the availability of a lock box to secure personal property. The Social Service Director or designee will be responsible for obtaining the lock box for the resident upon admission.</p> <p>All staff will be in serviced by the Administrator or designee that all allegations involving mistreatment, neglect, or abuse, including injuries of unknown origin and 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 the state survey and certification agency.</p> <p>All staff will be in serviced by the Administrator or designee that residents will have lock boxes to secure personal property/funds</p>		

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

PRINTED: 04/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185469	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2015
NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF CLINTON			STREET ADDRESS, CITY, STATE, ZIP CODE 108 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 226	Continued From page 9 Interview with the Administrator, on 04/01/15 at 2:00 PM, revealed she did not realize that it was necessary to report these allegations of missing money to other state agencies if she had completed an investigation and was unable to substantiate the complaint.	F 226	The facility Administrator or designee will review and monitor at the monthly QAPI meeting all allegations of mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriation of resident property for staff compliance with timely reporting to the facility Administrator or designee and facility reporting to state agencies and other officials in accordance with state law and through established procedures including the state survey and certification agency. All concern logs will be audited monthly in the QAPI meeting by the Administrator or designee and the QAPI committee for three months and then per schedule established by the QAPI Committee.	5/15/15	