STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(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
F000000	This visit was for the Investigation of Complaint IN00130525. Complaint IN00130525 - Substantiated. Federal/state deficiency related to the allegation is cited at F323. Survey dates: July 8 and 9, 2013 Facility number: 000305 Provider number: 155625 AIM number: 100287200 Survey team: Barbara Gray RN Census bed type: SNF/NF: 70 Total: 70 Census payor type: Medicare: 10 Medicaid: 56 Other: 4 Total: 70 Sample: 3 This deficiency reflects state findings cited in accordance with 410 IAC 16.2.	F000000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(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
	Quality review 7/12/13 by Suzanne Williams, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	07/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(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
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. Based on interview and record review, the facility failed to develop, and implement, individualized care plan interventions, for a resident who was one to one supervision with staff, due to being a high elopement risk, and a high smoking safety risk, for 1 of 3 residents reviewed for elopement and smoking safety in the sample of 3. (Resident #A) Findings include: Resident #A's record was reviewed on 7/8/13 at 11:11 A.M. Social Service documentation, from another local nursing home facility, indicated the following: 6/3/13-Resident #A went missing from the facility. 6/4/13-Resident #A was returned to the facility by State Police. Resident #A would remain on one to one supervision with staff, until a locked unit could be found. Documentation indicated Resident #A was admitted to the facility, on 6/4/13.	F000323	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after July 22, 2013. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident A no longer resides in facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents with a risk for elopement and who smoke have the potential to be affected by the alleged deficient practice All staff were in-serviced on 7/15/13, 7/17/13, 7/18/13 and 7/19/13 by the SDC/DNS on smoking and elopement policies. 100%**	07/22/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	His diagnoses included, but were not limited to, senile dementia, and persistent mental disorder. A physician's order, for Resident #A, indicated the following: Resident #A would reside on a secured unit. He was not to leave the facility without speaking to his guardian from Adult Protective Services (APS). He would wear a wander guard, with staff checking the placement, and functioning, every shift. He could smoke according to the facility's smoking policy. An Elopement Risk Assessment, for Resident #A, completed on 6/5/13, indicated Resident #A was independently mobile. He often requested to go home and/or searched for home. He had a history of eloping from home or a facility. He had been seen pushing on/trying to open/or pace near exit doors. He exhibited cognitive impairment and poor decision making abilities. He had been assigned a security bracelet. A Temporary Admission Care Plan, for Resident #A, completed on 6/5/13, indicated the following: Problem-Resident #A was an elopement risk, identified on the		**audit of the elopement assessments, smoking assessments, care plans and orders were reviewed by Social Services Director/designee and completed by 7/15/2013. Assessments, Care plans and orders were updated and individualized as needed relating to residents needs What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All staff were in-serviced on 7/15/13, 7/17/13, 7/18/13 and 7/19/13 by the SDC/DNS on smoking and elopement policy. 100% audit of the elopement assessments, smoking assessments, care plans and orders were reviewed by Social Services Director/designee and completed by 7/15/2013. Assessments, Care plans and orders were updated and individualized as needed relating to residents needs** IDT team will review residents plan of care on admission and with any significant change regarding smoking and elopements to ensure residents plans of care are individualized based on residents needs. DNS/designee will conduct rounds each shift to ensure smoking interventions and elopement interventions are implemented per plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	Elopement Risk Assessment. Goal-Resident #A would remain safe in the facility. Interventions-He would wear a wander guard, according to his physician's order. All facility exits were secured. He would reside on a secured unit. An Elopement Care Plan, for Resident #A, dated 6/5/13, indicated the following: Problem-Resident #A was at risk for elopement, due to exit seeking behavior. Goal-Resident #A would not leave the facility unattended. Approaches-Diversional activities would be provided, if Resident #A was exit seeking. He would wear an electronic bracelet, with placement, and functioning, checked every shift by staff. He would be involved in group activities of his choice. A Smoking Risk Assessment, for Resident #A, completed on 6/5/13, indicated the following: Resident #A smoked cigarettes. He attempted to smoke in unauthorized areas. He would inappropriately seek out, or took, smoking materials from others. A care plan would be initiated. A Smoking Care Plan, for Resident #A, initiated 7/1/13, indicated the following: Problem-Resident #A		care.**DNS/designee to ensure compliance. How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** This will be monitored through the elopement, smoking, and care plan CQI which will be completed weekly times four weeks and monthly times six months. The results of this audit will be reviewed by the Quality Assurance Committee. If the results of the CQI audit are less than the 90% benchmark, an action plan will be developed and implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	preferred to smoke, according to the facility policy, but did inappropriately seek out smoking materials, from others. Goal-Resident #A would be a safe smoker through his next review. Approach-Resident #A would be assessed for smoking at least quarterly. Staff would ensure he was safe when he smoked. Progress notes for Resident #A, indicated the following: 6/4/13 at 4:00 P.M.-Resident #A had arrived at the facility. He was alert and oriented, with confusion noted at times. 6/7/13 at 8:45 A.M.-Resident #A was not in his room. His window screen had been torn out. 6/7/13 at 8:50 A.M. -The Executive Director (ED), Assistant Director of Nursing Services (ADNS), and all available department heads, were notified, Resident #A's whereabouts, were unknown. The MD, and Power of Attorney (POA), were notified. A grounds search was initiated. Ancillary staff had extended the search to surrounding neighborhoods. 6/7/13 at 9:20 A.M. -The ED had been notified, Resident #A's whereabouts, had been located. He was at a local park, and stated, he was "walking home to Columbus." He had no signs or symptoms of distress. He was easily directed into a staff member's vehicle and was returning			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	to the facility. 6/7/13 at 9:50 A.M. -The MD, and Resident #A's POA, were notified. He showed no signs or symptoms of distress. 6/7/13 at 10:43 A.M. The Memory Care Facilitator (MCF), met with Resident #A, concerning his discharge to a local hospital. He had scored 10 on his Brief Interview for Mental Status, indicating he was moderately impaired, for his cognitive decision making skills. 6/7/13 at 11:30 A.M. -Resident #A was placed on 24 hour supervision. A window alarm was placed on his bedroom window. A physician's order had been received, for Resident #A, to be evaluated, and treated, at a local psychiatric unit. His POA was notified of the order. 6/7/13 at 12:25 P.M.-Resident #A had attempted to leave his bedroom through the window. He was easily redirected back into his bedroom, and into the living room. 6/7/13 at 5:47 P.M.-Resident #A was transported to a nearby psychiatric unit, for evaluation and treatment. 6/10/13 at 11:00 A.M.-The Interdisciplinary Team (IDT) had met, to discuss Resident #A's elopement, and exit seeking behavior. The immediate interventions, were to put a window alarm in place, and have Resident #A, on one to one supervision, with staff. The MD had given an order, for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	Resident #A, to receive a psychiatric evaluation, and treatment, due to being a safety risk to himself. The IDT felt Resident #A needed more psychiatric testing, to identify possible interventions, to divert him from exit seeking. A Care Plan was created. 6/26/13 at 4:15 P.M.-Resident #A returned to the facility. He had a wanderguard applied and was place on continuous one on one supervision. 6/26/13 at 5:00 P.M. -Resident #A was found smoking a cigarette in his bathroom. He had denied smoking, but then admitted, to smoking his last "butt." The MD and his POA were made aware. An Elopement Risk Assessment, for Resident #A, completed on 6/27/13, indicated Resident #A, was independently mobile. He often requested to go home and/or searched for home. He had a history of eloping from home or a facility. He had been seen pushing on/trying to open/or pace near exit doors. He had been assigned a security bracelet. A Temporary Admission Care Plan, for Resident #A, completed on 6/26/13, indicated the following: Problem-Resident #A was an elopement risk, identified on the Elopement Risk Assessment.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	Goal-Resident #A would remain safe in the facility. Interventions-He would wear a wander guard according to his physician's order. All facility exits were secured. He would reside on a secured unit. A Behavior Care Plan, for Resident #A, dated 6/27/13, indicated the following: Problem-Resident #A was an elopement risk, as he often looked for windows, and doors, to exit the facility from, and he may become aggressive with staff, when re-directed. Goal-Resident #A would not elope through his next review. Approaches-Intervention #1 indicated, staff would inform Resident #A, they were unable to provide him a ride, because the facility vehicle, was out picking up others. Intervention #2 indicated, staff would inform Resident #A, the facility was preparing him for hernia surgery, and recovery, for him to return home. Staff were to assist Resident #A, with an activity. Intervention #3 indicated, staff would give Resident #A, a cup of coffee, and allow him to sit, on the cottage porch. Progress notes for Resident #A, indicated the following: 6/27/13 at 2:57 P.M.-Resident #A's guardian was called, and informed he was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	becoming verbally aggressive with staff, and his exit seeking, had increased. 6/27/13 at 4:40 P.M. -Resident #A continued on one to one supervision with staff. He had attempted to open the window in his bedroom but was easily re-directed. He had become verbally aggressive with staff, due to wanting to go home.... 6/27/13 at 11:46 P.M.- Resident #A had tried to open his window, in his bedroom. There was a staff person with him at all times. 6/28/13 at 11:01 A.M.-The IDT met, concerning Resident #A's behavior. He remained one to one supervision with staff. 6/28/13 at 2:57 P.M. -Resident #A's guardian was informed of the facility's concerns, and they wanted to look for alternate long term placement. 6/28/13 at 3:52 P.M. -Resident #A went to the window 3 to 4 times but was easily re-directed. 7/1/13 at 11:56 A.M.-Resident #A, had received a 75 minute, emergency visit, from the doctor. Resident #A, had been threatening to break out of the facility, and then calling his threats, "jokes." He was testing various windows. His voice and gestures were aggressive. He used his size to intimidate staff, then denied he was "doing anything of that sort." He knew how to turn the window alarms off and was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	experimenting with the door codes. Staff would prepare a series of unrelated door keys, so if he figured out one, the next one would require new learning....His diagnosis was Bipolar disorder, hypo-manic type. 7/1/13 at 2:10 P.M.-Resident #A, was seen for psychiatric services, for his aggressive behavior, with staff, and exit seeking. 7/1/13 at 4:57 P.M. -Resident A claimed he needed to use the bathroom. Staff had kept an eye on Resident #A through the bathroom door. The staff member smelled smoke and confronted Resident #A. When staff asked Resident #A for the lighter, he became angry, and grabbed the staff members arm with one hand, and made a fist with his other hand. 7/2/13 at 4:36 P.M.-The ED had spoke with Resident #A's guardian, concerning him being non-compliant with the smoking policy. When staff had approached Resident #A, he had become physically aggressive, and stated, "I will punch you." He continued on one to one supervision with staff. He was continually monitored by staff from a short distance, to allow him space to himself. 7/2/13 at 6:33 P.M.-Resident #A had been aggressive with staff, and non-compliant, with the smoking policy. He was found smoking in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	bathroom. 7/2/13 at 8:45 P.M. -Resident #A was transferred to a psychiatric unit. On 7/8/13 at 10:15 A.M., the ED indicated, on 6/7/13, Resident #A, had ripped a piece of wood and screw, out of his bedroom window track, and left the facility. She indicated, he went to a nearby store, and bought some cigarettes, and a lighter. He then went to a near-by park, where he was found by staff. He was placed on one to one supervision, and then sent out to a hospital behavioral unit. He returned to the facility, after his evaluation, and treatment was completed. He was placed on one to one supervision with staff, upon his return. He was non-compliant with smoking. He wanted to keep his cigarettes and lighter. She stated "he constantly wanted to smoke and he constantly wanted to leave." She indicated he was sent out to a hospital behavioral unit again, and was currently still there, due to being unsafe to himself, and others. On 7/8/13 at 3:30 P.M., the ED indicated, Resident #A, was one to one supervision, with staff, upon his return from the hospital, on 6/26/13 She indicated he had returned to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	facility with a cigarette and lighter. She indicated, she had informed staff not to leave him, but give him enough space, so they could actually see what he was going to do. She indicated, at times, staff could get his lighter from him, by asking, if they could use it. At other times, that didn't work, and staff stayed right with him, to make sure he didn't smoke, in inappropriate areas. She indicated, staff handed Resident #A, his lighter during smoke brakes, and at times, he wouldn't give the lighter back to staff. She indicated, Resident #A, would say to staff, "I can light my own cigarette." On 7/8/13 at 4:06 P.M., the MCF indicated, staff would light a lighter for Resident #A's cigarette, and he would grab staff's hand and insist they let go of the lighter. She indicated, he would squeeze staff's hand so hard, they would have to let go of the lighter. She indicated, most of the time, Resident #A, would not give the lighter back to staff. She indicated, she had reported the situation, and had been instructed to tell Resident #A, she needed to use the lighter, in an attempt to get it back. She indicated, that intervention worked a couple of times.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	On 7/8/13 at 5:23 P.M., the Social Service Designee (SSD) indicated, she and the ED had spoke to Resident #A, sometime at the end of June, regarding the smoking policy. She indicated Resident #A was informed he could not keep smoking material on him, and all of the smoking material, was kept locked up. He allowed the SSD, and ED, to search his person, and bedroom. She indicated, a 30 day discharge, was discussed at that time, due to his non-compliance. She indicated, she did not document any information, related to the meeting. On 7/9/13 at 1:55 P.M., RN #1 indicated, she believed Resident #A would go out and smoke half a cigarette, and sneak the cigarette butt, back in the facility in his pocket. She indicated, she smelled smoke coming from his bathroom on 7/2/13. He was seated on the toilet. He yelled at her, he was not smoking, but using the bathroom. On 7/9/13 at 3:35 P.M., the SSD indicated Resident #A's care plan, related to smoking, was reviewed on 7/1/13, because he had been smoking in the bathroom. She indicated, no other interventions were added to the care plan, regarding			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	what staff were to do, when Resident #A was non-complaint, with the smoking policy. The SSD indicated there was no plan of care, related to Resident #A, being placed on one to one supervision, after returning from the hospital, on 6/26/13. The SSD indicated, staff just documented progress notes. The most recent Missing Resident/Resident Elopement policy and procedure, provided by the ED, on 7/8/13 at 4:05 P.M., indicated the following: ... "e.) Care plans will be developed and individualized for residents who exhibit elopement behavior/risk...." The most recent Smoking policy and procedure, provided by the Director of Nursing, on 7/8/13 at 4:30 P.M., indicated the following: ... "1.f.) Smoking materials (cigarettes, matches, lighters) are kept and distributed by staff not residents. Smoking materials are to be kept in a safe location in the facility monitored by designated staff... 9. Residents who are found to be non compliant with this policy (i.e. smoking in either the facility or non designated areas) will be considered a safety risk to the facility. an immediate meeting will occur with the resident and facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240	

(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
	management to discuss options up to and including discharge from the facility for safety reasons...." This federal tag relates to Complaint IN00130525. 3.1-45(a)(2)			