

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER Arbutus Park Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 207 Ottawa Street Johnstown, PA 15904	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>31760</p> <p>Based on review of policies, investigative reports, and residents' clinical records, as well as staff family interviews, it was determined that the facility failed to ensure that residents were free from neglect caused by a failure to follow a resident's care plan for preventing falls for one of four residents reviewed (Resident 1), resulting in a fall and fracture for the resident. This deficiency was cited as past noncompliance.</p> <p>Findings include:</p> <p>The facility's policy regarding resident abuse, dated January 10, 2024, revealed that neglect is defined as the failure of the facility, its employees, or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated January 5, 2024, revealed that the resident was cognitively intact and had diagnoses of seizure disorder. The resident's care plan, dated June 10, 2023, revealed that the resident was at risk for injury due to falls related to decreased mobility, muscle weakness, gait abnormality, lack of coordination, and history of falls. Staff was not to leave the resident alone with toileting, to walk the resident with use of gait belt (used to help nursing staff support a person who is unsteady or weak), and the resident was to be an assist two for the B (evening) and C (night) shifts.</p> <p>A Kardex report (a nursing worksheet that includes a summary of patient information, such as prescribed medications, clinical follow-ups, and daily care schedules) for Resident 1, dated March 7, 2024, revealed the following safety measures for staff to follow: Not to leave the resident alone with toileting, to walk the resident with use of gait belt, and the resident was to be an assist two for the B (evening) and C (night) shifts.</p> <p>A nursing note for Resident 1, dated March 7, 2024, revealed that at 12:10 a.m. the writer was called to the resident's room. The resident was lying on the floor in the bathroom. The resident had a large amount of blood coming out of her nose. The resident stated that she was dizzy and seeing double. When the writer asked the resident what she was doing, the resident stated she is dizzy and seeing double.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note for Resident 1, dated March 7, 2024, revealed that the resident returned to the facility at 6:48 p.m. from the hospital after having a fall. She was diagnosed with a closed fracture of the nasal bone and a urinary tract infection (UTI).</p> <p>Investigative documents for Resident 1, dated March 7, 2024, revealed that the resident's assigned caregiver was Nurse Aide 1, and that the incident occurred in the resident's bathroom. The resident stated that she got dizzy.</p> <p>A statement completed by Nurse Aide 1, dated March 7, 2024, revealed that he walked Resident 1 to the bathroom to get ready for bed, then left her alone on the toilet while he went to help the registered nurse change another resident in another room. When finished with the other resident, Nurse Aide 1 went back to Resident 1 and saw that she had fallen in the bathroom. He then went to get the nurse.</p> <p>A statement completed by the Director of Nursing, dated March 7, 2024, revealed that a call was placed to Nurse Aide 1 regarding the incident that occurred on the prior evening. Following the investigation of the incident, fall, and care delivered to the resident by this nurse aide, it was determined that neglect was identified and admitted in the employee's statement. He admitted to ambulating the resident to the bathroom with one assist and not using a gait belt. The resident was to be an assist of two for all ambulation and transfers during his shift and a gait belt was to be utilized. He also admitted to leaving her on the toilet in the bathroom when the resident's care plan specifically stated that she was not to be unattended in the bathroom. Failure to follow the care plan resulted in the resident falling off the toilet and sustaining multiple facial fractures and constituted serious harm to the resident. Neglect to follow the resident's care plan that leads to serious injury of a resident is considered abuse by definition. The Directed of Nursing explained this to Nurse Aide 1 on the telephone and he verbalized understanding of the reason for termination of employment.</p> <p>Review of Nurse Aide 1's personnel file revealed that he was hired by the facility as a nurse aide on October 12, 2011, and that he had completed training regarding preventing, recognizing, and reporting abuse on April 7, 2023.</p> <p>Interview with the Assistant Director of Nursing on March 14, 2024, at 11:40 a.m. confirmed that the facility's investigation substantiated neglect because Nurse Aide 1 did not follow Resident 1's care plan, did not use a gait belt when walking the resident, did not assist the resident with two staff when transferring, did not stay with the resident while she was in the restroom, and the resident received a fracture.</p> <p>Following the investigation on March 7, 2024, the facility's corrective actions included:</p> <p>Nurse Aide 1 was terminated from employment at the facility.</p> <p>Staff education on abuse was completed.</p> <p>Audits to identify any issues with abuse were started.</p> <p>The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F600 on March 8, 2024. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>31760</p> <p>Based on review of clinical records and investigative reports, as well as staff interviews, it was determined that the facility failed to ensure that staff implemented care-planned interventions for one of four residents reviewed (Resident 1) that was identified as a fall risk, resulting in a fall and fracture for the resident. This deficiency was cited as past noncompliance.</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated January 5, 2024, revealed that the resident was cognitively intact and had diagnoses of seizure disorder. The resident's care plan, dated June 10, 2023, revealed that the resident was at risk for injury due to falls related to decreased mobility, muscle weakness, gait abnormality, lack of coordination, and history of falls. Staff was not to leave the resident alone with toileting, to walk the resident with use of gait belt (used to help nursing staff support a person who is unsteady or weak), and the resident was to be an assist two for the B (evening) and C (night) shifts.</p> <p>A Kardex report (a nursing worksheet that includes a summary of resident information, such as prescribed medications, clinical follow-ups, and daily care schedules) for Resident 1, dated March 7, 2024, revealed the following safety measures for staff to follow: Not to leave the resident alone with toileting, walk the resident with use of gait belt, and the resident was to be an assist two for the B (evening) and C (night) shifts.</p> <p>A nursing note for Resident 1, dated March 7, 2024, revealed that at 12:10 a.m. the writer was called to the resident's room. The resident was lying on the floor in the bathroom. The resident had a large amount of blood coming out of her nose. The resident stated that she was dizzy and seeing double. When the writer asked the resident what she was doing, the resident stated she was dizzy and seeing double.</p> <p>A nursing note for Resident 1, dated March 7, 2024, revealed that the resident returned to the facility at 6:48 p.m. from the hospital after having a fall. She was diagnosed with a closed fracture of the nasal bone and urinary tract infection (UTI).</p> <p>Investigative documents for Resident 1, dated March 7, 2024, revealed that the resident's assigned caregiver was Nurse Aide 1, and that the incident location occurred in the resident's bathroom. The resident stated that she got dizzy.</p> <p>A statement completed by Nurse Aide 1, dated March 7, 2024, revealed that he walked Resident 1 to the bathroom to get ready for bed and left her alone on the toilet while he went to help the registered nurse change a resident in another room. When finished with the other resident, he went back to Resident 1 and saw that she had fallen in the bathroom and he went to get the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A interview with Nurse Aide 1, completed by the Assistant Director of Nursing for clarification on his written statement, revealed that he did not use a gait belt when walking the resident and that he transferred the resident by himself.</p> <p>A statement completed by the Director of Nursing, dated March 7, 2024, revealed that a call was placed to Nurse Aide 1 regarding the incident that occurred on the prior evening. Following the investigation of the fall incident and care that was delivered to the resident by this nurse aide, it was determined that neglect was identified and admitted in the employee's statement. He admitted to ambulating Resident 1 to the bathroom with an assist of only one and without using a gait belt. The resident was to be an assist of two for all ambulation and transfers during his shift and a gait belt was to be utilized. He also admitted to leaving her on the toilet in the bathroom when the resident's care plan specifically stated that she was not to be unattended in the bathroom. Failure to follow the care plan resulted in the resident falling off the toilet and sustaining a fracture, which constituted serious harm to the resident. Neglect to follow the resident's care plan that leads to serious injury of a resident is considered abuse by definition. The Director of Nursing explained this to Nurse Aide 1 on the telephone and he verbalized understanding of the reason for termination of employment.</p> <p>Interview with the Assistant Director of Nursing on March 14, 2024, at 11:40 a.m. confirmed that Nurse Aide 1 did not follow Resident 1's care plan of using a gait belt when walking the resident, assisting the resident with two staff when transferring, staying with the resident while she was in the restroom, and that the resident received a fracture.</p> <p>Follow the investigation on March 7, 2024, the facility's corrective actions included:</p> <p>Nurse Aide 1 was terminated from employment at the facility.</p> <p>Staff education on following the resident's care plan was completed.</p> <p>Audits to identify any issues with following a resident's care plan were started.</p> <p>The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary.</p> <p>Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F656 on March 8, 2024.</p> <p>28 Pa. Code 201.24(e)(4) Admission Policy.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>31760</p> <p>Based on review of the facility's policies, investigation documents, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to maintain a safe environment for one of four residents reviewed (Resident 1) resulting in a fall with fracture. This deficiency was cited as past non-compliance.</p> <p>Findings include:</p> <p>The facility's policy regarding gait belts (used to help nursing staff support a person who is unsteady or weak) for transfers and ambulation (walking), dated January 10, 2024, revealed that gait belts are provided to assist staff to safely transfer or ambulate residents. Gait belts are to be used on all residents who require one or two assist with weight bearing support for transfers and ambulation.</p> <p>The facility's policy regarding transfers, dated January 10, 2024, revealed that the facility must ensure that each resident receives adequate supervision and assistance. Staff will use a gait belt for all one or two assist transfers unless the lift is utilized. An assessment card will be posted above the resident's bed. The dot system will be utilized above the resident's bed to help communicate the resident's needs for assistance to direct care staff. The amount of assistance required by the resident will also be placed in the resident's care plan and flow sheets. The assessment card and the care plan indicates the least amount of assistance that the resident requires and they can be provided with more assistance depending on the abilities of the resident on a particular day and/or staff.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated January 5, 2024, revealed that the resident was cognitively intact and had a diagnosis of seizure disorder. The resident's care plan, dated June 10, 2023, revealed that the resident was at risk for injury due to falls related to decreased mobility, muscle weakness, gait abnormality, lack of coordination, and a history of falls. Staff was to walk the resident with the use of a gait belt, not leave the resident alone with toileting, and the resident was an assist two for the B (evening) and C (night) shifts.</p> <p>A Kardex report (a nursing worksheet that includes a summary of patient information, such as prescribed medications, clinical follow-ups, and daily care schedules) for Resident 1, dated March 7, 2024, revealed the following safety measures for staff to follow: Not to leave the resident alone with toileting, walk the resident with the use of a gait belt, and the resident was to be an assist two for the B (evening) and C (night) shifts.</p> <p>A nursing note for Resident 1, dated March 7, 2024, revealed that at 12:10 a.m. the writer was called to the resident's room. The resident was lying on the floor in the bathroom. The resident had a large amount of blood coming out of her nose. The resident stated that she was dizzy and seeing double. When I asked the resident what she was doing, the resident stated she was dizzy and seeing double.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note for Resident 1, dated March 7, 2024, revealed that the resident returned to the facility at 6:48 p.m. from the hospital after having a fall. She was diagnosed with a closed fracture of the nasal bone and urinary tract infection (UTI).</p> <p>Investigative documents for Resident 1, dated March 7, 2024, revealed that the resident's assigned caregiver was Nurse Aide 1 and that the incident location occurred in the resident's bathroom. The resident stated that she got dizzy.</p> <p>A statement completed by Nurse Aide 1, dated March 7, 2024, revealed that he walked Resident 1 to the bathroom to get ready for bed and left her on the toilet alone while he went to help the registered nurse change a resident in another room. When finished with the other resident, he went back to Resident 1 and saw that she had fallen in the bathroom and went to get the nurse.</p> <p>An interview with Nurse Aide 1, completed by the Assistant Director of Nursing for clarification on his written statement, revealed that he did not use a gait belt when walking the resident and that he transferred the resident by himself.</p> <p>A statement completed by the Director of Nursing, dated March 7, 2024, revealed that a call was placed to Nurse Aide 1 regarding the incident that occurred on the prior evening. Following the investigation of the incident involving a fall and care that was delivered to the resident by this nurse aide, it was determined that neglect was identified and admitted in the employee's statement. He admitted to not using a gait belt to ambulate the resident to the bathroom with one assist. The resident was to be an assist of two for all ambulation and transfers during his shift and a gait belt was to be utilized. He also admitted to leaving her on the toilet in the bathroom when the resident's care plan specifically stated that she was not to be unattended in the bathroom. Failure to follow the care plan resulted in the resident falling off the toilet and sustaining a facial fracture, which constituted serious harm to the resident. Neglect to follow the resident's care plan that leads to serious injury of a resident is considered abuse by definition. The Director of Nursing explained this to Nurse Aide 1 on the telephone and he verbalized understanding of the reason for termination of employment.</p> <p>Interview with the Assistant Director of Nursing on March 14, 2024, at 11:40 a.m. confirmed that Nurse Aide 1 did not follow Resident 1's care plan of using a gait belt when walking the resident, assisting the resident with two staff when transferring, staying with the resident while she was in the restroom, and that the resident received a fracture.</p> <p>Follow the investigation on March 7, 2024, the facility's corrective actions included:</p> <p>Nurse Aide 1 was terminated from employment at the facility.</p> <p>Staff education on following the resident's care plan for assistance with ambulation/transfers was completed.</p> <p>Audits to identify any issues with following a resident's care plan for assistance with ambulation/transfers were started.</p> <p>The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F689 on March 8, 2024. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.		