STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396069	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concordia at Arbutus Park	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to afford residents the right of self-determination to make choices for one of three residents reviewed (Resident R2).Findings include:A facility policy for Resident Rights dated January 16, 2026, indicated that the resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights. The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: the resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. An annual Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 2, dated February 2, 2026, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, and had a diagnosis that included Alzheimer's disease. Care plan for Resident 2 dated February 23, 2026, included that the resident was at risk for falls or injury related to falls, and she had an intervention that was active through March 6, 2026, that indicated the resident was to have a special lock to her bedroom door. Physician's orders for Resident 2 dated November 25, 2025, indicated that the resident was to have a door lock block to her room door when she was out of her room. Review of the Treatment Administration Record (TAR) for Resident 2 dated December 2025, January 2026, February 2026, and March 2026, revealed documented evidence that the resident had a door lock block to her room door when she was out of her room every shift in December, January and February, and through March 4, 2026. Observation of the door lock block used for Resident 2's door on April 8, 2026, at 1:12 p.m. revealed that it was a wooden block that was placed on a door where the door handle is, that prevented the door handle from being pushed in and thus preventing the door from being opened. There was a bolt and pin device on the bottom of it that prevented it from being easily removed from the door. Interview with Licensed Practical Nurse 1 at the time of this observation revealed that the Resident's son provided the facility with the bolt/pin lock for the wood block believing it was an improvement to what the facility had. She reported that the resident occasionally attempted to get into her room when the block was in place, and she was easily redirected. Interview with Nurse Aide 2 on April 8, 2026, at 2:05 p.m. revealed that a device was previously used on Resident 2's bedroom door that prevented her from entering her room. It was never used when anyone was in that room, and it did not interfere with the roommate having access to the room whenever she wanted because she was not independent with mobility and needed assistance to get to her room. Interview with Licensed Practical Nurse 3 on April 8, 2026, at 2:08 p.m. revealed that a door lock was previously used on Resident 2's room door to prevent her from being unsupervised in her room. The Resident's son requested that the lock be put on the door block. She was uncertain exactly how long the door block lock was in place, but did reveal that while the block was in place, the resident would make attempts to enter her room and staff would redirect her by telling her that someone was cleaning her room, or they would get her personal effects like her purse that she was looking for. The door block was never used when anyone was in the room, and it did not prevent that resident's roommate from having less (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	access to her room than she normally had. Interview with the Director of Nursing on April 8, 2026, at 2:33 p.m. revealed that the Resident's son insisted on keeping the resident out of her room believing he could prevent all falls, and he bought a special lock for the wood block the facility had that was primarily used in the past to secure resident belongings when they went to the hospital. They allowed the door lock to be put on the door, which prevented the Resident from accessing her room whenever she wanted. The Director of Nursing revealed that she felt bad that it prevented the Resident from going into her room and removed that door lock block at the resistance of the Resident's son. 28 Pa. Code 201.29(a) Resident Rights.