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	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbutus Park Manor	207 Ottawa Street Johnstown, PA 15904

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46994 Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that facility failed to determine if a resident was safe to self-administer medications for one of 31 residents reviewed (Resident 99). Findings include: The facility's medication policy, dated January 10, 2024, indicated that self-administration was permitted when specifically authorized by the physician. Control and supervision are the responsibility of the faculty. Review of the clinical record for Resident 99 revealed that she was admitted to the facility on [DATE], and had diagnoses that included diabetes. Physician's orders for Resident 99, dated September 11, 2024, included an order that the resident could use her insulin pump (a wearable medical device that supplies a continuous flow of insulin underneath the skin) as set by her endocrinologist (doctor who specializes in the diagnosis and treatment of hormone-related diseases and conditions, including diabetes) with 100 unit per milliliter of basal Novolog (insulin used to keep your blood glucose levels stable during periods of fasting) at a rate of 0.55 units per hour. Physician's orders for Resident 99, dated September 12, 2024, included an order that the resident could manage her insulin bolus (dose of insulin taken to handle a rise in blood glucose) as set up in her insulin pump by her endocrinologist, before meals and at bedtime, making sure she notifies staff prior to self-administering each bolus. There was no documented evidence in Resident 99's clinical record to indicate that an assessment was completed to determine if she was safe to self-administer her medication. A nurse's note for Resident 99, dated September 13, 2024, at 4:10 a.m. revealed that the resident appeared to be anxious and confused at times and that she continued to manage her diabetes with a continuous glucose machine. Observations of Resident 99 on September 17, 2024, at 2:30 p.m. revealed that the resident had an insulin pump attached to her right abdomen, which she reported at the time of the observation to be functioning properly. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on September 18, 2024, at 2:39 p.m. confirmed that an assessment to determine if Resident 99 was safe to self-administer her medications was not completed. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38012 Based on observations and staff interviews, it was determined that the facility failed to ensure that residents had a clean and homelike environment on one of three nursing units (secured unit). Findings include: Observations on September 16, 2024, at 8:17 p.m. revealed that the carpet in the hallway on the 400 side of the secured unit was stained and dirty. There was duct tape on the carpet of the threshold between the hallway and room [ROOM NUMBER] and between the hallway and room [ROOM NUMBER]. Interview with the Director of Maintenance on September 18, 2024, revealed that the carpet in the secured unit was to be scrubbed nightly and that it was in need of being replaced. He stated that the duct tape on the floor between the hallway and rooms [ROOM NUMBERS] was there because the strip that was there was a trip hazard. He stated that the duct tape made a smooth transition between the hallway and the resident rooms. Interview with the Director of Nursing on September 18, 2024, at 1:24 p.m. confirmed that the carpeting in the secured unit needed replaced and that duct tape should not have been placed on the threshold between the hallway and the resident rooms. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Responsibility.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 47819 Based on review of policies, as well as interviews with residents and staff, it was determined that the facility failed to ensure that residents and/or their representatives could file a grievance/concern anonymously by failing to ensure that information on how to file a grievance or complaint was available to residents or their representatives without asking. Findings include: The facility's Grievance Process policy, dated January 10, 2024, indicated that anyone may file a grievance anonymously if they chose to do so. During an interview with a group of residents on September 17, 2024, at 10:34 a.m., the residents indicated that they did not know how to file a grievance anonymously. Interview with the Director of Nursing on September 19, 2024, at 9:48 a.m. revealed that the facility's grievance forms were located behind each nursing station, and confirmed that nurses could give the forms to the residents; however, residents or their representatives could not access or file the grievance forms on their own. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29(i) Resident Rights.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 31760 Based on clinical record reviews and staff interviews, it was determined that the facility failed to notify the resident and legal guardian in writing regarding the reason for hospitalization for two of 31 residents reviewed (Residents 54, 83). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 54, dated July 25, 2024, revealed that the resident was understood, could understand others, and had a diagnosis that included a cerebral vascular accident (CVA - commonly known as a stroke) with hemiplegia (paralysis on one side of the body). Nursing notes for Resident 54, dated July 11, 2024, revealed that the resident's foley catheter (a thin, flexible tube that drains urine from the bladder into a collection bag) was changed the previous night. A urine was obtained that morning, and the resident has not had any output since. The nurse removed water from the foley catheter balloon to change it thinking that it was blocked, but blood came out from around the resident's penis and the catheter would not come out. When the nurse tried to advance the foley, blood came out. The resident had a temperature the previous night that went down but went back up to 101.2 degrees Fahrenheit (F), and he was having dyspnea (shortness of breath). The resident was started on oxygen and was sent to the emergency room and admitted with a diagnosis of sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection, damaging the body's own tissues and organs). There was no documented evidence that a written notice of Resident 54's transfer to the hospital was provided to the resident and/or the resident's responsible party regarding the reason for transfer. Interview with the Business Office Manager on September 18, 2024, at 1:03 p.m. confirmed that there was no documented evidence that a written notice of Resident 54's transfer to the hospital was provided to the resident and/or the resident's responsible party regarding the reason for transfer. A quarterly MDS assessment for Resident 83, dated August 1, 2024, indicated that the resident was cognitively impaired, was dependent on staff for his daily care needs, and had diagnoses that included dementia. A nurse's note for Resident 83, dated June 2, 2024, at 2:04 p.m., revealed that the resident had decreased urine output, his abdomen was distended, and he had abnormal drainage from his penis. The physician was notified, and orders were received to transport the resident to the emergency room for evaluation. A nurse's note at 8:14 p.m. revealed that the resident was admitted to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note for Resident 83, dated July 19, 2024, at 11:33 a.m., revealed that the physician reviewed the results of the resident's x-ray and recommended further testing be done at the hospital. The physician ordered the resident be transferred to the emergency room for evaluation. A nurse's note at 8:45 p.m. revealed that the resident was admitted to the hospital for further testing and treatment. A nurse's note for Resident 83, dated August 8, 2024, at 3:00 a.m., revealed that the resident had a change in condition that included a fever and elevated heart rate and blood pressure. The family was notified and gave permission to transfer the resident to the emergency room for evaluation. A nurse's note at 6:06 a.m. revealed that the resident was admitted to hospital. There was no documented evidence that a written notice of Resident 83's transfers to the hospital was provided to the resident's responsible party regarding the reason for transfer. Interview with the Business Office Manager on August 18, 2024, at 1:05 p.m. confirmed that the facility was not providing written notices to the residents or their responsible parties that indicated the reason for transfer to the hospital when a resident was transferred to the hospital. 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 201.29(f)(g) Resident Rights.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 31760 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to issue a bed-hold notice at the time of an anticipated leave of absence from the facility for two of 31 residents reviewed (Resident 54, 83). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 54, dated July 25, 2024, revealed that the resident was understood, could understand others, and had a diagnosis that included a cerebral vascular accident (CVA - commonly known as a stroke) with hemiplegia (paralysis on one side of the body). Nursing notes for Resident 54, dated July 11, 2024, revealed that the resident's foley catheter (a thin, flexible tube that drains urine from the bladder into a collection bag) was changed the previous night. A urine was obtained that morning, and the resident has not had any output since. The nurse removed water from the foley catheter balloon to change it thinking that it was blocked, but blood came out from around the resident's penis and the catheter would not come out. When the nurse tried to advance the foley, blood came out. The resident had a temperature the previous night that went down but went back up to 101.2 degrees Fahrenheit (F), and he was having dyspnea (shortness of breath). The resident was started on oxygen and was sent to the emergency room and admitted with a diagnosis of sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection, damaging the body's own tissues and organs). There was no documented evidence that a bed-hold notice was issued to Resident 54 or his responsible party at the time of his transfer to the hospital. Interview with the Business Office Manager on September 18, 2024, at 1:03 p.m. confirmed that there was no documented evidence that a bed-hold notice was issued to Resident 54 or his responsible party at the time of his transfer to the hospital. A quarterly MDS assessment for Resident 83, dated August 1, 2024, indicated that the resident was cognitively impaired, was dependent on staff for his daily care needs, and had diagnoses that included dementia. A nurse's note for Resident 83, dated June 2, 2024, at 2:04 p.m., revealed that the resident had decreased urine output, his abdomen was distended, and he had abnormal drainage from his penis. The physician was notified, and orders were received to transport the resident to the emergency room for evaluation. A nurse's note at 8:14 p.m. revealed that the resident was admitted to the hospital. A nurse's note for Resident 83, dated July 19, 2024, at 11:33 a.m., revealed that the physician reviewed the results of the resident's x-ray and recommended further testing be done at the hospital. The physician ordered the resident to be transferred to the emergency room for evaluation. A nurse's note at 8:45 p.m. revealed that the resident was admitted to the hospital for further testing and treatment. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note for Resident 83, dated August 8, 2024, at 3:00 a.m., revealed that resident had a change in condition that included a fever and elevated heart rate and blood pressure. The family was notified and gave permission to transfer the resident to the emergency room for evaluation. A nurse's note at 6:06 a.m. revealed that the resident was admitted to hospital. There was no documented evidence that a bed-hold notice was issued to Resident 83 or his responsible party at the time of his transfers to the hospital. Interview with the Business Office Manager on August 18, 2024, at 1:05 p.m. confirmed that the facility was not providing written bed-hold notices to the residents or their responsible parties when a resident was transferred to the hospital. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(3) Management.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46994 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to develop care plans to address individualized resident care needs for one of 31 residents reviewed (Resident 99). Findings include: The facility's policy regarding care plans, dated January 10, 2024, indicated that a resident care plan will be established within 24 hours of admission and will be reviewed and revised as indicated on readmission, significant change, and as needed for new or revised interventions. Resident care management is designed to ensure systemic comprehensive approach to assessing, planning, and meeting the resident's needs. Review of the clinical record for Resident 99 revealed that she was admitted to the facility on [DATE], and had diagnoses that included diabetes. Physician's orders for Resident 99, dated September 11, 2024, included an order that the resident may use her insulin pump (a wearable medical device that supplies a continuous flow of insulin underneath the skin) as set by her endocrinologist (doctor who specializes in the diagnosis and treatment of hormone-related diseases and conditions, including diabetes) with 100 unit per milliliter of basal Novolog (insulin used to keep blood glucose levels stable during periods of fasting) at a rate of 0.55 units per hour. Physician's orders for Resident 99, dated September 12, 2024, included an order that the resident may manage her insulin bolus (dose of insulin taken to handle a rise in blood glucose) as set up in her insulin pump by her endocrinologist, before meals and at bedtime, making sure she notifies staff prior to self-administering each bolus. Observations of Resident 99 on September 17, 2024, at 2:30 p.m. revealed that the resident had an insulin pump attached to her right abdomen, which she reported at the time of the observation to be functioning properly. As of August 16, 2024, there was no documented evidence that a care plan was developed to address Resident 99's individualized care needs related to her diabetes and self-administration of insulin using an insulin pump. Interview with the Director of Nursing on September 18, 2024, at 2:39 p.m. confirmed that Resident 99 did not have a care plan in place to address the care and treatment required for her diagnosis of diabetes and self-administering insulin using an insulin pump. 28 Pa. Code 211.10(d) Resident Care Plans.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46994 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for one of 31 residents reviewed (Resident 41). Findings include: The facility's policy regarding care plans, dated January 10, 2024, indicated that a resident care plan will be established within 24 hours of admission and will be reviewed and revised as indicated on readmission, significant change, and as needed for new or revised interventions. Resident care management is designed to ensure systemic comprehensive approach to assessing, planning, and meeting the resident's needs. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 41, dated August 16, 2024, indicated that the resident was understood and could usually understand others, required assistance from staff for daily care needs, and had diagnoses that included dementia and Post Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event). A psychiatry consult note for Resident 41, dated June 16, 2024, revealed that the resident acknowledged experiencing PTSD symptoms as a result of his military service. A review of Resident 41's plan of care revealed no documented evidence that his care plan was revised to address any triggers (stimulus that causes a painful memory to resurface) related to PTSD that could re-traumatize the resident. Interview with the Director of Nursing on August 19, 2024, at 8:45 a.m. confirmed that the facility did not attempt to identify Resident 41's PTSD triggers and revise his care plan to include care related to possible PTSD triggers. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 46994 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that residents were assessed and received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of Post Traumatic Stress Disorder (PTSD) (a mental and behavioral disorder that develops related to a terrifying event) for one of 31 residents reviewed (Resident 41). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 41, dated August 16, 2024, indicated that the resident was understood and could usually understand others, required assistance from staff for daily care needs, and had diagnoses that included dementia and PTSD. Review of the care plan for Resident 41, dated January 22, 2024, indicated that the resident had a diagnosis of dementia and PTSD. There was no documented evidence the facility identified Resident 41's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring. Interview with the Director of Nursing on August 19, 2024, at 8:45 a.m. confirmed that the facility did not complete a trauma informed care assessment on Resident 41. 28 Pa Code 201.24(e)(4) Admission Policy. 28 Pa Code 211.12(a)(d)(3)(5) Nursing Services. 28 Pa. Code 211.16(a) Social Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 31760 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were properly labeled for one of 31 residents reviewed (Resident 36). Findings include: The facility's policy regarding medication, dated January 10, 2024, indicated that medications that a resident brings with him/her on admission to the facility from home or another facility will be used if they are properly labeled and ordered by the physician, and the dose is the ordered dose. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 36, dated July 17, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included multiple sclerosis (MS - a chronic autoimmune disease that affects the central nervous system). Physician's orders for Resident 36, January 27, 2024, included orders for the resident to self-administer approximately sixty-one different over-the-counter biological and herbal supplements. Observations of the [NAME] Hall medication refrigerator on September 19, 2024, at 11:07 a.m. revealed that on the bottom shelf of the door were eight plastic, sandwich-size, zip-lock baggies that were 1/4 full of multiple tablets and capsules. However, there was no labeling on the eight plastic sandwich-size, zip-lock baggies to indicate who they belonged to or what the contents were. Interview with Licensed Practical Nurse 1 at the time of observation revealed that the eight plastic, sandwich-size, zip-lock baggies containing the multiple tablets and capsules belonged to Resident 36 and were her biological and herbal supplements. She indicated that the resident's son prepares the supplements at home and then brings the zip-lock baggies into the facility. She confirmed that there was no name or labeling of what the contents of the zip-lock bags contained. Interview with the Director of Nursing on September 19, 2024, at 11:55 a.m. confirmed that not having Resident 36's name on the zip lock baggies is a problem. She indicated that she maintains a list of the supplements that Resident 36 uses for the nursing staff that work on that unit. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(3) Nursing Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38012 Based on facility policies, observations, and staff interviews, it was determined that the facility failed to store food in accordance with professional standards for food service safety. Findings include: The facility's policy regarding labeling and dating food, dated [DATE], revealed that food was to be discarded on or immediately after the expiration/use by date. Observations in the kitchen on [DATE], at 6:15 p.m. revealed that there were two gallons of chocolate ice cream mix that expired [DATE], and one gallon of vanilla ice cream mix that expired [DATE], in the cooler. Observations in the freezer at that time revealed two bags of frozen chicken breasts that were open and exposed to air. The freezer also had opened ice cream cup containers and food container debris lying on the floor under the shelves. Observations on [DATE], in the dry storage room revealed food crumbs and debris on the floor and the floor was sticky. Observations in the kitchen on [DATE], at 10:05 a.m. revealed that a fan with a large accumulation of dust blowing on to the food prep area, and there was food, dirt, and debris on the floor in the freezer and on the floor in the dry storage room. Interview with the Food Service Director on [DATE], 10:09 a.m. confirmed that the ice cream mix and frozen chicken breasts should have been discarded, and that the freezer and dry storage rooms should have been clean. 28 Pa. Code 211.6(f) Dietary Services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46994 Based on review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of 31 residents reviewed (Resident 99). Findings include: Review of the clinical record for Resident 99 revealed that she was admitted to the facility on [DATE], and had diagnoses that included diabetes. Physician's orders for Resident 99, dated September 12, 2024, included an order that the resident may manage her insulin bolus (dose of insulin taken to handle a rise in blood glucose) as set up in her insulin pump (a wearable medical device that supplies a continuous flow of insulin underneath the skin) by her endocrinologist (doctor who specializes in the diagnosis and treatment of hormone-related diseases and conditions, including diabetes), before meals and at bedtime, making sure she notifies staff prior to self-administering each bolus. A nurse's note for Resident 99, dated September 15, 2024, at 10:05 a.m., revealed that the resident was nauseous and vomited. The nurse asked the resident if she gave herself a bolus of insulin, and she reported that she gave herself a small dose of less than three units. Review of the Medication Administration Record (MAR) for Resident 99, dated September 2024, revealed no documented evidence of the amount of insulin the resident was self-administering with boluses using her insulin pump. Interview with the Nursing Home Administrator on September 18, 2024, at 2:39 p.m. confirmed that there was no documented evidence of the amount of insulin the resident was self-administering with boluses using her insulin pump. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(5) Nursing Services.

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	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbutus Park Manor	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46994 Based on review of established infection control guidelines, facility policy, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for two of 31 residents reviewed (Residents 25, 37). Findings include: CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDRO's - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dated July 12, 2022, indicates that MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. The facility's policy regarding EBP, dated January 10, 2024, indicated that the facility will prevent the spread of novel or targeted multidrug-resistant organisms (MDROs). The precautions refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands. Enhanced barrier precautions apply to all residents with wounds and or indwelling medical devices (e. g. central line, urinary catheter, feeding tube, tracheostomy, or ventilator) regardless of MDRO colonization status. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 25, dated July 16, 2024, revealed that the resident was cognitively intact, required supervision with personal hygiene, had an indwelling urinary catheter (a flexible tube inserted into the bladder to collect urine into a drainage bag), and had diagnoses that included chronic kidney disease. Physician's orders for Resident 25, dated August 15, 2024, included an order for the resident to have a size 16 French Coude (type of catheter with a curved tip used to empty urine from the bladder) catheter inserted. Observations of Resident 25 on September 16, 2024, at 7:30 p.m. revealed that the resident was sitting in a recliner in his room with a catheter drainage bag in a basin on the floor to the left side of his feet. There was no signage or notification of the resident being on EBP posted at the resident's room, and there was no PPE observed in or around the resident's room. (continued on next page)

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	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbutus Park Manor	207 Ottawa Street Johnstown, PA 15904

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Registered Nurse 2 on September 16, 2024, at 7:56 p.m. confirmed that Resident 25 did not have EBP in place and that the resident should have. An admission MDS assessment for Resident 37, dated June 13, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, and had an indwelling urinary catheter (a soft, flexible plastic tube inserted in the bladder). Physician's orders for Resident 37, dated June 6, 2024, included an order for an indwelling foley catheter, size 14 French with a 10 milliliter balloon. Observations during the facility tour on September 16, 2024, at 7:55 p.m. revealed that Resident 37 was lying in bed with the indwelling catheter attached to the bed frame and visible from the doorway. There was no signage or notification of the resident being on EBP posted at the resident's room, and there was no PPE observed in or around the resident's room. Interview with the Director of Nursing on September 16, 2024, at 8:50 p.m. confirmed that Resident's 25 and 37 did not have EBP precautions in place and they should have. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38012 Based on observations and staff interviews, it was determined that the facility failed to ensure that the resident environment was maintained in a safe and sanitary environment in one of two shower rooms on the secured unit and in one resident's bathroom (Resident 49). Findings include: Observations in the shower room on the secured unit on September 16, 2024, at 8:17 p.m. and again on September 18, 2024, at 8:43 a.m. revealed that the toilet grab bars were loose and that the toilet had rust stains and a black, removable substance around it. Observations in Resident 49's room on September 16, 2024, at 8:17 p.m. and again on September 18, 2024, at 8:43 a.m. revealed that the resident's toilet grab bars were loose and not tightly secured to the wall or floor. Interview with the Director of Maintenance on September 18, 2024, at 8:43 a.m. confirmed that the shower room toilet grab bars should not be loose, there should not be rust or a black, removable substance around the toilet, and that Resident 49's toilet grab bars should not be loose. 28 Pa. Code 207.2(a) Administrator's Responsibility.