

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 08/21/2025
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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on review of policies and personnel files, as well as staff interviews, it was determined that the facility failed to complete a Nurse Aide Registry verification for one of two nurse aides reviewed (Nurse Aide 1), failed to conduct a criminal background check on one of two nurse aides reviewed (Nurse Aide 2), and failed to ensure that the status of nursing licenses was checked with the State Board of Nursing for two of two registered nurses reviewed (Registered Nurse 3 and Registered Nurse 4). Findings include: The facility's abuse policy, dated January 16, 2025, indicated that the facility will screen potential employees for a history of abuse, neglect, or mistreating residents. If employment references cannot be obtained, personal references may be obtained. State licensure and certification agencies, and applicable registries will be contacted prior to employment to validate current licensure or certification requirement and to determine if the potential employee is in good standing with the registry and potential employees will have a criminal background check completed at time of selection as required. The personnel file for Nurse Aide 1 revealed a hire date of June 30, 2025. However, there was no documented evidence that her standing on the Pennsylvania State Nurse Aide Registry was verified, and there was no documented evidence that reference checks from previous or current employers were obtained prior to the employees' start date. The personnel file for Nurse Aide 2 revealed a hire date of June 11, 2025. However, there was no documented evidence that her criminal background check was completed prior to the employees' start date. The personnel file for Registered Nurse 3 revealed a hire date of July 22, 2025. However, there was no documented evidence that her license was checked with the Pennsylvania State Board of Nursing, and there was no documented evidence that reference checks from previous employers were obtained prior to the employees' start date. The personnel file for Registered Nurse 4 revealed that a hire date of August 6, 2025. However, there was no documented evidence that her license was checked with the Pennsylvania State Board of Nursing prior to the employees' start date. Interview with the Nursing Home Administrator on August 20, 2025, 3:45 p.m. confirmed that there was no documented evidence to indicate that registry verification with the Pennsylvania State Nurse Aide Registry, licensure verification with the Pennsylvania State Board of Nursing, criminal background checks and reference checks from previous employers were completed prior to dates of hire for the above-mentioned nursing staff and there should have been. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on review of clinical records, as well as staff and resident interviews, it was determined that the facility failed to follow physician's orders for one of 36 residents reviewed (Resident 14). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 14, dated June 3, 2025, revealed that the resident was cognitively intact, required assistance with care needs, used oxygen, received hospice services and had diagnoses that included chronic obstructive pulmonary disease (COPD) (chronic lung disease making breathing difficult), chronic respiratory failure (blood does not have enough oxygen and causes difficulty breathing), and end stage heart failure (the heart is unable to pump enough blood to meet the body's needs). Physician's orders for Resident 14, dated July 13, 2025, included orders for the resident to receive one puff/inhalation of Trelegy Ellipta inhaler 200-62.5-25 micrograms (mcg) daily in the morning with instructions that the resident may keep the medication at the bedside for unsupervised self-administration. Observations during medication administration for Resident 14 on August 20, 2025, at 8:16 a.m. revealed that the resident did not have his Trelegy inhaler for administration. Licensed Practical Nurse 5 confirmed that the Trelegy inhaler was ordered on August 6, 2025, and the facility was waiting for the inhaler to be delivered. Interview with Resident 14 on August 20, 2025, at 8:40 a.m. revealed that he has not had his Trelegy inhaler for about two weeks. He reported that he had taken the medication for about 10 years and had been more short of breath since it has not been available to self-administer. Review of Resident 14's Medication Administration Record (MAR) for August 2025, revealed that the Trelegy Ellipta inhaler was coded U-SA for unsupervised self-administration. There was no documented evidence that the facility attempted to follow up with the pharmacy or the physician related to medication not being received. Interview with the Director of Nursing on August 20, 2025, at 2:43 p.m. indicated that she was not aware that the resident had not had his Trelegy inhaler. She indicated that she had received a notice from pharmacy, dated August 19, 2025, that indicated they cancelled the Trelegy inhaler due to the facility's account requiring Omnicare to obtain approved authorization prior to dispensing the medication and that the drug exceeded the facility's high dollar limit which required approval. She indicated that hospice should have covered that medication since he was on hospice for COPD and that she was checking with hospice regarding coverage for the future. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents received proper care for indwelling urinary catheters (a thin, flexible tube inserted into the bladder to drain urine from the bladder) for one of 36 residents reviewed (Resident 1) and failed to ensure that urinary output was monitored for one of 36 residents reviewed (Resident 44) who had an indwelling urinary catheter. Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated June 26, 2025, revealed that the resident was cognitively intact, required extensive assistance with most daily care needs, had a Foley catheter (a thin tube inserted into the bladder to allow urine drainage), and had diagnosis that included a pressure ulcer to the sacral region. Physician's orders dated June 20, 2025, indicated that Resident 1 was to have a 16 French catheter with a 30 ml (milliliter) balloon (an inflatable balloon that helps keep that catheter inside the bladder), routine change every 56 days related to a pressure area to the coccyx/sacrum. Urinary committee notes for Resident 1, dated June 23, 2025, indicated the resident now has a foley catheter in place due to a pressure sore impacted by urinary incontinence. A care plan for Resident 1's indwelling catheter, revised on June 24, 2025, indicated that the catheter was placed for a stage 4 pressure area affected by urinary incontinence, and that the urinary drainage tubing/bag should be changed at least twice a month, on the fifth and nineteenth of every month, or whenever necessary. A review of the resident's clinical record, including progress notes, treatment administration record's and a review of a treatment log notebook kept at the nurses station, did not indicate that the catheter drainage tubing/bag was changed on July 5 and 15, and August 5, 2025. Interview with Registered Nurse Supervisor 6 on August 21, 2025, at 9:35 a.m. revealed that it is standard practice for their facility to change the foley catheter drainage bag on the fifth and fifteenth of every month. She further indicated that there is no documentation in Resident 1's treatment administration record to indicate that the drainage bags were changed. Interview with the Director Of Nursing on August 21, 2025, at 11:58 a.m. confirmed that it is part of the facility's protocol to change the foley drainage bag twice a month and that she feels certain that it was done. However, there was no documented evidence that Resident 1's foley drainage bag was changed on July 5, 19 or August 5, 2025, as care planned, and it should have been. The facility's policy regarding intake and output documentation, dated January 16, 2025, indicated that foley output is to be documented in point of care, under the foley output task button. A quarterly MDS assessment for Resident 44, dated June 4, 2025, revealed that the resident was cognitively impaired, and had an indwelling urinary catheter. A care plan for the resident, dated May 6, 2024, revealed that the resident had a suprapubic catheter (a flexible tube that drains urine from the bladder through the abdomen), and his catheter bag was to be emptied, and the output measured every shift. Review of Resident 44's clinical record for March, April, May, June, July and August, 2025, revealed that there was no documented evidence that the resident's urinary output was measured on the following dates and shifts: May 19 and 25, June 9 and 27, July 8 and August 1 and 18 on the day shift; March 10 and 12, April 6, 12 and 29, May 6, 7, 9, 10, 13, 15 and 25, June 24 and 27, July 1, 21, 22, 27, 30 and 31, and August 2, 3, 4, 8, 15, 16, and 17 on the evening shift; and March 31, April 29 and 30, May 31, June 30 and July 27 and 31 on the night shift. Interview with the Director of Nursing on August 20, 2025, at 11:41 a.m. confirmed that there was no documented evidence that Resident 44's urinary output was measured as per facility policy and per the resident's care plan on the above-mentioned dates and shifts. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on facility policies, observations, and staff interviews, it was determined that the facility failed to ensure that food stored in the kitchen was dated once opened, discarded after the use by date and discarded after the manufacturer's expiration date. Findings include: The facility policy regarding food labeling and dating, dated January 16, 2025, revealed that all food items must be labeled and dated to ensure foods are being used in the proper timeframe. Twice daily the dining services manager on duty will check all perishables for proper covering, labeling and dating. Any perishables needing to be discarded will be discarded. Any unopened food or beverage item will be discarded by the manufacturer labeled expiration date. Observations in the kitchen refrigerator on August 18, 2025, at 9:05 a.m. revealed a package of pre-sliced bologna and ham wrapped in plastic wrap and dated August 10, 2025, with a discard date of August 15, 2025. Observations in the kitchen's walk-in refrigerator used for milk on August 18, 2025, at 9:15 a.m. revealed an opened gallon container of vanilla milk shake/ice cream mix dated as packaged on August 1, 2025, and received on August 12, 2025. The gallon container of vanilla milk shake/ice cream mix was not dated when opened and had no manufacturer's expiration date. Observations in the kitchen's walk-in refrigerator used for milk on August 20, 2025, at 11:27 a.m. revealed three unopened iced coffees that were stamped with the use by date of August 18, 2025. Interview with the Dietary Supervisor at the time of the observations confirmed that the pre-sliced bologna and ham should have been discarded, the gallon container of vanilla milk shake/ice cream mix should have been dated when opened and the unopened iced coffees should have been discarded after the use by date. 28 Pa. Code 211.6(f) Dietary Services.</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on a review of a list of nurse aides currently employed by the facility, including their hire dates and training hours, as well as staff interviews, it was determined that the facility failed to ensure that nurse aides had 12 hours of in-service training annually for two of five nurse aides reviewed (Nurse Aides 7 and 8). Findings include: A list of nurse aides provided by the facility revealed that based on their months and days of hire: Nurse Aide 7 should have received at least 12 hours of in-service training between February 23, 2024, and February 23, 2025. However, there was no documented evidence that she received at least 12 hours of in-service training as required. Nurse Aide 8 should have received at least 12 hours of in-service training between April 25, 2024, and April 25, 2025. However, there was no documented evidence that she received at least 12 hours of in-service training as required. Interview with the Nursing Home Administrator on August 20, 2025, at 3:45 p.m. confirmed that there was no documented evidence that the above nurse aides received at least 12 hours of in-service training as required. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 201.19(7) Personnel Policies and Procedures.</p>		