STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396069	A. BLDG: 00 B. WING:	04/09/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ARBUTUS PARK MANOR STATE LICENSE NUMBER: **012002**	**207 OTTAWA STREET** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an incident survey completed on April 9, 2025, it was determined that Arbutus Park Manor was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0689 SS=E	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Past noncompliance: no plan of correction required.	Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/28/2025**

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0689 SS=E	Continued from page 1 Based on review of policies, clinical records, and facility reports, as well as observations and staff interviews, it was determined that the facility failed to ensure that the residents' environment remained free of accident hazards for one of four residents reviewed (Resident 1). This deficiency was cited as Past Non-Compliance. Findings include: The facility's policy regarding residents who wander, dated January 16, 2025, indicated that the residents in the facility will be provided with a safe environment in which to live. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated March 5, 2024, indicated that the resident was usually understood and could usually understand others, did not have any wandering behaviors, required supervision with ambulating, and had diagnosis that included	F 0689		

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F 0689 SS=E	Continued from page 2 Alzheimer's dementia. A care plan intervention for Resident 1, dated April 12, 2024, indicated that the resident was independent with a front-wheeled walker on the unit. A care plan for Resident 1, dated March 25, 2025, indicated that the resident was at risk for injury from falls and included an intervention, dated March 27, 2025, through April 2, 2025, that the resident was to have a door alarm in use. A wandering risk assessment for Resident 1, dated March 26, 2025, indicated that the resident was at moderate risk for wandering, that the resident's family requested a room change, and that the resident comes out of her new room and needs redirected as she is looking for the lobby and dining room on the other unit. She was found in the hall by the offices near the fax room and was easily redirected. A door alarm was to be placed on the door to alert staff if she leaves her room.	F 0689		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ARBUTUS PARK MANOR STATE LICENSE NUMBER: 012002	207 OTTAWA STREET JOHNSTOWN, PA 15904

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F 0689 SS=E	Continued from page 3 A risk and environmental safety assessment for Resident 1, dated March 27, 2025, indicated that a new safety intervention was implemented that included a door alarm on the resident's room. An incident note for Resident 1, dated March 30, 2025, at 10:30 p.m. revealed that a staff member received a phone call reporting that Resident 1 was observed outside near the smoke shed. Nurse aides found the resident outside with her front-wheeled walker. After receiving the call, the registered nurse went back to check the resident's room and noted that the door alarm was off. Two licensed practical nurses brought the resident back to the nursing unit and Resident 1 was then provided a room on the Crossroads dementia unit for her safety, as she was a flight risk. A security bracelet was placed on Resident 1 and nursing administration was notified. An incident investigation for Resident 1, dated March 30, 2025, revealed that Resident 1 was assisted to her room by Licensed Practical Nurse 1.	F 0689		

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F 0689 SS=E	Continued from page 4 When License Practical Nurse 1 left the resident's room, she did not turn the door alarm on as care planned. The resident later exited her room, went through a door leading to the chapel that should have alarmed and did not, and through the door to exit the facility, which should have alarmed but did not. The facility was notified at around 10:30 p.m. that Resident 1 was observed outside the facility near the smoke shed. Review of a preventative maintenance log, dated 2025, revealed that monthly door alarm battery replacement was to be completed and documented; however, there was no document evidence that door alarm batteries were checked or replaced in 2025 until March 31. Interview with the Director of Nursing on April 9, 2025, at 2:40 p.m. confirmed that the door alarm on Resident 1's door was not turned on as care planned, the alarm on the interior door leading to the chapel was functioning properly, and the double doors on the left before entering the chapel that lead	F 0689		

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F 0689 SS=E	Continued from page 5 outside was not functioning properly due to the batteries being dead. This resulted in the resident being able to leave the facility undetected. The Director of Nursing also confirmed at this time that there was no documented evidence that monthly maintenance inspections of the batteries in the battery-operated door alarms were checked in January or February 2025, and were not checked in March until after the incident occurred. Following the incident on March 30, 2025, the facility's corrective actions included: Resident 1 was returned to her previous room on the Crossroads secured unit and a security bracelet was applied to alert staff of attempts to exit that unit. Licensed Practical Nurse 1, who failed to activate the door alarm on Resident 1's door, was given a two-day unpaid suspension for failing to follow established safety protocols. A review of the facility's plan of correction revealed	F 0689		

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F 0689 SS=E	Continued from page 6 that education was provided to staff regarding prevention of abuse and/or neglect, review of the policy for safety risks, and the staffs' responsibilities regarding changes in resident care plans related to safety interventions. Maintenance staff was educated on the importance of monitoring, testing, and monthly preventative maintenance including battery replacement on all alarmed doors. A review of the facility's plan of correction revealed all staff were informed of what doors had battery-operated door alarms and daily inspections of the battery-operated door alarms was being completed. Interviews with staff throughout the facility during the on-site investigation revealed that they were knowledgeable about the functioning of the facility's door alarms and identifying changes in the residents' safety risk interventions. A review of the facility's corrective actions revealed that they were in compliance with F689 on April 2,	F 0689		

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F 0689 SS=E	Continued from page 7 2024. Interview with the Director of Nursing on April 9, 2025, at 3:00 p.m. revealed staff education was completed, and ongoing review of the incident was to be discussed during the monthly Quality Assurance (QA) meeting. 28 Pa. Code 211.10(d) Resident Care Policies. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0689		

Certified End Page

ARBUTUS PARK MANOR

STATE LICENSE NUMBER: 012002

SURVEY EXIT DATE: 04/09/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY