STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396069	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that the resident and/or responsible party was informed about the items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services, by failing to provide a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) for two of 39 residents reviewed (Residents 109, 177). Findings include: A Notice of Medicare Non-Coverage (NOMNC - A written notice that conveys information to the beneficiary about his/her right to an expedited review of a service termination, but does not fulfill the facility's obligation to advise the beneficiary of potential liability for payment. The facility must sill issue a SNFABN to address liability for payment) for Resident 177 indicated that his Medicare Part A services would end on December 15, 2019. A nursing note dated December 16, 2019, indicated that the resident remained in the facility with hospice (end-of-life) services. There was no documented evidence that a SNFABN (provides information to residents/beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility for these services) was provided to the resident when his Medicare Part A coverage ended. A NOMNC for Resident 109 indicated that her skilled (Medicare Part A) services would end on January 31, 2020. A resident roster provided by the facility showed that the resident continued to reside in the facility after her skilled services ended. There was no documented evidence that a SNFABN was provided to the resident when her Medicare Part A coverage ended. Interview with the Director of Nursing on March 10, 2020, at 2:05 p.m. confirmed that SNFABN's were not provided as required for Residents 109 and 177.
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** Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to develop care plans that included specific and individualized interventions regarding the services to be furnished to meet the resident's needs for one of 39 residents reviewed (Resident 327). Findings include: The facility's policy regarding comprehensive and baseline care plans, dated January 20, 2020, indicated that specific interventions for individualized care would be identified on each resident's care plan and communicated to the staff by way of the care plan Kardex (a summary of the information needed by nurse aides to provide care to each resident). A [DIAGNOSES REDACTED]. A nursing note, dated March 7, 2020, revealed that the resident presented with 4+ [MEDICAL CONDITION] (when you press on a swollen area, an indentation remains) (measured on a scale of 1 to 4 where 4 is the most severe) to both lower extremities and that an order was received for the resident to wear TED hose (compression stockings) to both legs, to be put on in the morning and taken off at bedtime. physician's orders [REDACTED]. Interview with the Registered Nurse Assessment Coordinator 3 (RNAC - a registered nurse who is often involved in the development of care plans) on March 10, 2020, at 3:05 p.m. confirmed that a care plan related to Resident 327's [MEDICAL CONDITION] should have been developed. Interview with the Director of Nursing on March 11, 2020, at 11:50 a.m. confirmed that a care plan addressing Resident 327's [MEDICAL CONDITION] should have been in place. 28 Pa. Code 211.11(d) Resident care plans. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that a discharge summary, including a recapitulation of the resident's stay, was completed for one of two discharged residents reviewed (Resident 128). Findings include: A nursing note for Resident 128, dated January 14, 2020, revealed that it was okay for the resident to be discharged home to the services of home health on January 16, 2020, and a note dated January 16, 2020, revealed that the resident was discharged home via ambulance service and the resident's spouse was given medications and discharge instructions as well as a copy of the Medication Administration Record [REDACTED]. As of March 12, 2020, there was no documented evidence that a discharge summary that included a recapitulation of the resident's stay was completed for Resident 128. Interview with the Assistant Director of Nursing on March 12, 2020, at 2:52 p.m. confirmed that there was no documented evidence that a discharge summary was completed for Resident 128. 28 Pa. Code 211.5(d) Clinical records.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations and staff interviews, it was determined that the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice by failing to ensure that physician's orders [REDACTED]. Findings include: A [DIAGNOSES REDACTED]. A nursing note, dated March 7, 2020, revealed that the resident presented with 4+ [MEDICAL CONDITION] (when you press on a swollen area, an indentation remains) (measured on a scale of 1 to 4 where 4 is the most severe) to both lower extremities and that an order was received for the resident to wear TED hose (compression stockings) to both legs, to be put on in the morning and taken off at bedtime. physician's orders [REDACTED]. Interview with Resident Family Member 327 on March 9, 2020, at 1:35 p.m. confirmed that the resident's legs were swollen, that staff do not always put his TED hose on, and that the staff do not elevate his legs on a pillow. Interview with Nurse Manager 1 on March 9, 2020, at 3:05 p.m. confirmed that Resident 327 did not have his TED hose on and that his feet should be elevated off the bed with a pillow but they were not. Interview with the Director of Nursing on March 11, 2020, at 11:50 a.m. confirmed that Resident 327 should have had his TED hose on and his legs should have been elevated. 28 Pa. Code 211.12(d)(1) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations and staff interviews, it was determined that the facility failed to ensure

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

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.

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) that residents received care to prevent pressure ulcers by failing to ensure that care planned interventions for the prevention of pressure ulcers were provided for one of 39 residents reviewed (Resident 327). Findings include: A [DIAGNOSES REDACTED]. (remove pressure from the heels). Observations of Resident 327 on March 9, 2020, at 1:35 p.m. and March 10, 2020, at 2:43 p.m. revealed that the resident was in bed with his heels touching the mattress. Interview with Resident Family Member 327 on March 9, 2020, at 1:35 p.m. revealed that the staff do not elevate the resident's legs on a pillow. Interview with Nurse Manager 1 on March 9, 2020, at 3:05 p.m. confirmed that Resident 327 should have had his feet elevated off the bed with a pillow but did not. Interview with the Director of Nursing on March 11, 2020, at 11:50 a.m. confirmed that Resident 327 should have had his legs elevated off the bed. 28 Pa. Code 211.12 (d)(5) Nursing services.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations and family and staff interviews, it was determined that the facility failed to ensure that sufficient fluids were offered and/or consumed daily for one of 39 residents reviewed (Resident 327). Findings include: A [DIAGNOSES REDACTED]. The resident's care plan, dated February 14, 2020, indicated that he was at risk for hydration issues and staff were to encourage fluids during the day, to monitor intake and output, and to monitor the resident for signs and symptoms of dehydration. physician's orders [REDACTED]. A physician's orders [REDACTED]. An admission dehydration assessment for Resident 327, dated February 27, 2020, indicated that the resident could not help himself to water in his room, does not ask for beverages, and was at moderate risk for dehydration. An admission nutrition assessment dated [DATE], revealed that the resident's estimated daily fluids needs were 1900 milliliters (ml). Resident 327's fluid intake reports for February 15 through March 12, 2020, which reflected the amount of fluids consumed at meals, showed that the resident did not consume sufficient fluids to meet his estimated daily requirement. The reports indicated that the resident's fluid intake (in cubic centimeters) was: February 15- 240 February 17- 1260 February 18- 1200 February 19- 1120 February 21- 1260 February 23- 900 February 24- 1140 February 26- 900 February 27- 1460 March 2- 1060 March 4- 1340 March 5- 1080 March 8- 840 March 9- 1200 March 10-1140 March 12- 1260 There was no documented evidence that staff identified that Resident 327 was not meeting his daily fluid needs, or that additional fluids were offered, or offered and refused. Observations of Resident 327 on March 9, 2020, at 1:25 p.m. and March 10, 2020, at 1:02 p.m. revealed that the resident was in bed in his room, his bedside stand was on the other side of the room, and a clear cup with a blue lid and straw and that was full of water was on resident's bedside table, and the cup felt warm to touch. Observations on March 12, 2020, at 2:10 p.m. revealed that the resident was in his bed with his bedside stand on the other side of the room, and a pink pitcher full of water was on the resident's bedside stand. Observations on March 10, 2020, at 10:34 a.m.; March 11, 2020, at 11:24 a.m.; and March 12, 2020, at 9:16 a.m. revealed that the resident was in his wheelchair in the lobby with other residents. Drinks were offered to the residents between breakfast and lunch, but there were no drinks readily available or accessible to Resident 327. An interview with Resident Family Member 327 on March 9, 2020, at 1:25 p.m. revealed that she does not see any water missing from the resident's cups or staff offering the resident a drink when she visits daily from 12:30 p.m. to 5:00 p.m. Interview with the Director of Nursing on March 12, 2020, at 12:30 p.m. confirmed that there was no documented evidence that staff offered Resident 327 sufficient fluids to meet his estimated minimum daily requirements, that it was not required for staff to document fluid intake unless an intake/output was ordered, that fluid passes were completed between meals, that fluids were encouraged at meals, but that there was no documentation of staff offering fluid or the resident refusing fluids. Interview with the Dietitian on March 12, 2020, at 2:40 p.m. revealed that she uses the look back report to determine fluid intake but she confirmed that refusals and offerings were not documented, she could not be sure of the accuracy of the report, but felt that Resident 327 was getting enough fluids. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, by failing to ensure that when a resident had ineffective pain relief it was addressed timely for one of 39 residents reviewed (Resident 177). Findings include: A physician's history and physical for Resident 177, dated December 11, 2019, indicated that the resident had [DIAGNOSES REDACTED]. A comprehensive admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs), dated December 17, 2019, indicated that the resident was cognitively intact, required assistance for bed mobility and transfers, and frequently had pain that he rated as a 9 (on a scale of 0 to 10 where 10 is the worst pain). physician's orders [REDACTED]. A nursing note for Resident 177, dated December 11, 2019, at 10:46 p.m. revealed that the resident's family stated that they wanted his pain well controlled and to wake him up every three hours. A communication record, dated December 15, 2019, indicated that the resident still complained of frequent pain and was constantly asking for more pain medication before the time it was due, and that he cried with pain last night. physician's orders [REDACTED]. Resident 177's Medication Administration Record [REDACTED]. A nursing note at 9:24 p.m. (1 hour and 54 minutes later) indicated that the resident's pain relief was ineffective, he was asking for more pain medication, and the registered nurse was notified. A nursing note documented by a licensed practical nurse on December 15, 2019, at 9:57 p.m. indicated that [MEDICATION NAME] was provided twice during the evening shift with some relief from the first dose provided; however, the second dose was ineffective and the resident requested the pain medication be provided when it was due at the end of the shift. There was no documented evidence that Resident 177 was assessed by the registered nurse and/or that any other pain relief interventions were provided until 10:31 p.m. when the Medication Administration Record [REDACTED]. A nursing note dated December 15, 2019, at 11:00 p.m. indicated that the [MEDICATION NAME] sulfate was ineffective. There was no documented evidence that any additional pain relief interventions were attempted when the [MEDICATION NAME] sulfate was ineffective until December 16, 2019, at 12:30 a.m. (90 minutes later) when staff administered a 5-325 mg tablet of [MEDICATION NAME]-[MEDICATION NAME], which the MAR indicated [REDACTED]. 28 Pa. Code 211.12(d)(3)(5) Nursing services.
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.** Based on observation and interview, it was determined that the facility failed to maintain fire-rated door assemblies in one instance, one out of eight smoke compartments. Findings include: 1. Observation on March 10, 2020, at 11:05 a.m. revealed the fire door, serving the emergency generator enclosure, did not contain a rating label. The rating of the door was unable to be confirmed at the time of inspection. Interview with the Facility Administrator and Environmental Services Director on March 10, 2020, at 2:00 p.m., confirmed the fire door deficiency.
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.** Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety by not labeling and dating opened food items, and by failing to ensure that staff did not touch ready-to-eat foods with their bare hands for one of 39 residents reviewed (Resident 78). Findings include: The facility's policy regarding labeling and dating, dated January 20, 2020, revealed that all food items were to be labeled and dated to ensure foods were being used within a proper time frames, and all food items were to be labeled with either a manufacturer's label or a hand-written label. Observation in the dry storage area on March 9, 2020, at 8:56 a.m. revealed that there were previously opened bags of raspberry gelatin mix, lemon gelatin mix, and rainbow sprinkles that were not labeled with the dates they were opened. Observations in the walk-in freezer on March 9, 2020, at 8:59 a.m. revealed that there were previously opened bags of breaded chicken breasts and chicken chunks that were not labeled with the product name and the date they were opened. There

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) were also previously opened bags of French-style green beans, Brussel sprouts and sliced carrots that were not labeled with the dates they were opened. Observations in the walk-in cooler on March 9, 2020, at 9:05 a.m. revealed that there was a previously opened block of cheddar cheese that was not labeled with the date it was opened. Interview with the Dietary Manager on March 9, 2020, at 9:06 a.m. confirmed that the above food items should have been labeled with the product name and/or with the date they were opened. The facility's policy regarding food preparation and serving, dated January 20, 2020, indicated that gloves were to be worn by all staff who are touching food during service and post-meal clean up. Observations in the Crossroads dining room during the lunch meal on March 9, 2020, at 1:42 p.m. revealed that Nurse Aide 2 cut orange sections into bite-sized pieces and then fed them to Resident 78 with her bare hands. Interview with Nurse Aide 2 on March 9, 2020, at 1:46 p.m. confirmed that she used her bare hands to cut and feed orange pieces to Resident 78 and that she was not aware that she should not have touched the resident's food with her bare hands. Interview with the Director of Nursing on March 11, 2020, at 11:50 a.m. confirmed that gloves were to be worn any time staff are touching residents' food. 28 Pa. Code 211.6(f) Dietary services.
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** Based review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain clinical records that were accurately documented for one of 39 residents reviewed (Resident 327). Findings include: The facility's policy regarding charting for nursing staff, dated January 20, 2020, indicated that nursing staff should not chart in advance and they were to chart all occurrences after they happened to ensure accuracy. A [DIAGNOSES REDACTED]. physician's orders [REDACTED]. Observations of Resident 327 on March 9, 2020, at 1:35 p.m. and March 10, 2020, at 10:34 a.m. and 2:43 p.m. revealed that Resident 327's legs were swollen and that he did not have TED hose on. Interview with Resident Family Member 327 on March 9, 2020, at 1:35 p.m. confirmed that the resident's legs were swollen and that he does not always have his TED hose on. Documentation on Resident 327's Treatment Administration Record (TAR) for March 9 and 10, 2020, revealed that staff initialed that bilateral TED hose were placed on the resident in the morning as ordered. Interview with Nurse Manager 1 on March 9, 2020, at 3:05 p.m. confirmed that Resident 327 did not have his TED hose on and that she documented on the TAR that they were applied and would need to mark them as refused. Interview with the Director of Nursing on March 11, 2020, at 11:50 a.m. confirmed that Resident 327 should have had his TED hose on and that the TAR should not have been initialed if the TED hose were not applied. 28 Pa. Code 211.5(f) Clinical records.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to maintain compliance with nursing home regulations and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of correction for the State Survey and Certification (Department of Health) surveys ending December 20, 2018, and June 6, 2019, revealed that the facility developed plans of corrections that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending March 12, 2020, identified repeated deficiencies related to a failure to develop comprehensive care plans, ensuring that medications were stored properly, and following proper infection control practices. The facility's plan of correction for a deficiency regarding developing comprehensive care plans, cited during the survey ending December 20, 2018, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding the development of comprehensive care plans. The facility's plan of correction for a deficiency regarding proper storage of medications, cited during the survey ending June 6, 2019, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding proper medication storage. The facility's plan of correction for a deficiency regarding following infection control practices, cited during the survey ending December 20, 2018, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F880, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding following infection control practices. Refer to F656, F761, F880. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** 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 proper infection control practices and techniques were followed during the administration of medications. Findings include: The facility's policy regarding medication administration, dated January 20, 2020, revealed that good infection control should be maintained during medication pass. Nurses were not to touch medications directly with their hands and were to practice good hand hygiene. If a medication was contaminated with an unclean surface or a hand, then it was to be disposed of, and a replacement dose was to be obtained for administering to the resident. Observations during medication administration on March 11, 2020, at 8:48 a.m. revealed that Licensed Practical Nurse 7 was preparing to administer Resident 67's medications. She took scissors and cut open the medication packets, and then poured the medications from the packets into a medication souffle cup that was sitting on top of a computer keyboard on the top of the medication cart. Four pills missed the medication souffle cup and landed on the computer keyboard. With her bare hand, Licensed Practical Nurse 7 picked up the medications, placed them into the medication souffle cup, and then administered the medications to the resident. Interview with Licensed Practical Nurse 7 on March 11, 2020, at 8:53 a.m. confirmed that she should not have picked up Resident 67's medications with her bare hand. Interview with the Director of Nursing on March 11, 2020, at 1:55 p.m. confirmed that Licensed Practical Nurse 7 should not have picked up Resident 67's medication with her bare hand. 28 Pa. Code 211.12(d)(1) Nursing services.