Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

March 1, 2023

[REDACTED], ADMINISTRATOR
ARBUTUS PARK MANOR INC
207 OTTAWA STREET
JOHNSTOWN, PA, 15904

RE: ARBUTUS PARK MANOR
207 OTTAWA STREET
JOHNSTOWN, PA, 15904
LICENSE/COC#: 30006

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/24/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ARBUTUS PARK MANOR* **License #**: *30006* **License Expiration**: *12/03/2023*

Address: *207 OTTAWA STREET, JOHNSTOWN, PA 15904*

County: *CAMBRIA* **Region**: *CENTRAL*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *ARBUTUS PARK MANOR INC*

Address: *207 OTTAWA STREET, JOHNSTOWN, PA, 15904*

Phone: **Email**:

of Occupancy

Type: *C-1* **Date**: *01/04/1985* **Issued By**: *Department of Health*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *26* **Waking Staff**: *20*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Complaint* **Exit Conference Date**: *01/24/2023*

Inspection Dates and Department Representative

01/24/2023 - On-Site: Nadine Neal, Margie Dulashaw

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *35* **Residents Served**: *25*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *25*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

01/24/2023 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/09/2023*

02/13/2023 - POC Submission

Submitted By: **Date Submitted**: *02/27/2023*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/21/2023*

Inspections / Reviews *(continued)*

02/21/2023 POC Submission

Submitted By: [redacted]
Date Submitted: *02/27/2023*
Reviewer: [redacted]
Follow Up Type: *Document Submission* **Follow Up Date:** *02/28/2023*

03/01/2023 Document Submission

Submitted By: [redacted]
Date Submitted: *02/27/2023*
Reviewer: [redacted]
Follow Up Type: *Not Required*

65a - FS Orientation 1st Day

1. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Staff Member A whose first date of work was [redacted] did not receive orientation on the following topics until 8/10/2022:

1. Evacuation procedures
2. Staff duties & responsibilities -fire drills
3. Designated meeting place outside/interior fire safe area
4. Smoking safety procedures/policy
5. Location & use of fire extinguishers
6. Smoke detectors & fire alarms
7. Telephone use and notification of emergency services

Staff Member B whose first date of work was [redacted], did not receive orientation on the following topics until 8/9/2022:

1. Evacuation procedures
2. Staff duties & responsibilities -fire drills
3. Designated meeting place outside/interior fire safe area
4. Smoking safety procedures/policy
5. Location & use of fire extinguishers
6. Smoke detectors & fire alarms
7. Telephone use and notification of emergency services

Plan of Correction ***Accept ([redacted] - 02/17/2023)***

Violation:
Staff Member A whose first date of work was [redacted] did not receive orientation on the following topics until 8-10-2022.
Staff Member B whose first date of work was [redacted], did not receive orientation on the following topics until 8-9-2022.

1. Evacuation procedures
2. Staff duties and responsibilities-fire drills
3. Designated meeting place outside /interior fire safe area
4. Smoking safety procedures/policy
5. Location and use of fire extinguishers
6. Smoke detectors & fire alarms
7. Telephone use and notification of emergency services

65a FS Orientation 1st Day (continued)

Plan of Correction:
1. PCD spoke with HR to make sure that after the new staff person for personal care completes his/her orientation day with HR they are sent to personal care to be trained by the PCD or APCD, in the above topics in 65a before new staff goes home. PCD spoke to HR the following Monday (01 30 2023) due to being on vacation then week before. HR does cover the above topics in a new hire orientation, but PCD or APCD will go over what is expected in the personal care setting of the home.

2. The PCD miss understood what was meant by "first worked day". So as of 01 30 2023 when any new staff member for personal care are hired they will be trained on 65a the day they come for orientation. This will happen on 02 13 2023 which is when our next newly newly hired staff person is to start in personal care! The PCD or APCD will conduct the training.

3. This training will be conducted yearly there after. (We do this usually in August or September of every year.) We have guest speakers and fire instructors come.

4. We will document the training on the form provided by DHS and the forms used by HR. This will be done by the PCD and APCD, and HR in service coordinator. Our personal care education committee will schedule the upcoming training's and speakers.

Licensee's Proposed Overall Completion Date: *02/15/2023*

Implemented (█ - 02/27/2023)

103f - Refrigerator/Freezer Temps

2. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On █ at approximately 10:25 AM, the thermometer in the True Refrigerator located in the home's kitchen registered at 70° and was also warm to the touch.

Plan of Correction ***Directed (█ - 02/17/2023)***

Violation:
On 01 24 2023 at approximately 10:45 AM, the thermometer in the True Refrigerator located in the home's kitchen registered at 70 degrees and was also warm to the touch.

Immediate action taken:
1. Immediate action was that once the cleaning of the refrigerator by the dietary staff member was completed the refrigerator was turned back on and the temperature went from 70 degrees to 41 degrees. The Inspector was to come back later that day and recheck the temperature.

2. On 01 25 2023 The Inspector called and spoke with APCD and told her there was an additional violation which was not mentioned on the exit interview. This was the above violation. The Food Service Director was immediately

103f - Refrigerator/Freezer Temps (continued)

notified of the violation by APCD on 01-25-2023.

Reason for the issue:
1. In between meal service the Dietary staff is instructed to do any cleaning or deep cleaning if necessary to the coolers. At the time of inspection the reach-in cooler door had been opened for an extended period of time. During this time the temperature rose above 40 degrees Fahrenheit.
2. All perishable items had been moved to another cooler during cleaning for safe keeping.
3. The inspector was to come back and recheck the cooler since it was discovered it was being cleaned. This did not occur.
4. Cooler checks are done twice daily, prior to breakfast service and prior to dinner service. The recorded temperatures for that day reflect that the reach-in had been running at appropriate temperatures throughout the day.

Plan of Correction:
1. Staff members have been educated on proper procedures for checking cooler temperatures.
2. Temperatures will be checked twice daily, once in the AM hours and once during the PM hours.
3. At a time of inspection if a cooler is at an unacceptable temperature , the Food Service Director and or Food Production Manager will be notified. At the time either person will inspect the cooler for any immediate issues.
4. If nothing can be corrected, the cooler is to be shut down and food must be transferred to another cooler or be thrown away based on temperatures at the time.
5. From there maintenance will be notified with a documented maintenance request form. From there the process or the work that is done on the cooler will be kept on file in the Equipment Maintenance Log located in the Dietary Management office.

Continuing Monitoring:
1. Management will ensure temperatures on all reach in coolers are being checked daily each week and month that follows.
2. If there are any issues reported or discovered they will be addressed with the above Plan of Correction.
3. All monthly temperature logs will also be collected and kept on file at the end of each month in the Dietary Management office.

(Directed)

1. *Beginning 02/08/23, the PCD will ensure staff members were educated on proper procedures for checking cooler temperatures*
2. *Beginning 02/08/23, the PCD will ensure the refrigerator temperatures are checked twice daily by the Food Service Manager, once in the AM hours and once during the PM hours.*
3. *At the time of inspection if a cooler is at an unacceptable temperature, the Food Service*
4. *Director and or Food Production Manager will be notified the date of discovery. The Food Service Director or Food Production Manager will inspect the cooler for any immediate issues.*
5. *If the issue cannot be corrected, the cooler will be shut down by the The Food Service Director or Food Production Manager and food transferred to another cooler or be thrown away based on temperatures*

103f - Refrigerator/Freezer Temps (continued)

at the time.

6. *Maintenance will be notified with a documented maintenance request form; the process or the work that is done on the cooler will be kept on file in the Equipment Maintenance Log located in the Dietary Management office*
7. *Beginning 02/08/23, management will ensure temperatures on all reach in coolers are being checked daily each week and the month that follows.*
8. *If there are any issues reported or discovered they will be addressed with the above Plan of Correction.*
9. *Beginning 02/08/23, all monthly temperature logs will be collected and kept on file at the end of each month in the Dietary Management office.*

Directed Completion Date: *02/21/2023*

Implemented (- 02/27/2023)

183b - Meds and Syringes Locked

3. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 01/24/23 at 2:21 PM, a bottle of was observed in resident 1's medicine cabinet located in the bathroom. Resident 1's DME dated and dated indicate that the Resident cannot self-administer medications.

Resident 1 is prescribed Give 1 Lozenge by mouth as needed for sore throat. On 01/24/23 at approximately 3:20 PM, the medication was not found in the medication cart. On 01/24/23 at approximately 3:50 PM, resident 1's were found in resident's room by Staff Member C.

On 01/24/23 at approximately 3:10 PM, the home's first aid kit was reviewed and 4 connected but individually packaged packets of prescribed to the home were observed in an unlocked and unattended, personal care utility room.

Plan of Correction

Accept - 02/17/2023)

Violation:
On 01-24-23 a bottle of was observed in resident 1's medicine cabinet located in the bathroom.
Comment: Resident 1's DME dated a d Rasp dated indicate that the resident cannot self administer medication.

Plan of correction:
1. The was immediately removed from Resident 1's bathroom, labeled and put in Med Cart by APCD on 01-24-2023 inspection day! APCD showed both inspectors that it was removed- (01-24-2023).

2. Resident 1 was informed that the medication was removed and put in the med cart by LPN Charge nurse on

183b - Meds and Syringes Locked (continued)

2-10 shift on 01-24-2023. In speaking with Resident 1 it was discovered Resident 1's family brought the [redacted] in and did not tell staff.

3. PCD and APCD developed a letter to be sent to each POA about bringing in over the counter medications for their loved one with out speaking to PCD, APCD, or Charge Nurse.

4. Letter was generated and mailed to all POA's on 02-15-2023. Enclosed was two letters, one to be signed and returned in self addressed envelope to PCD and will be filed in their chart. We also asked the POA to notify other family and friends of our medication policy.

5. On admission PCD and APCD will continue to inform Resident, POA and Family members of our procedure on no medications in the resident's room. A form about medications will be part of our admission packet as of 02-15-2023 with signature required. This will also be added to our house rules-by 2-10-2023.

6. This procedure will be ongoing with admissions. There will be no end date.

Completion Date: 02-15-20.23

Violation:
Resident 1 was prescribed [redacted] 5-6-10MG ([redacted]) Give one Lozenge by mouth as needed for sore throat. On 01-24-2023at approximately 3:20PM, the medication was not found in the medication cart. On 01-24-2023 at approximately 3:50PM, resident 1's [redacted] were found in resident's room by Staff Member C. It was not found in the med cart but was found in the residents room by Staff Member C.

Plan of Correction:
1. [redacted] was removed on 01-24-2023 day of inspection and placed back in the med cart by Staff Member C.

2. PCD, APCD and Medication Trainer will reeducate the LPN's and Med Tech's on the importance of not giving a resident medication to keep in their room when their care plan states they cannot self medicate.

3. This training will take place from 2-13-2023 to 2-28-2023. We will conduct this training yearly there after by the Medication Trainer.

Completion Date: 02-28-2023

Violation: On 01-24-2023 at approximately 3:10PM, the home's first aid kit was reviewed and 4 connected but individually packaged packets of [redacted] prescribed to the home were observed in an unlocked and unattended and unattended, personal care utility room.

Plan of Correction:
1. The first aid bag was immediately removed from the personal care utility room and placed in the nursing station by assistant personal care director during inspection on 1-24-2023.

2. On 1-25- 2023 after the APCD spoke to the PCD the [redacted] was removed from the First Aid bag and disposed

183b Meds and Syringes Locked (continued)

of through our drug buster procedure. Per DHS guidelines we do not need [redacted] in our first aid bag.

3. The First aid bag was returned to the shelf in the personal care utility room for easy access in an emergency.

4. 10 6 Charge Staff will check the First Aid Bags 3 times a year. This will be done on the first Sunday of February , June and October.

5. Charge Staff 10 6 will make sure all the required elements are in the bag and nothing is expired or not required in the bag per DHS guidelines.

6. All Charge Personal (LPN's, and Med Tech's) will be trained on this procedure 02 15 2023.

7. Charge Staff will have sign off sheets to be signed once the first aid bag check has been completed every 4 months. this sheet will be located in each of the nurses stations.

Completion Date: 02 15 2023

Licensee's Proposed Overall Completion Date: *02/28/2023*

Implemented ([redacted] - 02/27/2023)

183d - Prescription Current

4. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident 2 is prescribed [redacted] to be applied to coccys and buttocks as needed only if skin is moist as needed for wound care. The medication expired 12/18/22.

Plan of Correction ***Accept [redacted] - 02/17/2023)***

Violation:
Resident 2 is prescribed [redacted] to be applied to coccyx and buttocks as needed only if skin is moist as needed for wound care. The medication expired 12/18/2022.

Plan of Correction :

1. [redacted] that expired 12 18 2022 was removed from the med cart by APCD on inspection 01 24 2023 in front of the inspector. It was properly disposed of through our drug buster procedure..

2. APCD immediately obtained a new bottle of Cavilon Spray from our Supply Clerk. The [redacted] bottle was labeled with residents name, room number and placed back into the med cart. Inspector observed this being done on 01 24 2023.

183d Prescription Current (continued)

3. As of 01 29 2023 all med carts will be checked for out dated medications on Sunday and Wednesday by the 6 2 Charge Nurse. Treatment carts will be checked on Saturday and Tuesday by the 2 10 Charge Nurse for outdated medications and creams.

4. Charge LPN's and Med Techs will sign off and date that it was done.

5. Training of this procedure was conducted by APCD From 01 24 2023 to 01 29 2023.

6. There will be no end date. This will be a weekly procedure indefinitely.

Licensee's Proposed Overall Completion Date: *02/14/2023*

Implemented (- 02/27/2023)

185a - Implement Storage Procedures

5. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident 3's Glucometer readings were compared to the MAR resulting in the following:
On 1/07/23 at 07:43 AM the glucometer shows a reading of
On 1/07/23 at 07:30 AM the MAR shows a reading of

Plan of Correction ***Accept (- 02/17/2023)***

Violation:
Resident 3's Glucometer readings were compared to the Mar resulting in the following:
On 1/07/23 at 07:43 AM the glucometer shows a reading of
On 1/07/23 at 07:30 AM the MAR shows a reading of

Plan of Correction:
1. The LPN did not document correctly what was on the Glucometer to the E MAR. The resident did receive the correct dose of insulin from the Glucometer reading that day.

2. The error was discovered two weeks later by the Inspector upon inspection on 01 24 2023.

3. Since this error was discovered two weeks later by the Inspector there is no way of correcting the wrong documentation immediately.

4. LPN that documented wrong was on the day of the inspection 01 24 2023, but had left before med cart inspection took place. The LPN was made aware the next day of the error.

5. Moving forward LPN'S and Med Techs will be re educated on how to document a reading correctly and also be re educated on our Q&A for Glucometers.

185a Implement Storage Procedures (continued)

6. The Assistant Personal Care Director will retrain all LPN's and Med Techs on how to compare the Glucometer to the MAR and Green Diabetic sheet. This will be done from 02 13 23 to 02 17 23. This will become a training that we conduct annually.

7. We started checking the documentation of the Glucometer readings at the change of shifts. The 2 10 LPN or Med Tech will check the glucometer documentation of the LPN or Med Tech from 6 2 shift to ensure immediate correction of incorrect documentation. The 10 6 LPN or Med Tech will check the glucometer documentation of the LPN or Med Tech from 2 10 shift and if the 10 6 LPN or Med Tech uses the glucometer the 6 2 LPN or Med Tech will check the glucometer documentation to ensure immediate correction of incorrect documentation.

8. The LPN's or Med Tech's will then sign off to ensure the documentation was done correctly.

9. This procedure will be done indefinitely.

Licensee's Proposed Overall Completion Date: *02/14/2023*

Implemented (- 02/27/2023)