STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395650	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Manor	682 Pleasant Drive Warren, PA 16365

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to assure physician orders, residents' Physician Order for Life Sustaining Treatment (POLST- a legal document specifying the resident/responsible party choices regarding life-sustaining treatments), and paper charts were consistent for two of 23 residents reviewed (Residents R99 and R106). Findings include: The facility policy entitled Advanced Directives Policy - PA dated [DATE], indicated that The physician's order should also be noted on the resident's plan of care and on the inside of the resident's clinical record. Resident R99's clinical record revealed an admitted [DATE], with diagnoses including dysphagia (difficulty swallowing), hypertension (high blood pressure), and cerebral infarction (stroke). Resident R99's physician orders dated [DATE], revealed an order for Do Not Resuscitate (Allow Natural Death) - DNR. Resident R99's clinical record revealed a POLST dated [DATE], that revealed Resident R99 requested Do Not Resuscitate (DNR), Comfort Measures Only. Resident R99's paper chart revealed a sticker on the cover and on the face sheet to Resuscitate (provide CPR [cardiopulmonary resuscitation-emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest])- Full Code. During an interview on [DATE], at 1:30 p.m. the Director of Nursing, confirmed Resident R99's physician's orders, POLST, and paper chart were not consistent with each other. Resident R106's clinical record revealed and admitted [DATE], with diagnoses including fractured right hip, high blood pressure, and anxiety. Resident R106's physician order dated [DATE], revealed an order for DNR - Limited interventions, antibiotics as needed and no artificial feeding. (continued on next page)

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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R106's clinical record revealed a POLST dated [DATE], that revealed DNR, limited interventions, antibiotics as needed, intravenous (IV) fluids if needed, and no artificial feeding. Resident R 106's paper chart revealed a sticker on the cover and on the face sheet to Resuscitate - Full Code. During an interview on [DATE], at 2:02 p.m. the Registered Nurse Assessment Coordinator, confirmed Resident R106's physician's orders, POLST, and paper chart were not consistent with each other. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.10(c) Resident care policies

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NAME OF PROVIDER OR SUPPLIER Warren Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 682 Pleasant Drive Warren, PA 16365	

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of clinical records and Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care), and staff interview, it was determined that the facility failed to ensure that MDS assessments accurately reflected the status of four of 23 residents reviewed (Residents R12, R71, R21, and R86). Findings include: MDS instructions for section P0200E stated to identify all alarms that were used at any time (day or night) during the seven-day look-back period and to code the frequency of use as not used, used less than daily, or used daily. The MDS instructions further indicated that a wander / elopement alarm includes devices such as bracelets, pins/buttons worn on the residents clothing, sensors in shoes, or building/unit exits sensors worn by/attached to the resident that activates an alarm and/or alert staff when the resident nears or exits a specific area of the building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings. MDS instructions for H0300 Urinary Continence stated that urinary continence is to be coded as Not rated if during the seven-day look-back period the resident had an indwelling bladder catheter (tubing from the bladder to drain urine into a bag), condom catheter, ostomy, or no urine output for the entire seven days. MDS instructions for O0110G1 Non-invasive mechanical ventilator stated to code any type of CPAP or BiPAP (respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask). Code under while a resident is performed while a resident of the facility and within the last fourteen days. Resident R12's clinical record revealed an admitted [DATE], with diagnoses that included diabetes, dementia (disease that affects the brains ability to think, remember, and function normally), and depression. Resident R12's clinical record revealed a physician's order dated 2/22/24, for secure care band (a bracelet worn by resident to alert staff when resident is near or attempts to exit the facility) every shift due to elopement risk. Resident R12's annual MDS with an Assessment Reference Date (ARD) of 4/19/24, and Resident R12's quarterly MDS with an ARD of 5/2/24, were coded as Not Used for a wander / elopement alarm, although Resident R12 had a wander / elopement alarm in place for entire look-back period for both the 4/19/24, and 5/2/24, MDS. During an interview on 5/23/24, at 1:38 p.m. Registered Nurse Assessment Coordinator (RNAC) confirmed that the 4/29/24, and 5/2/24, MDS's were coded inaccurately regarding usage of a wander / elopement alarm and should have been coded as used daily. (continued on next page)

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident R71's clinical record revealed an admitted [DATE], with diagnoses that included dementia, high blood pressure, and anxiety. Resident R71's clinical record revealed a physician's order dated 10/27/23, for a secure care band to be worn with placement verified every shift and function verified every day. Resident R71's quarterly MDS with an ARD of 11/9/23, was coded as Not Used for wander / elopement alarm, although Resident R71 had a wander / elopement alarm in place for the entire look-back period. During an interview on 5/22/24, at 3:12 p.m. the RNAC confirmed that the 11/9/23, MDS was coded inaccurately regarding usage of a wander/elopement alarm and should have been coded as used daily. Resident R21's clinical record revealed an admitted [DATE], with diagnoses that included paraplegia (paralysis typically from the waist down), high blood pressure, and diabetes. Resident R21's clinical record revealed a physician's order dated 3/20/20, for indwelling suprapubic catheter (tube inserted through the abdomen directly into the bladder to drain urine) to gravity drainage. Resident R21's quarterly MDS's with an ARD of 1/26/24, and 4/19/24, were coded as Always incontinent for urinary continence, although Resident R21 had an indwelling suprapubic catheter for the entire look-back period. During an interview on 5/22/24, at 3:12 p.m. the RNAC confirmed that the 1/26/24, and 4/19/23, MDS's were coded incorrectly regarding urinary continence and should have been coded as not rated. Resident R86's clinical record revealed an admitted [DATE], with diagnoses that included obstructive sleep apnea (a disorder that causes repeated breathing interruptions during sleep), chronic obstructive pulmonary disease (a lung disease that causes difficulty breathing), and depression. Resident R86's clinical record revealed a physician's order dated 10/20/23, for CPAP every evening shift related to obstructive sleep apnea. Resident R86's admission MDS with an ARD of 10/25/23, and quarterly MDS's with an ARD of 1/19/24, 4/12/24, 5/1/24, and 5/2/24, were coded as not being used while a resident at the facility and within the last fourteen days, although Resident R86 had and used a CPAP nightly for each of the MDS's entire look-back period. During an interview on 5/23/24, at 10:43 a.m. the RNAC confirmed that the 10/25/23, 1/19/24, 4/12/24, 5/1/24, and 5/2/24, MDS's were coded inaccurately and should have been checked for the respiratory device being used while a resident and within the last fourteen-days. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f)(ix) Medical Records

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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** 40177 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to develop a comprehensive care plan for one of 23 residents reviewed (Resident R71). Findings include: A facility policy entitled Comprehensive Care Plan, dated 12/19/23, indicated that the facility will develop a comprehensive person centered care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Resident R71's clinical record revealed an admitted [DATE], with diagnoses that included dementia (disease that affects the brains ability to think, remember, and function normally), high blood pressure, and anxiety. Resident R71's clinical record revealed a physician's order dated 10/27/23, for a secure care band (a bracelet worn by resident to alert staff when resident is near or attempts to exit the facility) to be worn with placement verified every shift and function verified every day. The clinical record lacked evidence that a care plan had been developed to address Resident R71's risk for elopement and use of secure care band. During an interview on 5/22/24, at 3:12 p.m. the Registered Nurse Assessment Coordinator confirmed that a care plan had not been developed to address Resident R71's risk for elopement and use of a secure care band. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to review and revise comprehensive care plans to reflect the current care and services for four of 23 residents reviewed (Residents R99, R106, R31, and R85). Findings include: A facility policy entitled, Comprehensive Care Plan, dated [DATE], indicated that resident care plans would include measurable objectives and timetables to meet a resident's medical, nursing, mental and physiological needs, include the services that are to be furnished to attain or maintain the resident's highest practicable physicial, mental and psychosocial well-being, and periodically be reviewed and revised by a team of qualified persons after each assessment. Resident R99's clinical record revealed an admitted [DATE], with diagnoses including dysphagia (difficulty swallowing), hypertension (high blood pressure), and cerebral infarction (stroke). Resident R99's physician orders dated [DATE], revealed an order for Do Not Resuscitate (Allow Natural Death) - DNR. Resident R99's clinical record revealed a POLST dated [DATE], that revealed Resident R99 requested Do Not Resuscitate (DNR), Comfort Measures Only. Resident R99's care plan dated [DATE], revealed Full Code (CPR-emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest), indicating that the care plan was not reviewed and revised to reflect the current care and services. Resident R106's clinical record revealed an admitted [DATE], with diagnoses including fractured right hip, high blood pressure, and anxiety. Resident R106's physician order dated [DATE], revealed an order for DNR - Limited interventions, antibiotics as needed and no artificial feeding. Resident R106's clinical record revealed a POLST dated [DATE], that identified for DNR, limited interventions, antibiotics as needed, intravenous (IV) fluids if needed, and no artificial feeding. Resident R106's care plan dated [DATE], revealed Full Code, indicating that the care plan was not reviewed and revised to reflect the current care and services. During an interview on [DATE], at 1:46 p.m. the Director of Nursing (DON) confirmed that the care plans for Residents R99 and R106 were not reviewed and revised to reflect current resident care and services. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident R31's clinical record revealed an admitted [DATE], with diagnoses including stage four pressure ulcers (full thickness loss of skin) to the left and right buttocks, bacterial infection of the bone, and Methicillin-resistant Staphylococcus aureus (MRSA- infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections). Resident R31's clinical record revealed a physician's order dated [DATE], to apply a wound vacuum to his/her wounds on the left buttock and right hip pressure ulcers three times per week. Resident R31's care plan dated [DATE], lacked evidence to address the application of the wound vacuum to his/her wounds on the left buttock and right hip three times per week, and that the care plan was not reviewed and revised to reflect the current care and services. Resident R85's clinical record revealed an original admitted [DATE], with diagnoses including flaccid neuropathic bladder (nerves to the bladder are interrupted and cause the bladder to become underactive), kidney failure, stage four (extend into muscle and/or supporting structures) pressure ulcer at the base of the spine, and malnutrition. Resident R85's clinical record revealed a physician's order dated [DATE], to apply a wound vacuum to his/her wound at the base of the spine three times per week. Resident R85's care plan dated [DATE], lacked evidence to address the application of the wound vacuum to his/her wound at the base of the spine three times per week, and that the care plan was not reviewed and revised to reflect the current care and services. During an interview on [DATE], at 10:30 a.m. the DON confirmed that there was no evidence that the wound vacuum was added to Residents R31 and R85's care plans. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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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 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** 40832 Based on review of facility documents and clinical records, observations, and staff interviews, it was determined that the facility failed to ensure that wound treatments provided were consistent with physician orders to promote healing for one of three residents reviewed for wound care (Resident R31) and failed to ensure staff competencies related to wound care were performed annually. Findings include: A facility document entitled Skills Competency Checklist- Aseptic Dressing Technique indicated the Competency Performance Criteria included Physician's order verified for aseptic dressing change and perform treatment per physician's order. Resident R31's clinical record revealed an admitted [DATE], with diagnoses that included stage four pressure ulcers (full thickness loss of skin) to the left and right buttocks, bacterial infection of the bone, and Methicillin-resistant Staphylococcus aureus (MRSA- infection caused by a type of staph bacteria that becomes resistant to many of the antibiotics used to treat ordinary staph infections). Resident R31's clinical record revealed a physician's order dated 5/19/24, to apply a wound vacuum to his/her wounds on the left buttock and right hip pressure ulcers three times per week. A physician's order dated 5/15/24, revealed to cleanse and apply Vashe moistened gauze to the left hip wound and cover with a dry dressing. Observation of wound care on 5/22/24, at 12:55 p.m. revealed the soiled wound vacuum dressing was removed from the left hip and a soiled Vashe moistened dressing was removed from the left buttock. During an interview at that time, Registered Nurse Employee E6 and Licensed Practical Nurse Employee E5 confirmed that the left hip dressing and the left buttock dressings were reversed and not in compliance with physician's orders. During an interview on 5/23/24, at 9:45 a.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to complete wound care as ordered by the physician and failed to ensure competencies related to the provision of wound care were conducted annually. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to label multi-dose insulin pens, (medication to treat elevated blood sugar levels) with the date it was opened in one of two medication carts (C Hall), failed to label a multi-dose vial of tuberculin solution (used to test for the disease tuberculosis) with the date it was opened in one of one medication storage rooms, and failed to permanently affix a locked narcotic storage container in the medication refrigerator in one of one medication rooms to prevent unauthorized access to resident specific medications for one resident (Resident R70). Findings include: A facility policy dated [DATE], entitled Administering Drugs indicated that Medications are to be administered at the time they are prepared .Only the nurse who prepares the medication may administer it. That same nurse is then responsible for recording the administration in the resident's medication administration record at the time it is given. A facility policy entitled Vials and Ampules of Injectable Medications dated [DATE], indicated that the date opened is recorded by the first person to use each multi-dose vial and vials expire 28 days after initial use, unless otherwise indicated by the manufacturer. Observation of Resident R70's room on [DATE], at 9:00 a.m. revealed a medication cup filled with multiple unknown medications sitting on the resident's bedside tray table, Resident R70 was sound asleep, and the Licensed Practical Nurse (LPN) Employee E1 was down the hallway assisting other residents. During an interview on [DATE], at that time the LPN Employee E1 confirmed that Resident R70's medications should not have been left alone in the room for the resident and he/she should have ensured Resident R70 took the mediation prior to leaving the room. Observation on [DATE], at 2:00 p.m. of C Hall medication cart storage revealed a multi-dose insulin pen dated opened [DATE], and expired [DATE], and a multi-dose insulin pen dated opened [DATE], and expired [DATE]. Observation of the refrigerator in the facility medication storage room revealed an opened, undated multi-dose vial of tuberculin solution, and that the secured narcotic storge box inside the refrigerator was not permanently affixed to the inside of the refrigerator. During an interview on [DATE], at 2:08 p.m. LPN Employee E4 confirmed that the multi-dose insulin pens were expired and should be discarded and that the multi-dose vial of tuberculin solution lacked an opened date and could not determine when the vial should expire. During an interview on [DATE], at 2:12 p.m. the Director of Nursing confirmed that the secured narcotic box in the refrigerator was not permanently affixed to the refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.9(c) Pharmacy services 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of manufacturer's instructions and clinical records, observations, and staff interviews, it was determined that the facility failed to prevent the potential for cross contamination during the provision of wound care and urinary catheter care for one resident (Resident R85), and during medication administration. Findings include: Review of manufacturer's instructions for the Nisus pump wound vacuum indicated that the pump should be kept in the black carrying case provided, and in a clean environment. Resident R85's clinical record revealed an original admitted [DATE], with diagnoses that included flaccid neuropathic bladder (nerves to the bladder are interrupted and cause the bladder to become underactive), kidney failure, stage four (full thickness loss of skin) pressure ulcer at the base of the spine, and malnutrition. Resident R85's clinical record revealed physician orders dated 1/08/24, to maintain an indwelling foley catheter (thin tube inserted into the bladder to drain urine); 2/06/24, to provide enhanced barrier precautions while the foley catheter and wound care are present; and 4/16/24, to apply a wound vacuum to his/her wound at the base of the spine three times per week. Observation on 5/21/24, at 2:40 p.m. revealed Resident R85 laying in bed with his/her foley catheter bag (device used to collect the urine from the catheter) and tubing laying on the bedroom floor, and the collection canister of the wound vacuum and it's tubing also laying on the floor. The black carrying case for the vacuum pump was laying on the bedside stand. During an interview at that time, Registered Nurse Employee E2 and Licensed Practical Nurse (LPN) Employee E3 confirmed that the foley catheter urine collection bag and tubing, and wound vacuum collection canister and tubing should not be laying on the bedroom floor. Observation of medication administration on 5/22/24, at 8:24 a.m. revealed that LPN Employee E5 transferred individual resident pills/tablets into a clear plastic medication cup and then placed his/her ungloved finger on the pills/tablets to hold them in the cup as he/she poured one pill/tablet at a time into clear plastic envelopes for crushing. During an interview at that time, LPN Employee E5 confirmed that he/she should not have touched the resident's pills with their bare hand. During an interview on 5/23/24, at 10:15 a.m. the Director of Nursing (DON) confirmed that the urine collection bag/tubing and the vacuum canister/tubing should not be on the floor, and also that there is no policy. During an interview on 5/23/24, at 11:15 a.m. the DON confirmed that LPN Employee E5 should not have touched the pills with his/her ungloved hand, and also that there is no policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.10(a)(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services