

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Warren Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655</p> <p>Based on review of clinical and facility records, resident and staff interviews, and observations, it was determined that the facility failed to provide a bath/shower as resident preference for one of 26 residents reviewed (Resident R68).</p> <p>Findings include:</p> <p>A facility policy entitled, Quality of Care Policy/Activities of Daily Living, dated 12/04/24, revealed each resident will receive and the Manor will provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Activities of Daily Living - A resident's abilities in activities of daily living will not diminish unless circumstances of the individuals's clinical condition demonstrate that diminution (the act was unavoidable). A resident who is unable to carryout activities of daily living receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene.</p> <p>Resident's R68's clinical record revealed an admitted [DATE], with diagnoses that included morbid (severe) obesity due to excess calories, urinary tract infection, hypokalemia (low potassium in the blood), and hypothyroidism (a condition where the thyroid does not produce enough thyroid hormone).</p> <p>Review of Resident R68's bath/shower documentation for 3/06/25, through, 4/02/25, revealed he/she was scheduled for a bath/shower on Wednesday/Saturday 3-11 p.m., however, his/her clinical record lacked evidence that a bath/shower was provided on:</p> <p>3/10/25, documented as not applicable</p> <p>3/20/25, documented as not applicable</p> <p>3/24/24, documented as not applicable</p> <p>3/27/25, documented as not applicable</p> <p>3/31/25, documented as not applicable</p> <p>(continued on next page)</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Resident R68 on 4/02/25, at 12:30 p.m. revealed his/her shower was scheduled for Monday and Thursday, but he/she has not received the scheduled shower in the past several weeks. While grabbing his/her hair, Resident R68 stated, Look, my hair is really greasy and full of knots in the back.</p> <p>An observation on 4/02/25, at 12:30 p.m. revealed Resident R68 laying in bed with greasy, knotted hair.</p> <p>An interview with the Director of Nursing on 4/04/25, at 11:45 a.m. confirmed that baths/showers were not provided according to Resident R68's scheduled days and preference for the period of 3/06/25, through 4/02/25.</p> <p>28 Pa. Code 211.10 (d) Resident care policies</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p>		

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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655</p> <p>Based on review of facility policy and documents, and resident and staff interviews, it was determined that the facility failed to ensure that resident financial records were made available through quarterly statements for one of 26 residents reviewed (Resident R68).</p> <p>Findings include:</p> <p>A facility policy entitled Resident Personal Funds (Pennsylvania) dated 12/04/24, revealed the resident understands that they have the right to maintain personal money in the Manor while they are a resident. They also understand that in the event that they become eligible for Medicaid, they will receive a personal needs allowance that they may use as they wish. Quarterly accountings - They also understand that they will receive a quarterly accounting of deposits, interest earned, and withdrawals made from their account.</p> <p>Resident's R68's clinical record revealed an admitted [DATE], with diagnoses that included morbid (severe) obesity due to excess calories, urinary tract infection, hypokalemia (low potassium in the blood), and hypothyroidism (a condition where the thyroid does not produce enough thyroid hormone).</p> <p>Facility documentation indicated that the facility was responsible for handling Resident R68's finances through a resident trust fund account which had a balance of \$1.74 on 3/07/25.</p> <p>During an interview on 4/02/25, at 12:30 p.m. Resident R68 indicated that he/she has not received any financial statements regarding his/her funds, and that he/she should have a monthly allowance to use as he/she wishes.</p> <p>During an interview on 4/03/25, at 2:15 p.m. the Business Office Manager Employee E5 indicated that he/she has not provided quarterly financial statements at the end of the quarter, or within 30-days of the end of the quarter. He/she further confirmed the facility lacked evidence that Resident R68 was provided financial statements including deposits, interest earned, and withdrawals made from his/her account.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(2) Management</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident has the right to receive notices in a format and a language he or she understands.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655</p> <p>Based on review of clinical and facility records, and staff interviews, it was determined the facility failed to ensure accurate accounts in communication and writing for insurance coverage for resident services for one of 26 residents reviewed (Resident CR109).</p> <p>Findings include:</p> <p>Resident CR109's clinical record revealed an admitted [DATE], and discharge date of [DATE], with diagnoses that included osteomyelitis (inflammation of bone caused by infection) of left ankle and foot, anemia (a condition where the blood does not have enough healthy red blood cells to carry oxygen throughout the body), metabolic encephalopathy (a condition where the brain's function is impaired due to an imbalance in chemicals in the brain affecting cognitive function, consciousness, and behavior), and chronic atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow throughout the heart and body).</p> <p>A facility invoice dated 3/17/25, revealed a balance due of \$13,939.05 for Resident CR109's stay/services from 12/09/24, through 1/24/25.</p> <p>An interview with the Business Office Manager (BOM) Employee E5 on 4/03/25, at 2:15 p.m. revealed that he/she communicated to Resident CR109's resident representative on 12/23/24, that Resident CR109 had Medicare days available to cover days of stay/services at the facility, indicating the stay at the facility would be covered by his/her insurance, and that Resident CR109 and/or their responsible party would not be responsible to pay privately. The BOM Employee E5 further confirmed that on 1/28/25, he/she later discovered that Resident CR109 had exhausted his/her Medicare insurance benefits, and Resident CR109 would be financially responsible as private pay for the days of stay/services from 12/09/24, through 1/24/25. The BOM Employee E5 indicated that it is sometimes confusing how insurance and Medicare coverage plays catch up, and referenced the January 2025 billing cycle that Resident CR109 would be financially responsible as private pay since no Medicare days were available to cover days of stay.</p> <p>This failure of adherence to thorough principles of communication resulted in Resident CR109/their resident representative not having an opportunity to make an adequate informed decision to continue Resident CR109's stay at the facility, or have the choice to be discharged to alternative home care services and other financial options.</p> <p>28 Pa. Code 201.18(g) Management</p>

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>40832</p> <p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>Based on review of facility documentation and staff interview, it was determined that the facility failed to provide the required notice to the resident, or the resident's representative, following the end of Medicare covered services for one of two residents reviewed who remained in the facility for long-term care (Resident R166).</p> <p>Findings include:</p> <p>Review of Resident R166's clinical record revealed that he/she began Medicare covered services following the return from a qualifying hospital stay on 12/6/24, and the facility-initiated discharge from Medicare Part A coverage was starting 12/21/24. The resident's benefit days were not exhausted. Resident R166 remained in the facility until 3/02/25.</p> <p>There was no evidence that a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) of Non-coverage (document that provides information to residents so they can decide if they wish to continue skilled services that may not be paid for by Medicare and assume financial responsibility) was provided as required in advance of the time that Medicare Part A was discontinued.</p> <p>During an interview on 4/03/25, at 2:14 p.m. the Business Office Manager confirmed that the facility did not provide SNFABN form to Resident R166, or his/her representative, when the facility discharged the resident from Medicare covered services.</p> <p>28 Pa. Code 201.18(b)(2) Management</p> <p>28 Pa. Code 201.18(e)(1) Management</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>42655</p> <p>Based on a review of facility policy, facility grievances, and resident and staff interviews, it was determined that the facility failed to resolve resident and resident representative's grievance concerns related to care/treatment for four of 26 residents reviewed (Residents R19, R50, R58, and R68).</p> <p>Findings include:</p> <p>A facility policy entitled, Grievances - Resident Rights dated 12/04/24, revealed The Manor will assist residents, their representatives, other interested family members, or advocates in filing grievances when such requests are made. It is the policy of the Manor to encourage all residents and visitors to bring to the attention of the Administrator their complaints. The Administrator is the designated Grievance Officer. The Grievance Officer can be reached at the main phone number or by writing the Manor's main mailing address. All persons will be provided with an opportunity to present their complaints through a formal grievance procedure. All complaints or grievances will be resolved promptly and fairly. Sharing concerns with us. If you or another interested party has a concern regarding the Manor's delivery of services, the behavior of other residents or staff members, or any other concern, we encourage you to share your thoughts with us. You are encouraged to discuss your concern with the immediate supervisor or director of the involved department. It is our policy that concerns raised with us will be reviewed, and that we will report back to the person registering the concern with a prompt resolution. Filing of written grievance form. Grievance forms are located in the Administrator's office. A formal grievance must be submitted in writing to the Grievance Officer and signed by the resident or the person filing the grievance. It is our policy to assist residents/sponsors in filing a grievance.</p> <p>A review of facility Grievances for January through April 2025, lacked evidence of Grievances from Resident 19, Resident 58, Resident R68, and Resident R50's family member. No Grievances were noted for January 2025. Four Grievances for February 2025, involved four residents with missing belongings. Two Grievances for March 2025, involved a resident with hearing aides not working and a resident with missing diabetic slippers. No Grievances were noted for April 2025.</p> <p>An interview with Resident R19 on 4/01/25, at 1:30 p.m. revealed he/she has concerns with the communication by the nursing staff, as he/she must ask several times for lab and test results. Resident R19 stated, I am currently awaiting results from a sleep study that I've asked about several times. Resident R19 further indicated that he/she has talked to different employees regarding this concern with no resolve.</p> <p>An interview with Resident R58 on 4/01/25, at 1:45 p.m. revealed that he/she has communicated a concern to facility staff without any resolution about the resident smoking area which is located outside of his/her window, and frequently the noise level and lingering smoke can be a problem. He/she further indicated that the smoke prevents him/her from opening his/her window, and the noise level prevents him/her from sleeping.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Resident R68 on 4/2/25, at 12:30 p.m. revealed that he/she has asked several different facility employees regarding his/her BIPAP (BiPAP is a non-invasive ventilation therapy that helps a person breathe by delivering pressurized air through a mask) machine. Resident R68 indicated he/she has been without his/her machine for numerous days with no prompt resolution.</p> <p>An interview with Resident R50's family member on 4/01/25, at 2:50 p.m. revealed that numerous care concerns were communicated to several different employees of the facility with no prompt resolution. Specific concerns were related to the location of the resident smoking area, which is adjacent to resident rooms, allowing smoke to linger near the rooms, and intrusive noise levels preventing residents from sleeping. Additional Resident R50's family member's concerns were related to resident hydration and times that residents are awakened for morning care.</p> <p>An interview with the Nursing Home Administrator (NHA) on 4/04/25, at 10:00 a.m. indicated that the facility Grievance process typically only addressed missing/broken items. The NHA further confirmed that the facility lacked evidence of Grievances for Residents R19, R50 (family member), R58, and R68's care and treatment concerns, and the care and treatment concerns were not addressed timely.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</p> <p>28 Pa. Code 201.18(e)(1)(3) Management</p> <p>28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832</p> <p>Based on review of clinical records, facility documentation, and staff interview, it was determined that the facility failed to complete the Minimum Data Set (MDS-periodic assessment of resident care needs) to accurately reflect the resident's status at the time of the assessment for one of 26 residents reviewed (Resident R43).</p> <p>Findings include:</p> <p>Resident R43's admission record revealed an admitted [DATE], with diagnoses that included bacterial bone infection in the right ankle and foot, Type 2 diabetes (conditiona when the body cannot use insulin correctly and sugar builds up in the blood), and irregular heartbeat.</p> <p>Review of Resident R43's Medication Administration Records (MARs) revealed he/she received Trulicity (a non-insulin injectable diabetes medication to help improve blood sugar control by stimulating insulin release) every seven days in May 2024, July 2024, September 2024, October 2024, November 2024, and February 2025.</p> <p>The Quarterly MDS dated [DATE], Medications Section N0350A indicated that Resident R43 received insulin one time during the seven-day look back period.</p> <p>The Quarterly MDS dated [DATE], Medications Section N0350A indicated that Resident R43 received insulin one time during the seven-day look back period.</p> <p>The Quarterly MDS dated [DATE], Medications Section N0350A indicated that Resident R43 received insulin one time during the seven-day look back period.</p> <p>The Quarterly MDS dated [DATE], Medications Section N0350A indicated that Resident R43 received insulin one time during the seven-day look back period.</p> <p>The Quarterly MDS dated [DATE], Medications Section N0350A indicated that Resident R43 received insulin one time during the seven-day look back period.</p> <p>The Annual MDS dated [DATE], Medications Section N0350A indicated that Resident R43 received insulin one time during the seven-day look back period.</p> <p>During an interview on 4/03/25, 11:00 a.m. Registered Nurse Assessment Coordinator Employee E4 confirmed that Section N - Medications category N0350A Insulin of the Quarterly MDS's dated 5/15/24, 7/12/24, 9/27/24, 10/31/24, 11/02/24, and the Annual MDS dated [DATE], were incorrectly coded for Resident R43 (as related to Trulicity) and should have been zero days.</p> <p>28 Pa. Code 211.5(f)(x) Medical records</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832</p> <p>Based on review of clinical records and facility policy and staff interview, it was determined that the facility failed to show evidence of having resident care plan conference meetings or invitation to care plan meetings and failed to revise comprehensive care plans to reflect the current necessary care and services for two of 26 residents reviewed (Residents R3 and R93)</p> <p>Findings include:</p> <p>Review of facility policy entitled Comprehensive Care Plan dated 12/04/24, indicated Residents will have the opportunity to discuss their goals for care . and Periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Review of Resident R3's clinical record revealed an admitted [DATE], with diagnoses including broken left hip, spinal stenosis with disc degeneration (narrowing of the space that houses the spinal cord and nerve roots leading to the spinal disks between the vertebrae to wear down), and difficulty walking.</p> <p>Further review of Resident R3's clinical record revealed a physician's order dated 3/19/25, for no weight bearing on left leg. A care plan entitled Self-Care Deficit dated 3/01/22, and updated 2/18/25, revealed to transfer with extensive assistance and a rolled walker. A care plan entitled At Risk for Falls dated 3/01/22, revealed it was updated 8/13/24, to include to walk three to six days per week (supervised by staff) with a wheeled walker.</p> <p>Resident R3's clinical record lacked evidence that his/her care plan was updated to reflect the non-weight bearing status of the left leg.</p> <p>During an interview on 4/03/25, at 3:40 p.m. the Director of Nursing confirmed that Resident R3's care plan was not updated to reflect his/her current status.</p> <p>Review of Resident R93's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (condition when your lungs do not have adequate air flow), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and hyperlipidemia (high cholesterol).</p> <p>Review of Resident R93's clinical record lacked evidence that he/she and/or resident representative had been invited/attended a care plan conference meeting.</p> <p>During an interview on 4/01/25, at 1:40 p.m. Resident R93 disclosed that he/she had not attended and/or been invited to a care plan conference meeting.</p> <p>During an interview on 4/03/25, at 12:25 p.m. the Social Service Manager Employee E2 confirmed there was no evidence that Resident R93 and/or his/her representative had attended and/or had been invited to a care plan conference meeting after his/her last assessment dated [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832</p> <p>Based on review of clinical records, observations, and staff interviews, it was determined that the facility failed to follow physician's orders for four of 26 residents reviewed (Residents R1, R68, CR109, and R3).</p> <p>Findings include:</p> <p>No policy was provided regarding following a physician's order.</p> <p>Resident's R1's clinical record revealed an admitted [DATE], with diagnoses that included neurologic neglect syndrome (a neurological disorder that makes a person lack awareness to stimuli on one side of the body or space), diabetes mellitus (a disease that affects how blood sugar is regulated in the blood), asthma (a chronic condition in which a person's airways become inflamed making it difficult to breathe), and weakness.</p> <p>Resident R1's clinical record revealed a physician's order dated 3/20/25, reposition every two hours offload coccyx.</p> <p>Observations on 4/02/25, at 8:50 a.m., 9:30 a.m., 10:30 a.m., 11:00 a.m., 11:30 a.m., 12:05 p.m., and 12:40 p.m. revealed Resident R1 out of bed in his/her wheelchair sitting upright. A further observation at 12:58 p.m. revealed Resident R1 laying in bed.</p> <p>During an interview with Nurse Aide (NA) Employee E7 on 4/02/25, at 12:58 p.m. revealed that Resident R1 was out of bed to his/her wheelchair before 9:00 a.m. on 4/02/25, and not repositioned until he/she was laid down in bed after lunch at approximately 12:50 p.m. by NA Employee E7.</p> <p>An interview with Licensed Practical Nurse (LPN) Employee E8 on 4/02/25, at 1:00 p.m. confirmed that Resident R1 was out of bed and sitting in his/her wheelchair before 9:00 a.m. and not turned/repositioned until after lunch, a time span of approximately four hours. LPN Employee E8 further confirmed that Resident R1 has a history of a Stage Three (full thickness loss of skin) pressure injury to his coccyx (tailbone), and there were physician's orders to reposition every two hours and offload coccyx.</p> <p>During an interview on 4/0/25, at 12:57 p.m. the Director of Nursing (DON) confirmed Resident R1 has a history of a Stage Three pressure injury to his coccyx and should be repositioned every two hours per the physician's order dated 3/20/25.</p> <p>Review of Resident R3's clinical record revealed an admitted [DATE], with diagnoses including broken left hip, spinal stenosis with disc degeneration (narrowing of the space that houses the spinal cord and nerve roots leading to the spinal disks between the vertebrae to wear down), and difficulty walking. The clinical record also revealed a physician's order dated 3/19/25, for no weight bearing on left leg.</p> <p>Observation on 4/02/25, at 1:38 p.m. revealed NA Employee E7 transfer Resident R3 into bed and permitted weight bearing to his/her left leg during the transfer.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Warren Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/02/25, at 2:13 p.m. NA Employee E7 confirmed that he/she transfers Resident R3 using a bear hug and pivot and turn into bed.</p> <p>Observation on 4/03/25, at 1:05 p.m. revealed that NA Employee E8 assisted Resident R3 to stand from the toilet to the grab bar in the bathroom and adjusted Resident R3's clothing while he/she held onto the bar and permitted weight bearing to his/her left leg during the transfer.</p> <p>During an interview at that time, NA Employee E8 confirmed that Resident R3 stands and holds onto the bar while transferring from the toilet.</p> <p>During an interview on 4/03/25, a 3:40 p.m. the Director of Nursing confirmed that Resident R3's current transfer order is no weight bearing on left leg and that staff should maintain non-weight bearing until the order is updated.</p> <p>Resident's R68's clinical record revealed an admitted [DATE], with diagnoses that included morbid (severe) obesity due to excess calories, urinary tract infection, hypokalemia (low potassium in the blood), and hypothyroidism (a condition where the thyroid does not produce enough thyroid hormone).</p> <p>Resident R68's clinical record revealed a physician's order dated 10/18/24, BI-PaP at hours of sleep with 4 l/min [liters per minute] oxygen piped in to equal FIO2 of 35% pre set Settings of V=60, Max IPAP=18, EPAP=9 Make Nasal Mask Type. (BiPAP is a non-invasive ventilation therapy that helps a person breathe by delivering pressurized air through a mask).</p> <p>An interview with Resident R68 on 4/02/25, at 12:30 p.m. revealed that Resident R68 has been without his/her BIPAP for several months. Observations during the interview, revealed Resident R68 laying in bed and no BIPAP machine located in his/her room.</p> <p>During an interview with LPN Employee E10 on 4/03/25, at 12:00 p.m. confirmed that Resident R68 did not have a BIPAP machine to utilize per the physician order.</p> <p>During an interview on 4/04/25, at 11:45 a.m. the DON confirmed Resident R68's physician's order dated 10/18/24, was not followed for the resident to utilize a BIPAP at hours of sleep.</p> <p>Resident CR109's clinical record revealed an admitted [DATE], with diagnoses that included osteomyelitis (inflammation of bone caused by infection) of left ankle and foot, anemia (a condition where the blood does not have enough healthy red blood cells to carry oxygen throughout the body), metabolic encephalopathy (a condition where the brain's function is impaired due to an imbalance in chemicals in the brain affecting cognitive function, consciousness, and behavior), and chronic atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow throughout the heart and body).</p> <p>Resident CR109's clinical record revealed a physician's order dated 1/10/25, Active Critical Care two times a day for wound healing 30 ml [milliliters].</p> <p>Resident CR109's Medication Administration Record (MAR) dated 1/10/25, lacked evidence of amount of Active Critical Care administered to Resident CR109 on:</p> <p>1/10/25, 8:00 a.m. and 8:00 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1/11/25, 8:00 a.m.</p> <p>1/12/25, 8:00 a.m. and 8:00 p.m.</p> <p>1/13/25, 8:00 a.m. and 8:00 p.m.</p> <p>1/14/25, 8:00 a.m. and 8:00 p.m.</p> <p>and lacked evidence that Active Critical Care was administered on:</p> <p>1/11/25, at 8:00 p.m. with documentation noted as HN=Hold/See Nurse Notes with nurse documentation needs clarification on amount</p> <p>1/17/25, 8:00 p.m. with documentation noted as HN=Hold/See Nurse Notes with no evidence of a nurse's documentation in progress notes.</p> <p>During an interview on 4/04/25, at 11:45 a.m. the DON confirmed Resident R109's physician's order dated 1/10/25, was not followed for the resident to have Active Critical Care 30 ml two times a day for wound healing.</p> <p>28 Pa. Code 211.10 (a)(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47356</p> <p>Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to ensure a safe environment related to smoking for one of two residents reviewed who smoke at the facility (Resident R42).</p> <p>Findings include:</p> <p>A facility policy entitled, Smoking Policy, dated 12/4/24, revealed for those Manors that permit smoking the purpose is to provide maximum safety to all residents at all times. It is the intent of the Manor to provide an environment to all those residents, who wish to smoke, the opportunity to do so in a safe environment, with optimal safety to themselves, other residents, volunteers, visitors, and staff members. For the purpose of this policy, all references to smoking will also include the use of electronic cigarettes and vaporizers. Residents will be informed of the written smoking policy prior to admission. Smoking in bed is strictly prohibited, this includes the use of electronic cigarettes and vaporizers. Smoking will be allowed in designated areas only. Residents must be accompanied by staff, family, or properly trained volunteers while smoking. Smoking materials will be kept in a designated area accessible only by staff. This includes the safekeeping of electronic cigarettes. Staff members are strictly prohibited from furnishing their personal smoking materials to residents. Residents electing to smoke must provide their own smoking materials.</p> <p>Observations during the full health survey on 4/1/25, 4/2/25, and 4/3/25 throughout each day revealed Resident R42 had several electronic cigarettes/vaporizers sitting on his/her bedside table and one electronic cigarette/vaporizer in his/her hand and on 4/2/25, at approximately 2:30 p.m. Resident R42 was observed smoking his/her electronic cigarette/vaporizer in his/her room.</p> <p>An interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on 4/3/25, at approximately 4:00 p.m. confirmed that Resident R42 smokes his/her electronic cigarette/vaporizer in his/her room, which is an unauthorized smoking area and against facility policy. The NHA and DON further confirmed that this resident also keeps his/her own electronic cigarettes/vaporizers, therefore the facility has no accountability of them, and Resident R42 refuses to follow the facility smoking policy which places other residents, staff, and visitors at a safety risk.</p> <p>28 Pa. Code 201.14(a) Responsibility of license</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 209.3(a) Smoking</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496</p> <p>Based on review of clinical records, observations, and staff interview, it was determined that the facility failed to promote cleanliness and help prevent the spread of infection regarding respiratory care equipment for three of three residents and failed to provide oxygen according to physician's orders for one of three residents reviewed for respiratory services (Residents R16, R93 and R95).</p> <p>Findings include:</p> <p>Review of Resident R16's clinical record revealed an admitted [DATE], with diagnoses that included hypertension (high blood pressure), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones).</p> <p>Review of Resident R16's physician's orders revealed an order dated 8/11/23, to apply oxygen 1-2 lpm (liters per minute) per nasal cannula (oxygen tubing that has prongs that go into the nostrils and loops around the ears to secure in place to ensure adequate oxygen delivery) continuously to maintain oxygen saturation at or greater than 88%-92%, and an order dated 8/11/23, for Oxygen Maintenance Change O2 [oxygen] tubing and supply bag weekly, Wipe down concentrator and clean filter weekly, Change water jug weekly.</p> <p>Review of Resident R16's care plan revealed a plan of care with the focus of being at risk for impaired gas exchange and an intervention to administer O2 as ordered dated 3/4/24.</p> <p>Observations on 4/1/25, at 1:00 p.m. revealed an oxygen concentrator with a large amount of a white fluffy substance covering the top and the back of the concentrator. Observations on 4/2/25, at 9:00 a.m., 10:00 a.m. and 10: 22 a.m. revealed that oxygen was not being administered to Resident R16 and his/her nasal cannula was laying on the floor. Further observations revealed the large amount of a white fluffy substance covering the top and back of the oxygen concentrator remained.</p> <p>Review of Resident R93's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD-when your lungs do not have adequate air flow), anxiety, and hyperlipidemia (high cholesterol).</p> <p>Review of Resident R93's physician's orders revealed an order dated 12/6/24, for Oxygen Maintenance Change O2 tubing and supply bag weekly, Wipe down concentrator and clean filter weekly, Change water jug weekly.</p> <p>Observation on 4/1/25, at 1:05 p.m. revealed an oxygen concentrator with a large amount of a fluffy white substance covering the top and back of the concentrator and drops of a dried liquid substance on the top of the concentrator. Observations on 4/2/25, at 9:05 a.m., 10:05 a.m. and 10:22 a.m. revealed the large amount of white fluffy substance and drops of dried liquid substance remained on the oxygen concentrator.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident R95's clinical record revealed an admitted [DATE], with diagnoses that included acute and chronic respiratory failure (a condition where your lungs don't exchange air properly), COPD, and hypertension.</p> <p>Review of Resident R95's physician's orders revealed an order for Oxygen Maintenance Change O2 tubing and supply bag weekly, Wipe down concentrator and clean filter weekly, Change water jug weekly 12/6/24.</p> <p>Observation on 4/1/25, at 1:05 p.m. revealed an oxygen concentrator with a large amount of a fluffy white substance covering the top and back of the concentrator and drops of a dried liquid substance on the top of the concentrator. Observations on 4/2/25, at 9:05 a.m., 10:05 a.m. and 10:22 a.m. revealed the large amount of white fluffy substance and drops of dried liquid substance remained on the oxygen concentrator.</p> <p>During an interview on 4/2/25, at 10:22 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed that Resident R16 was not wearing his/her oxygen, and his/her nasal cannula was laying on the floor. LPN Employee E1 confirmed that there was a large amount of a white fluffy substance and a dried liquid substance on the oxygen concentrators. LPN Employee E1 confirmed that the oxygen concentrators should be clean and Resident R16 should have had his/her oxygen being administered per physician's order and that his/her nasal cannula should not be on the floor.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(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>48496</p> <p>Based on review of a facility policy, observations, and staff interview, it was determined that the facility failed to ensure that food was stored in accordance with standards for food safety in one of one walk-in coolers reviewed in the kitchen.</p> <p>Findings include:</p> <p>Review of facility policy entitled Storage of Perishable Foods dated 12/4/24, indicated Prepared or leftover foods should be stored tightly covered, clearly labeled, dated, and used within 3 days or discarded.</p> <p>Observation during kitchen tour on 4/1/25, at 12:00 p.m. revealed a clear plastic container containing five leftover potato triangles (hashbrowns) with a prepared date of 3/28/25, and no discard date.</p> <p>During an interview with the Dietary Manager Employee E3 on 4/1/25, during the time of observations he/she confirmed that the clear plastic container containing five leftover potato triangles were beyond their use by date. He/she also confirmed that the potato triangles should have been discarded by their use by date.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>40832</p> <p>Based on observations, review of manufacturer's guidelines and facility documents, and staff interviews, it was determined that the facility failed to properly clean and prevent the potential for cross contamination during the use of a blood glucose meter (BGM-a device to collect and measure the level of glucose [sugar] in the blood) for two of nine residents observed during the administration of medications (Residents R17 and R65).</p> <p>Findings include:</p> <p>Review of manufacturer's cleaning and disinfecting procedures indicated that the BGM should be cleaned and disinfected after use on each patient.</p> <p>Review of a facility skills demonstration/evaluation form for Blood Glucose Testing revealed that staff are instructed to disinfect the BGM per manufacturer's guidelines after completion of sample testing.</p> <p>Observation of blood glucose monitoring for Resident R51 on 4/01/25, at 3:27 p.m. revealed that Licensed Practical Nurse (LPN) Employee E9 entered Resident R51's room, obtained the blood specimen using the BGM, then exited Resident R51's room and laid the soiled BGM on the top of the medication cart and failed to clean the BGM per manufacturer's guidelines. It was unable to be determined if the the BGM was cleaned prior to/after use for blood glucose monitoring for Resident R51.</p> <p>Observation of blood glucose monitoring for Resident R65 on 4/01/25, at 3:39 p.m. revealed that LPN Employee E9 entered Resident R65's room, obtained the blood specimen using the BGM, then exited Resident R65's room and laid the soiled BGM on the top of the medication cart and failed to clean the BGM per manufacturer's guidelines.</p> <p>Observation of blood glucose monitoring for Resident R17 on 4/01/25, at 4:07 p.m. revealed that LPN Employee E9 entered Resident R17's room, obtained the blood specimen using the BGM, then exited Resident R17's room and laid the soiled BGM on the top of the medication cart and failed to clean the BGM per manufacturer's guidelines.</p> <p>During an interview on 4/01/25, at 4:10 p.m. LPN Employee E9 confirmed that he/she failed to clean the BGM unit prior to obtaining blood specimens from Residents R65 and R17.</p> <p>During an interview on 4/02/25, at 12:49 p.m. Infection Control/Infection Preventionist Employee E6 confirmed that the BGM unit should have been cleaned and disinfected after use on each patient.</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p>		