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	04/02/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of information submitted by the facility to the State Agency, policies, clinical records, facility documentation, and resident and staff interviews, it was determined that the facility failed to ensure essential resident safety measures were followed to prevent a fall which resulted in the actual harm of a right femur (thigh) fracture requiring surgical repair for one resident (Resident R5); and a fall which resulted in the actual harm of a nasal bone fracture for one resident (Resident R2); failed to provide adequate safety interventions to prevent a fall for one resident (Resident R7) and failed to provide supervision to prevent injury for two residents (Residents R4 and R104).Findings include:A facility policy entitled, ?Smoking Policy dated 12/23/25, indicated that nursing staff will conduct an assessment upon admission to establish frequency and guidelines for each resident who wishes to smoke, any restrictions will be noted in the resident's record, and resident must be accompanied by staff, family, or properly trained volunteers while smoking.A facility document entitled, Instructional Guide to Forms for Incident Investigation Follow-up Form indicated: the form is to be completed by the individual completing the investigation and witness statements are to be completed by the witnesses, and include:Name of investigating supervisor completing this form.Date of investigation.Name of employee who completed the incident form.Body part(s) affected by the incident, if injury occurred.Date the incident occurred or onset of symptoms reported.Supervisor's understanding of what happened.Name of witness (Document who actually saw/witnessed the incident). Witness account of what actually happened (Needs to be completed and signed by the witness).Incident causes. (Detail any equipment, tasks, management practice/behavior, or environmental circumstances that may have contributed to the occurrence).Notes: Document facts and findings, conclusion, root cause possibilities and determinations, specific concerns, any other important factors related to the incident/investigation.Recommended solutions related to the determined root cause and prevention of this type of incident from occurring int eh future.Person assigned the responsibility of ensuring the recommended solution is implemented.Expected completion date, follow-up date to ensure recommended solution was implemented.Supervisor's signature.Administrators' signature.Review of the facility's Van Driver Job Description revealed that the van driver is expected to drive safely in all weather conditions, follow facility policies and procedures, and follow all safety policies and procedures during daily tasks.Resident R5's clinical record revealed a most recent admission date of 10/22/24, with diagnoses that included fractured right femur (thigh), respiratory failure, chronic obstructive pulmonary disease [COPD-lung disease causing restricted airflow and breathing problems], morbid obesity (complex disease involving having too much body fat that increases the risk of many other diseases and health conditions), and pulmonary edema (abnormal buildup of fluid in your lungs that can cause shortness of breath and difficulty breathing).Resident R5's clinical record revealed departmental progress notes dated 12/23/25, which indicated that while on transport in the facility owned van Resident R5 was displaced from his/her wheelchair injured and transported to the hospital by Emergency Medical Services for evaluation and treatment of a fractured femur.Review of the information submitted by the (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

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	04/02/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	facility to the State Agency on 12/24/25, revealed that Resident R5 was being transported via the facility-owned van by the facility's van driver when he/she heard a loud bang, stopped the van and found Resident R5 lying on the floor of the van. The van driver called 911 and Resident R5 was transported to the hospital for evaluation and treatment of a fractured right femur.Review of a report dated 12/23/25, from emergency services company indicated that they were dispatched at 2:55 p.m. to a motor vehicle accident in which a patient fell from his/her wheelchair while riding in a van, and that the patient reported that the van driver hit the brakes hard causing him/her to slide out of the wheelchair and land on his/her knees and become pinned in-between the rear seats, and reported severe right knee pain, back pain and a developing headache.Review of facility investigation of Resident R5's accident revealed: Lack of witness statements from Resident R5 and the van driver. Lack of evidence of van driver education regarding safety procedures prior to Resident R5's accident and/or after the accident.Review of facility van driver education after Resident R5's accident revealed lack of job specific interventions to ensure resident safety during transport in the facility van.Documentation of an interview on 3/30/26, with Resident R5 by the Ombudsman (official or designated person who investigates complaints, ensures fairness, and helps resolve disputes impartially) indicated that Resident R5 was not secured in his/her wheelchair by a seatbelt and that the van driver suddenly slammed on the brakes and Resident R5 was propelled forward out of his/her wheelchair and landed between the first and second seats of the van. Resident R5's statement stated that he/she was never interviewed by the facility regarding the incidents leading up to his/her fall and fracture.Interview with Resident R5 on 4/01/26, at 8:30 a.m. confirmed that the documented interview with the Ombudsman on 3/30/36, was accurate and that he/she was never interviewed to tell his/her side of the story.During an interview on 4/01/26, at 3:13 p.m. the Nursing Home Administrator (NHA) confirmed there was no evidence of van driver education prior to Resident R5's accident. Resident R2's clinical record revealed an admission date of 10/16/23, with diagnoses that included COPD, Type 2 Diabetes (condition when the body cannot use insulin correctly and sugar builds up in the blood) and Parkinson's Disease (brain disorder that affects movement and causes tremor, stiffness, and slowness), and epilepsy (long-term brain disorder that causes recurrent, unprovoked seizures caused by abnormal electrical activity in the brain). A care plan entitled, I am a smoker dated 11/13/25, included interventions to assess ability to smoke safely, obtain a physician's order and consent, and will smoke at established smoking times and location.Resident R2's most recent smoking assessment dated [DATE], indicated he/she drops ashes on self, follows the facility's policy on location and time of smoking, and requires the application of a smoking apron.Review of information submitted by the facility to the State Agency on 2/06/26, indicated that on 1/30/26, Resident R2 was observed lying on the ground in the designated resident smoking area outside. Resident R2 stated that he/she bent over in his/her wheelchair to pick up a dropped cigarette off the ground, fell, and couldn't get back up. Initial assessment revealed a large (8cm) protruding hematoma, numerous small abrasions on forehead, nasal area and mouth. An ice pack applied to nose & hematoma. On 1/31/26, Resident R2 complained of increasing pain to his/her nose and increased swelling was also noted. Resident R2 was sent to the hospital and was found to have multiple facial soft tissue contusions/ecchymoses, and a slightly comminuted & mildly displaced bilateral nasal bone fracture.Review of the facility's investigation revealed lack of evidence that Resident R2 was supervised while outside smoking in the designated resident smoking area. During an interview on 4/01/26, at 2:19 p.m. the NHA confirmed staff should have been supervising Resident R2 while he/she was outside smoking. Resident R7's clinical record revealed an admission date of 7/17/24, with diagnoses that included paraplegia (type of paralysis that affects the lower half of the body, typically caused by spinal cord injury or neurological disease), Type 2 Diabetes, and spinal stenosis (narrowing of spaces within the spine, which can compress the spinal cord and nerves, leading to pain, numbness, or weakness).Review of the information submitted by the facility to the State Agency on 7/15/25, Resident R7 was being transported via the facility-owned van by the (continued on next page)

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	04/02/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	facility's van driver and his/her wheelchair tipped over when the van driver had taken a turn. The van driver was unable to move Resident R7 on his/her own. The security staff for the facility where he was stopped summoned the emergency department staff to assist the van driver. Resident R7 was taken to the hospital emergency department for evaluation and was found to have no injuries via radiological testing and was taken back to the facility.Resident R7's clinical record lacked evidence of an investigation of the incident and/or an assessment of Resident R7 upon his return to the facility. On 7/29/25, a physician's progress note referenced Resident R7's fall from a wheelchair on the bus.There was no evidence of van driver education regarding safety procedures prior to Resident R7's accident and/or after the accident.During an interview on 4/01/26, at 3:13 p.m. the NHA confirmed there was no evidence of van driver education prior to or after Resident R7's accident.During an interview on 4/02/26, at 7:45 a.m. the NHA confirmed that there was no evidence that the facility investigated Resident R7's accident. Resident R4's clinical record revealed an admission date of 8/29/24, with diagnoses that included COPD, post-traumatic stress disorder [PTSD (mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it, causing flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event)], and open sores and infections of both lower legs/feet.Resident R4's care plan entitled, I am a smoker dated 8/29/24, included interventions to agree to follow the smoking policies by not having smoking materials on my person, or in a location that puts others at risk, follow smoking times, adhere to recommendations of safe smoking, and that if the facility is non-smoking, to go off the grounds to smoke, tell staff and sign out each time.Resident R4's most recent smoking assessment dated [DATE], indicated that he/she would follow the facility's policy on location and time of smoking. There was no evidence of specific safety interventions recommended and/or determination of supervision requirements. Resident R104's clinical record revealed an admission date of 12/23/24, with diagnoses that included COPD, respiratory failure, Schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking), and anxiety.Resident R104's most recent smoking assessment dated [DATE], indicated that he/she would follow the facility's policy on location and time of smoking There was no evidence of specific safety interventions recommended and/or determination of supervision requirements.Observation on 3/30/26, at approximately 9:40 a.m. revealed Resident R4 and Resident R104 in their wheelchairs entering the door leading out to the designated resident smoking area. At the time of the observation, the surveyor inquired if staff go out and supervise them when they smoke. Both Residents R4 and R104 shared that staff do not go out to supervise them when they smoke.During an interview on 4/01/26, at 2:19 p.m. the NHA confirmed staff should have been outside supervising residents while they smoke. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services28 Pa. Code 201.18(b)(1)(3) Management28 Pa. Code 201.18(e)(1) Management

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	04/02/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on a review of facility policy, facility and clinical records, observations, and resident and staff interviews, it was determined that the facility failed to adhere to proper infection control practices related to a gastrointestinal outbreak for four of four resident care units observed (A, B, C, and D Units).Findings include: Facility policy Infection Control - Plan Overview dated 12/23/25, revealed the primary of the MANOR's Infection Control Plan is to establish guidelines to follow in preventing, identifying, reporting, investigation, and controlling the spread of contagious, infectious or communicable diseases. The major activities of the plan are: Surveillance of infections - An on-going surveillance and monitoring for infections among residents and personnel and subsequent documentation of infections that occur. Implementation of control measures - Prevention of spread of infections is accomplished through the use of Standard Precautions and other barriers, appropriate treatment and follow-up, and employee work restrictions for illness. Prevention of Infection - Staff and resident education is done to focus on risk of infection and practices to decrease this risk. Policies, procedures and aseptic practices are followed by personnel in performing procedures and in disinfection of equipment. Immunizations are offered as appropriate to residents and staff to decrease the incidence of preventable infectious diseases. Facility policy Standard Precautions - Transmission Based Precautions General Principles dated 12/23/25, revealed it is the policy of this facility to use Transmission Based Precautions (TBP) in addition to Standard Precautions for a resident with documented or suspected infection or colonization with highly transmissible epidemiologically important pathogens for which additional precautions are necessary. When TBP isolation is necessary, the signage can posted on the resident's door for visitors to see the nurse before entering. Initiating TBP - Should there be reason to believe that a resident has an infection or communicable disease requiring TBP isolation, the Nurse will notify the resident's attending physician for appropriate instructions i.e., TBP for a specific type of isolation. The Nurse will enter the physician's order in the medical record. The physician's orders must be carried out quickly as practicable. The failure of the attending physician, or his/her alternate, to take appropriate action concerning a suspected or confined infectious or contagious disease, will be promptly reported to the Administrator. In the event the attending physician fails to take appropriate actions, the Administrator, Director of Nursing and/or the Infection Preventionist Nurse will have the authority to implement TBP isolation. TBP isolation will remain in effect until discontinued by the attending physician. Orders for discontinuing TBP isolation will be recorded in the medical record. Orders must be signed and dated by the attending physician. When TBP isolation is implemented, the Nurse will notify the dietary, housekeeping and laundry department supervisors that TBP isolation has been implemented. Set up isolation with supplies available to staff in an efficient manner. Post the TBP isolation sign on the outside doorframe so all personnel will be aware that TBPs isolation have been implemented. Make sure that a receptacle is placed in the room and lined with a plastic liner. Make sure laundry placed in the laundry room is properly marked to alert of TBP. After the disease signs and symptoms have resolved with physician order, the precautions may be discontinued. Personal Protective Equipment (PPE - gloves, masks, gowns) - PPE should be readily available near the entrance to the resident's room. Resident Transport - Limit transport and movement of residents outside of the room for essential purposes only. If transport or movement is necessary, minimize dispersal of droplets by masking the resident if possible. Facility provided infection control documentation revealed nine residents (Residents R61, R39, R16, R55, R51, R106, R24, R36, and R22) on 3/24/26, with a gastrointestinal illness with loose stools, nausea and vomiting on the D unit. Nine residents (Residents R109, R111, R59, R82, R41, R47, R23, R33, and R9) on A, B, C, and D units with similar symptoms of loose stool, nausea and/or vomiting were subsequently noted 3/26/26, through 3/30/26. Review of clinical records for residents involved in the gastrointestinal outbreak revealed a lack of evidence that transmission-based precautions were implemented to prevent the spread of the (continued on next page)

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	04/02/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	gastrointestinal illness. Review of clinical records for Resident R9 indicated on 3/29/26 that he/she continued with foul loose stools. Stool was be obtained and evaluated for C. diff (a bacteria that causes severe, watery diarrhea and abdominal pain). Observations of Resident R9 revealed no transmission-based precautions related to a gastrointestinal illness were maintained during days of observations 3/30/26, 3/31/26, and 4/01/26. During an interview with Resident R33 on 3/30/26, at 1:45 p.m. he/she was observed resting in bed with a ginger ale and saltine crackers on the bedside table. Resident R33 stated, I threw up a couple times and just feel awful. No transmission-based precautions were maintained during the interview/observation. Interview with Licensed Practical Nurse (LPN) Employee E3 on the C unit on 3/30/26, at approximately 2:45 p.m. revealed that he/she was leaving work due to feeling nauseous. LPN Employee E3 further indicated that the unit had several residents not feeling well with a gastrointestinal illness. Interview with LPN Employee E1 on the C unit on 3/31/26, at 4:30 p.m. revealed no knowledge or Nurse/Nurse report of any residents on C unit with a gastrointestinal illness. Interview on 4/01/26, at 1:50 p.m. the Infection Control Registered Nurse (RN) confirmed that the facility was not following proper infection control practices and failed to recognize that further residents who were symptomatic with loose stools, nausea and/or vomiting and failed to implement transmission based precautions to mitigate the gastrointestinal illness from spreading throughout A, B, C and D units. Interview on 4/01/26, at 2:40 p.m. the Nursing Home Administrator (NHA) confirmed that the facility lacked evidence of surveillance and implementation of infection control measures to prevent the spread of further gastrointestinal illness throughout the facility from A unit to further residents on A, B, C, and D units. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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	04/02/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to appropriately maintain respiratory care equipment according to physician's orders for four of 22 residents reviewed (Residents R1, R28, R30, and R70).Findings include: A facility policy entitled, Portable Oxygen Concentrators Usage, Care and Maintenance dated 12/23/25, indicated cleaning/maintenance for the particle screens that removes dust fragments must be cleaned with mild soap and water and allow to dry to ensure adequate air flow through the device. The policy further indicated the nasal cannula [NC-a flexible tube to deliver oxygen placed in the nose] should be replaced on a weekly basis along with all oxygen disposables the resident uses. Disposable supplies should be stored in supply bags to keep them from contamination from other surfaces such as the floor, other equipment. Resident R70's clinical record revealed Resident R70 was admitted on [DATE], with diagnoses of respiratory failure (a serious condition occurs when not enough oxygen passes from the lungs to the blood), chronic obstructive pulmonary disease (COPD - a lung condition caused by damage to the lungs and airways that restricts your breathing), asthma (a chronic respiratory condition that causes inflammation, narrowed airways and difficulty breathing), and lupus (a chronic disease where the immune system mistakenly attacks healthy tissues causing damage to organs). Resident R70's clinical record revealed a physician's order dated 3/04/26, Oxygen Maintenance: Change O2 [oxygen] tubing and supply bag weekly; wipe down concentrator (medical device that extracts oxygen from ambient air and delivers a concentrated oxygen supply to patients who need supplemental oxygen); clean filter weekly; and change water jug weekly. Directions indicated one time a day every Sunday. Resident R70's physician's orders dated 3/04/26, further indicated him/her to be on 1 liter per minute (LPM) via NC as needed to maintain oxygen levels at or greater than 90%. Observations made on 3/30/26, at 1:30 p.m. revealed Resident R70 resting in bed with oxygen infusing at 1 LPM via NC from an oxygen concentrator at his/her bedside. The oxygen tubing was noted with a label 3/6. Resident R30's clinical record revealed Resident R30 was admitted on [DATE], with diagnoses of diabetes (a group of diseases that affect how the body uses blood sugar), COPD, neutropenia (a blood disorder involving low neutrophils, a type of white blood cells which are part of the immune system fighting infections), and high blood pressure. Resident R30's clinical record revealed a physician's order dated 7/20/25, Oxygen Maintenance: Change O2 tubing and supply bag weekly; wipe down concentrator and clean filter weekly; and change water jug weekly. Directions indicated one time a day every Sunday. Resident R30's physician orders dated 8/14/25, further indicated that he/she is to receive 2 LPM via NC as needed (prn) to maintain oxygen levels at or greater than 90%. Observations made on 3/30/26, at 1:38 p.m. revealed Resident R30 resting in bed with oxygen infusing at 2 LPM via NC from an oxygen concentrator at his/her bedside. The oxygen tubing was noted with a label 3/10. Resident R28's clinical record revealed an admission date of 2/26/26, with diagnoses that included encephalopathy (group of conditions that cause brain dysfunction and can appear as confusion, memory loss, personality changes and/or coma in the most severe form), asthma (condition that causes your airways to swell, narrow and fill with mucus), morbid obesity (when body fat accumulation is so excessive that it poses serious health risks), and lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system). Resident R28's clinical record revealed a physician's order dated 2/28/26, to administer oxygen at 2 LPM via NC prn to maintain oxygen levels at or greater than 90% every shift, if unable to maintain oxygen saturation at or greater than 90% on 2 LPM call the physician. A physician's order dated 2/28/26, Oxygen Maintenance: Change O2 tubing and supply bag weekly; wipe down concentrator and clean filter weekly; and change water jug weekly. Directions indicated one time a day every seven days for oxygen therapy. Resident R28's Medication Administration Record for February 2026 revealed that he/she received oxygen every night on the (continued on next page)

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	04/02/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	overnight shift. Observation on 3/30/26, at 3:15 p.m. revealed that Resident R28's oxygen tubing was dated 3/16/26, and that the oxygen tubing was hanging over the top of the water jug. During an interview on 3/30/26, at 3:40 p.m. Registered Nurse (RN) Employee E2 confirmed that the above respiratory equipment was currently used by these residents, and the equipment was not dated/changed/cleaned/maintained as per Resident R28, R30, and R70's physician's orders and facility policy. Resident R1's clinical record revealed an admission date of 2/18/26, with diagnoses that included sudden respiratory failure, lung cancer, nicotine and alcohol dependency, and Schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking). Resident R1's clinical record revealed a physician's order dated 2/18/26, to administer oxygen at 2 LPM via NC prn to maintain oxygen levels at or greater than 90% every shift, if unable to maintain oxygen saturation at or greater than 90% on 2 LPM call the physician. A physician's order dated 2/25/26, Oxygen Maintenance: Change O2 tubing and supply bag weekly; wipe down concentrator and clean filter weekly; and change water jug weekly. Directions indicated one time a day every Sunday. Resident R1's departmental progress notes indicated he/she was wearing the oxygen mask on multiple occasions. Observation on 3/31/26, at 8:40 a.m. revealed Resident R1 lying in bed and an oxygen mask (mask placed over the nose and mouth and connected to a supply of oxygen, used when the body is not able to gain enough oxygen by breathing air) laying in the open top drawer of the bedside stand with the tubing attached to the concentrator and concentrator running, the external concentrator filter was covered with a moderate amount of gray fluffy substance. The tubing connected to the oxygen mask was labeled with white tape and the date was worn and unreadable, and water jug was empty. During an interview on 3/31/26, at 8:50 a.m. Licensed Practical Nurse Employee E1 confirmed the position and functioning of the oxygen mask, the moderate amount of gray fluffy substance on the external concentrator filter, the worn illegible tape on the tubing, and the empty water jug. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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	04/02/2026

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 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. Based on review of facility policies and clinical records, and staff interviews, it was determined that the facility failed to develop a comprehensive care plan for trauma-informed care for one of 22 residents (Resident R4).Findings include: A facility policy entitled, Care Plan Policy dated 12/23/25, indicated that the facility will develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timelines to meet a resident's medical, nursing, and mental and psychological needs. The care plan must include 1.) services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychological well-being, 2.) any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment. Resident R4's clinical record revealed an admission date of 8/29/24, with diagnoses that included COPD, post-traumatic stress disorder (PTSD-mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it, causing flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the even) dated 4/01/25, and open sores and infections of both lower legs/feet. Resident R4's admission Pennsylvania Preadmission Screening Resident Review Identification Level I Form (federal requirement to help ensure that individuals with a neurocognitive disorder or a mental health condition are not inappropriately placed in nursing homes for long term care) Section III-A dated 8/29/24, identified a diagnosis of depression. A behavioral health consultation dated 4/01/25, indicated that Resident R4 required a diagnosis of PTSD added to his/her clinical record. Further review of Resident R4's clinical lacked evidence of a trauma informed plan of care which included: development of trauma-informed approaches; identification and implementation of individualized interventions to eliminate or mitigate triggers that may re-traumatize Resident R4; and describe corresponding interventions for care that are in accordance with professional standards of practice. During an interview on 3/31/26, at 3:10 pm. the Nursing Home Administrator confirmed the facility failed to develop a care plan to address trauma-informed care for Resident R4's diagnosis of PTSD. 28 Pa. Code 211.12(d)(1)(5) Nursing services