

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395650	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/26/2024
NAME OF PROVIDER OR SUPPLIER: WARREN MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 682 PLEASANT DRIVE WARREN, PA 16365		
STATE LICENSE NUMBER: 233202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0806 SS=D	Findings of an Abbreviated Complaint Survey completed on December 26, 2024, it was determined that Warren Manor was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0806		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395650	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/26/2024
NAME OF PROVIDER OR SUPPLIER: WARREN MANOR STATE LICENSE NUMBER: 233202		STREET ADDRESS, CITY, STATE, ZIP CODE: 682 PLEASANT DRIVE WARREN, PA 16365		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0806 SS=D	Continued from page 1 483.60(d)(4)(5) Resident Allergies, Preferences, Substitutes §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by:	F 0806	R1 was immediately sent to the hospital for assessment after incident. All other food allergies in facility were reviewed and residents were interviewed to verify no allergic foods have been provided to them. An updated allergy list will be available to dietary staff and nursing staff to review. Nutrition Services Supervisor or designee will highlight food allergies on meal tickets for every meal. Nutrition Services Supervisor or designee will educate dietary and nursing staff on how to read meal tickets and how to cross reference the tray with the ticket before serving by 1/23/25. Nutrition Services Supervisor or designee will audit all trays with food allergies for accurate meal items during one meal per day daily for one week, weekly for one month and monthly thereafter. Findings will be discussed at Quality Assurance Performance Improvement meeting.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395650	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/26/2024	
NAME OF PROVIDER OR SUPPLIER: WARREN MANOR STATE LICENSE NUMBER: 233202		STREET ADDRESS, CITY, STATE, ZIP CODE: 682 PLEASANT DRIVE WARREN, PA 16365		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0806 SS=D	Continued from page 2 Based on review of facility policies, clinical records, and facility documentation, and staff interview, it was determined that the facility failed to ensure that one resident reviewed with food allergies (Resident R1) was free from exposure to a food allergen resulting in an allergic reaction. Findings include: The facility policy entitled, "Nutrition Services Communication Form" dated June 2016 revealed that it will be used to enhance communication between nursing and dietary of the need to change in diet or for nutritional interventions. The facility policy entitled "Food Allergen Awareness" dated January 2018, revealed that food allergies will be identified by a common name of the food or any part of the food that contains a food allergen with the purpose to prevent an allergic reaction. Resident R1's clinical record revealed an admission date of 9/15/2019, with diagnoses that included	F 0806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395650	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/26/2024	
NAME OF PROVIDER OR SUPPLIER: WARREN MANOR STATE LICENSE NUMBER: 233202		STREET ADDRESS, CITY, STATE, ZIP CODE: 682 PLEASANT DRIVE WARREN, PA 16365		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0806 SS=D	Continued from page 3 anemia (iron deficiency), major depression, and anxiety disorder. Resident R1's clinical record included a diet that identified a food allergy to fish. Facility documentation revealed that on 11/11/2024, Resident R1 was served dinner with his/her son present with a meal tray ticket that specified "breaded pork patty." When Resident R1's son questioned the food item and the meal tray, a staff member read the ticket and said it was a pork patty. Resident R1 ate a portion of the patty and began to develop a rash. The patty was then determined to actually be a breaded fish patty. Facility documentation verified that there was an error in the provision of an alternate food item related to a food allergy. During an interview on 12/23/2024, the Nursing Home Administrator, confirmed that the facility did not follow the physician's orders to not provide a food allergen to Resident R1 that resulted in an allergic reaction to fish.	F 0806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395650	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/26/2024
NAME OF PROVIDER OR SUPPLIER: WARREN MANOR STATE LICENSE NUMBER: 233202		STREET ADDRESS, CITY, STATE, ZIP CODE: 682 PLEASANT DRIVE WARREN, PA 16365		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0806 SS=D	Continued from page 4 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 201.29(c) Resident rights 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c) Nursing services	F 0806		



Certified End Page

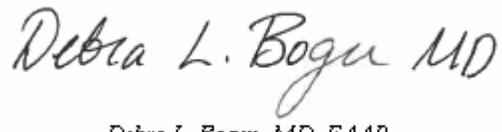
WARREN MANOR

STATE LICENSE NUMBER: 233202

SURVEY EXIT DATE: 12/26/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY