STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395609	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rouse Warren County Home	701 Rouse Avenue Youngsville, PA 16371

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of facility policy, review of facility documentation and clinical records, and staff interviews, it was determined that the facility failed to ensure that one resident was free of neglect during care which resulted in actual harm of an acute non-displaced fracture of the lateral malleolus and medial malleolus (a recent break located on the outer side of the ankle at the end of the fibula and the inner side of the ankle at the end of the tibia with the bone fragments not shifting out of their normal position) for one of four residents reviewed (Resident R1).Findings include: The Abuse, Neglect, and Exploitation policy, dated 1/5/26, revealed It is the policy of the Rouse Home to prevent, report, and investigate all allegations of abuse, neglect, or misappropriation of property relative to all residents in our care. Resident R1's clinical record revealed an admission date of 11/1/25, with diagnoses that included dementia (a decline in mental abilities severe enough to interfere with daily life), depression, and weakness. Resident R1's Functional Self Performance Deficit care plan, date initiated 4/14/26, revealed, Broda chair (a specialized chair used for residents who require pressure relief, advanced postural support, and long-term sitting) with pommel cushion (cushion with a raised center section) with footrest and footbuddy (a cushioned wheelchair accessory used to support the lower legs and feet) on at all times. Resident R1's clinical record revealed a nursing note written by Licensed Practical Nurse (LPN) Employee E1, dated 5/25/26, at 1:25 p.m. Resident was being pushed up the hallway to lunch when her right foot dropped and got caught under her Broda chair. Resident c/o (complained of) 8/10 pain (pain scale ranging from 0-10, with 10 being the worst pain ever experienced). Right ankle swollen. Pain medication administered, right ankle elevated, ice pack applied, RN (Registered Nurse) and family notified. VS (Vital Signs) baseline. X-ray ordered. Staff teaching done on the importance of using footrests. Will continue to monitor. Resident R1's clinical record revealed a nursing note written by RN Employee E2, dated 5/25/26, at 1:32 p.m. LPN reported resident's right leg buckled under wheelchair, c/o pain, ibuprofen administered. Writer assessed resident. Resident assisted into bed by two nursing staff, very heavy assist as resident will not bear weight on right leg. FOB (foot of bed) elevated. Writer observed right with significant swelling, bruising. Resident with c/o pain. Resident R1's clinical record revealed a nursing note written by RN Employee E2, dated 5/25/26, at 2:34 p.m. Transfer resident to ER (Emergency Room) to be evaluated and treated for right ankle trauma. Writer called diagnostics x-ray to inquire if x-ray could be performed in house today. After one-hour diagnostics had not returned phone call. Resident R1's clinical record revealed a nursing note written by RN Employee E2, dated 5/25/26, at 3:15 p.m. Resident R1 has left the facility. The resident was transferred to the hospital .Reason for Transfer/Condition: trauma to right ankle with c/o pain, will not bear on right extremity, significant swelling with bruising to right ankle . Resident R1's clinical record revealed x-ray scan results dated 5/25/26, at 5:58 p.m. indicating an acute non-displaced fracture of the lateral malleolus and medial malleolus. Resident R1's clinical record revealed a nursing note written by RN Employee E3, dated 5/25/26, at 11:11 p.m. Patient returned from ER at 10:30 p.m. Doctor made aware. Patient to be non-weight bearing to right lower extremity. Ice and elevate right extremity. Keep splint on at all times. Follow up with Ortho (specialize in treating bone fractures) in morning. Resident R1's clinical (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 0600 Level of Harm - Actual harm Residents Affected - Few	record revealed a nursing note written by RN Employee E4, dated 5/26/26, at 8:20 a.m. OT (Occupational Therapy) eval for positioning in new chair support of LE (Lower Extremity) r/t (related to) acute ankle fracture. The facility investigation revealed that CNA (Certified Nursing Assistant) Employee E5 provided a written statement with an incident date of 5/25/26, which revealed, [He/she]helped another aide get [Resident R1] to the restroom, once they got [him/her] off and into [his/her] chair the aide told [him/her] to take [him/her] to the dining room. When wheeling [him/her] to the dining room [his/her] right leg dropped and got caught under [his/her] wheelchair. [He/she] immediately informed the nurse of what happened.Was missing footrests. The facility investigation revealed that LPN Employee E6 provided a written statement with an incident date of 5/25/26, which revealed, Heard [Resident R1] crying out and aide apologizing. Resident was grasping [his/her] leg and grimacing. Aide was comforting resident. After a few minutes noticed resident's, right ankle was very swollen and was discolored and resident was expressing that it was painful .foot pedals were missing. The facility investigation revealed that CNA Employee E7 provided a written statement with an incident date of 5/25/26, which revealed, [He/she] was walking back on the hall from taking a resident to the dining room for lunch to get another resident when [he/she] saw CNA Employee E5 pushing Resident R1 to the dining room and [he/she] put [his/her] foot down and it got caught under the Broda chair .footrests were not on chair. Review of facility orientation documents dated 10/22/25, for CNA Employee E5 revealed he/she received training related to Resident Abuse Policy and Procedure, indicating he/she understood the policy is to prevent neglect relative to all residents. Review of facility orientation documents dated 11/8/25, for CNA Employee E5 revealed he/she received training related to safe transports related to a Broda chair and reviewed the facility's Foot Rest Policy. Interview with the Assistant Director of Nursing and the Nursing Home Administrator on 6/18/26, at approximately 4:45 p.m. confirmed CNA Employee E5 failed to place the leg rests on Resident R1's Broda chair per his/her care plan and facility policy during transport on 5/25/26, causing harm to Resident R1. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(1)(5) Nursing services

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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. Based on review of facility policy, review of facility documentation and clinical records, observations, and staff interviews, it was determined that the facility failed to provide necessary precautionary measures to maintain resident safety and prevent injury during transport in a wheelchair and/or Broda chair (a specialized chair used for residents who require pressure relief, advanced postural support, and long-term sitting) resulting in actual harm of an acute non-displaced fracture of the lateral malleolus and medial malleolus (a recent break located on the outer side of the ankle at the end of the fibula and the inner side of the ankle at the end of the tibia with the bone fragments not shifting out of their normal position) for one of four residents reviewed (Resident R1). Findings include: Facility policy entitled Wheelchair Footrest Assessment, dated 1/5/26, states, No Resident is to be transported by staff or family members unless the wheelchair footrest are properly attached during transport. Resident R1's clinical record revealed an admission date of 11/1/25, with diagnoses that included dementia (a decline in mental abilities severe enough to interfere with daily life), depression, and weakness. Resident R1's Functional Self Performance Deficit care plan, date initiated 4/14/26, revealed, Broda chair with pommel cushion (cushion with a raised center section) with footrest and footbuddy (a cushioned wheelchair accessory used to support the lower legs and feet) on at all times. Resident R1's clinical record revealed a nursing note written by Licensed Practical Nurse (LPN) Employee E1, dated 5/25/26, at 1:25 p.m. Resident was being pushed up the hallway to lunch when her right foot dropped and got caught under her Broda chair. Resident c/o (complained of) 8/10 pain (pain scale ranging from 0-10, with 10 being the worst pain ever experienced). Right ankle swollen. Pain medication administered, right ankle elevated, ice pack applied, RN (Registered Nurse) and family notified. VS (Vital Signs) baseline. X-ray ordered. Staff teaching done on the importance of using footrests. Will continue to monitor Resident R1's clinical record revealed a nursing note written by RN Employee E2, dated 5/25/26, at 1:32 p.m. LPN reported resident's right leg buckled under wheelchair, c/o pain, ibuprofen administered. Writer assessed resident. Resident assisted into bed by two nursing staff, very heavy assist as resident will not bear weight on right leg. FOB (foot of bed) elevated. Writer observed right with significant swelling, bruising. Resident with c/o pain. Resident R1's clinical record revealed a nursing note written by RN Employee E2, dated 5/25/26, at 2:34 p.m. Transfer resident to ER (Emergency Room) to be evaluated and treated for right ankle trauma. Writer called diagnostics x-ray to inquire if x-ray could be performed in house today. After one-hour diagnostics had not returned phone call. Resident R1's clinical record revealed a nursing note written by RN Employee E2, dated 5/25/26, at 3:15 p.m. Resident R1 has left the facility. The resident was transferred to the hospital .Reason for Transfer/Condition: trauma to right ankle with c/o pain, will not bear on right extremity, significant swelling with bruising to right ankle . Resident R1's clinical record revealed x-ray scan results dated 5/25/26, at 5:58 p.m. indicating an acute non-displaced fracture of the lateral malleolus and medial malleolus. Resident R1's clinical record revealed a nursing note written by RN Employee E3, dated 5/25/26, at 11:11 p.m. Patient returned from ER at 10:30 p.m. Doctor made aware. Patient to be non-weight bearing to right lower extremity. Ice and elevate right extremity. Keep splint on at all times. Follow up with Ortho (specialize in treating bone fractures) in morning. Resident R1's clinical record revealed a nursing note written by RN Employee E4, dated 5/26/26, at 8:20 a.m. OT (Occupational Therapy) eval for positioning in new chair support of LE (Lower Extremity) r/t (related to) acute ankle fracture. The facility investigation revealed that CNA (Certified Nursing Assistant) Employee E5 provided a written statement with an incident date of 5/25/26, which revealed, [He/she] helped another aide get [Resident R1] to the restroom, once they got [him/her] off and into [his/her] chair and the aide told [him/her] to take [him/her] to the dining room. When wheeling [him/her] to the dining room [his/her] right leg dropped and got caught under [his/her] wheelchair. [He/she] immediately informed the nurse of what happened.Was missing (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	footrests. The facility investigation revealed that LPN Employee E6 provided a written statement with an incident date of 5/25/26, which revealed, Heard [Resident R1] crying out and aide apologizing. Resident was grasping [his/her] leg and grimacing. Aide was comforting resident. After a few minutes noticed residents, right ankle was very swollen and was discolored and resident was expressing that it was painful .foot pedals were missing. The facility investigation revealed that CNA Employee E7 provided a written statement with an incident date of 5/25/26, which revealed, [He/she] was walking back on the hall from taking a resident to the dining room for lunch to get another resident when [he/she] saw CNA Employee E5 pushing Resident R1 to the dining room and [he/she] put [his/her] foot down and it got caught under the Broda chair .footrests were not on chair. Review of facility orientation documents dated 11/8/25, upon hire for CNA Employee E5 revealed he/she received training related to safe transports related to a Broda chair and reviewed the facility's Foot Rest Policy. Observations made on 6/18/26, between approximately 2:00 p.m. and 2:30 p.m. revealed that Resident's R2, R3, and R4 were being pushed by staff down the hallways in wheelchairs and/or Broda chairs without footrests in place. Interview with the Assistant Director of Nursing (ADON) and Nursing Home Administrator (NHA) on 6/18/26, at approximately 4:45 p.m. confirmed that during Resident R1's transport on 5/25/26, leg rest were not in place, and the resident sustained actual harm of an acute non-displaced fracture of the lateral malleolus and medial malleolus. ADON and NHA confirmed the leg rests should always be in place during transport and were not in place for Residents R2, R3, and R4. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(1)(5) Nursing services