

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395609	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Rouse Warren County Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. (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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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on review of clinical records and facility policy, observations, and staff interview, it was determined that the facility failed to appropriately maintain respiratory care equipment and promote cleanliness and help prevent the spread of infection regarding respiratory care equipment according to physician's orders for three of 25 residents reviewed (Resident R22, R55, and R120). Findings include: A facility policy entitled Oxygen dated 1/08/25, indicated that the humidifier (bottle of distilled water that adds moisture to the dry oxygen flow, preventing irritation and promoting comfort during inhalation) and tubing (tubing that connects the oxygen source (like a concentrator or tank), which then delivers the oxygen to the patient) will be changed and the concentrator (medical device that draws in room air, filters out nitrogen, and provides a concentrated stream of oxygen) filter will be cleaned every two weeks and as needed, and would be labeled with the date every time the humidifier/tubing is changed. Review of Resident R22's clinical record revealed an admission date of 2/19/24, with diagnoses that included respiratory failure, stroke with left-sided weakness, and metabolic encephalopathy (form of brain dysfunction caused by systemic illnesses, infections, toxins, or imbalances in the body's chemicals that affect brain function). Further review of Resident R22's clinical record revealed a physician's order dated 7/18/25, to administer ipratropium-albuteral solution (medication that relaxes and opens the air passages to the lungs to make breathing easier) through a nebulizer (small machine that turns liquid medicine into a mist that can be easily inhaled) by mouth three times a day for cough was discontinued on 7/20/25. Observation on 8/19/25, at 10:27 a.m. revealed a nebulizer machine on Resident R22's bedside stand and a nebulizer mask dated 7/26/25, lying on the floor between the bed and bedside stand. During an interview at that time, the Director of Nursing confirmed that the nebulizer mask and machine should have been removed from Resident R22's room upon the nebulizer order being discontinued. Resident R55's clinical record revealed an admission date of 6/12/23, with diagnoses that included heart failure, long-term kidney disease, and Type 2 Diabetes (condition where the body cannot use insulin correctly and sugar builds up in the blood). Further review of Resident R55's clinical record revealed a physician's order dated 12/30/23, to administer oxygen through a nasal cannula (thin, flexible tube that goes around your head with two prongs that go inside your nostrils that deliver the oxygen) to maintain blood oxygen saturations between 88-92%; a physician's order dated 3/18/24, to change oxygen tubing, water (humidifier) bottle, and clean the filter every two weeks. Review of Resident R55's treatment administration record (TAR) revealed that he/she received supplemental oxygen routinely. Observation on 8/19/25, at 10:50 a.m. revealed Resident R55's tubing bag was dated 8/05/25, the humidifier bottle was dated 8/11, there was no date on the oxygen tubing, and the external concentrator filter was covered with a copious amount of white fluffy substance. During an interview at that time, Licensed Practical Nurse (LPN) Employee E5 confirmed that the tubing bag and humidifier bottle should have been changed, the tubing should have been dated; and that the filter was dirty and needed cleaned/replaced. Resident R120's clinical record revealed an admission date of 2/17/23, with diagnoses that included emphysema (lung disease leading to difficulty breathing), heart failure, and chronic obstructive pulmonary disease (COPD- a progressive group of lung diseases causing airflow obstruction and breathing problems). Further review of Resident R120's clinical record revealed a physician's order dated 5/13/25, to administer oxygen through a nasal cannula to maintain blood oxygen saturations between 88-92%; a physician's order dated 3/18/24, to change oxygen tubing, water bottle, and clean the filter every two weeks. Review of Resident R120's TAR revealed he/she received supplemental oxygen routinely. Observation on 8/19/25, at 10:40 a.m. revealed Resident R120's oxygen concentrator external concentrator filter was covered with a copious amount of white fluffy substance. During an interview at that time LPN Employee E6 confirmed that the filter was dirty and needed to be cleaned. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations and staff interviews, it was determined that the facility failed to appropriately discard outdated medications for one of three medication carts reviewed (700 cart). Findings include: Review of facility policy entitled Medication Cart, Cleaning of dated [DATE], indicated the Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) is to check expiration date and dispose of medications that are expired. Insulin expiration is 28 days after opening and is to be dated accordingly; this supersedes the manufacturer expiration date. Review of manufacturer's guidelines revealed that an open NovoLog (type of Insulin) FlexPen (pre-filled syringe) must be used within 28 days after opening or be discarded, even if the vial still contains insulin. Observation of drug storage on [DATE], at 1:46 p.m. of Unit 700 medication cart revealed an open NovoLog FlexPen with an open date of [DATE], which was beyond the 28 days after opening. During an interview at the time of observation, LPN Employee E7 confirmed that the open date on the NovoLog FlexPen was beyond the 28 days and it should have been discarded. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1) 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 - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on review of a facility policy, observations and staff interviews, it was determined that the facility failed to safely store food containers in the main kitchen and ensure that food was stored in accordance with standards for food safety in pantry refrigerators on two of three nursing units observed (100 Unit and 700 Unit). Findings include: A facility policy entitled Cleaning-Dishes with Dish Machine dated 1/08/25, indicated that staff are to allow dishes to dry on racks, do not dry with towels, and do not put any dishes away wet. A facility policy entitled Handling and Storage of Food brought in by Family or Friends dated 1/08/25, indicated that food should be stored with the name of the resident and date brought in, a refrigerator is available on B-side of the building for storage of Family/Friend delivered perishable food, perishable food or beverages brought in to residents from outside are not co-mingled with main facility refrigerators, and food handled safely will be held for 72 hours. Observation in the main kitchen on 8/18/25, at 11:05 a.m. revealed a moderate amount of clear liquid and a small amount of moist food particles between metal stacked steam table trays. Interview at that time with Dietary Manager Employee E2 confirmed that the metal trays were stacked wet and that they would have to be rewashed and dried properly. Observation in the main kitchen on 8/19/25, at 10:20 a.m. revealed a moderate amount of clear liquid between metal stacked steam table trays. During an interview at that time Dietary Aide Employee E1 confirmed the wet stacking between metal steam table trays. Observation on 8/18/25, at 12:36 p.m. of the 700 Unit pantry refrigerator revealed unknown food item wrapped in foil lacked name and/or date, facility side salad lacked a date, and a white foam cup containing ham salad that lacked name/date. During interview at that time, Dietary Employee E3 confirmed that the above listed items were in the facility unit pantry and lacked labels for names and dates. Observation on 8/18/25, at 12:49 p.m. of the 100 Unit pantry refrigerator revealed the following: 1/2 of a bologna and cheese sandwich in an open baggie and lacked a date; three 1/2 cup clear containers with red lids (2 containing gray tinted sauerkraut, one containing unidentifiable food item) and the containers were labeled with an unknown name and lacked a date; and one white oblong container with clear lid containing two pieces of blueberry cake/muffins and lacked a name and date. Interview at that time Dietary Employee E4 confirmed that food items need to be dated and labeled with resident names. During an interview on 8/19/25, at approximately 12:45 p.m. the Director of Nursing confirmed that there is a specific refrigerator for families to use when they bring items into the facility and that the refrigerators in the unit pantries are only for dietary staff to use during mealtimes. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.6(f) Dietary services</p>		