

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Rose City Nursing and Rehab at Lancaster		STREET ADDRESS, CITY, STATE, ZIP CODE 425 North Duke Street Lancaster, PA 17602	
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>22502</p> <p>Based upon clinical record review and staff interview, it was determined the facility failed to comprehensively assess a resident who developed a pressure ulcer for one of four residents reviewed (Resident 4).</p> <p>Findings include:</p> <p>Review of Resident 4's clinical record included diagnoses of but not limited to Paraplegia (paralysis of the legs and lower body caused by a problem with the spinal cord or nerves, type 2 Diabetes (condition resulting from insufficient production of insulin, resulting in high blood sugar), and Peripheral Vascular Disease (condition that affects blood flow to the limbs and organs outside of the heart and brain).</p> <p>Review of physician's orders included an order for weekly skin assessment, progress note, and vital signs. Document skin assessment under Forms tab Weekly Skin Review every day shift every Thursday.</p> <p>Review of Resident R4's nursing progress note of July 9, 2024, revealed resident observed with a 3 centimeter (cm) by 2 cm open area to the right buttock. Area was cleansed and treatment applied. Treatment order received July 9, 2024, for the right buttock to cleanse, barrier cream, and foam border. D/C (discontinue) when healed.</p> <p>Review of the clinical record revealed a weekly skin review was completed on July 11, 2024. Further review of the clinical record failed to reveal subsequent weekly skin reviews were completed. There was also no other documentation of the wound including the stage, description, infection, or pain, from July 11, 2024, until August 2, 2024, when the resident was admitted to the hospital.</p> <p>Interview with the Nursing Home Administrator on August 12, 2024, at 12:55 p.m. confirmed that there was no documentation for the continued assessment of Resident 4's pressure ulcer.</p> <p>28 Pa. Code: 211.5(f) Clinical records</p> <p>Previously cited 3/15/24</p> <p>28 Pa. Code: 211.12(d)(1)(5) Nursing services</p> <p>Previously cited 3/15/24</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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22502</p> <p>Based on observations and staff interview, it was determined that the facility failed to maintain a safe environment for one of four resident bathrooms on the second floor.</p> <p>Findings include:</p> <p>Observation of the bathroom in room [ROOM NUMBER] on August 12, 2024, at 11:00 a.m. revealed a missing ceiling tile, exposing pipes in the ceiling.</p> <p>An additional observation revealed that the plastic grab bar for the toilet was cracked.</p> <p>Interview with the Nursing Home Administrator on August 12, 2024, at 1:00 p.m. confirmed the above observations.</p> <p>28 Pa. Code 207.2 (a) Administrator's responsibility</p>		