STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395177	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose City Nursing and Rehab at Lancaster	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)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents and staff interview, it was determined that the facility failed refund to the resident or resident representative any and all refunds due to the resident within 30 days from the resident's date of discharge from the facility for one of three residents (Resident R1). Findings include: Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE] and ceased to breathe while in the facility on 5/28/25. Review of the record of Resident R1's payer source revealed that Resident R1 had privately paid for care. During an interview on 8/6/25, at 9:55 a.m., the Business Office Manager (BOM) confirmed that she had submitted a request for a refund of payment to Resident R1's Representative. The BOM provided evidence of a communication with the financial office, dated 6/11/25. The BOM was able to provide a request for an update Resident R1's Representative refund, dated 8/5/25. The BOM was able to provide evidence that the refund request was processed and provided to the Resident Representative on 8/6/25. During an interview on 8/6/25, at approximately 12:45 p.m., the Director of Nursing confirmed that the facility failed to refund the Resident or Resident Representative the refunds due to the Resident within 30 days from the Resident's date of discharge from the facility. 28 Pa. Code 201.24 (b) admission Policy.28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(b)(2) Management.28 Pa. Code 201.29(a) Resident Rights.

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