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	02/13/2026

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, clinical records review, and staff interviews, it was determined that the facility failed to provide behavioral services in a timely manner for one out of three residents reviewed (Resident 1).Findings: A review of the facility's policy titled Behavioral Health Services, undated, revealed the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Review of Resident 1's diagnosis list revealed the following diagnoses: Alzheimer's disease (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability), Dementia (A term used to describe a group of symptom affecting memory, thinking and social abilities severely enough to interfere with daily life), and Mood Disorder (A mental health condition that primarily affects your emotional state). Review of Resident 1's Annual Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents) dated December 31, 2025, revealed the resident had severe cognitive impairment and was independent with transferring and walking. Review of Resident 1's Psychiatrists' consult, dated April 30, 2025, revealed the residents did not have mood or behavioral disturbances documented for the last 30 days. The same note revealed Sertraline (A medication used to treat depression) was discontinued in April 2025. Assessment and Plan include: No psychotropic medication (A prescription drugs that manage mental health conditions by altering brain chemicals to improve mood) recommended at this time; Recommend continued monitoring and documenting of mood and behavioral disturbances with description of behavior and if redirectable; and follow up as needed. Review of Resident 1's nursing progress note dated July 19, 2025, at 10:38 p.m., revealed Female resident made an allegation, stating that this resident pulled his pants down and showed her his penis. The same note revealed, This resident is now on 15 minutes check. Further review of Resident 1's nursing progress note dated September 7, 2025, at 9:13 p.m., revealed Inappropriate sexual gestures, spitting, yelling, cursing. Further review of Resident 1's nursing progress note dated September 28, 2025, at 9:57 p.m., revealed The resident has been acting inappropriately towards staff and other residents. He was found opening the doors of female residents, looking at them in bed. The same note revealed that the resident was difficult to redirect. Nursing progress note dated November 3, 2025, at 6:38 p.m., revealed Client observed rummaging through the roommate's personal items and personal food stash. Nursing progress note dated December 16, 2025, at 10:30 p.m., revealed Received verbal report that on dayshift, client was kissing another female resident. No behaviors involving other residents this shift. Nursing progress note dated December 30, 2025, at 2:19 p.m., revealed Resident found jerking himself off in the levator by staff, redirected to go to his room. Nursing progress note dated January 31, 2026, at 10:22 p.m., revealed Seen behind the door, kissing and attempting to pull his pants down. Redirected due to inappropriate behavior. A review of facility documents revealed an Event Report and investigation dated February 2, 2026, stating that at (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:15 p.m., on the same day, Resident 1 was found in a female resident's (Resident 2) room masturbating with one of his hands, with his other hand on Resident 2's side. The report indicated that Resident 2's gown was down to the knee, but the brief was intact and not open. Resident 1's hand was on Resident 2's side above the brief. Resident 1 was removed from Resident 2's room and was placed on 1:1. The physician and family were notified. The above behavioral notes dated September 7, 2025, September 28, 2025, November 3, 2025, December 16, 2025, December 30, 2025, and January 31, 2026, failed to reveal that the primary physician was notified of the resident's inappropriate/sexual behaviors. Further review of the nursing progress notes from July 19, 2025, until January 31, 2026, revealed that the facility did not provide Resident 1 with behavioral services despite multiple episodes of inappropriate/sexual behaviors until after February 2, 2026, the incident when the resident was found masturbating in another female resident's room. Review of Resident 1's psychiatry note dated February 9, 2026, revealed [resident] seen today for psychiatric follow-up per facility request due to recent increase in sexually inappropriate behaviors. The same note revealed: Plan and Assessment: Dementia with behavioral disturbances - ongoing, disease progressing as expected, consider Sertraline as recommended. The additional plan includes Recommend continuing 1:1 for safety related to sexually inappropriate behavior. An observation was conducted on February 10, 2026. at 10:00 a.m., and 1:00 p.m., revealed Resident 1 was lying in bed, with a 1:1 staff supervision. The resident was calm and quiet and refused to answer questions. The above findings were conveyed to the Nursing Home Administrator on February 10, 2026, at 2:00 p.m. The facility failed to ensure Resident 1 was provided with timely behavioral services for increasing inappropriate /sexual behaviors. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(1)(5) Nursing Services