

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 03/15/2024
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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>46166</p> <p>Based on a review of the minutes from Residents' Council meetings and grievances lodged with the facility and staff and resident interviews it was determined that the facility failed to demonstrate efforts to respond and resolve resident complaints raised at resident group meetings including those voiced by four Residents (Residents 20, 65, 57, and Resident 24).</p> <p>Findings include:</p> <p>Review of resident concern/Grievance log revealed there were no grievances recorded for the months of August 2023, September 2023, October 2023, November 2023, or December 2023.</p> <p>During resident council meeting on March 13, 2024, 10:00 a.m. four residents (Residents 20, 65, 57, and Resident 24) all reported filing grievances during the months listed above.</p> <p>Interview conducted with the facility's social worker (SW) on March 14, 2024, at 11:28 a.m. revealed social worker started working in the facility near the end of December 2023. SW reported the previous SW did not keep any copies or list of grievances for the months of August 2023, September 2023, October 2023, November 2023, or December 2023. The social worker stated he/she was unable to provide any evidence that grievances were investigated or resolved during the months noted above.</p> <p>During an Interview with the Nursing Home Administrator (NHA) on March 15, 10:14 a.m. The NHA revealed the facility has gone through three social workers since May 2023. The NHA also reported that since the turnover rate in the social work department has been high that the investigations into resident grievances have fallen through the cracks. The above information was discussed with the Administrator who confirmed the facility administration is unable to provide evidence the facility investigated resident grievances during the months noted above.</p> <p>28 Pa. Code: 201.18(e)(4) Management</p> <p>28 Pa. Code: 201.29(i) Resident Rights</p> <p>28 Pa. Code: 211.12(d)(3) Nursing Services</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35913</p> <p>Based upon clinical record review and review of facility documentation, it was determined the facility failed to protect a resident from abuse for one of 24 residents reviewed (Resident 91).</p> <p>Findings include:</p> <p>Review of Resident 91's diagnosis list revealed diagnoses including Dysphagia (inability/difficulty swallowing) and protein calorie malnutrition. Resident 91 expired on [DATE], on hospice services.</p> <p>Review of Resident 91's clinical record revealed multiple occasions between [DATE] and [DATE], when a family member was observed forcefully feeding Resident 91 and causing the resident to cough and choke.</p> <p>Further review of the clinical record revealed staff members attempting to educate the family member, but the family member continued to provide the resident foods that were not on the resident's appropriate diet per physician's order.</p> <p>Further review of the clinical record revealed an incident that occurred on [DATE], which prompted the facility to halt visitation by the family member.</p> <p>Review of Resident 91's progress notes dated [DATE], and [DATE], revealed the family member was continually force feeding the resident inappropriate food items and ultimately had to be physically removed from the premises by the local police department.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on [DATE], revealed that between [DATE] and [DATE], no attempts were made to stop Resident 91's family member from feeding Resident 91 inappropriate food items. Multiple incidents occurred and were only met with re-education. The family member was continually permitted to visit Resident 91 and attempt to feed Resident 91 inappropriate items which was witnessed by multiple staff members.</p> <p>The facility failed to protect Resident 91 from abuse by a family member.</p> <p>28 Pa. Code 201.18(a)(b)(1)(2) Management</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>30934</p> <p>Based on clinical record review and staff interview it was determined the facility failed to review and revise the resident care plan quarterly for one of 24 residents reviewed. (Resident 53)</p> <p>Findings Include:</p> <p>Review of Resident 53's care plan revealed a target date of December 29, 2023.</p> <p>Review of Resident 53's clinical record revealed no documented evidence of a care plan conference in the past year.</p> <p>Interview with Social Worker E3 on December 15, 2024 at 11:30 a.m. confirmed Resident 53 has not had a care plan conference in the past year and the care plan was out of date.</p> <p>28 Pa. Code 211.5(f) Clinical Records</p> <p>28 Pa. Code 211.11(d) Resident Care Plan</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>30934</p> <p>Based on review of the Pennsylvania Professional Nursing Practice Act, facility policy and procedure review, observations and staff interview it was determined the facility failed to ensure staff met the professional standards for a Registered nurse during medications administration for one of three residents reviewed. (Resident 69)</p> <p>Findings Include:</p> <p>The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and on going data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carrying out nursing care actions that promote, maintain and restore the well-being of individuals.</p> <p>Review of facility policy and procedure titled Medication Administration- General Guidelines, undated, revealed medications are administered at the time they are prepared. Medications are not pre-poured.</p> <p>Observations of medication administration on March 15, 2024 at 8:45 a.m. revealed Registered Nursing Employee E4 administering medications to a resident. This surveyor asked employee E4 if they were administering medications and would like to observe. Employee E4 stated they were going to administer medications to Resident 69 but had already prepared the medications because they needed to dissolve, Employee E4 then pulled a medications cup half filled with an orange liquid and dissolved medications inside that was unlabeled and uncovered. The surveyor stated that they needed to see medications administration from the beginning of preparation. Employee E4 then placed the medications cup back into the medications cart and proceeded to administer medications to two other residents before administering the pre-poured medications to Resident 69.</p> <p>Interview with the Director of Nursing and the Nursing Home Administer on March 15, 2023 at 11:45 a.m. confirmed Licensed Nursing Employee E4 had no followed professional standards by not administering medications at the time it was prepared.</p> <p>28 Pa. 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(5) Nursing services</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30934</p> <p>Based on clinical record review, facility policy and procedure review, and staff interview it was determined the facility failed to monitor the nutritional status for three of nine residents reviewed. (Residents 53, 69, and Resident 87)</p> <p>Findings Include:</p> <p>Review of facility policy and procedure titled Weight Assessment and Intervention, revised March 2019, revealed the nursing staff will measure the resident weight on admission then weekly for four weeks. If no weight concerns are noted at this point, weights will be monitored monthly thereafter or as per Dietitian or MD. Weights will be recorded in each individual's medical record. Any weight change of 5 pounds or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing will notify the Physician and Dietitian. The threshold for significant unplanned and undesired weight loss will be based on the following criteria. 1 month - 5% weight loss is significant, 3 months- 7.5% is significant, 6 months 10% is significant.</p> <p>Review of Resident 53's weights revealed weights on February 4, 2024 of 244.8 pounds and a weight on March 4, 2024 of 213.3 pounds after returning to the facility after a hospital stay. This was a significant weight loss of 13.1% loss over one month.</p> <p>Further review of Resident 53's weights revealed there was no weight to determine the accuracy of the readmission weight on March 4, 2024.</p> <p>Review of the progress notes revealed a Dietary entry on March 11, 2024 at 3:56 p.m. revealed the resident triggered for a significant weight loss and requested a re-weight to verify the weight loss and would follow-up pending the new weight.</p> <p>Review of Resident clinical record revealed Resident 53 was sent out tot the hospital again on March 11, 2024 and the facility was unable to obtain the re-weight.</p> <p>Review of Resident 69's weights revealed a weight on December 2, 2023 of 132 pounds and a weight on January 2, 2024 of 125.2 pounds, a significant weight loss of 5.15%.</p> <p>Further review of Resident 69's weights revealed there was no re-weight to determine accuracy and the next weight was obtained on January 24, 2024 of 122.6 pounds.</p> <p>Review of Resident 69's progress notes revealed a Dietary entry dated January 6, 2024 stating weight 130 pounds within normal limits. Monthly weight is stable.</p> <p>Further review of Resident 69's progress notes revealed a Dietary entry dated January 25, 2024 stating weight loss with a weight on January 12, 2024 of 97.8 pounds and the resident tube feeding rate was increased for added calories.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 69's weights revealed there was no weight obtained by the facility on January 12, 2024 and the most current weight was January 24, 2024 which was not addressed by the dietitian on January 25, 2024.</p> <p>Review of Resident 87's clinical record revealed they were admitted to the facility on [DATE] with a weight 128 pounds.</p> <p>Further review of Resident 87's weights revealed the next weight obtained was December 2, 2023 of 118.6 pounds a significant weight loss of 7.34%.</p> <p>Further review of Resident 87's weights revealed the next weight obtained was on February 1, 2024 after the resident had signed on to hospice services.</p> <p>Review of Resident 87's admission Nutritional Risk Assessment completed November 17, 2023 noted the weight admission 128 pounds.</p> <p>Further review of Resident 87's clinical record revealed there was no further documentation by the dietitian until January 3, 2024 which did not address the significant weight loss since admission and had no recommendations due to a hospice eval which the resident was not admitted to until January 11, 2024.</p> <p>Interview with the Nursing Home Administrator and the Director of Nursing on March 15, 2024 at 11:45 a.m. confirmed the facility failed to obtain re-weights and admission weight per policy and there was a delay in interventions being developed by the clinical dietitian to maintain residents' weights.</p> <p>28 Pa. Code 211.5(f) Clinical Records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p> <p>28 Pa Code: 211.10(c) Resident care policies</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>30934</p> <p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observations, staff interview, clinical record review and facility policy and procedure review it was determined the facility failed to administer medications accurately to one of three residents reviewed resulting in a medications administration error rate of 25%. (Resident 70)</p> <p>Findings Include:</p> <p>Review of Facility policy and procedure titled Enteral Tube Medications Administration undated, revealed crushed medications are not mixed together. The powder from each medication is mixed with water, or other suitable dilutant if water is unacceptable, before administration. Each medication is administered separately to avoid interaction and clumping.</p> <p>Review of Resident 70's diagnosis list revealed a diagnosis of Gastrostomy (gastrostomy is the creation of an artificial external opening into the stomach for nutritional support).</p> <p>Review of resident 70's physician orders revealed an order dated January 5, 2023 stating may crush meds and administer per PEG (feeding tube).</p> <p>Observations of medications administration on March 15, 2024 at 8:45 a.m. revealed Registered Nursing Employee E4 preparing the following medications for Resident 70: midodrine 10mg (milligram) (increased blood pressure), Eliquis 5mg (blood thinner), glycopyrrolate 1mg (decreases drooling), Multivitamin, Senna plus 8.6-50mg (stool softener), Iron Sulfate 325mg (supplement), and Phos-Nak Packet (supplement). All the medications were crushed together and placed in a medication cup except for the Phos-Nak Packet which was poured into the same medication cup. The medication was then dissolved in approximately 15 milliliters of water in the medication cup. A piston syringe was attached to the residents PEG tube and flushed with 30 milliliters of water followed by the liquid containing all the medications then another 30 milliliters of water flushed through the tube.</p> <p>Interview with the Director of Nursing and the Nursing Home Administrator on March 15, 2024 at 11:45 a.m. confirmed the medications were administered incorrectly per policy.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) 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 - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>22502</p> <p>Based on review of facility policy, observations and interview with staff, it was determined that the facility failed to maintain appropriate temperatures during dishwashing.</p> <p>Findings include:</p> <p>Review of facility policy, Dish Machine Temperatures (High Temperature Machines), revised July 2023, indicated a minimum wash temperature of 150 degrees Fahrenheit and a minimum rinse temperature of 180 degrees Fahrenheit. Additionally, the policy revealed that if the temperature does not reach the required minimum, DO NOT run any dishes through a wash/rinse cycle. If minimum temperatures are not reached, the Culinary & Nutrition Services Manager and/or the Administrator should be notified.</p> <p>Observation on March 14, 2024, at 9:15 a.m. with the Food Service Director (FSD), revealed staff using the dishmachine, but the gauges were not working on the dishmachine. The FSD indicated that the gauges had stopped working the day before and staff had used the three compartment sink to wash dishes. The FSD was not sure if the dishmachine was a high temperature machine (uses heated water for sanitation) or low temperature machine (uses chemicals for sanitizing). The FSD indicated that staff put a thermometer through the machine to obtain a temperature and had switched to using chemicals, but had no way to measure the concentration of the sanitizer.</p> <p>Review of the Dish Machine Temperature Log for March 2024 revealed that the wash temperature did not reach 150 degrees Fahrenheit on 16 of 36 occasions.</p> <p>Additional interview with the FSD on March 15, 2024, 9:30 a.m. confirmed that the minimum wash temperatures had not been reached. The FSD indicated that earlier in the month maintenance adjusted the water temperature when the temperatures were noted to be below the minimum. The repair company was called on March 13, 2024, and had been in to make repairs on March 14, 2024. The repair company was observed working on the machine at the time of the interview.</p> <p>Interview with the Nursing Home Administrator on March 15, 2024, at 11:30 a.m. confirmed that the minimum dishmachine temperatures had not been met.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>Previously cited 12/1/23</p> <p>28 Pa Code 201.18(b)(3) Management</p>

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35913</p> <p>Based upon clinical record review, it was determined the facility failed to ensure a Speech Therapy Evaluation was completed as ordered for one of 24 residents reviewed (Resident 91).</p> <p>Findings include:</p> <p>Review of Resident 91's diagnosis list revealed diagnoses including Dysphagia (inability/difficulty swallowing) and protein calorie malnutrition.</p> <p>Review of Resident 91's physician's orders dated [DATE] revealed an order for a speech evaluation and treatment.</p> <p>Review of Resident 91's clinical record revealed Resident 91 expired on [DATE].</p> <p>Review of Resident 91's clinical record failed to reveal evidence that a Speech Evaluation was completed.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on [DATE] at 11:00 a.m. confirmed a speech evaluation was never completed for Resident 91 as per physician's order.</p> <p>28 Pa. Code: 201.18(e)(4) Management</p> <p>28 Pa. Code: 211.12(d)(3) Nursing Services</p>		