

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395177	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/08/2025
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		
STATE LICENSE NUMBER: 040702				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT	E 0000		
E 0004	483.73(a) Develop EP Plan, Review and Update Annually	E 0004		Completion Date: 04/29/2025
SS=C	<p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be</p>		<p>1. The emergency preparedness plan was reviewed and signed off on and placed in the emergency preparedness binder on 04-09-2025.</p> <p>2. NHA, or designee, will ensure that facility emergency preparedness plan is reviewed at QAPI when all other manuals, policy and procedures are reviewed and signed off by appropriate department directors on an annual basis in June during QAPI each year</p>	Status: APPROVED Date: 04/18/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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E 0004 SS=C	Continued from page 1 [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by:	E 0004		

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E 0004 SS=C	Continued from page 2 Based on document review and interview, it was determined the facility failed to provide documentation verifying the emergency preparedness plan had been reviewed within the previous twelve months, affecting the entire component. Findings include: 1. Review of documentation on April 8, 2025, at 9:55 AM, revealed the facility failed to provide documentation verifying the emergency preparedness plan had been reviewed within the previous twelve months. Interview with the Maintenance Director on April 8, 2025, at 9:55 AM, confirmed the lack of documentation verifying the emergency preparedness plan had been reviewed within the previous twelve months.	E 0004		



Certified End Page

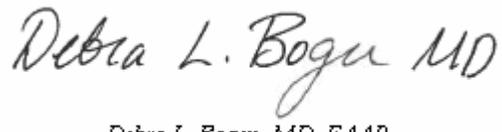
ROSE CITY NURSING AND REHAB AT LANCASTER

STATE LICENSE NUMBER: 040702

SURVEY EXIT DATE: 04/08/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	INITIAL COMMENT Facility ID #040702 Component 01 Building 01 Based on a Medicare/Medicaid Recertification Survey completed on April 8, 2025, it was determined that Rose City Nursing and Rehab at Lancaster was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a four-story, Type III (211), protected ordinary structure, with a basement, which is fully sprinklered.	K 0000		
K 0100 SS=E		K 0100		

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K 0100 SS=E	Continued from page 1 NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	1. The fire blanket cabinet on the second floor clean linen room contains a fire blanket as of 04-14-2025. 2. Maintenance Director, or designee, will audit weekly for two weeks that there is a fire blanket in the containers labeled "fire blanket." Then audits will be monthly for 2 months and ongoing monthly. Results of audits will be submitted to monthly QAPI for review and recommendations.	Completion Date: 04/29/2025 Status: APPROVED Date: 04/18/2025

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K 0100 SS=E	Continued from page 2 28 Pa. Code § 201.14(a). RESPONSIBILITY OF THE LICENSEE (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents. This REGULATION has not been met. 35 P.S. § 448.808. Issuance of license. (a) STANDARDS - The Department shall issue a license to a health care provider when it is satisfied that the following standards have been met: (2) that the place to be used as a health care facility is adequately constructed, equipped, maintained and operated to safely and efficiently render the services offered. Based on observation and interview, it was	K 0100		

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K 0100 SS=E	Continued from page 3 determined the facility failed to meet the minimum standards for the operation of a facility, as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents within the component. Findings include: 1. Observation on April 8, 2025, at 11:22 AM, revealed the fire blanket cabinet, located within the 2nd floor Clean Linen Room, did not contain a fire blanket. Interview with the Maintenance Director on April 8, 2025, at 11:22 AM, confirmed the fire blanket cabinet was empty.	K 0100		
K 0211 SS=E		K 0211		

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K 0211 SS=E	Continued from page 4 NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 0211	1. a. The plastic chair was removed from within the swing of the exterior exit door on the front porch on 04/08/2025 at time of observation. b. The padlock on the walk-in refrigerator in the kitchen was removed on 04-09-2025. 2. Maintenance Director, or designee, will document and audit (a) there are no obstacles for exterior exit "swing area" and (b) there are no padlocks on walk-in refrigerator weekly for two weeks, then monthly for two months. Results of audits will be submitted to monthly QAPI for review and recommendations. a. A building wide audit of the exterior exit doors area was completed. Random audits will be done weekly to ensure there is no blockage of exterior exit doors "swing area."	Completion Date: 04/29/2025 Status: APPROVED Date: 04/21/2025

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K 0211 SS=E	Continued from page 5 Based on observation and interview, it was determined the facility failed to maintain the means of egress as unobstructed and readily available to full and instant use, affecting two of eight smoke compartments within the component. Findings include: 1. Observation on April 8, 2025, at 11:30 AM, revealed a plastic chair within the swing of the exterior exit door, on the Front Patio. Interview with the Maintenance Director on April 8, 2025, at 11:30 AM, confirmed the obstructed swing of the exterior door. 2. Observation on April 8, 2025, at 11:44 AM, revealed an operable padlock hasp lock installed on the Kitchen walk-in refrigerator. This lock was not defeatable with the emergency release from within the refrigerator. Interview with the Maintenance Director on April 8,	K 0211		

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K 0211 SS=E	Continued from page 6 2025, at 11:44 AM, confirmed the refrigerator could be locked against egress.	K 0211		
K 0225 SS=E	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:	K 0225	1. The zone 4, third floor stair tower 1 door was repaired on 04/11 to ensure that it latches properly. The zone 3, third floor stair tower 2 door was repaired on 04/15 to ensure that it latches properly. 2. Maintenance Director, or designee, will audit weekly for two weeks, then monthly and submit audits to monthly QAPI for review and recommendations. a. A building wide audit of the stair tower doors latching properly was completed. Audits will be done monthly to ensure stair tower doors latch properly.	Completion Date: 04/29/2025 Status: APPROVED Date: 04/21/2025

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K 0225 SS=E	Continued from page 7 Based on observation and interview, it was determined the facility failed to maintain the fire resistance of stairtower enclosures, affecting two of eight smoke compartments within the component. Findings include: 1. Observation on April 8, 2025, between 11:11 AM and 11:16 AM, revealed stairtower doors, in the following locations, failed to positively latch within their respective door frames: a) 11:11 AM, Zone 4, 3rd floor Stair 1; b) 11:16 AM, Zone 3, 3rd floor Stair 2. Interview with the Maintenance Director on April 8, 2025, at 11:16 AM, confirmed the stairtower doors did not positively latch within the door frames.	K 0225		
K 0353 SS=E		K 0353		

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K 0353 SS=E	Continued from page 8 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	1. The white wires that were wire-tied to the sprinkler piping, above the suspended ceiling within Zone 1 corridor by resident room 412 was disconnected from the sprinkler piping on 04-08-2025, at time of observation. There are no wires resting on sprinkler piping. 2. Maintenance Director, or designee, will audit weekly for two weeks, then monthly for two months to ensure that the stair tower doors latch properly. Results of audits will be submitted to monthly QAPI for review and recommendations. a. Audits will be conducted whenever there is above ceiling work performed. An above ceiling process for vendors will be implemented so that when they perform above ceiling work, that the Maintenance Director will sign off there is no wiring laying on the sprinkler pipes before the vendor leaves the building.	Completion Date: 04/29/2025 Status: APPROVED Date: 04/18/2025

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K 0353 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain the automatic sprinkler protection system as free from extraneous weight, affecting one of eight smoke compartments within the component. Findings include: 1. Observation on April 8, 2025, at 11:02 AM, revealed white wires, wire-tied to sprinkler piping, above the suspended ceiling, within the Zone 1 Corridor, by Resident Room 412. Interview with the Maintenance Director on April 8, 2025, at 11:02 AM, confirmed the wires were supported by the sprinkler system.	K 0353		
K 0372 SS=E		K 0372		

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K 0372 SS=E	Continued from page 10 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 0372	1. The unprotected penetration of the second floor smoke barrier wall, above the cross-corridor double doors by resident room 210 around a gray wire was repaired using an approved through penetration fire stop system on 04-14-2025. The facility will maintain the rating of smoke barrier walls. 2. Maintenance Director, or designee, will audit weekly for two weeks, then monthly. Results of audits will be submitted to monthly QAPI for review and recommendations.	Completion Date: 04/29/2025 Status: APPROVED Date: 04/21/2025

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K 0372 SS=E	Continued from page 11 Based on observation and interview, it was determined the facility failed to maintain the smoke resistance of smoke barrier walls, affecting two of eight smoke compartments within the component. Findings include: 1. Observation on April 8, 2025, at 11:20 AM, revealed an unprotected penetration of the 2nd floor smoke barrier wall, above the cross-corridor double doors by Resident Room 210, around a gray wire. Interview with the Maintenance Director on April 8, 2025, at 11:20 AM, confirmed the unprotected penetration of the smoke barrier wall.	K 0372		
K 0920 SS=E		K 0920		

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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		
STATE LICENSE NUMBER: 040702				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0920 SS=E	Continued from page 12 NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 0920	1. The receptacle multiplier, supplying electrical power to a radio and a camera by the Lobby fireplace was removed on 04-14-2025. 2. Maintenance Director, or designee, will audit weekly for two weeks, then monthly to ensure there are no receptacle multipliers being used in the facility. Results of audits will be submitted to monthly QAPI for review and recommendations. a. Maintenance Direcotr, or designee, will perform weekly audits of facility areas for unauthorized electrical equipment that may be brought in by families for their loved ones.	Completion Date: 04/29/2025 Status: APPROVED Date: 04/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395177	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/08/2025
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K 0920 SS=E	Continued from page 13 Based on observation and interview, it was determined the facility failed to monitor the use of receptacle multipliers, affecting one of eight smoke compartments within the component. Findings include: 1. Observation on April 8, 2025, at 11:33 AM, revealed a receptacle multiplier, supplying electrical power to a radio and a camera, by the Lobby fireplace. Interview with the Maintenance Director on April 8, 2025, at 11:33 AM, confirmed the use of a receptacle multiplier.	K 0920		
K 0929 SS=E		K 0929		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395177	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/08/2025
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		
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K 0929 SS=E	Continued from page 14 NFPA 101 Gas Equipment - Precautions for Handling Oxyg Gas Equipment - Precautions for Handling Oxygen Cylinders and Manifolds Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99) 11.6.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0929	1. The oxygen cylinders that were unsecured were secured and placed appropriately in racks on 04-08-2025. 2. Maintenance Director and Director of Nursing, or designees, will educate maintenance and nursing staff on properly securing oxygen cylinders. Maintenance Director will audit weekly for two weeks, then monthly to ensure that oxygen cylinders are properly secured in racks. Results of audits will be submitted to monthly QAPI for review and recommendations.	Completion Date: 04/29/2025 Status: APPROVED Date: 04/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395177	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/08/2025
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K 0929 SS=E	Continued from page 15 Based on observation and interview, it was determined the facility failed to secure portable oxygen cylinders, affecting four of eight smoke compartments within the component. Findings include: 1. Observation on April 8, 2025, between 10:50 AM and 11:27 AM, revealed unsecured portable oxygen cylinders, in the following locations: a) 10:50 AM, Zone 1, 4th floor Therapy Room, 1 cylinder; b) 11:09 AM, Zone 2, 4th floor Medicine Room, 2 cylinders; c) 11:13 AM, Zone 4, 3rd floor Medicine Room, 1 cylinder; d) 11:25 AM, Zone 6, 2nd floor Director of Nursing Office, 2 cylinders; e) 11:27 AM, Zone 6, 2nd floor Medicine Room, 1 cylinder. Interview with the Maintenance Director on April 8,	K 0929		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395177	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/08/2025
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K 0929 SS=E	Continued from page 16 2025, at 11:27 AM, confirmed the portable oxygen cylinders were not secured.	K 0929			



Certified End Page

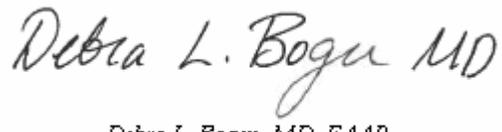
ROSE CITY NURSING AND REHAB AT LANCASTER

STATE LICENSE NUMBER: 040702

SURVEY EXIT DATE: 04/08/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY