STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395177	A. BLDG: 00 B. WING:	04/25/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ROSE CITY NURSING AND REHAB AT LANCASTER STATE LICENSE NUMBER: **040702**	**425 NORTH DUKE STREET LANCASTER, PA 17602**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance Survey, and three complaint investigation completed on April 25, 2025, it was determined that Rose City Nursing and Rehabilitation at Lancaster was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulation as they relate to the Health portion of the survey process.	F 0000		
F 0580 SS=D		F 0580		

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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F 0580 SS=D	Continued from page 1 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this	F 0580	1. The physician was notified of Resident 34 significant weight loss on 05/01/2025. No new orders at that time. 2. Facility audit was completed to determine if any other residents trigger for significant weight loss, and none determined 3. DON, or designee will educate nursing staff on obtaining resident weights as ordered and will educate nursing staff on weight policy. 4. DON, or designee, will randomly audit resident weights weekly for 2 weeks, then monthly for 2 months. Results of audits will be submitted to monthly QAPI for review and recommendations.	Completion Date: **06/12/2025** Status: **APPROVED** Date: **05/12/2025**

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F 0580 SS=D	Continued from page 2 section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 0580		

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F 0580 SS=D	Continued from page 3 Based upon review of clinical records, it was determined the facility failed to notify the physician of a significant weight loss for one of 21 residents reviewed (Resident 34). Findings include: Review of Resident 34's Weight Summary revealed Resident 34 weighed 192.3 pounds on August 2, 2024. Further review of Resident 34's Weight Summary revealed that on October 8, 2024, the next available weight, Resident 34 weighed 178.0 pounds indicating a 7.4 percent weight loss. Review of Resident 34's clinical record failed to reveal evidence that Resident 34's physician was notified of Resident 34's significant weight loss. Interview with the Nursing Home Administrator and Director of Nursing on April 25, 2025, at 10:08 a.m. confirmed that Resident 34's physician was not notified of Resident 34's weight loss.	F 0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0580 SS=D	Continued from page 4 28 Pa. Code 211.12(c)(d)(3) Nursing Services Previously cited 8/12/2024	F 0580		
F 0604 SS=D	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or	F 0604	1. Resident 74 discharged on 04/28/2025 2. Facility audit was done to ensure other current residents had restraints. No other residents observed with restraints. Current and new admitted residents may be at risk for restraints. 3. DON, or designee, will educate nursing staff restraint policy, to include (1) if restraints are necessary, then the restraint assessment will be completed per guidelines and (2) a physician order will be obtained. 4. DON, or designee, will perform random audits of all new admissions to ensure no need for restraints weekly for 2 weeks, then monthly for 2 months. Results of audits will be submitted to monthly QAPI for review and recommendations.	Completion Date: **06/12/2025** Status: **APPROVED** Date: **05/12/2025**

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F 0604 SS=D	Continued from page 5 convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by:	F 0604		

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F 0604 SS=D	Continued from page 6 Based on observations, facility policy and procedure review, clinical record review, and staff interview, it was determined that the facility failed to ensure that residents were free from the use of restraints for one of the eight residents reviewed. (Residents 74). Findings include: A review of the facility's policy titled "Use of Restraints", revised in July 2023, revealed, that restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars, Geri-chairs, and lap cushions and trays that the resident cannot remove. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative.	F 0604		

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F 0604 SS=D	Continued from page 7 Orders for restraints will not be enforced for longer than 12 hours unless the resident's condition requires continued treatment. Clinical records review revealed Resident 74 was admitted to the facility on February 25, 2025, with a diagnosis of Alzheimer's disease (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability), and Alcoholic cirrhosis of the liver (is a severe condition resulting from prolonged excessive alcohol consumption, leading to the replacement of healthy liver tissue with scar tissue). An observation was conducted on April 22, 2025, at 10:02 a.m., and 1:52 p.m. Both observations revealed Resident 74 was lying in bed, with their eyes closed. Observations also revealed Resident 74 was wearing a blue hand mitt on both hands. The resident was calm and quiet during the observation. An observation conducted on April 23, 2025, at 9:18 a.m., revealed that the resident was lying in	F 0604		

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F 0604 SS=D	Continued from page 8 bed, with hand mitts on both hands. The resident was calm with eyes closed. An interview with non-licensed Employee 4 was conducted on April 22, 2025, at 1:55 p.m. Employee E4 reported that the resident was admitted to the facility with the hand mitts. Employee E4 reported that the hand mitts were used because the resident had restless behaviors of hitting self and grabbing especially when being fed. A review of the hospital records dated February 21, 2025, revealed: "Pt (patient) appears to be sleeping comfortably. No PRN (as needed) needed. Mitts on, pt does not appear to be striking chest anymore as he was yesterday". A review of the clinical records failed to reveal an assessment was completed for the use of the hand mitts. Further review failed to reveal a physician's order for the use of the hand mitts and that the responsible party was notified.	F 0604		

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F 0604 SS=D	Continued from page 9 An interview with the Director of Nursing conducted on April 24, 2025, at 11:52 a.m., confirmed that Resident 74 was not assessed for the use of hand mitts on both hands. The DON also confirmed that there was no physician order and that the responsible party was not notified of the use of the hand mitts. The facility failed to ensure Resident 74 was free from the use of restraints. 28 Pa. Code 211.5(f) Clinical Records Previously cited 3/15/24, 8/12/24. 28 Pa. Code 211.8(a)(c)(d)(e) Use of Restraints 28 Pa. Code 211.12(d)(1)(5) Nursing Previously cited 3/15/24, 8/12/24.	F 0604		

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F 0610 SS=D	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	1. Facility cannot retroactively investigate resident 47's bruise of unknown origin. 2. DON performed a facility audit to ensure current residents have no bruises of unknown origin. None were found. Current and new admit residents are at risk for bruises of unknown origin. 3. DON, or designee, will educate facility staff on Policy of bruises of unknown origin when they observe a bruise on a resident. DON, or designee, will educate staff on providing a written statement regarding observed bruises. 4. DON, or designee, will perform random autis of nursing notes and incident reports for bruising of unknown origin weekly for 2 weeks, then monthly for 2 months. Results of audits will be submitted to monthly QAPI for review and recommendations.	Completion Date: **06/12/2025** Status: **APPROVED** Date: **05/12/2025**

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F 0610 SS=D	Continued from page 11 Based on review of facility policy, review of clinical record, review of facility documentation and staff interview, it was determined that the facility failed to conduct a comprehensive investigation for an injury of unknown origin for one of 19 residents reviewed (Resident 47). Findings include: Review of facility policy, "Abuse Policy", undated, indicated that all reports of resident abuse, neglect,, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be thoroughly investigated by the administrator or designee. Review of Resident 47's quarterly MDS (Minimum Data Set - periodic assessment of resident needs) dated December 6, 2024, indicated that the resident had severe cognitive impairment and had a diagnosis of dementia (irreversible, progressive degenerative disease of the brain, resulting in a loss of reality contact and functioning ability).	F 0610		

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F 0610 SS=D	Continued from page 12 Review of Resident 47's nursing progress note of December 31, 2024, revealed an assessment of the resident showed a 5 x 6 (no further unit of measurement) hematoma with a 3 x 3 purple bruise in the center. Assessment indicated that "most likely cause was hitting right forehead at the brow against the wall or headboard when transferring into bed at some point last night". Interview with the Director of Nursing (DON) on April 25, 2025, at 12:04 p.m. revealed that protocol is to interview staff on the shift the injury was identified and the prior shift to determine the cause of the injury. The DON confirmed that a thorough investigation had not been completed to determine the cause of the injury. 28 Pa. Code 201.18(b)(1) Management Previously cited 3/15/24 28 Pa. Code 201.18(e)(1) Management	F 0610		

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F 0610 SS=D	Continued from page 13 28 Pa. Code 201.29(a)(c) Resident rights 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0610		
F 0641 SS=E		F 0641		

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F 0641 SS=E	Continued from page 14 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	1. Resident 32, Resident 52 and Resident 67 MDS's were corrected at time DOH surveyor presented issue to MDS Coordinator and NHA 2. MDS Coordinator performed an audit of all current and open resident MDS's to ensure accuracy. No further discrepancies noted. 3. NHA, or designee, will re-educate MDS Coordinator to ensure accurate MDS's are completed and submitted 4. NHA, or designee, will perform weekly random audits for two weeks, then monthly random audits for two months for accuracy before submission. Results of audits will be presented at monthly Quality Assurance and Improvement Plan meetings for review and recommendations.	Completion Date: **06/12/2025** Status: **APPROVED** Date: **05/12/2025**

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F 0641 SS=E	Continued from page 15 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that resident assessments accurately reflect the residents' status for three of 23 residents reviewed (Residents 32, Resident 52 and Resident 67). Findings include: Review of Resident 32's quarterly MDS (Minimum Data Set - periodic assessment of resident needs) dated February 8, 2025, revealed under section N0415 - High Risk Drug Classes, that the resident was not marked for receiving opioid. Further review of Resident 32's physician orders dated November 1, 2024, revealed evidence that the resident was ordered Oxycodone HCl oral Tablet 5 mg every 6 hours as needed for pain. Review of the February 2025 and April 2025 Medication Administration Record (MAR) revealed that the resident did receive a daily dose of Oxycodone HCl 5 mg daily except for April 19, and	F 0641		

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ROSE CITY NURSING AND REHAB AT LANCASTER STATE LICENSE NUMBER: 040702	425 NORTH DUKE STREET LANCASTER, PA 17602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 0641 SS=E	Continued from page 16 April 23 2025. Interview with Licensed Employee E3 on April 25, 2025, at 12:33 p.m. confirmed that the assessment was coded inaccurately for Residents 32. Review of Resident 52's Quarterly MDS dated April 1, 2025 revealed Resident 52 had an active diagnosis including MDRO (multi-drug resistant organism). Review of Resident 52's active diagnosis list failed to reveal evidence of an MDRO. Interview with Licensed Employee E3, Nursing Home Administrator and Director of Nursing on April 25, 2025 at 10:10 a.m. confirmed Resident 52 did not have a current diagnosis of MDRO and further confirmed the Quarterly MDS dated April 1, 2025 was inaccurate. Review of Resident 67's Quarterly MDS dated March 6, 2025 revealed Resident 67 had an active	F 0641		

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F 0641 SS=E	Continued from page 17 diagnosis including MDRO. Review of Resident 67's active diagnosis list failed to reveal evidence of an MDRO. Interview with Licensed Employee D3, Nursing Home Administrator and Director of Nursing on April 25, 2025 at 10:10 a.m. confirmed Resident 67 did not have a current diagnosis of MDRO and further confirmed the Quarterly MDS dated March 6, 2025 was inaccurate. 28 Pa. Code 211.5(f) Clinical Records Previously cited 8/12/2024	F 0641		
F 0656 SS=E		F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0656 SS=E	Continued from page 18 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	1. Resident 32 care plan was updated to include oxygen therapy; Resident 37 care plan was updated to include dialysis and the presence of dialysis shunt; Resident 91 care plan was updated to include resident's weight loss 2. Facility performed house audit to ensure care plans were accurate. Current residents and new admit residents are at risk for not having a comprehensive care plan. 3. NHA, or designee, will educate department leaders and DON, or designee, will educate licensed staff on policy for developing comprehensive care plans for residents. 4. NHA, DON, or designee, will perform random audits of current and new admit residents to ensure comprehensive care plans are done, weekly for 2 weeks, then monthly for 2 months. Results of audits will be submitted to monthly QAPI for review and recommendations.	Completion Date: **06/12/2025** Status: **APPROVED** Date: **05/12/2025**

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F 0656 SS=E	Continued from page 19 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=E	Continued from page 20 Based on observation, review of the clinical record, and interview with resident and staff, it was determined that the facility failed to develop a comprehensive care plan for three of 24 residents reviewed (Residents 32, 37, and 91). Findings include: Observation on April 22, 2025, at 10:25 a.m. revealed Resident 32 was receiving oxygen at 4 liters per minute through a nasal cannula (device used to deliver supplemental oxygen or increased airflow to a person in need of respiratory help). Review of Resident 32's physician's orders included an order on June 20, 2024 for oxygen at 4 Liter/minute via nasal cannula every shift for shortness of breath. Review of the Resident 32's current active care plan failed to reveal a care plan or interventions for oxygen therapy.	F 0656		

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F 0656 SS=E	Continued from page 21 Interview with the Nursing Home Administrator on April 25, 2025, at 12:20 p.m. confirmed that Resident 32 did not have a care plan for oxygen therapy. A review of Resident 37's diagnosis list includes End Stage Renal Failure (ESRD- Where kidney function has declined to the point that the kidneys can no longer function on their own). Clinical records review revealed Resident 37 has Hemodialysis (A process of purifying the blood of a person whose kidneys are not working normally) three times weekly. An observation conducted on April 22, 2025, at 9:45 a.m., revealed resident was sitted in the wheelchair. Further observations revealed bumps on the resident's left upper arm skin. An interview with Resident 37 conducted on April 22, 2025. At 9:50 a.m., confirmed going to dialysis three time a week every Tuesdays, Thursdays, and	F 0656		

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F 0656 SS=E	Continued from page 22 Saturdays. The resident also confirmed presence of dialysis shunt (A connection between a vein and artery that helps your body create the flow of blood it needs for dialysis to work) to the left upper arm. A review of Resident 37's care plan failed to reveal that a comprehensive care plan for Dialysis and presence of dialysis shunt to the left upper arm was developed. An interview with the Director of Nursing (DON) on April 25, 2025, at 1:00 p.m., confirmed that a comprehensive care plan for Resident 37's Dialysis was not developed. Review of Resident 91's quarterly MDS (Minimum Data Set - periodic assessment of resident needs) of March 18, 2025, section K0300, Weight Loss, revealed that the resident had a loss of 5% or more in the last month or loss of 10% or more in the last six months and was not on a physician prescribed weight loss regimen.	F 0656		

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F 0656 SS=E	Continued from page 23 Review of Resident 91's clinical record revealed a weight change note of April 11, 2025, that indicated resident had continued weight loss. Further review of the clinical record revealed no evidence that a comprehensive care plan was developed to address the resident's weight loss. Interview with the DON on April 25, 2025, at 10:14 a.m. confirmed that there was no care plan to address Resident 91's nutritional status.	F 0656		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 24 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. Facility cannot retroactively provide wound care to a resident 37 left lateral foot. Wound treatment orders for resident 37 were changed to daily treatment dressing changes to time when not at dialysis. 2. Current and new admit dialysis residents with wound orders could be at risk for wound care during dialysis. Facility audit of dialysis residents was completed to ensure no treatments are to be done when a resident is at dialysis. 3. DON, or designee, will educate licensed staff on policy for wound care and documentation. 4. DON, or designee, will perform random audits on wound treatment care and documentation to ensure treatments are being completed weekly for 2 weeks, then monthly for 2 months. Results of audits will be submitted to monthly QAPI for review and recommendations.	Completion Date: **06/12/2025** Status: **APPROVED** Date: **05/12/2025**

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F 0684 SS=D	Continued from page 25 Based on clinical records review, and resident and staff interview, it was determined that the facility failed to follow the physician's order for a diabetic wound order for one of three residents reviewed (Resident 37). Findings include: A review of Resident 37's diagnoses list includes End Stage Renal Disease (ESRD- Where kidney function has declined to the point that the kidneys can no longer function on their own), and Diabetes (A group of metabolic disorders characterized by a high blood sugar level over a prolonged period of time). Clinical records review revealed Resident 39 goes out for Hemodialysis (A process of purifying the blood of a person whose kidneys are not working normally) three times a week. An interview with Resident 37 was conducted on April 22, 2025. At 9:50 a.m., confirmed going to	F 0684		

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F 0684 SS=D	Continued from page 26 dialysis three times a week every Tuesday, Thursday, and Saturday. The resident reported leaving the facility at approximately 10:15 a.m. and returning to the facility at around 5:00 p.m. Clinical records review revealed Resident 39 had a Diabetic wound (Open sores or wounds that commonly occur on the feet, especially to the bottom of the foot, in people with diabetes) to the left lateral (side) foot upon admission. A review of the physician order dated March 14, 2025, revealed an order to cleanse the left lateral foot wound with normal saline solution, apply Collagen (A wound care that contributes to the formation of a strong, flexible matrix that supports tissue regeneration and repair), cover with dry dressing daily and as needed. A review of the April 2025, Treatment Administration Record revealed that from April 1, 2025, until April 11, 2025, Resident 37's diabetic wound was not treated on the following dates: April	F 0684		

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F 0684 SS=D	Continued from page 27 3, 6, 10, 11, and 12. April 3 and April 12, 2025, documentation revealed treatment was not done due to "Leave of Absence". There was no documentation/reason as to why wound treatment was not done on April 6, 10, and 11, 2025. An interview with the Director of Nursing was conducted on April 25, 2025, at 1:00 p.m. The DON confirmed that the diabetic wound care was not done during dialysis days on April 3, 10, and 12, but was unable to provide documented evidence as to why it was not done on April 6, and 11 which was a non-dialysis day. The facility failed to follow the physician's order for Resident 37's left lateral foot diabetic wound. 28 Pa. Code 211.5(f) Clinical Record Previously cited 3/15/24, 8/12/24 28 Pa. Code 211.12(d)(1)(5) Nursing Previously cited 3/15/24, 8/12/24	F 0684		

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F 0684 SS=D	Continued from page 28	F 0684		
F 0689 SS=D	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	1. Resident 24 smoking assessment was completed 2. Facility audit completed and no other residents at risk. 3. DON, or designee, will educate licensed staff regarding smoking assessment needing completed monthly for resident 24. 4. DON, or designee, will perform audits monthly and as needed on resident 24 for completion of smoking assessment. Results of audits will be submitted to monthly QAPI for review and recommendations.	Completion Date: **06/12/2025** Status: **APPROVED** Date: **05/12/2025**

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F 0689 SS=D	Continued from page 29 Based upon review of clinical records and interview, it was determined the facility failed to ensure that a current smoking assessment for one of one resident reviewed (Resident 24). Findings include: Review of Resident 24's diagnosis list revealed diagnoses including Multiple Sclerosis (slow progressive disease of the central nervous system), major depressive disorder and unspecified dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability). Interview with Resident 24 on April 23, 2025, at 12:00 p.m. revealed Resident 24 to be alert and oriented. Resident 24 stated that resident periodically leaves the premises to smoke and follows the rules of the smoking agreement with the facility. Review of the facility Smoking Agreement revealed	F 0689		

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F 0689 SS=D	Continued from page 30 the "resident must leave the property to smoke and never to smoke on the premises or in the building." Further review of the Smoking Agreement revealed "the resident will never share nor give, nor hand out any smoking materials to any other resident." Further review of the Smoking Agreement revealed "resident will sign in and out for LOA (leave of absence) as per policy and procedure." Review of Resident 24's clinical record revealed Resident 24 is currently a smoking resident due to a grandfather clause in the facility's policy. Review of Resident 24's clinical record revealed a Smoking Safety Evaluation dated July 29, 2023. Further review of Resident 24's clinical record failed to reveal evidence that a current Smoking Safety Evaluation was completed since July 2023. Interview with the Nursing Home Administrator and	F 0689		

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F 0689 SS=D	Continued from page 31 Director of Nursing on Aril 25, 2025 at 9:56 a.m. revealed that no Smoking Safety Evaluation was completed for Resident 24 since July 2023. 28 Pa. Code 201.18(c)(4) Management Previously cited 3/15/2024	F 0689		
F 0692 SS=D		F 0692		

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F 0692 SS=D	Continued from page 32 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	1. Facility cannot retroactively monitor weight loss and weight gain for resident 34 and resident 79. 2. Facility performed a house wide audit to ensure no other resident trigger for weight loss or weight gain. None found 3. DON, or designee, will educate nursing staff on weight policy, to include reweights and notifications to dietician. 4. DON, or designee, will perform random audits to ensure weights/reweights are being obtained as ordered and notification to dietician, weekly for 2 weeks, then monthly for 2 months. Results of audits will be submitted to monthly QAPI for review and recommendations.	Completion Date: **06/12/2025** Status: **APPROVED** Date: **05/12/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=D	Continued from page 33 Based upon review of facility policy and procedure and review of clinical records, it was determined the facility failed to ensure weight loss and weight gain was adequately monitored for two of 23 residents reviewed (Resident 34 and Resident 79). Findings include: Review of facility policy and procedure titled Weight Assessment and Intervention, revised March 2022, revealed "Any weight change of five percent or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing." Review of Resident 34's diagnosis list revealed diagnoses including dysphagia (inability/difficulty swallowing), Diabetes Mellitus (DM - failure of the body to produce insulin to enable sugar to pass from the blood stream to cells for nourishment), and dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality	F 0692		

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F 0692 SS=D	Continued from page 34 contact and functioning ability). Review of Resident 34's physician orders dated September 2022 revealed an order for monthly weights. Review of Resident 34's Weight Summary revealed on August 2, 2024, Resident 34 weighed 192.3 pounds. Further review of Resident 34's Weight Summary revealed the next weight obtained was on October 8, 2024. Resident 34 weighed 178.0 pounds on October 8, 2024. This indicated a 7.44% weight loss between August 2024 and October 2024. Review of Resident 34's clinical record failed to reveal a weight for September 2024. Further review of Resident 34's clinical record failed to reveal evidence of a reweight after the October 8,	F 0692		

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F 0692 SS=D	Continued from page 35 2024, was obtained. Further review of Resident 34's clinical record failed to reveal evidence that the facility dietitian was notified of Resident 34's weight loss. Interview with the Nursing Home Administrator and Director of Nursing on April 25, 2025, at 10:08 a.m. confirmed that no reweight was obtained and further confirmed that the dietitian was not notified of Resident 34's weight loss. A review of Resident 79's weights and vitals revealed that on March 14, 2025, the resident's weight was 406 pounds and on April 2, 2025, the weight was 434 pounds, a 28 pounds (6.90%) significant weight gain in 19 days period. A review of the Dietitian's progress notes dated April 4, 2025, at 11:07 a.m., revealed resident with significant weight gain, their previous weight was 406 pounds likely inaccurate. The resident receives outside food and continues to eat snacks despite	F 0692		

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F 0692 SS=D	Continued from page 36 frequent counseling from staff. Clinical records review failed to reveal that Resident 79 was reweighed to confirm the significant weight change identified on April 2, 2025. An interview with the Director of Nursing on April 25, 2025, at 1:00 p.m., confirmed that Resident 79's weight was not re-checked after a significant weight change was identified on April 2, 2025. 28 Pa. Code 211.10(c) Resident Care Policies 28 Pa. Code 211.12(c)(d)(3) Nursing Services Previously cited 8/12/2024	F 0692		

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F 0698 SS=E	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	1. Facility cannot retroactively document fluid restrictions documentation for resident 37 and resident 56. The times for resident 37's gabapentin and calcium acetate were changed to non dialysis times. 2. Facility completed an audit of residents on fluid restrictions for proper documentation of fluid intake and no other discovered. Current and new admit dialysis residents could be at risk for proper documentation of fluid restrictions and medication administration while at dialysis. 3. DON, or designee, will educate nursing staff on policy "encouraging and restricting Fluids" 4. DON, or designee, will perform random audits of fluid restrictions in cc's weekly for 2 weeks, then monthly for 2 months. DON, or designee, will perform random audits to ensure dialysis residents do not have orders to administer medications while at dialysis. Results of audits will be submitted to monthly QAPI for review and recommendations.	Completion Date: **06/12/2025** Status: **APPROVED** Date: **05/12/2025**

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F 0698 SS=E	Continued from page 38 Based on observations, a review of the facility's policy and clinical records, and interview with resident and staff, it was determined that the facility failed to ensure medications and fluid restriction orders for dialysis residents were followed for two of three residents reviewed (Residents 37 and 56). Findings include: A review of the facility's policy titled "Encouraging and Restricting Fluids", undated, revealed the following guidelines for restricting fluids: Remove the resident's water pitcher and cup from the room. Store in designated area. If the resident refuses to have the water pitcher removed, notify the supervisor and in turn the physician; Record the amount of fluid consumed on the intake and output record. Record fluid intake in ml's; and Remove fluid container. Documentation includes the amount (in ml's) of fluids consumed by the resident during the shift. A review of Resident 37's diagnosis list includes End	F 0698		

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F 0698 SS=E	Continued from page 39 Stage Renal Failure (ESRD- Where kidney function has declined to the point that the kidneys can no longer function on their own), and dependence on renal Hemodialysis (A process of purifying the blood of a person whose kidneys are not working normally). An observation conducted on April 22, 2025, at 9:50 a.m., revealed Resident 37 was in the room sitting in a wheelchair. Further observation revealed a big white Styrofoam cup on the resident's tray table (approximately 16 oz size) half filled with water. An observation conducted on April 23, 2025, at 9:30 a.m., revealed a big white cup on the resident's tray table, almost empty. An interview with Resident 37 was conducted on April 23, 2025, at 9:32 a.m. The resident reported that staff usually refill her cup with fresh water every shift but "sometimes they do, sometimes they don't". The resident denied being educated by staff on how	F 0698		

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F 0698 SS=E	Continued from page 40 much fluids she/he can consume every shift/daily. A review of the physician's order dated March 3, 2025, revealed an order for Fluid restriction:1500ml total per 24 hours as follows: Dietary: 1080 ml on meal trays, Breakfast 360 ml, Lunch 360 ml, Dinner 360 ml. Nursing: 420 ml, Day shift 180 ml, Evening shift 150 ml, Night shift 90 ml. Clinical records review failed to reveal that Resident 37's fluid intake was monitored and that the order for a 1500 cc fluid restriction in 24 hours was being followed. A clinical records review revealed Resident 37 goes to dialysis every Tuesday, Thursday, and Saturday. Interview with Resident 37 on April 22, 2025, at 9:50 a.m., confirmed going to dialysis every Tuesday, Thursday, and Saturday. Resident 37 reported that the pickup time was usually 10:30 a.m., and the return time was usually 5:00 p.m.	F 0698		

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F 0698 SS=E	Continued from page 41 A review of Resident 37's physician's order dated January 2, 2025, revealed an order for Gabapentin (A medication used to treat nerve pain) 100mg 1 capsule three times a day for pain, and Calcium Acetate (A phosphate binder medication used to treat excess phosphate in the blood) 667 give two tablets three times a day. Both medications were scheduled at 8:00 a.m., 12:00 noon, and 4:00 p.m. A review of the April 2025 Medication Administration Record (MAR) revealed that from April 1, 2025, until April 22, 2025, medications Gabapentin and Calcium Acetate's 12:00 noon scheduled medications were not administered ten times. MAR review revealed that the ordered medications were missed during dialysis days. The above was conveyed to the Nursing Home Administrator and Director of Nursing on April 24, 2025, at 1:30 p.m. Review of Resident 56's clinical record revealed diagnoses including but not limited to end stage renal	F 0698		

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F 0698 SS=E	Continued from page 42 disease (ESRD- failure of kidney function to remove toxins from blood) and diabetes. Review of Resident physician's orders revealed an order for daily fluid restriction of 2L (liters) daily as follows: 7-3 shift 1000cc (cubic centimeters which equal milliliters); 3-11 shift 750 cc; 11-7 shift 250cc. Review of Resident 56's Medical Administration Record (MAR) failed to reveal evidence of the amount of fluid Resident 56 was receiving each shift. Interview with Nursing Home Administrator on April 25, 2025, at approximately 12:25pm confirmed the above findings. The facility failed to ensure Resident 37 and Resident 56's medications and fluid restrictions ordered by the physician were followed. 28 Pa. Code 211.5(f) Clinical Record Previously cited 3/15/24, 8/12/24	F 0698		

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F 0698 SS=E	Continued from page 43 28 Pa. Code 211.12(d)(1)(5) Nursing Previously cited 3/15/24, 8/12/24	F 0698		
F 0730 SS=F		F 0730		

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F 0730 SS=F	Continued from page 44 483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	1. Facility completed performance reviews on Employee 5, Employee 6, Employee 7, Employee 8, and Employee 9. 2. All employees reviewed and those needing a performance review will be completed. 3. NHA and HR to educate department leaders on completing annual reviews for respective staff and departments. 4. NHA, HR, or designee, will perform random audits to ensure employee reviews are done annually around their hiring anniversary date weekly for 2 weeks, then monthly for 2 months. Results of audits will be submitted to monthly QAPI for review and recommendations.	Completion Date: **06/12/2025** Status: **APPROVED** Date: **05/12/2025**

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F 0730 SS=F	Continued from page 45 Based upon review of staffing records and performance reviews it was determined the facility failed to ensure performance reviews were completed for five of five staffing records reviewed, (Employee E5,Employee E6,Employee E7,Employee E8 and Employee E9). Findings include: Review of staffing records and performance reviews revealed five staff members, E5, E6, E7, E8 and E9, did not have annual performance reviews performed within the last year. Interview with the Nursing Home Administrator on April 25, 2025, at 12:30 p.m. confirmed staff performance reviews were not completed. 28 Pa. Code 201.20(a)(c) Staff Development	F 0730		

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F 0756 SS=F	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for	F 0756	1. Residents 37, 43, 59, 75, and 84 were reviewed by pharmacist. Recommendations forwarded to physician for review and orders were written as indicated/recommended. 2. Facility performed an audit of current residents' pharmacy recommendations completed to ensure physician reviewed and orders written as indicated/recommended. 3. Pharmacy consultant was requested by DON to send pharmacy recommendations to DON, then DON will print our recommendations and present to physician for review and written orders. 4. DON, or designee, will perform random weekly audits for 2 weeks, then monthly audits for 2 months to ensure pharmacy recommendations are completed by physician and orders entered as indicated. Results of audits will be presented at monthly Quality Assurance and Improvement Plan meetings for review and recommendations.	Completion Date: **06/12/2025** Status: **APPROVED** Date: **05/12/2025**

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F 0756 SS=F	Continued from page 47 the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756		

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F 0756 SS=F	Continued from page 48 Based upon review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure medication regimen reviews were acted upon by a physician for five of five residents reviewed (Residents 37, 43, 59, 75, and 84). Findings include: Review of undated facility policy titled, "Pharmacy Medication Regimen Review", indicated that the clinical pharmacist reviews condition concerns and reviews resident's medication regimen to identify any potential causes/concerns. The clinical pharmacist then faxes recommendations back to the facility. The clinical nurse then reviews recommendations and contacts physician for further orders. The physician signs Medication Regimen Review when reviewed. Review of Resident 37's clinical record revealed that medication regimen reviews were completed on January 15, 2025, February 12, 2025, March 13,	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395177	A. BLDG: 00 B. WING:	04/25/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ROSE CITY NURSING AND REHAB AT LANCASTER STATE LICENSE NUMBER: **040702**	**425 NORTH DUKE STREET LANCASTER, PA 17602**

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F 0756 SS=F	Continued from page 49 2025, and recommendations were made. Further review of Resident 37's clinical record revealed no evidence of the reviews, recommendations, or evidence that the recommendations were addressed by the physician. Review of Resident 43's clinical record revealed that medication regimen reviews were completed on January 15, 2025, March 13, 2025, and recommendations were made. Further review of Resident 37's clinical record revealed no evidence of the reviews, recommendations, or evidence that the recommendations were addressed by the physician. Review of Resident 59's clinical record revealed that medication regimen reviews were completed on July 16, 2024, August 14, 2024, and December 10, 2024, and recommendations were made. Further review of Resident 59's clinical record revealed no evidence of the reviews, recommendations, or evidence that the recommendations were addressed by the physician.	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0756 SS=F	Continued from page 50 Review of Resident 75's clinical record revealed that medication regimen reviews were completed on June 24, 2024, January 1, 2025, and February 25, 2025, and recommendations were made. Further review of Resident 75's clinical record revealed no evidence of the reviews, recommendations, or evidence that the recommendations were addressed by the physician. Review of Resident 84's clinical record revealed that medication regimen reviews were completed on July 16, 2024, and August 14, 2024, and recommendations were made. Further review of Resident 84's clinical record revealed no evidence of the reviews, recommendations, or evidence that the recommendations were addressed by the physician. Interview with the Nursing Home Administrator on April 25, 2025, at 12:00 p.m. confirmed that there was no evidence that the pharmacy recommendations were addressed by the physician.	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0756 SS=F	Continued from page 51 28 Pa. Code 211.5(f) Clinical records Previously cited 8/12/24, 3/15/24 28 Pa. Code 211.10(c) Resident care policies Previously cited 3/15/24 28 Pa. Code 211.12(d)(3)(5) Nursing services	F 0756		
F 0758 SS=E		F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0758 SS=E	Continued from page 52 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	1. Facility cannot retroactively add in monitoring of psychotropic medication side effects for resident 37, resident 43 and resident 59. 2. Current residents receiving psychotropic medications are at risk to have side effects monitoring of psychotropic medications. Facility performed an audit to ensure those residents on psychotropic medications have side effect monitoring included in clinical records 3. DON, or designee, will educate licensed nursing staff on ensuring residents on psychotropic medications have orders for monitoring side effects. 4. DON, or designee, will perform weekly audits for 2 weeks, then monthly for 2 months to ensure side effects monitoring is being completed on psychotropic medications. Results of audits will be submitted to monthly Quality Assurance and Improvement Plan meetings for review and recommendations.	Completion Date: **06/12/2025** Status: **APPROVED** Date: **05/12/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0758 SS=E	Continued from page 53 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0758 SS=E	Continued from page 54 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure residents receiving psychotropic medications (any medication that affects brain activity associated with mental processed and behavior) were monitored for their side effects for three of five residents reviewed (Residents 37, 43, and 59). Findings include: Review of facility policy "Psychotropic Medication Use", revised February 2025, revealed that residents are monitored for adverse consequences associated with psychotropic medications. A review of Resident 37's diagnosis list includes major depressive disorder, recurrent, with severe psychotic symptoms. A review of Resident 37's physician order dated January 23, 2025, revealed an order for Aripiprazole (An anti-psychotic medication) 2 mg	F 0758		

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F 0758 SS=E	Continued from page 55 (milligram) given one tablet by mouth one time daily. Clinical records review failed to reveal that Resident 37 was monitored for a side effect of the medication from January 23, 2025, until April 23, 2025. A review of Resident 43's diagnosis list includes anxiety disorder (A mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) and Major Depressive Disorder (Characterized by a low mood or loss of interest in activities that last for a long time that can interfere with normal functioning). A review of Resident 43's physician order dated April 3, 2025, revealed an order for Risperidone (An anti-psychotic medication) 0.5 mg one tablet at bedtime. Clinical records review failed to reveal that Resident 43 was monitored for a side effect of the medication from April 3, 2025, until April 23, 2025.	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0758 SS=E	Continued from page 56 A review of Resident 59's diagnosis list included diagnoses of but not limited to anxiety disorder, schizophrenia, and depression. Review of Resident 59's physician's orders included orders for olanzapine 20 mg (anti-psychotic) at bedtime for schizophrenia, rexulti 2 mg (anti-psychotic) at bedtime for schizophrenia, remeron 15 mg (anti-depressant) one tablet in the evening for depression, sertraline HCL 25 mg (anti-anxiety) at bedtime for anxiety, clonazepam 0.5 mg (anti-anxiety) one tablet three times a day for anxiety disorder. Further review of Resident 59's clinical record revealed no evidence that the resident was monitored for side effects of psychotropic medications. An interview with the Director of Nursing on April 25, 2025, at 1:00 p.m., confirmed that Residents 39, 47, and 59 were not monitored for side effects	F 0758		

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F 0758 SS=E	Continued from page 57 from the use of antipsychotic medications. 28 Pa. Code 211.5(f) Clinical Records Previously cited 3/15/24, 8/12/24. 28 Pa. Code 211.12(d)(1)(5) Nursing Previously cited 3/15/24, 8/12/24.	F 0758		
F 0761 SS=E		F 0761		

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F 0761 SS=E	Continued from page 58 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	1. The novolog Insulin that was opened and not dated was discarded, the lantus insulin that was opened and not dated was discarded, the basaglar insulin kwikpen that was not dated when opened was discarded, the Apisol that was not dated when opened was discarded, the Acetylcysteine that was not dated when opened was discarded. 2. Facility completed a house audit and no other multi-dose vials were discovered not dated when opened. 3. DON, or designee, will educate licensed staff on dating multi-dose vials when they open them. 4. DON, or designee, will perform random audits to ensure multi-dose vials are dated when opened weekly for 2 weeks, then monthly for 2 months. Results of audits will be submitted to monthly QAPI for review and recommendations.	Completion Date: **06/12/2025** Status: **APPROVED** Date: **05/12/2025**

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F 0761 SS=E	Continued from page 59 Based on observations, a review of the medication manufacturer's guidelines, and staff interviews, it was determined that the facility failed to ensure that medications were properly stored and labeled on one of two medication carts (Fourth Floor Medication cart) and one of two Medication Rooms (Second Floor Medication Room). Findings Include: A review of the manufacturer's storage guidelines for Novolog Insulin (fast-acting insulin), revealed that the medication must be stored at room temperature and discarded within 28 days after opening. A review of manufacturers' storage guidelines for Lantus Insulin Pen (long-acting insulin) revealed that the medication may be stored at room temperature and discarded within 28 days after opening. A review of the manufacturer's guidelines for Basaglar Insulin Kwikpen (a long-acting insulin) revealed that the medicine should be discarded 28	F 0761		

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F 0761 SS=E	Continued from page 60 days after opening or removal from refrigeration. A review of the manufacturer's storage guidelines for Aplisol-Purified Protein Derivative (PPD) (a combination of proteins that are used in the diagnosis of tuberculosis), revealed vials in use for more than 30 days should be discarded due to possible oxidation (a reaction in which the element and degradation combine with oxygen) and degradation A review of the manufacturer's guidelines for Acetylcysteine vials (A medication used to clear mucus) revealed that an open vial must be used right away. The opened container should be discarded after four days. An observation was conducted on the fourth-floor medication cart in the presence of licensed nurse Employee E10 on April 23, 2025, at 9:20 a.m. The observation revealed the following: One Novolog Insulin pen opened and undated; One Lantus Insulin pen opened and undated; and One Basaglar Insulin	F 0761		

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F 0761 SS=E	Continued from page 61 pen, opened and undated. An interview with Employee E10 was conducted on April 23, 2025, at 9:20 a.m. Employee E4 confirmed that the above insulin pens should have been dated when opened. An observation was conducted on the second-floor medication room refrigerator on April 23, 2025, at 9:26 a.m., in the presence of licensed nurse Employee E11. The observation revealed one PPD vial, opened and undated, and one vial of Acetylcysteine, opened and undated. An interview conducted with Employee E11 on April 23, 2025, at 9:30 a.m., confirmed that the above medications should have been dated when opened. The above was conveyed to the Nursing Home Administrator on April 25, 2025, at 12:45 p.m. The facility failed to ensure medications were	F 0761		

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F 0761 SS=E	Continued from page 62 properly stored and labeled on the fourth-floor medication cart and second-floor medication room. 28 Pa. Code 211.12(d)(1)(5) Nursing Previously cited 3/15/24, 8/12/24	F 0761		
F 0947 SS=F		F 0947		

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F 0947 SS=F	Continued from page 63 483.95(g)(1)-(4) Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 0947	1. Facility staff were re-educated on annual education trainings 2. No harm to current residents related to cited deficient practice. 3. Human Resources Director re-instituted annual education for all Rose City Staff. NHA re-educated staff on annual education requirements. Those staff members that have their anniversary month between now and next April 2026 will have to complete another annual education training in their hire month anniversary to remain educated every 12 months. 4. NHA, or designee, will audit weekly for 2weeks, then monthly for 2 months to ensure that all new hires receive general orientation to include all necessary trainings and then add to monthly trainings listings for following years on their hire date anniversary month. Results of audits will be submitted to monthly Quality Assurance and Improvement Plan meetings for review and recommendations.	Completion Date: **06/12/2025** Status: **APPROVED** Date: **05/12/2025**

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F 0947 SS=F	Continued from page 64 Based on review of staff documentation, it was determined the facility failed to ensure the required 12 hours of annual training was completed by five of five staff members reviewed (Employee E5, Employee E6, Employee E7, Employee E8 and Employee E9. Findings include: Review of Employees E5, E6, E7, E8, E9 training documentation regarding 12-hour annual training failed to reveal evidence that Employees E5, E6, E7, E8 andE9 completed the annual 12-hour training as required. Interview with the Nursing Home Administrator April 25, 2025, at 12:30 p.m. confirmed Employees E5, E6, E7, E8 and E9 did not complete the required 12-hour annual training. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management	F 0947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395177	A. BLDG: __00_____ B. WING: _____	04/25/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ROSE CITY NURSING AND REHAB AT LANCASTER STATE LICENSE NUMBER: **040702**	**425 NORTH DUKE STREET LANCASTER, PA 17602**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 0947 SS=F	Continued from page 65	F 0947		

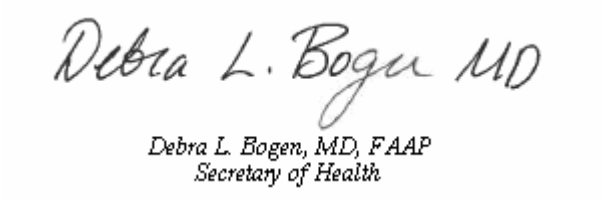
Certified End Page

ROSE CITY NURSING AND REHAB AT LANCASTER

STATE LICENSE NUMBER: 040702

SURVEY EXIT DATE: 04/25/2025

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



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY