

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395177	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/06/2025
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
F 0000	INITIAL COMMENT	F 0000		
F 0582 SS=D	Findings of an Abbreviated Complaint Survey completed on August 6, 2025, at Rose City Nursing and Rehabilitation at Lancaster, identified deficient practice, related to the reported complaint allegations, under the requirements of 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey process.	F 0582		

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 0582 SS=D	Continued from page 1 483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation	F 0582	1. Resident R1's representative was issued a refund on 08-06-2025. 2. BOM performed an audit on 08-06-2025 of any potential refunds that are due to current and discharged residents. Rose City is working on one refund currently that is within the allotted time frame for re-imbursement. 3. NHA will educate the BOM to ensure all refunds are addressed timely. NHA will reach out Accounts Payable if there are delays in reimbursements to ensure timely distribution. 4. BOM will perform weekly audits to ensure that any potential refunds are addressed per regulations. Audits will be weekly for two weeks, then every two weeks for two weeks, then monthly for one month. Results of audits will be submitted to monthly QAPI for review and recommendations.	Completion Date: 08/20/2025 Status: APPROVED Date: 08/15/2025

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F 0582 SS=D	Continued from page 2 of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 0582		

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F 0582 SS=D	Continued from page 3 Based on review of facility documents and staff interview, it was determined that the facility failed refund to the resident or resident representative any and all refunds due to the resident within 30 days from the residents date of discharge from the facility for one of three residents (Resident R1). Findings include: Review of the clinical record indicated Resident R1 was admitted to the facility on 5/9/25 and ceased to breathe while in the facility on 5/28/25. Review of the record of Resident R1s payer source revealed that Resident R1 had privately paid for care. During an interview on 8/6/25, at 9:55 a.m., the Business Office Manager (BOM) confirmed that she had submitted a request for a refund of payment to Resident R1s Representative. The BOM provided evidence of a communication with the financial office, dated 6/11/25. The BOM was able to provide a request for an update Resident R1s Representative refund, dated 8/5/25. The BOM was able to provide evidence that the refund request was processed and provided to the Resident Representative on 8/6/25.	F 0582		

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F 0582 SS=D	Continued from page 4 During an interview on 8/6/25, at approximately 12:45 p.m., the Director of Nursing confirmed that the facility failed to refund the Resident or Resident Representative the refunds due to the Resident within 30 days from the Residents date of discharge from the facility. 28 Pa. Code 201.24 (b) Admission Policy. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a) Resident Rights.	F 0582		



Certified End Page

ROSE CITY NURSING AND REHAB AT LANCASTER

STATE LICENSE NUMBER: 040702

SURVEY EXIT DATE: 08/06/2025

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