STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395282	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Center for Rehabilitation & Healthcare	1412 Lansdowne Avenue Darby, PA 19023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation, review of clinical record, and interview with staff it was determined that the facility failed to ensure that residents/resident's next of kin/legal guardian/power of attorney are notified of changes in resident's care related to ankle monitoring bracelet for one of 37 residents reviewed (Resident R175). Review of facility policy on notification and change of condition, revised May 2025, revealed that the facility shall utilize a notification process when there is change in the resident's medical condition and or status. Unless otherwise instructed by the resident, a nurse will notify the residents' representative Review of Resident R175's clinical record revealed that Resident R175 has a diagnosis of anxiety disorder (intense, excessive, persistent worry or fear) and unspecified dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities). Observation conducted on June 2, 2026, at 11:24 a.m. revealed Resident R175 was in his/her room and was wearing a monitoring device on his/her ankle. Review of Resident R175's physician orders revealed orders dated April 3, 2026, to check function and placement of [NAME] Chip Function (monitoring device) to the right ankle, daily to prevent elopement.Further review of Resident R175's clinical record revealed no documented evidence that the family was notified of the wander guard use.Interview June 4, 2026, with Director of Nursing (DON), Employee E2, confirmed that the unit manager did not call the family to inform them of the wander guard applied to Resident R175's ankle. 28 Pa Code 211.10 (c) Resident care policies28 Pa. Code 211.12 (d)(1) Nursing services

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, review of clinical records, and staff and resident interviews it was determined that the facility failed to provide written notice of a room change for one of 37 residents reviewed (Resident R105). Findings Include:Review of Resident R105's clinical record revealed the resident was admitted to the facility on [DATE], and was cognitively intact. Interview with Resident R105 on June 2, 2026, revealed on May 28, 2026, his/her room was moved from room [ROOM NUMBER] to room [ROOM NUMBER]. Resident R105 further reported being unhappy with the room move and was not informed why he/she needed to move.Review of Resident R105's entire clinical record revealed no documented evidence that the resident or resident representative were notified of the room change and subsequent response from the resident or resident representative.Interview with the Director of Nursing, Employee E2, on June 2, 2026, confirmed there was no documented evidence of the room move process/notification to the resident/representative and stated Social Services would be responsible for such documentation.Interview on June 4, 2026, with the Social Worker, Employee E5, confirmed no documented evidence was available to show that Resident R105 was given written notice, including the reason for the room change, prior to Resident R105's room change on May 28, 2026. 28 Pa. Code 201.14 (a) Responsibility of licensee.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, review of clinical records, and staff and resident interviews it was determined that the facility failed to provide proper notification to the physician in a timely manner for one of 37 residents reviewed (Resident R26).Findings Include:Review of Resident R26's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated May 14, 2026, revealed the resident has a BIMS (Brief Interview for Mental Status - cognitive assessment) Score of 7 (severe cognitive impairment) and diagnoses of anemia (lack of healthy red blood tissues), osteoarthritis (degenerative joint disease) , and malnutrition (lack of sufficient nutrients in the body). Resident R26 was admitted to the facility on [DATE]. Continued review of Resident R26's comprehensive MDS dated [DATE], revealed the resident required partial/moderate assistance from staff for rolling left/right and sitting to lying.Review of Resident R26's comprehensive care plan revealed the resident is on anticoagulant therapy and is at risk of bleeding and bruising. During an interview on June 3, 2026, at 10:00 a.m. Resident R26 reported a bump to the top of his/her head because nurses were careless during care.Review of Resident R26's clinical record revealed a nursing note dated May 31, 2026, at 7:45 a.m. that indicated Resident R26 complained of head pain. Per the nursing note, an assessment revealed a quarter size hematoma on the top of Resident R26's head. Resident R26 alleged he/she was dropped at home being carried up the steps by family.Further review of Resident R26's clinical record revealed a nursing note dated May 31, 2026, at 11:30 a.m. that Resident R26's representative was seeking information about the hematoma and further alleged Resident R26 was manhandled.Review of facility documentation revealed a facility incident report for Resident R26 Bruise dated May 31, 2026, that indicated while Resident R26 was being repositioned in bed, staff unintentionally hit his/her head on the headboard. The incident report indicated that the incident happened on May 31, 2026.Review of Employee Statement Via Telephone dated May 31, 2026, by Nurse Aide, Employee E11, revealed with assistance from Registered Nurse, Employee E12, Resident R26 was repositioned in bed. When moving Resident R26, he/she hit the headboard by accident. The statement was not signed by the employee.Review of Employee Statement Via Telephone dated May 31, 2026, by Registered Nurse, Employee E12, revealed when assisting Nurse Aide, Employee E11, to reposition Resident R26 in bed and pulling him/her up, the staff unintentionally hit Resident R26's head on the headboard. The statement was not signed by the employee.Review of facility staffing punch reports revealed Registered Nurse, Employee E12, did not work on the date the alleged incident occurred (May 31, 2026).Interview on June 5, 2026, at 10:30 a.m. with Director of Nursing, Employee E2, and Regional Staff, Employee E13, and E14, revealed based on a follow-up interview with Nurse Aide, Employee E11, and Registered Nurse, Employee E12, the incident happened on May 30, 2026, during the 3:00 p.m. to 11:00 p.m. shift.Interview on June 5, 2026, at 10:30 a.m. with Director of Nursing, Employee E2, and Regional Staff, Employee E13, and E14, confirmed Nurse, Aide, Employee E11, and Registered Nurse, Employee E12, did not promptly notify the physician or document accidentally hitting Resident R26's head on the headboard. It was not until they were questioned after a hematoma was found in the morning of May 31, 2026, that staff reported hitting Resident R26's head on the headboard. 28 Pa. Code 201.14 (a) Responsibility of licensee.28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, and staff and resident interviews it was determined that the facility failed to conduct a complete, accurate, and thorough investigation of alleged abuse and neglect for two of 37 residents reviewed (Resident R37 and R26). Findings Include: Review of facility policy Abuse Prevention/Reporting revised February 25, 2025, revealed the facility will investigate of all suspected cases of abuse. Further review of the facility policy revealed the facility will collect written documentation such as signed witness statements, statements of accused personnel, medical records, incident reports and other pertinent information. Review of Resident R37's quarterly MDS (an assessment of resident needs) dated May 3, 2026, revealed the resident was severely cognitively impaired and diagnosed with obstructive uropathy (blockage in the urinary system). Review of the MDS revealed Resident R37 used a supra pubic catheter for urinating (a tube inserted through a small incision in the lower abdomen to drain urine directly from the bladder) and was incontinent of bowel needing staff assistance with toileting. Review of Resident R37's care plan revealed a history of falls with interventions that included keeping the resident's bed in the lowest position (lowering the bed closer to the floor shortens the distance a person would fall, which lessens the severity of potential injuries). Review of Resident R37's nursing progress note dated May 12, 2026, at approximately 4:00 a.m. revealed the resident was found on the floor next to his/her bed bleeding on the side of the head. The physician gave new orders to transfer Resident R37 to the hospital for further evaluation. Review of facility documentation related to the incident, revealed a witness statement from Resident R37's nurse aide, Employee E15, revealed, The patient was last taken care of at 2:30 a.m., (does not state what type of care was provided) and was last seen at 3am. Continued review of facility documentation revealed no documented evidence that the facility determined what was the positioning of the bed when Resident R37 was found on the floor an hour after care was provided. Interview with the second-floor unit manager, Employee E6, on June 4, 2026, at 10:48 a.m. revealed Resident R37 sustained a 4-centimeter (cm) laceration to the head. Interview with the Director of Nursing, Employee E2, on June 5, 2026, at 12:00 p.m. confirmed the facility failed to determine the position of Resident R37's bed after the fall. Review of Resident R26's comprehensive Minimum Data Set (MDS – federally mandated resident assessment and care screening) dated May 14, 2026, revealed the resident has a BIMS (Brief Interview for Mental Status – cognitive assessment) Score of 7 (severe cognitive impairment) and diagnoses of anemia (lack of healthy red blood tissues), osteoarthritis (degenerative joint disease) , and malnutrition (lack of sufficient nutrients in the body). Resident R26 was admitted to the facility on [DATE]. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of Resident R26's comprehensive MDS dated [DATE], revealed the resident required partial/moderate assistance from staff for rolling left/right and sitting to lying. Review of Resident R26's comprehensive care plan revealed the resident is on anticoagulant therapy and is at risk of bleeding and bruising. During an interview on June 3, 2026, at 10:00 a.m. Resident R26 reported a bump to the top of his/her head because nurses were careless during care. Review of Resident R26's clinical record revealed a nursing note dated May 31, 2026, at 7:45 a.m. that indicated Resident R26 complained of head pain. Per the nursing note, an assessment revealed a quarter size hematoma on the top of Resident R26's head. Resident R26 alleged he/she was dropped at home being carried up the steps by family. Further review of Resident R26's clinical record revealed a nursing note dated May 31, 2026, at 11:30 a.m. that Resident R26's representative was seeking information about the hematoma and further alleged Resident R26 was manhandled. Review of facility documentation revealed a facility incident report for Resident R26 Bruise dated May 31, 2026, that indicated while Resident R26 was being repositioned in bed, staff unintentionally hit his/her head on the headboard. The incident report indicated that the incident happened on May 31, 2026. Continued review of facility documentation revealed employee statements were obtained by alleged perpetrators Nurse Aide, Employee E11, and Registered Nurse, Employee E12. Employee statements were electronically typed and noted to be via telephone with interviews conducted by the Director of Nursing, Employee E2. Review of Employee Statement Via Telephone dated May 31, 2026, by Nurse Aide, Employee E11, revealed with assistance from Registered Nurse, Employee E12, Resident R26 was repositioned in bed. When moving Resident R26, he/she hit the headboard by accident. The statement was not signed by the employee. Review of Employee Statement Via Telephone dated May 31, 2026, by Registered Nurse, Employee E12, revealed when assisting Nurse Aide, Employee E11, to reposition Resident R26 in bed and pulling him/her up, the staff unintentionally hit Resident R26's head on the headboard. The statement was not signed by the employee. Review of facility staffing punch reports revealed Registered Nurse, Employee E12, did not work on the date the alleged incident occurred (May 31, 2026). Further review of facility documentation revealed no witness statements were obtained from Resident R26, or other staff and residents. Interview on June 5, 2026, at 10:00 a.m. with the Director of Nursing, Employee E2, confirmed the timeline of alleged incident was unclear and further confirmed no statement from Resident R26, or other staff and residents was obtained. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.10 (c) Resident care policies 28 Pa. Code 211.12 (d)(1) Nursing services 28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, observation, interviews with resident and staff it was determined that the facility failed to provide quality of care in accordance with physician orders for two of 37 residents reviewed (Resident R287 and R78). Findings Include: Review of Resident R287's clinical record revealed the resident was admitted to the facility on [DATE], and had diagnoses of malignant neoplasm of the tongue (tongue cancer) and protein-calorie malnutrition (inadequate intake of protein and calories, leading to loss of fat and muscle). Continued review of Resident R287's clinical record revealed a physician order dated May 24, 2026, to use Infuvite Adult Intravenous (IV) Solution (multiple vitamin) at 80 milliliter/hour (ml/hr) intravenously one time per day. Further review of Resident R287's clinical record revealed a physician order dated June 2, 2026, for Sodium Chloride Intravenous Solution 0.9% (Sodium Chloride - used to maintain fluid and electrolyte balance) administered at 75 ml/hr intravenously every shift for four days. Observations on June 2, 2026, at 11:45 a.m. revealed Resident R287 was in bed with the IV Sodium Chloride Solution running at 75 ml/hr. Observations revealed the contents of the Sodium Chloride Solution were discolored bright yellow. Interview on June 2, 2026, at approximately 12:00 p.m. with Licensed Nurse, Employee E8, confirmed Resident R287's Sodium Chloride Solution bag was not properly labeled and was mixed together with the Infuvite Adult Intravenous (IV) Solution. Further interview on June 2, 2026, at approximately 12:00 p.m. Licensed Nurse, Employee E8, confirmed that the physician order for infuvite did not indicate to mix it with the sodium chloride solution, but that that it was a recommendation by the pharmacy instructions to add infuvite to sodium chloride. Review of Resident R78's clinical records revealed the resident was alert and oriented, admitted to the facility on [DATE], and has a diagnosis of Prurigo nodularis (is a chronic skin condition characterized by extremely itchy, firm nodules that often result from persistent scratching). During an interview with Resident R78 on June 2, 2026, at 10:00 a.m. the resident stated, I have been itchy, I told them (the nursing staff) weeks ago. It is getting worse it hurts sitting in my wheelchair. The resident continued to say when he/she has an incontinent episode in the adult brief, the urine burns his/her rash. Observations of Resident R78's torso appeared to have linear red marks from the resident scratching. Review of Resident R78's clinical record revealed a physician progress note dated, May 1, 2026, that noted a rash around the resident's diaper areas and ordered zinc oxide ointment to be applied topically to the resident's area. The ointment was applied two times a day from May 1, 2026, until May 11, 2026. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During this time (May 1, 2026, through May 11, 2026) there was no documented evidence of an ongoing assessment of the resident's response to the treatment. Review of the resident's weekly skin checks did not note any new or current skin changes. Continued review of Resident R78's clinical record revealed there were no new treatment changes after the zinc order was completed, until 7 days later when the physician saw the resident again on May 18, 2026. Review of Resident R78's clinical record revealed a physician note dated May 18, 2026, which revealed Earlier this month, he/she developed a diaperˆarea rash and was started on zinc oxide BID (twice per day). Today, Resident R78 states the rash feels like it is getting worse instead of better. I spoke with patient and sister at bedside and discussed starting clotrimazole TID (three times a day) and they agreed. Clotrimazole 1% ointment to groin and inner thighs TID x 14 days. Review of Resident R78's medication administration record revealed the resident's Clotrimazole cream was ordered for seven days and not 14 days, as initially prescribed. Further review of Resident R78's clinical record revealed a physician note dated May 27, 2026, that revealed Resident R78 was seen due to worsening pain and irritation in the diaperˆarea rash. Resident R78 reported increased discomfort and states the rash is not improving with zinc oxide and clotrimazole. Based on worsening symptoms, the physician transitioned treatment to nystatin cream QID (four times a day) and for wound care nurse to evaluate. Further review of Resident R78's wound notes revealed the resident was not assessed for the skin rash until June 4, 2026. Interview with the Director of Nursing, Employee E2, on June 5, 2026, at 11:00 a.m. confirmed the above. 28 Pa. Code 211.12 (d)(5)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy, review of clinical records, and staff interviews it was determined that the facility failed to obtain a physician order for tracheostomy size for one of one resident reviewed with tracheostomy (Resident R2).Findings:Review of facility policy Tracheostomy Care revealed tracheostomy tubes should be changed as needed or as ordered. Preparation and assessment include checking the physician order. Review of Resident R2's Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated May 1, 2026, revealed the resident was severely cognitively impaired and had a diagnosis of respiratory failure (not enough oxygen passes from your lungs to your blood). Review of Resident R2's MDS revealed the resident received tracheostomy care (a surgically created hole in your trachea that allows for breathing).Review of Resident R2's care plan revised June 11, 2025, revealed the resident had altered respiratory status related, but not limited to, tracheostomy and pulmonary edema.Observations on June 3, 2026, at 12:30 p.m. revealed Resident R2 had a tracheostomy.Review of Resident R2's clinical record revealed a physician order dated December 12, 2025, to change the tracheostomy disposable inner cannula every day shift.Review of Resident R2's clinical record revealed no physician order for size of tracheostomy to be used.Interview on June 4, 2026, at 1:20 p.m. with Resident R2's assigned Licensed Nurse, Employee E10, revealed the employee was unable to find a physician order for tracheostomy size and was further unaware what tracheostomy size Resident R2 required.Interview on June 4, 2026, at 1:25 p.m. with the 4th floor Unit Manager Licensed Nurse, Employee E7, confirmed there was no physician order for Resident R2's tracheostomy size.28 Pa. Code 201.14 (a) Responsibility of licensee.28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, observations, and staff interviews it was determined that the facility failed to ensure that all drugs and biologicals were labeled in accordance with professional standards for 1 of 37 residents observed (Resident R287).Findings Include:Review of Resident R287's clinical record revealed the resident was admitted to the facility on [DATE], and had diagnoses of malignant neoplasm of the tongue (tongue cancer) and protein-calorie malnutrition (inadequate intake of protein and calories, leading to loss of fat and muscle).Continued review of Resident R287's clinical record revealed a physician order dated May 24, 2026, to use Infuvite Adult Intravenous (IV) Solution (multiple vitamin) at 80 milliliter/hour (ml/hr) intravenously one time per day.Further review of Reisdent R287's clinical record revealed a physician order dated June 2, 2026, for Sodium Chloride Intravenous Solution 0.9% (Sodium Chloride) administered at 75 ml/hr intravenously every shift for four days.Observations on June 2, 2026, at 11:45 a.m. revealed Resident R287 was in bed with the IV Sodium Chloride Solution running at 75 ml/hr. Observations revealed the contents of the Sodium Chloride Solution was discolored bright yellow.Further observations on June 2, 2026, at 11:45 a.m. revealed a label Intravenous Solution Additives affixed to Resident 287's IV Sodium Chloride Solution bag, but did not indicate the additive.Interview on June 2, 2026, at approximately 12:00 p.m. with Licensed Nurse, Employee E8, confirmed Resident R287's Sodium Chloride Solution bag was not properly labeled with the additive. Licensed Nurse, Employee E8, reported that the Sodium Chloride Solution had been mixed together with the Infuvite Adult Intravenous (IV) Solution for administration.28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and interview with staff, it was determined that the facility failed to implement an effective infection control program related personal protective equipment for one of 37 residents observed (Resident R2).Findings Include: Review of facility policy on personal protective equipment revealed that personal protective equipment appropriate to specific task requirements is available at all times. Further review of facility policy revealed employees required to perform tasks that may involve exposure to blood/body fluids will be provided appropriate protective clothing and equipment. Review of Resident R2's clinical record revealed that Resident R2 was admitted to the facility on [DATE], with diagnoses of, but not limited to, Anoxic Brain Damage (when the brain is deprived of oxygen) and Chronic Respiratory Failure with Hypoxia (the lungs cannot supply enough oxygen to the blood). Observation conducted on June 5, 2026, at 9:52 a.m. revealed that an enhanced barrier precaution sign (infection control measures that expand the use of gowns and gloves during high-contact care activities to prevent the spread of multidrug-resistant organisms) was posted outside Resident R2's bedroom door with available personal protective equipment, including re-washable cloth gowns Observation on June 5, 2025, at 9:53 a.m. revealed Resident R2 was in bed and had a tracheostomy (a surgically created hole in your trachea that allows for breathing).Observation on June 5, 2026, at 9:58 a.m. revealed that yellow re-washable cloth gowns, and a plastic bag containing yellow cloth gowns were on top of the chair inside Resident R2's room.Interview on June 5, 2026, at 9:58 a.m. with Licensed Nurse, Employee E9, confirmed that that yellow re-usable cloth gowns and a plastic bag containing yellow cloth gowns were on top of the chair inside Resident R2's room. Further, Licensed Nurse, Employee E9, confirmed the gowns should be used only once and then properly disposed of for laundering. Licensed Nurse, Employee E9, subsequently placed the gowns in plastic bag, and took them out of the room to dispose of properly. 28 Pa. Code 211.12 (d)(1) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395282	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Center for Rehabilitation & Healthcare	1412 Lansdowne Avenue Darby, PA 19023

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on review of facility documentation and staff interview it was determined that the facility failed to include active input from residents, their representative(s), family members, and representatives of direct care staff in the facility assessment process.Findings Include: Review of facility documentation titled, Facility Assessment dated April 22, 2026, states the people involved in the process are the Administrator, Director of Nursing, Governing Body Rep, and the Medical Director. Review of the facility assessment and the sign-in sheet for individuals involved in completing the annual review of the facility assessment on April 22, 2026, revealed no documented evidence that the facility included input from residents/resident representatives, or active involvement from direct care staff (including but not limited to Registered Nurses (RNs), Licensed Practical Nurses (LPNs), or Nurse Aides (NA), input from resident.Interview on June 5, 2026, at 1:00 p.m. with Nursing Home Administrator, Employee E1, confirmed no documentation was available to support evidence of active involvement from direct care staff or input from residents. 28 Pa. Code 201.14 (a) Responsibility of licensee.