STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policies, clinical records, facility-provided investigative documentation, observations, and staff interviews, it was determined the facility failed to ensure that one resident (Resident 1) was free from sexual abuse perpetrated by another resident (Resident 2). This failure placed one of eight residents sampled in Immediate Jeopardy to the health and safety of residents.Findings include: A review of the current facility policy entitled Abuse Prevention Program, last reviewed by the facility December 8, 2025, revealed the residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. A review of the facility policy entitled Identifying Sexual Abuse and Capacity to Consent last reviewed December 8, 2025, revealed sexual abuse is non-consensual sexual conduct of any type with a resident. Sexual abuse includes but is not limited to unwanted intimate sexual touching of any kind especially to the breasts or perineal area. Further it is indicated that sexual contact is non-consensual if the resident appears to want the contact to occur but lacks the cognitive ability to consent. The policy further revealed the facility will investigate and protect a resident from non-consensual sexual relations any time there is a reason to suspect that the resident does not wish to engage in sexual activity or may not have the capacity to consent. The policy revealed that during an investigation into sexual abuse, evidence will be preserved and not tampered with. The policy identified examples of tampering as washing linens or clothing, destroying documentation, bathing or cleaning the resident before the resident has been examined including a rape kit, or otherwise impeding a law enforcement investigation. Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with a diagnosis of dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). An Annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process completed periodically to plan resident care) dated October 21, 2025, revealed that the resident had a BIMS score of 7 (Brief Interview for Mental Status a tool within the Cognitive Section of the MDS that assesses the resident's attention, orientation, and ability to register and recall new information. A score of 0-7 indicates severe cognitive impairment, reflecting impaired judgment and decision-making capacity). Clinical record review revealed the facility admitted Resident 2 on November 18, 2025, with a diagnosis of cerebral infarction (occurs when a blood vessel to the brain is blocked, causing tissue death due to a lack of oxygen and nutrients). A review of an admission MDS dated [DATE], revealed that Resident 2 had a BIMS score of 14 (a score of 13-15 indicates cognition is intact). A review of facility-provided investigative documentation revealed that on January 1, 2026, at 7:50 PM Resident 1 was in the shared bathroom connecting her room and Resident 2's room. The documentation indicated that Employee 1 (Nurse Aide) observed Resident 1 unlock and slightly open the door to Resident 2's room, which was documented as a (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	habitual action by Resident 1 to indicate she was finished using the bathroom. The documentation revealed that Resident 2 opened his door and leaned toward Resident 1, at which time he kissed Resident 1 on the lips. Employee 1 immediately removed Resident 1 from the bathroom and notified the RN Supervisor on duty. An interview with Employee 1 (Nurse Aide) on January 15, 2026, at 9:35 AM confirmed the events as documented. Employee 1 stated she was waiting in the bathroom area to assist Resident 1 back to her bed when Resident 1 unlocked and cracked open the door to Resident 2's room, which Employee 1 stated Resident 1 routinely did out of habit to signal that the bathroom was available. Employee 1 stated Resident 2 was standing just inside the doorway, opened the door further, and leaned in to kiss Resident 1 on the lips.Employee 1 stated she immediately removed Resident 1 from the bathroom and reported the incident to the RN (registered nurse) Supervisor. Employee 1 stated that following the incident on January 1, 2026, she and another Nurse Aide (Employee 2) frequently remained in Resident 1's room to ensure her safety due to Resident 2's continued behaviors toward Resident 1. Employee 1 stated that on multiple occasions she observed Resident 2 sitting outside Resident 1's room or staring at Resident 1 while in common areas of the facility.Further review of the investigative documentation revealed the facility implemented an intervention to lock the inside of Resident 2's bathroom door to prevent Resident 2 from accessing the shared bathroom. The documentation indicated the facility provided Resident 2 with a bedside commode to limit his access to the shared bathroom with Resident 1. The investigative documentation indicated the facility attempted to relocate Resident 2 to another room following the incident; however, Resident 2 declined the room change. The documentation indicated Resident 2 was questioned regarding the incident and stated, She is my friend. Who cares if we kissed. A review of a written witness statement dated January 1, 2026, written by Employee 1, corroborated the investigative documentation and interview findings, documenting that Resident 1 opened the door to Resident 2's room and Resident 2 leaned through the doorway and kissed Resident 1 on the lips. An interview with the Nursing Home Administrator (NHA) on January 15, 2026, at 10:00 AM revealed the facility did not relocate Resident 1 following the incident on January 1, 2026. The NHA stated the decision was made due to concern that moving Resident 1 would increase confusion. Despite Resident 1's documented cognitive impairment, the resident was not offered a room change. A review of Resident 2's progress notes revealed that on January 3, 2026, Resident 2 was documented as exiting Resident 1's room following a visit with Resident 1 and her family. Further review of Resident 2's progress notes revealed that on January 7, 2026, at 8:37 PM Resident 2 was documented as having argued with the Nurse Aide on duty (Employee 1) at 4:00 PM and again at 8:00 PM. The progress note documented that Resident 2 stated he felt he was being watched and followed by staff. The note documented that Resident 2 made comments toward the aide, brought up past events, and caused agitation in another female resident toward the aide. The progress note indicated Resident 2 was unable to be redirected at that time. Further review of Resident 2's progress notes revealed that Social Services met with Resident 2 on January 8, 2026, due to ongoing agitation with staff. The progress note documented that Resident 2 reflected on past interactions with Resident 1. The note further documented that Social Services educated Resident 2 that he may speak with and be friends with the female resident in common areas, but that he should not enter Resident 1's room or allow Resident 1 to enter his room. Review of facility investigative documentation revealed that on January 11, 2026, at 1:15 AM Employee 3 (Nurse Aide) observed Resident 1 located in Resident 2's bed, naked, with Resident 2 seated in his wheelchair next to the bed. Employee 3's witness statement dated January 11, 2026, documented that during routine rounding, Employee 3 observed Resident 1 was not in her bed and noted that Resident 1's wheelchair, which she frequently used, was located next to her bed and empty. The (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	statement further documented Employee 3 checked the shared bathroom between Resident 1's and Resident 2's rooms and found the door locked from the inside. Due to prior resident-to-resident history, Employee 3 proceeded to Resident 2's room.The witness statement documented that upon entering Resident 2's room, Employee 3 observed Resident 1 lying naked in Resident 2's bed. The statement documented that Resident 2 was touching Resident 1's private area, with Resident 1's legs observed to be open. Employee 3 shouted for the supervisor, at which time Resident 1 walked to the bathroom and put her gown back on. Employee 3 escorted Resident 1 back to her room, where Resident 1 complained of vaginal pain and was observed checking herself in the bathroom. Further review of facility investigative documentation revealed that both residents were questioned regarding why they were together and both stated they were talking. The documentation indicated the facility determined there was no evidence of penetration and no further assessment was completed at that time. An interview with Employee 3 on January 15, 2026, at 10:07 AM confirmed the accuracy of the information documented in her January 11, 2026, written witness statement. During the interview, Employee 3 stated that when she entered Resident 1's room to conduct rounding, Resident 1 was not in her bed. Employee 3 stated she checked the shared bathroom and found the door locked from the inside. Employee 3 stated she then proceeded to Resident 2's room based on known prior interactions between the residents. During the interview, Employee 3 stated facility staff had been aware of multiple prior incidents involving Resident 2 exhibiting inappropriate behaviors toward Resident 1. Employee 3 stated Resident 2 previously had bathroom privileges removed after being found in the bathroom with Resident 1 on multiple occasions. Employee 3 stated that between January 1, 2026, and January 11, 2026, there was an additional incident in which Resident 2 was found caressing Resident 1's breast; however, Employee 3 was unable to recall the specific date of that incident. Employee 3 stated during the interview that she observed Resident 2's fingers inside Resident 1's vagina and that she yelled for the supervisor, causing Resident 2 to stop the contact. A second interview with Employee 3 on January 15, 2026, at 12:34 PM revealed Employee 3 did not document in her initial written witness statement that she observed Resident 2's fingers inside Resident 1's vagina because she believed documenting that Resident 2's hand was on Resident 1's private area sufficiently conveyed what occurred. Employee 3 stated she was emotionally distressed by the incident and remained upset at the time of the interview. A review of a separate written witness statement authored by Employee 4 (Nurse Aide) revealed Employee 4 and Employee 3 were conducting rounds together when Resident 1 was not located in her room. The statement documented that the shared bathroom door was locked, prompting both employees to check Resident 2's room. The witness statement written by Employee 4 documented that upon entering Resident 2's room, Resident 1 was observed lying naked in Resident 2's bed and that Resident 2 was observed touching Resident 1's vaginal area. The statement documented that both Nurse Aides yelled for the supervisor and that Resident 1 went to the bathroom to dress and wipe herself. The statement further documented Resident 1 complained of vaginal pain. Multiple attempts to contact Employee 4 for interview on January 15, 2026, were unsuccessful. An interview with Employee 1 (Nurse Aide) on January 15, 2026, at 10:39 AM revealed that after the January 11, 2026, incident, Resident 1 and Resident 2 were found unattended together on multiple occasions, despite the facility's awareness of prior sexual abuse concerns. Employee 1 stated that at the time of the interview, Resident 1 and Resident 2 were alone together in the facility chapel. Following this statement, the surveyor proceeded to the chapel and observed Resident 2 being wheeled back toward his room, while Resident 1 was observed returning from the chapel hallway, confirming the residents had been alone together without staff supervision. An interview with Resident 2 on January 15, 2026, at 11:00 AM confirmed that Resident 1 and Resident 2 had been alone (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	together in the chapel prior to the interview. During the interview, Resident 2 denied touching Resident 1's vaginal area. Resident 2 stated that Resident 1 frequently sought him out, described her as infatuated, and stated they spent time together, often alone, despite acknowledging Resident 1's diagnosis of dementia. A review of Resident 1's care plan revealed that 15-minute safety checks were not initiated until January 13, 2026, two days after the sexual abuse incident involving Resident 2. A review of Resident 1's physician orders revealed that every 15-minute safety checks were ordered for every shift beginning January 12, 2026, at 4:00 PM, which was over 36 hours after the January 11, 2026, incident. A review of Resident 1's 15-minute safety check documentation provided by the facility on January 15, 2026, at 3:00 PM revealed an incomplete form, indicating the safety checks were not completed at the ordered frequency. After multiple additional requests by the surveyor the facility provided additional 15-minute safety check documentation on January 16, 2026. Review of this documentation revealed new entries and signatures added after the originally submitted form, despite the documented dates and times having already passed. The updated documentation conflicted with the originally provided record, which reflected incomplete monitoring. A review of Resident 2's 15-minute safety checks revealed that no safety checks were documented immediately following the January 11, 2026, incident. The first documented safety check for Resident 2 was completed on January 11, 2026, at 3:00 PM, 13 hours after the incident. Further review revealed that on January 15, 2026, Resident 2's ordered 15-minute safety checks were not completed from 12:00 AM through 3:00 AM, and no other documentation accounted for Resident 2's whereabouts during that time. An interview with the Director of Nursing (DON) on January 16, 2026, at 10:00 AM revealed that when questioned regarding the newly added documentation and signatures on Resident 1's safety check records, the DON was unable to explain why the original incomplete documentation was later supplemented, despite the original record indicating the checks were not completed as ordered. As of the survey date of January 15, 2026, the facility had not implemented effective interventions to prevent Resident 1 from engaging in sexual contact with Resident 2, despite Resident 1's documented inability to consent due to cognitive impairment. The facility failed to rule out sexual abuse, despite facility policy requiring investigation of any allegation or suspicion of sexual abuse. An interview with the Nursing Home Administrator (NHA) on January 15, 2026, at 12:00 PM revealed the facility did not send Resident 1 to the emergency department for evaluation, despite facility policy indicating the need for evaluation following suspected sexual abuse. The interview revealed that the facility did not fully investigate or report the sexual abuse incident and did not develop or implement timely interventions for a resident with a known history of inappropriate sexual behaviors, either prior to or after the sexual abuse occurred. Applying the reasonable person concept, for Resident 1, who is unable to advocate for herself due to cognitive impairment, the circumstances surrounding the sexual abuse would be expected to result in psychosocial harm, fear, humiliation, and emotional distress. An interview with Employee 1 on January 15, 2026, at 11:00 AM revealed observable changes in Resident 1's behavior following the January 11, 2026, incident. Employee 1 stated Resident 1 typically went to bed between 8:00 PM and 9:00 PM; however, since the incident, Resident 1 stayed awake later and was not sleeping as usual. Employee 1 further stated Resident 1 appeared fearful when using the bathroom, frequently looking toward the doorway where Resident 2 had previously accessed the shared bathroom. An interview with the Nursing Home Administrator and Director of Nursing on January 15, 2026, at 3:15 PM included a review of survey findings related to the facility's failure to ensure that Resident 1 was free from sexual abuse perpetrated by Resident 2. These failures placed residents who are cognitively impaired at risk for sexual abuse resulting in Immediate Jeopardy (IJ). The facility was notified of the Immediate Jeopardy (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	on January 15, 2026, at 12:40 PM and the IJ template was provided to the facility at 12:56 PM. An immediate IJ removal plan was requested and received on January 15, 2026, at 2:13PM and accepted on January 15, 2026, at 2:27PM. The IJ removal plan included: Resident 2 was discharged from the facility on January 15, 2026. All staff education was initiated immediately on the facility abuse policies including allegations of sexual abuse. Starting with the 7:00 PM to 7:00 AM shift, Nurse Aides and Licensed Nurses, education will be completed on documenting resident behaviors and will continue to be monitored by the Social Services Director and resident care plans will be updated as needed. Education will continue prior to each licensed staff members next shift. In the event of sexual abuse, the perpetrator and victim will immediately be placed on 1:1 supervision. The Immediate Jeopardy was lifted on January 16, 2026, at 11:45AM upon receipt of the facility's immediate action plan and verification that the actions had been implemented. Refer to F609 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29 (a)(c) Resident Rights 28 Pa. Code 211.10 (a)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(5) Nursing Services

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, information submitted by the facility, the facility's abuse prohibition policy and staff interviews, it was determined the facility failed to accurately and completely report and document an alleged incident of sexual abuse for 1 of 8 residents reviewed (Resident 1) to the State Survey Agency and the Area Agency on Aging. Findings include: A review of facility policy entitled Abuse Protection last reviewed by the facility on December 8, 2025, revealed under the category Reporting Serious crimes, it is the facility's responsibility to report any occurrences of abuse, neglect, misappropriation of resident property, and suspicions of a crime to the State Survey Agency, Department of Aging and local law enforcement. The policy further revealed if the reportable event resulted in serious bodily injury (sexual abuse), the facility is to report the event within 2 hours of forming the suspicion. A review of a facility policy entitled Identifying Sexual Abuse and Capacity to Consent last reviewed by the facility on December 8, 2025, revealed for any alleged violation of sexual abuse, protective measure and an investigation will begin immediately. The policy further details the protective measures, and investigation will include immediately implementing safeguards to prevent further potential abuse, immediately reporting the allegation to the appropriate authorities, conducting a thorough investigation of the allegation, including the resident's capacity to consent, and thoroughly documenting and reporting the result of the investigation of the allegation. A review of clinical record revealed that Resident 1 was admitted to the facility on [DATE], with a diagnosis of dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). An Annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process completed periodically to plan resident care) dated October 21, 2025, revealed that the resident had a BIMS score of 7 (Brief Interview for Mental Status a tool within the Cognitive Section of the MDS that assesses the resident's attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment. Clinical record review revealed that Resident 2 was admitted to the facility on [DATE], with a diagnosis of cerebral infarction (a type of stroke that occurs when blood flow to the brain is blocked, resulting in damage to brain tissue). An admission Minimum Data Set assessment dated [DATE], indicated Resident 2 had a BIMS score of 14, which reflects intact cognition (a score of 13-15 indicates cognition is intact). Review of a facility-provided abuse investigation report revealed that on January 11, 2026, at approximately 1:15 AM, a nurse aide (Employee 3) observed Resident 1 on Resident 2's bed. The report documented that Resident 2 was seated in his wheelchair at the bedside and Resident 1 was unclothed. The report further stated both residents indicated they were talking and concluded there was no evidence of penetration. However, review of a written witness statement completed by Employee 3 revealed additional information not accurately reflected in the facility's report. Employee 3 documented that at approximately 12:50 AM, Resident 1 was last observed seated in her chair. During routine rounds, Employee 3 noted Resident 1 was no longer in her bed and her wheelchair was empty and positioned beside the bed. Employee 3 checked the shared bathroom, which was locked, and then entered Resident 2's room where Resident 1 was found unclothed in Resident 2's bed. The witness statement documented that Resident 2 was observed touching Resident 1's vaginal area while Resident 1's legs were open. Employee 3 documented she immediately called for supervisory assistance. The statement further documented that Resident 1 walked to the bathroom, put her gown back on, and was escorted back to her room, where she complained of vaginal pain and was observed checking (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	herself in the bathroom. Review of an additional witness statement from Employee 4 corroborated that Resident 2 was observed touching Resident 1's vaginal area and that Resident 1 complained of vaginal discomfort following the incident.Review of information submitted by the facility to the State Survey Agency and the local Area Agency on Aging on January 11, 2026, at 8:24 PM revealed the facility failed to accurately and completely report the incident. The report did not identify that staff directly observed Resident 2 touching Resident 1's vaginal area and failed to report that Resident 1 complained of vaginal pain immediately following the incident. The facility reported that Resident 1 exhibited no signs or symptoms of distress, which was inconsistent with the eyewitness documentation provided by Employees 3 and 4. The same inaccurate and incomplete information was reported to the Area Agency on Aging. During an interview conducted on January 15, 2026, at 10:00 AM, the Nursing Home Administrator stated the facility did not report all observed findings to the State Survey Agency and Area Agency on Aging because both residents stated they were just talking, despite staff eyewitness accounts documenting physical sexual contact. The facility's clinical consultant further stated that the nurse who submitted the report to the Area Agency on Aging was not present at the time of the incident and was later suspended for reporting false information, despite the reported information being inconsistent with the written witness statements. An interview with the NHA and DON (Director of Nursing) on January 15, 2026, at 2:15PM reviewed the findings that the facility did not follow their established abuse policy and procedures for reporting abuse and that the facility failed to factually report all relevant information obtained during an investigation 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29 (a)(c) Resident Rights 28 Pa. Code 211.10 (a)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(5) Nursing Services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on a review of clinical records, select facility policies, documentation provided by the facility, and interviews with residents and staff, it was determined that the facility failed to effectively use its resources to promote resident safety and maintain the highest practicable physical and mental well-being of residents in accordance with federal requirements. Specifically, the facility's administration failed to ensure that one of eight residents sampled (Resident 1) was free from sexual abuse perpetrated by another resident (Resident 2). This failure resulted in Immediate Jeopardy to resident health and safety.Findings included: A review of the job description for the Nursing Home Administrator (NHA) signed and dated August 19, 2024, revealed the administrator will be knowledgeable of and demonstrate the ability to provide quality care by fostering a safe environment for residents and staff, providing emotional and psychological support for the residents within the facility, directing, and overseeing the day-to-day operation of the facility to ensure that the highest degree of quality care is maintained at all times in accordance with current state and federal standards, and implementing and enforcing company policies and procedures. The Job Description for Director of Nursing (DON) Services signed and dated October 1, 2025, revealed the DON will assure resident safety through nursing staff, evaluate effects of care delivered and assign special treatments when indicated, and review and revise care plans and assessments as necessary. Review of facility documentation and interviews with staff revealed that administrative oversight failed to ensure effective coordination, monitoring, and implementation of facility systems designed to protect residents from abuse. Specifically, the facility failed to identify, mitigate, and manage known and foreseeable risks associated with resident interactions, particularly for residents with cognitive impairment (a condition that limits a person's ability to understand, process, or make safe decisions), thereby failing to protect Resident 1 from sexual abuse by Resident 2. The failure of the Administrator and Director of Nursing to carry out their respective administrative responsibilities demonstrated ineffective use of facility resources, including failure to ensure appropriate supervision, failure to ensure consistent implementation of facility policies related to resident safety and abuse prevention, and failure to ensure timely administrative intervention when resident safety risks were present. As a result of these administrative failures, the facility did not maintain an effective system of oversight to ensure residents were protected from abuse, and one resident experienced sexual abuse, placing residents, particularly those who were cognitively impaired, at continued risk for serious harm. This deficient practice is directly related to and supported by the Immediate Jeopardy citation under F600 (Freedom from Abuse, 42 CFR S483.12), which identified that the lack of effective administrative oversight, monitoring, and enforcement of policies by facility leadership contributed to the Immediate Jeopardy situation. Refer F600 28 Pa. Code: 201.14 (a) Responsibility of licensee28 Pa. Code: 201.18 (e)(1) Management28 Pa. Code 211.12 (d)(3) Nursing services