

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Nightingale Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 607 East 26th Street Erie, PA 16504	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832</p> <p>Based on review of the Pennsylvania Code Title 49. Professional and Vocational Standards, facility job descriptions, clinical records, and facility documents, and staff interviews, it was determined that the facility failed to follow nursing standards of practice to ensure medications were administered appropriately and residents were assessed and treated in a timely manner for one of 24 residents reviewed (Resident R108).</p> <p>Findings include:</p> <p>Review of Pennsylvania Code Title 49. Professional and Vocational Standards 21.145. Functions of the Licensed Practical Nurse (LPN), (a) The LPN is prepared to function as a member of the health-care team by exercising sound nursing judgment based on preparation, knowledge, experience in nursing and competency. The LPN participates in the planning, implementation and evaluation of nursing care using focused assessment in settings where nursing takes place.</p> <p>Review of the facility job description for an LPN included: prepare and administer medication as ordered by the physician; be knowledgeable of nursing and medical practices and procedures, as well as, laws, regulations, and guidelines; must possess the ability to make independent decisions when circumstances warrant such action; implement and maintain established nursing objectives and standards; administer professional services; and monitor seriously ill residents as necessary.</p> <p>A facility policy entitled, Administering Oral Medications dated 1/07/25, included verifying the physician's medication order, and instructing the resident to place sublingual (situated beneath the tongue) medications under the tongue and allow the drug to dissolve.</p> <p>A facility policy entitled, Assessment of Chest Pain dated 1/07/25, revealed that assessing a resident experiencing chest pain in a skilled nursing facility requires prompt and systematic action to ensure resident safety, and included the following:</p> <ol style="list-style-type: none"> 1. Immediate assessment and monitoring: pain evaluation- quickly assess the characteristics of the chest pain; vital signs monitoring- measure and document vital signs. 2. Medication administration: administer medications as per standing orders, and resident's care plan. <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident R108's clinical record revealed an admitted [DATE], with diagnoses that included heart disease, heart failure, and anxiety. The clinical record revealed a physician's order dated 1/07/25, to give Nitrostat (nitroglycerin- prevents and treats chest pain by relaxing your blood vessels) 0.4 milligram tablet sublingual every five minutes as needed for chest pain every five minutes up to three doses. The clinical record revealed a care plan entitled Altered cardiovascular status with interventions including assess for chest pain, administer medications as ordered and monitor for side effects and effectiveness.</p> <p>Observations on 2/27/25 revealed the following:</p> <p>-At 2:09 p.m. female voice heard yelling help, nurse from behind a closed door. Resident R108 stated, Please help. I am having chest pain. Resident R108's right leg was over the side of bed, his/her oxygen tubing was laying on bed, and the call bell was under the bed. Licensed Practical Nurse (LPN) Employee E4 was observed seated at the nurse's station and was notified of Resident R108's report of chest pain, and responded Three people have already been in there and remained seated at nurse's station.</p> <p>-At 2:10 p.m. the Director of Nursing inquired of Resident R108's as needed medications, and was informed by LPN Employee E3 of the available nitroglycerin.</p> <p>-At 2:15 p.m. LPN Employee E3 sat at nurse's station with an amber plastic pharmacy bag containing nitroglycerin.</p> <p>-At 2:33 p.m. LPN Employee E3 entered Resident R108's room, administered one tablet of nitroglycerin with water to Resident R108 to swallow, and then returned to the nurse's station.</p> <p>-At 2:41 p.m. LPN Employee E3 remained at the nurse's station and was notified by the Assistant Director of Nursing that Resident R108 required another administration of nitroglycerin.</p> <p>-At 2:44 p.m. LPN Employee E3 entered Resident R108's room, administered one tablet of nitroglycerin with water to Resident R108 to swallow, and then returned to the nurse's station.</p> <p>-At 2:59 p.m. Emergency Medical Services arrived on the unit to transport Resident R108 to the hospital and LPN Employee E3 was observed seated at the nurse's station.</p> <p>LPN Employee E3 entered Resident R108's room twice to administer nitroglycerin with water and failed to assess Resident R108's medical condition and/or monitor for changes in condition.</p> <p>During an interview on 2/27/25, at approximately 3:05 p.m. the Director of Nursing confirmed that the Nitrostat should have been given sublingual and that having the resident swallow the medication was inappropriate. The Director of Nursing also confirmed that LPN Employee E3 failed to act within his/her professional standards in response to Resident R108's calling out about chest pain and possible medical condition.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code 211.10(c) Resident care policies</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832</p> <p>Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to label a multi-dose insulin (medication to treat elevated blood sugar levels) vial with the date it was opened and discard an expired multi-dose insulin vial; and failed to prevent the opportunity for unauthorized access to medications in three of five medication carts (Unit D North, Unit E, and Unit C South); and failed to store Schedule II-V medications in a separately locked, permanently affixed compartment in two of five medication rooms (Unit C North and Unit D South).</p> <p>Findings include:</p> <p>A facility policy entitled, Security of Medication Cart dated, [DATE], revealed that medication carts must be securely locked at all times when out of the nurse's view.</p> <p>A facility policy entitled, Storage of Medications dated, [DATE], revealed that unlocked medication carts are not left unattended, and Schedule II-V controlled medications are stored in separately locked permanently affixed compartments.</p> <p>A facility policy entitled, Insulin Administration dated, [DATE], revealed to check expiration date, if drawing from an opened multi-dose vial; if opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening).</p> <p>Observation on [DATE], at 8:52 a.m. of the Unit D North medication cart revealed one multi-dose vial of Lantus (long-acting insulin) labeled with an opened date of [DATE], (36 calendar days prior) and a pharmacy label that indicated to discard after 28 days opened.</p> <p>During an interview at that time, Licensed Practical Nurse (LPN) Employee E6 confirmed that the multi-dose vial was expired and should have been discarded.</p> <p>Observation on [DATE], at 10:13 a.m. of the Unit E medication cart revealed one opened multi-dose vial of insulin glargine (long-acting type of insulin) and lacked an opened date.</p> <p>During an interview at that time, Registered Nurse Employee E3 confirmed that the vial should contain an opened date and that he/she was unable to determine a discard date.</p> <p>Observation on [DATE], at 1:26 p.m. of the Unit C North medication refrigerator rack contained a locked compartment with two boxes of injectable lorazepam (controlled substance used to treat anxiety disorders). The rack of the refrigerator was not permanently affixed.</p> <p>During an interview at that time, the Assistant Director of Nursing confirmed that the refrigerator rack was not permanently affixed.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on [DATE], at 1:37 p.m. of the Unit S South medication refrigerator rack contained a locked compartment with one box of injectable lorazepam. The rack of the refrigerator was not permanently affixed.</p> <p>During an interview at that time, LPN Employee E1 confirmed that the refrigerator rack was not permanently affixed.</p> <p>Observation on [DATE], at 11:04 a.m. revealed the Unit C South medication cart was unsecured and unattended outside of a resident room (approximately 25 feet from nurse's station and was unable to be seen from nurse's station). Several staff and residents walked by the unsecured cart, and LPN Employee E4 approached the medication cart from nurse's station area.</p> <p>During an interview at that time, LPN Employee E4 confirmed that the medication cart should have been locked.</p> <p>During an interview on [DATE], at 11:35 a.m. the Director of Nursing confirmed the medication cart should have been locked when not attended to and/or in view.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa. Code 211.10(c) Resident care policies</p>