STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395042	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nightingale Nursing and Rehab Center	607 East 26th Street Erie, PA 16504

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide the Resident and/or Resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day), and failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital, for eight of eight residents reviewed (Residents R3, R9, R11, R14, R72, R95, R99, and R149).Findings include: Review of a facility policy entitled Transfer or Discharge, Facility-Initiated dated 2/9/26, indicated Notice of facility bed-hold and return policies are provided to the resident and representative within 24 hours of emergency transfer. And Information conveyed to receiving provider: Contact information of the practitioner responsible for the care of the residentResident representative information including contact informationAdvance directive informationAll other information necessary to meet the resident's needs.All special instructions or precautions for ongoing care.Comprehensive care plan goals.All other information necessary to meet the residents' needs, including but may not be limited to:Resident status.Diagnosis and allergiesMedicationsMost relevant labs. Review of Resident R3's clinical record revealed an admission date of 8/15/25, with diagnoses that included cerebral infarction (a blockage of blood vessels in the brain resulting in tissue death due to a lack of oxygen), muscle weakness, and dysphagia (difficulty swallowing). Review of Resident R3's progress notes revealed notes dated 8/16/25, 9/19/25, and 12/25/25, identified transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. The clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 8/16/25, 9/19/25, and 12/25/25. Review of Resident R9's clinical record revealed an admission date of 10/20/25, with diagnoses that included dependence of renal dialysis (a treatment that helps remove extra fluid and waste products from the blood when the kidneys cannot), atrial fibrillation (irregular heartbeat), and chronic pain. Review of Resident R9's progress notes revealed notes dated 11/3/25, 12/3/25, and 2/1/26, identified transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. The clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 11/3/25, 12/3/25, and 2/1/26. Review of Resident R11's clinical record revealed an admission date of 12/12/24, with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and hypertension (high blood pressure). Review of Resident R11's progress notes revealed notes dated 4/19/25, 6/6/25, 6/17/25, 6/29/25, 7/14/25, 7/17/25, 7/23/25, 8/9/25, 8/27/25, 12/8/25, and 12/20/25, identified transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. The clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 4/19/25, 6/6/25, 6/17/25, 6/29/25, (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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/14/25, 7/17/25, 7/23/25, 8/9/25, 8/27/25, 12/8/25, and 12/20/25. Review of Resident R14's clinical record revealed an admission date of 08/23/21, with diagnoses that included spinal stenosis (the narrowing of the spinal canal, which compresses nerve roots or the spinal cord, leading to pain, numbness, or weakness in the neck, back, arms, or legs), osteoarthritis (a common degenerative, non-inflammatory joint disease, caused by the gradual breakdown of cartilage, leading to bone-on-bone friction, pain, stiffness, and reduced mobility.), and hypertension. Review of Resident R14's progress notes revealed notes dated 9/11/25, that identified a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. The clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfer on 9/11/25. Review of Resident R72's clinical record revealed an admission date of 12/11/25, with diagnoses that included chronic diastolic heart failure (The stiffening of the heart muscle causing it to not be able to properly relax to fill with blood, despite normal pumping strength), type 2 diabetes (a chronic metabolic disorder where the body develops insulin resistance, causing high blood sugar levels because cells fail to respond properly to insulin.), and morbid obesity (chronic life threatening disease defined as having a body mass index of 40 or higher or over 35 with severe obesity related health conditions such as diabetes). Review of Resident R72's progress notes revealed notes dated 11/10/25, and 12/26/25, identifying transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. The clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 11/10/25, and 12/26/25. Review of Resident R95's clinical record revealed an admission date of 10/31/25, with diagnoses that included chronic respiratory failure (a condition where your lungs don't exchange air properly), diabetes, and hypertension. Review of Resident R95's progress notes revealed notes dated 11/16/25, 12/9/25, and 12/28/25, identifying transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. The clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 11/16/25, 12/9/25, and 12/28/25. Review of Resident R99's clinical record revealed an admission date of 11/3/25, with diagnoses that included diabetes, dependence of renal dialysis, and hyperlipidemia (high cholesterol). Review of Resident R99's progress notes revealed notes dated 11/12/25, identifying a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. The clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 11/12/25. Review of Resident R149's clinical record revealed an admission date of 10/31/25, with diagnoses that included diabetes, sleep apnea (a condition when a person repeatedly stops and starts breathing when they are sleeping), and hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones). Review of Resident R149's progress notes revealed notes dated 12/10/25, identifying a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. The clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 12/10/25. During an interview on 2/19/26, at 2:13 p.m. the Director of Nursing confirmed that Resident's R3, R9, R11, R14, R72, R95, R99 and R149's clinical records lacked evidence that the necessary clinical information was provided to the receiving healthcare provider upon transfer and the clinical records lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfer as required. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3)(2) Resident rights

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide evidence that non-pharmacological interventions (interventions attempted to calm a resident other than medication) were attempted prior to the administration of an as needed (PRN) psychotropic (mind altering) medication for one of five residents reviewed (Resident R11).Findings include: Review of a facility policy entitled Psychotropic Medication Use dated 2/9/26, indicated Non-pharmacological approaches are used to minimize the need for medications. Review of Resident R11's clinical record revealed an admission date of 12/12/24, with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and hypertension (high blood pressure). Review of Resident R11's physician's orders revealed an order for Lorazepam (anti-anxiety) 0.5 milligrams (mg) by mouth every 12 hours PRN for anxiety. Review of Resident R11's February 2026 medication administration record (MAR) revealed that the PRN Lorazepam was used on 2/1/26, 2/3/26, 2/4/26, 2/5/26, 2/6/26, 2/10/26, 2/11/26, 2/12/26, 2/13/26, 2/14/26, and 2/18/26. The clinical record lacked evidence that non-pharmacological interventions were being attempted prior to administering the PRN Lorazepam for the 11 administrations. During an interview on 2/20/26, at 9:35 a.m. the Director of Nursing (DON) confirmed that Resident R11's clinical record lacked evidence that non-pharmacological interventions were being attempted prior to administering the PRN Lorazepam. The DON also confirmed that non-pharmacological interventions should be attempted prior to administering psychotropic medication. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to ensure medications were administered according to physician's orders for residents receiving dialysis (method of mechanically cleaning the blood) for one resident reviewed for dialysis (Resident R9).Findings include: Review of the facility policy Administering Medications, dated 2/9/26, revealed Medications are administered in accordance with prescriber orders, including any required time frame. Review of Resident R9's clinical record revealed an admission date of 10/20/25, with diagnoses that included dependence of renal dialysis (a treatment that helps remove extra fluid and waste products from the blood when the kidneys cannot), atrial fibrillation (irregular heartbeat), and chronic pain. Review of physician's orders revealed the following orders: change medications and treatment timing from facility's medication and treatment administration time to accommodate hemodialysis treatment; Carafate (medication used to treat stomach ulcers) one gram (GM) give one tablet by mouth before meals and at bedtime; Gabapentin (medication used to treat nerve pain) capsule 100 milligrams (mg) give one capsule by mouth three times a day; Hydralazine (medication used to treat high blood pressure) 10 mg give one tablet by mouth three times a day; Insulin Lispro routine (medication used to lower blood sugar) dose before meals; Insulin Lispro sliding scale (medication used to lower blood sugar, sliding scale determines amount administered based on blood glucose level) before meals; and Losartan (medication used to treat high blood pressure) 50 mg give one tablet by mouth in the afternoon. Review of Resident R9's progress notes and Medication Administration Records for November 2025, December 2025, January 2026, and February 2026 revealed Resident R9 did not receive the following medications as ordered on the following days:11/21/25 Carafate, Insulin Lispro, and Insulin Lispro sliding scale11/26/25 Insulin Lispro sliding scale12/15/25 Carafate, Hydralazine, Gabapentin, Insulin Lispro, and Insulin Lispro sliding scale12/31/25 Insulin Lispro, Insulin Lispro sliding sale, and Hydralazine 1/19/26 Losartan, Gabapentin, Hydralazine, and Carafate1/21/25 Gabapentin and Hydralazine1/26/26 Insulin Lispro sliding scale and Insulin Lispro2/13/26 Carafate, Hydralazine, and GabapentinThere was no documentation that the physician was notified of a need to hold or alter the time of administration for the above listed medications for Resident R9 on dialysis days.During an interview on 2/19/26, at 2:54 p.m. the Director of Nursing confirmed that the above medications for Resident R9 were not administered on dialysis days as ordered by the physician. 28 Pa. Code 211.12(d)(1)(3)(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. Based on review of facility policy, manufacturer's guidelines, observations, and staff interviews, it was determined that the facility failed to ensure that medications were properly dated when opened, failed to ensure expired medications were discarded in a timely manner, and failed to ensure medications were properly labeled with a resident name in one of three medication rooms reviewed and in one of three medication carts reviewed (D-North medication room and D-North medication cart). Findings include: Review of a facility policy entitled Medication Labeling and Storage dated 2/9/26, revealed that, .The medication label includes, at a minimum: resident's name.multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Manufacturer's guidelines for Tubersol PPD (solution used for tuberculosis testing upon admission and for employment), indicate that vials which are entered and in use for 30 days should be discarded. Observation on 2/17/26, at 2:50 p.m. of the D-North medication room refrigerator revealed an opened vial of Tubersol PPD without an open date, therefore the staff were unable to determine the discard date. During an interview at that time, the Director of Nursing confirmed that the opened Tubersol PPD vial lacked an open date, and staff were unable to determine the discard date. Observation on 2/17/26, at 3:02 p.m. of the D-North medication cart revealed an open Fluticasone Propionate inhaler (medication used for asthma or other conditions that cause difficulty with breathing) with instructions to discard 30 days after opening and with an open date of 1/9/26, therefore the medication was expired. There was also an open Trelegy inhaler (used for asthma or other conditions that cause difficulty with breathing) without a resident name. During an interview at that time, Licensed Practical Nurse Employee E1 confirmed that the Fluticasone Propionate inhaler with the open date of 1/9/26, was expired and should have been discarded and the Trelegy inhaler should have had a resident's name. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services