STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39A434	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pennsylvania Soldiers and Sailors Home	560 East Third St Erie, PA 16512

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 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 make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital for three of three residents reviewed (Residents R1, R5, and R9).Findings include: Review of facility policy entitled Transfers and Discharge dated 2/2/26, revealed For a transfer/discharge to another provider, for any reason, the following information must be provided to the receiving provider:Contact information of the practitioner who was responsible for the care of the resident,Resident representative information.Advance directive information.All other information necessary to meet the residents needs, which includes, but may not be limited to:Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs.Diagnoses and allergies.Medications (including last received); andMost recent relevant labs, other diagnostic tests, and recent immunizations.All special instructions and/or precautions for ongoing care, as appropriate such as:Treatments and devices (oxygen, implants, IVs, tubes/catheters). Transmission based precautions such as contact, droplet. or airborne.Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions.The resident's comprehensive care plan goals. Additional information, if there is any, outlines in the transfer agreement with the acute care provider. Review of Resident R1's clinical record revealed an admission date of 2/6/25, with diagnoses that included hypertension (high blood pressure), chronic pain, and heart disease. Review of Resident R1's progress notes revealed notes dated 11/16/25, 12/2/25, 12/14/25, 1/11/26, 1/27/26, 2/15/26, and 3/8/26, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Review of Resident R5's clinical record revealed an admission date of 9/20/23, with diagnoses that included hypertension, hyperlipidemia (high cholesterol), and chronic pain. Review of Resident R5's progress notes revealed notes dated 6/10/25, 11/5/25, and 12/20/25, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Review of Resident R9's clinical record revealed an admission date 11/25/25, with diagnoses that included hypertension, hyperlipidemia, and hypothyroidism (a condition where the thyroid gland does not produce enough hormones causing a slowed metabolism). Review of Resident R9's progress notes revealed notes dated 12/23/25, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. During an interview on 3/12/26, at 12:32 p.m. the Nursing Home Administrator confirmed that Resident R1, R5, and R9's clinical records lacked evidence that the necessary clinical information was provided to the receiving healthcare provider upon transfer and that when the transfers occurred clinical information should have been provided to the receiving healthcare provider. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3)(2) Resident rights

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 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 R100).Review of facility policy entitled Psychotropic Medication Use & GDR Process dated 2/2/26, indicated Residents who use psychotropic medications shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drugs. And non-pharmacological interventions will be utilized and documented in the EMAR [electronic medication administration record]. Review of Resident R100's clinical record revealed an admission date of 4/18/25, 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 diabetes (a health condition that is caused by the body's inability to produce enough insulin). Review of Resident R100's physician's orders revealed an order for Lorazepam (anti-anxiety) 0.5 milligrams (mg) by mouth every four hours PRN for anxiety. Review of Resident R100's March 2026 medication administration record revealed that the PRN Lorazepam was used on 3/7/26, 3/8/26, and twice on 3/9/26, and lacked evidence that non-pharmacological interventions were being attempted prior to administering the PRN Lorazepam for four administrations. During an interview on 3/12/26, at 12:32 p.m. the Nursing Home Administrator (NHA)confirmed that Resident R100's clinical record lacked evidence that non-pharmacological interventions were being attempted prior to administering the PRN Lorazepam. The NHA 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 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. Based on review of facility policy and clinical records, observations, and staff interviews, it was determined that the facility failed to ensure adequate safety measures were implemented per physician's orders by not attaching leg rests (supportive device attached to a wheelchair for the feet to rest upon) to the wheelchair during transport for four residents reviewed (Residents R45, R73, R75, and R101).Findings include: Review of facility policy entitled Medical Provider Orders dated 2/2/26, revealed .the written physician orders are to provide the essential care needs to the resident, consistent with their mental and physical status.physician orders are administered and carried out in accordance with the written or verbal orders of the attending medical provider. Review of Resident R45's clinical record revealed an admission date of 10/3/25, with diagnoses that included muscle spasm, hypothyroidism (a condition where the thyroid gland does not produce enough hormones causing a slow metabolism), and pain.Review of Resident R45's clinical record revealed a physician's order for B (Bilateral) leg rest for transport only dated 10/3/25. Review of Resident R73's clinical record revealed an admission date of 12/21/23, with diagnoses that included restless leg syndrome, muscular degeneration, and lumbar disc degeneration.Review of Resident R73's clinical record revealed a physician's order for BL (Bilateral) leg rest to PRN (as needed) wheelchair for transport only dated 12/10/24. Review of Resident R75's clinical record revealed an admission date of 10/18/23, with diagnoses that included arthritis, age related physical debility, and heart failure.Review of Resident R75's clinical record revealed a physician's order for Leg rest for transport dated 10/18/23. Review of Resident R101's clinical record revealed an admission date of 7/17/23, with diagnoses that included atrial fibrillation (irregular heartbeat), muscle weakness, and heart failure.Review of Resident R101's clinical record revealed a physician's order for Leg rest for transport dated 8/16/23. Observations on 3/11/26, at 10:15 a.m. in the hallway revealed Resident R45 was being pushed by a staff member down the hallway in his/her wheelchair without leg rests and his/her feet were dragging on the ground; at 11:16 a.m. Resident R45 was being pushed by a staff member to the dining room in his/her wheelchair without leg rests and his/her feet were dragging on the ground; at 11:18 a.m. Resident R101 was being pushed by a staff member to the dining room in his/her wheelchair without leg rests and his/her feet were dragging on the ground; at 11:21 a.m. Resident R73 was being pushed by a staff member to the dining room in his/her wheelchair without leg rests and his/her feet were dragging on the ground; and at 11:24 a.m. Resident R75 was being pushed by a staff member to the dining room in his/her wheelchair without leg rests and his/her feet were dragging on the ground. During an interview on 3/11/26, at 11:40 a.m. the Director of Nursing confirmed that the wheelchair leg rests should have been in place per physician's orders to ensure safe transport for Residents R45, R73, R75, and R101. During an interview on 3/11/26, at 12:45 p.m. the Director of Rehab confirmed that it is unsafe for a resident to be transported in a wheelchair without leg rests with their feet dragging on the ground. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of facility policy and clinical record and staff interview, it was determined that the facility failed to ensure recommendations made from the consultant pharmacist were acted upon for one of five residents reviewed (Resident R66).Review of facility policy entitled Medication Regimen Review [MRR] dated 2/2/26, indicated The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities., The pharmacist shall communicate any irregularities to the facility., The facility shall provide the licensed pharmacist. answers to the previous month's pharmacy recommendations. and Facility staff shall act upon all recommendations. Review of Resident R66's clinical record revealed an admission date of 9/29/25, with diagnoses that included diabetes (a health condition that is caused by the body's inability to produce enough insulin), Parkinson's (a chronic and progressive movement disorder that causes shaking, slows a person's ability to move and worsens over time), and anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Review of pharmacist MRR dated 11/18/25, revealed recommendations for the following medications Meloxicam (anti-inflammatory) from PRN (as needed) to routine daily, extend and increase Lorazepam (antianxiety), add Melatonin (sleep aid), and evaluate the continued need for Carbidopa/Levodopa (Parkinson medication). The pharmacist MRR recommendations lacked evidence that they were reviewed and addressed by the physician. During an interview on 3/12/26, at 11:30 a.m. with the pharmacist, he/she confirmed that Resident R66's pharmacist MRR recommendations dated 11/18/25, lacked evidence that they were reviewed or addressed by the physician. During an interview on 3/13/26, at 10:00 a.m. the Nursing Home Administrator (NHA) confirmed the pharmacist MRR recommendations dated 11/18/25, were not addressed by the physician. The NHA also confirmed that all pharmacist MRR recommendations should be reviewed and addressed by the physician. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 211.9(k) Pharmacy services