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	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nightingale Nursing and Rehab Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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
	395042	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nightingale Nursing and Rehab Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to follow professional standards of care with a lack of an immediate physician notification for one of seven closed records reviewed (Resident CR1) and failed to follow physician's orders for two of seven residents reviewed (Residents R2 and R3). Findings include: Review of a facility policy entitled, Change in a Resident's Condition or Status, dated 1/07/25, revealed Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Resident CR1' s clinical record revealed an admission date of 9/17/25, with diagnoses that included pneumonia (an infection of the lungs), Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease that causes ongoing inflammation and narrowing of the airways, making it difficult to breathe), acute respiratory failure with hypoxia (a condition when the lungs can't release enough oxygen into your blood), and severe protein-calorie malnutrition (a condition a person does not consume enough protein and calories to meet their body's needs). Resident CR1's progress notes dated 9/28/25, 10:35 p.m. indicated the resident continued to remove oxygen. Oxygen (O2) saturation 55% on room air. Reapplied oxygen and recheck O2 saturation O2 saturation at 77%. Resident is confused and talking to people that are not visible. Resident refusing all meds and refused dinner. Resident did drink his milkshake. Registered Nurse (RN) supervisor made aware of oxygen saturation. Will continue to monitor. Further review of Resident CR1 ' s clinical record lacked evidence of physician notification related to low oxygen saturations and confusion. During an interview on 10/23/25, at 4:10 p.m. the Nursing Home Administrator (NHA) confirmed that Resident CR1's clinical record lacked evidence of physician notification for Resident CR1's change in condition of his/her oxygen saturation at 77 % with oxygen reapplied and confusion. Review of a facility policy entitled, Administering Medications, dated 1/07/25, revealed Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Resident R2's clinical record revealed an admission date of 10/17/25, with diagnoses that included end stage renal disease (kidneys have deteriorated and can no longer perform), dialysis dependent (when a person depends on a dialysis machine to filter waste and excess fluid from the blood due to kidneys not functioning), history of a fall, and diabetes mellitus type two (a chronic condition where blood sugar levels are not regulated due to ineffective use of insulin or not enough insulin produced). Resident R2's Medication Administration Record (MAR) revealed a physician's order dated 10/20/25, for Cefepime Hydrochloride (HCl) Intravenous (IV) Solution Reconstituted 2 gram (GM) (Cefepime HCl) Use 2 GM IV one time a day every Monday, Wednesday for infection until 11/22/25, post dialysis - Start Date 10/20/25, at 9:00 a.m. Resident R2's clinical record, including MAR, lacked evidence that he/she received the Cefepime IV antibiotic for infection on Monday, 10/20/25. Resident R3's clinical record revealed an admission date of 10/17/25, with diagnoses of subarachnoid hemorrhage (bleeding between the brain and membranes covering the brain), seizures, pressure ulcer of sacral region stage 4 (skin breakdown extending into muscle, tendon, ligament, cartilage or bone- involvement of the triangular bone in the lower back), and osteomyelitis (infection of bone). Resident R3's MAR revealed a physician's order dated 10/18/2025, for Daptomycin IV Solution Reconstituted Use 725 milligrams (mg) IV in the afternoon for Daptomycin in Normal Saline (NS) 50 milliliter (ml) IV piggyback (IVPB) until 10/31/25, 23:59 Infuse 725 mg at 129 ml/hour over 30 minutes - Start Date-10/18/25, 2:00 p.m Resident R3's clinical record, including MAR, lacked evidence that he/she received the Daptomycin per physician's order on 10/18/25, 10/19/25, and 10/20/25 at 2:00 p.m. During an interview on 10/23/25, at 4:05 p.m. the Director of Nursing (DON) confirmed that physician's orders were not followed for Resident R2 and R3 related to Cefepime and Daptomycin IV antibiotic medication administration respectively. The DON further confirmed that Resident R2 and R3's clinical record lacked evidence that Residents R2 and R3 received the IV antibiotics as prescribed by their physician. 28 Pa. Code 211.12(d)(1)(5)Nursing services

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	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nightingale Nursing and Rehab Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and clinical and facility records, and staff interview, it was determined that the facility failed to maintain accurate and complete documentation related to a resident's change of status for one of two closed records reviewed (Resident CR1). Findings include: Review of facility policy entitled Charting and Documentation dated 1/07/25, revealed All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Resident CR1' s clinical record revealed an admission date of 9/17/25, with diagnoses that included pneumonia (an infection of the lungs), Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease that causes ongoing inflammation and narrowing of the airways, making it difficult to breathe), acute respiratory failure with hypoxia (a condition when the lungs can't release enough oxygen into your blood), and severe protein-calorie malnutrition (a condition where a person does not consume enough protein and calories to meet their body's needs). Resident CR1's progress notes dated 9/28/25, 10:35 p.m. revealed resident continues to remove oxygen. Oxygen (O2) saturation 55% on room air. Reapplied oxygen and recheck O2 saturation O2 saturation at 77%. Resident is confused and talking to people that are not visible. Resident refusing all meds and refused dinner. Resident did drink his milkshake. Registered Nurse (RN) supervisor made aware of oxygen saturation. Will continue to monitor. Further review of Resident CR1 ' s clinical record lacked evidence of further documentation of resident progress, nursing follow-up care and treatment, and physician notification related to low oxygen saturations and confusion. Review of facility provided nursing documentation, a nurse's written statement provided by the Nursing Home Administrator (NHA), for Resident CR1's care and treatment on 9/28/25, indicated per report resident non-compliant with oxygen therapy, oxygen low all day. After report, resident vital signs obtained by this writer. RN aware. Throughout shift resident assessed multiple times oxygen reapplied and education provided. Overnight shift resident restless and removing oxygen, as needed medications offered at time refused. This writer 1:1 resident in room [ROOM NUMBER]:00 a.m.-3:30 a.m. incontinence care provided by nursing assistant at 0330 this writer returned to desk 4:15 a.m. resident reassessed oxygen reapplied resident restless. During an interview on 10/23/25, at 4:10 p.m. the NHA confirmed that the facility provided nursing documentation for Resident CR1's care and treatment provided 9/28/25, was not part of Resident CR1's permanent clinical record. The NHA further confirmed that Resident CR1's clinical record lacked evidence of the nursing response to Resident CR1's change in condition including resident's progress, changes, and communication between the interdisciplinary team regarding the resident's condition and response to care. 28 Pa. Code 211.5(f)(ii)(iii) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services