STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105448	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Titusville Rehabilitation & Nursing Center	1705 Jess Parrish CT Titusville, FL 32796

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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the provision of care for blood pressure monitoring for 1 resident, (#2), reviewed for Quality of Care, and failed to ensure staff implemented physician orders to ensure residents received treatment and care in accordance with professional standards of practice, (#5), of a total sample of 7 residents.Findings: 1. Review of the medical record revealed resident #2, an [AGE] year-old male was admitted to the facility from on acute care hospital on 9/16/25 with diagnoses that included Alzheimer's Disease, altered mental status, history of transient ischemic attack (stroke), and essential primary hypertension (high blood pressure). The most recent Comprehensive admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 9/22/2025 noted resident #2 scored 8/15 on the Brief Interview for Mental Status (BIMS) that indicated moderate cognitive impairment. The assessment indicated a diagnosis of hypertension, and that the resident received high-risk anti-platelet (blood clot prevention) medication during the look-back period. The current Care Plan Report revealed there was no Cardiovascular/Hypertension care plan included in the Comprehensive Care Plan, for two months. A Focus titled Cardiovascular related to hypertension and high cholesterol was added on 11/12/25, the same day the survey began. The Order Summary Report showed resident #2's active physician ordered medications included, Metoprolol Tartrate 50 Milligrams (MG) once daily for essential primary hypertension started on 9/17/25, Lisinopril 5 MG every day at bedtime from 9/17/25 to 9/22/25 and increased to 10 Milligrams (MG) on 9/23/25 for essential primary hypertension, and Hydralazine HCl 10 MG every 8 hours as needed with systolic (first/upper number) blood pressure greater than 160 millimeters of mercury (mmHg) for essential primary hypertension. On 11/12/25 at 11:54 AM, Licensed Practical Nurse (LPN) A explained nurses were expected to check and enter blood pressures into the Electronic Health Record (EHR) prior to blood pressure medication administration. The nurse said the typical practice was to obtain a blood pressure during medication pass and stated, it's nursing 101; it doesn't have to be on the Medication Administration Record (MAR), it's proper standard of care; all nurses should know that; if you went to nursing school you know that. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/25 at 1:35 PM, Registered Nurse (RN) B said all nurses were expected to check blood pressures for all residents who take blood pressure medications prior to their administration. She explained readings were checked and documented in the medical record regardless of any noted parameters. According to the American Heart Association, High blood pressure, also known as hypertension, can lead to serious health problems including heart attack or stroke. Measuring your blood pressure is the only way to know if you have it. Controlling high blood pressure can help prevent major health problems. It measures the pressure your blood is pushing against your artery walls when the heart beats, (retrieved from www.heart.org on 11/14/25). Review of the Weights/Vitals record from 9/16/25 to 11/12/25 revealed nurses failed to check resident #2's blood pressure at least once daily, a total of 25 times over the almost two-month period. The MARs for September, October, and November 2025 showed resident #2's scheduled blood pressure medications were administered every day, and no additional as needed medication was administered. On 11/12/25 at 1:40 PM, the Unit 3 Manager explained she expected all nurses to obtain blood pressures for all residents who received anti-hypertensive medications prior to administration of the medication. She said it was important to make sure the blood pressure was not too low prior to giving those medications because that could be dangerous and if it was too high, additional medication may be needed, or the doctor may need to be notified. The RN said nurses wouldn't know if resident #2 needed additional medication without checking the blood pressure. She said she tried to spot check nurses for accuracy and missing orders however she was unaware resident #2 had missing blood pressure checks. In a telephone interview on 11/13/25 at 11:39 AM, Advanced Practice Registered Nurse (APRN) C said she expected all nurses to check resident's blood pressure prior to administration of all blood pressure medications. She explained it was important to check and make sure the pressure wasn't too low or high before giving that type of medication because it could potentially cause avoidable complications when not monitored. The APRN relayed resident #2 had a history of stroke and unchecked high blood pressure could potentially contribute to stroke and she relied upon nurses to keep the medical record up to date so she could accurately assess if medications were effective or needed to be revised. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/13/25 at 9:09 AM, the Director of Nursing (DON) explained it was her expectation that nurses checked blood pressure prior to any administration of blood pressure medications. She relayed the measurement required an EHR entry where a historical record was maintained and accessed by providers who assessed residents and monitored their medication regimens for effectiveness. The DON checked resident #2's medical record and acknowledged he was prescribed three different blood pressure medications, including one for as needed use for systolic blood pressure readings over 160 mmHg. She checked the MARs from September, October, and November 2025, and acknowledged there were no administrations of the as needed medication. She said nurses had to know the blood pressure reading to determine whether additional medication was needed for a high reading. She checked the Weights/Vitals records and acknowledged resident #2 had multiple missing blood pressure checks since he was admitted to the facility in September 2025, two months prior. She conveyed that if resident #2 required three medications to control his blood pressure that meant it was unstable and required close monitoring to avoid potentially serious complications and/or re-hospitalization. The DON said she was unaware the entries were missing and said it was possible nurses had not entered them into the computer. She checked the Comprehensive Care Plan and said the Cardiovascular/Hypertension care plan should have been added in September 2025 and was not sure why it was delayed and entered the previous day, which was after the survey began. Review of the facility's standards and guidelines dated September 2018, and titled Medication Administration General Guidelines noted that nurses were expected to obtain and record any vital signs necessary prior to administering medications. 2. Resident #5 was admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy, pneumonia, type two diabetes mellitus, acute kidney failure and adult failure to thrive. Review of the Quarterly MDS assessment dated [DATE] revealed resident #5 was cognitively intact with a BIMS score of 14/15. The assessment detailed the resident was frequently incontinent and required one person for transfers. On 11/12/25 at 11:15 AM, resident #5's son was standing in the hallway and explained he was waiting on the nurse to follow up on the urine collection. He said over the weekend, his mom complained of urinary tract infection (UTI) symptoms and staff were supposed to collect a urine sample for testing. He said he was following up on this because his mom told him they had not yet collected the sample, and now it was Wednesday. On 11/12/25 at 2:17 PM, resident #5 was in bed. She said she did not feel very well and wanted to see the physician. Resident #5 complained of burning pain upon urination for a few days. She explained she had told the nurses previously about the pain and was given Tylenol. Resident #5 continued to explain she was told they would collect a urine sample, but they had not. The resident said her son had to speak with the nurse today to find out what was going on. Review of the medical record revealed no change in condition nor progress notes addressing resident #5's concerns or symptoms over the last week. A physician's order dated 11/12/25 at 1:13 PM, for a Urinalysis (UA) with Culture and Sensitivity (C&S) was noted in the resident's electronic medical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Urine Re, or urinalysis analyzes a urine sample for its appearance, concentration, and content. Used for detecting a wide range of health issues, including: Urinary tract infections, kidney disease Diabetes. Urine CS, or urine culture sensitivity test identifies the microbes causing urinary infections and to which antibiotic the infectious agent (microbe) is susceptible. A sample of urine is added to a medium that promotes microbial growth (bacterial or fungal growth): Negative culture: No microbial growth Positive culture: Microbial growth, (retrieved on 11/14/25 from www.medicinenet.com). On 11/13/25 at 10:12 AM, the assigned RN B said she became aware yesterday that the resident was complaining of pain on urination but was not aware the resident had complained to other nurses before. RN B said the APRN placed orders for UA C&S. RN B said she did not have a chance to collect the sample yesterday, so she passed it on to the oncoming 3:00 PM to 11:00 PM nurse who said she would collect it sometime today. RN B confirmed that usually they had 48 hours to collect the sample. The Unit 3 Manager (UM) standing nearby was informed by the nurse that resident #5's urine sample had not been collected. The UM said she told the Certified Nursing Assistant (CNA), Whenever resident #5 got up to the bathroom, they needed a urine sample, and explained it would be collected today. On 11/13/25 at 10:23 AM, assigned CNA G, said she had not been informed by the Unit Manager that resident #5 needed a urine sample. She explained the nurses informed them verbally when urine samples were needed because the task did not come up on the electronic tasks. CNA G informed the Unit 3 Manager she had not been aware the resident needed a urine sample, the UM acknowledged she had told a different CNA. On 11/13/25 at 11:14 AM, the DON stated she was not aware of a 48-hour collection policy for urine samples. A few minutes later the DON returned and said, there was no facility policy on specimen collection that nurses had 48 for the collection. She explained it was the standard of practice for nurses to collect urine specimen as soon as possible. The DON acknowledged the order for resident #5's UA C&S placed at 1:13 PM, yesterday was not collected, and that there were not any progress notes as to why the sample had not been collected over three shifts. The DON was unable to answer why the urine sample was not collected by staff and did not know why some staff thought they had 48 hours to collect the urine. On 11/13/24 at 1:01 PM, in a telephone interview RN F acknowledged he knew collection of a urine sample was needed for resident #5 because it came up on his tasks in the electronic medical record. He explained he did not want to wake the resident up in the middle of the night, since she would be able to void in the morning. He said that he passed the message to RN B and the Unit 3 Manager but did not write a progress note about it. On 11/13/25 at 1:42 PM, the DON said nurses should follow the standard of practice to collect urine specimen as soon as possible. The facility did not have a policy that specifically addressed specimen collection for diagnostic testing.

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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 observation, interview, and record review, the facility failed to maintain accurate documentation for medication administration for 1 out of 7 sampled residents, (#7). Findings:Resident #7 was readmitted to the facility on [DATE] with diagnoses which included quadriplegia, neuromuscular dysfunction of the bladder and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE], resident # 7 was cognitively intact with a Brief Interview for Mental Status score of 15 out of 15. A review of the physician's orders revealed that resident # 7 had orders for Midodrine HCl Oral Tablet 10 milligrams (mg), give one tablet by mouth three times a day for low blood pressure. The order directed nurses to hold the medication if the systolic blood pressure (the first number) was greater than 120. On 11/13/25 at 12:10 PM, the Medication Administration Record (MAR) indicated the assigned nurse Registered Nurse (RN) B, administered Midodrine 10 mg at 9:00 AM. The MAR had a check mark with the nurse's initial's to indicated she had administered the medication. The corresponding blood pressure was 125/70 and per the physician's order, the medication should have been held. Further review of the MAR revealed that for November 2025, resident #7 was administered the Midodrine 10 mg outside the physician's ordered parameters a total of 14 times. 12 out of the 14 times by RN B. The MAR revealed in October 2025, resident # 7 received Midodrine 10 mg a total of 28 times documented by six different nurses. RN B documented the medication as given for a total of 17 out of 28 times. On 11/13/25 at 12:17 PM, the Director of Nursing (DON) acknowledged the documentation on the MAR for October and November of 2025 which indicated nurses administered midodrine without following the physician's ordered parameters. The DON could not give a reason why the order was not followed. On 11/13/25 at 12:33 PM, assigned RN B acknowledged the MAR indicated she administered Midodrine 10 mg. The nurse explained she must have checked it off in error because she did not actually give the medication. RN B said she would hold the medication if the resident's blood pressure was greater than 120 and explained she would never give the medication if the systolic blood pressure was greater than 120. She could not say why she did not mark the medication as not given or held on the MAR as she was familiar with the codes for documenting refusals, held, or not available. RN B again acknowledged the MAR contained documentation that she gave the medication when it should have been held and said she could not prove it was not given. She explained she would change today's documentation of the medication and write a progress note to explain the discrepancy. On 11/13/25 at 1:42 PM, the DON could not explain why the nurses documented Midodrine 10 mg was given to resident # 7 when it should have been held. She explained that RN B was immediately educated and confirmed she was just clicking in error. The DON continued to explain that the expectation was to document accurately in the medical record and if it was in error, the nurse should immediately correct the error and/write a follow up note. The facility's policy on Late entry, Addendum, Corrections and Clarification of the Medical Record effective March 2024 revealed, The facility will utilize the following guidelines when documentation problems or mistakes occur and changes or clarifications are necessary. The procedure for correction in section eight indicated, For electronic record correction, follow the electronic record process to strike out the error. After striking out the documentation, click follow up to enter corrected note.