

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Titusville Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff was available on 1 of 3 units to meet residents' needs related to the timely administration of scheduled medications, (Unit 2). Findings: Cross Reference F755 1. During a medication pass observation with Licensed Practical Nurse (LPN) A on 6/03/26 at 10:05 AM, eight residents listed on the electronic Medication Administration Record (MAR) appeared in red, indicating their scheduled morning medications had not yet been administered. When asked why the residents' names appeared in red, LPN A stated the morning medications were past due. She explained nurses were expected to administer 9:00 AM medications between 8:00 AM and 10:00 AM. LPN A prepared and administered medications for resident #4 at 10:33 AM. Upon completion of the medication administration at approximately 10:40 AM, LPN A stated medication administration required significant time to complete because residents could not be rushed, often required assistance, asked questions, and often requested additional time during medication pass. Review of the staffing assignment sheet and documentation on Unit 2's assignment board with the assignment dated 6/03/26 revealed a census of 36 residents. The assignment sheet showed two licensed nurses were assigned to the unit. LPN A was assigned rooms 202-236. Review of the resident census list revealed LPN A was responsible for approximately 25 to 26 residents during the morning medication pass. 2. On 6/03/26 at 10:53 AM, resident #3 stated he had been in the facility for approximately seven months. He shared he had his physician change his pain medication from as needed to a scheduled administration time because he needed the medication administered timely; however, the change had not improved the timeliness of administration. He indicated that, as of that time, he had not yet received his morning medications. He mentioned one of the medications he received in the morning was Oxycontin 15 milligrams (mg) for chronic pain related to a spinal cord injury and a wound on his coccyx. He stated his pain level was currently 9 out of 10 and explained after receiving his medication his pain level typically decreased to 7 out of 10. He further stated if received his pain medication as scheduled, his pain would be manageable. Review of the medical record revealed resident #3 was readmitted to the facility on [DATE] with diagnoses including paraplegia, type 2 diabetes, unstageable pressure ulcers on the left and right buttocks, insomnia, and major depressive disorder. Review of resident #3's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/24/26 revealed a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition. Review of resident #3's MAR for May and June 2026 revealed the following medications were scheduled for administration: *8:00 AM: Oxycodone 10 mg *9:00 AM: Amlodipine 10 mg, Aspirin 81 mg, Ascorbic acid 500 mg, Furosemide 20 mg, Gabapentin 300 mg, Oxycontin 15 mg, Senna-S 8.6-50 mg, Tizanidine 2 mg, Baclofen 20 mg *12:00 PM: Oxycodone 10 mg *1:00 PM: Baclofen 20 mg Review of the Medication Admin (Administration) Audit Report for resident #3 revealed the 8:00 AM medication was administered at 10:16 AM and 9:00 AM medications were administered between 10:16 AM and 10:17 AM on 5/29/26. The 12:00 PM medication was administered at 2:22 PM on 5/29/26. On 5/30/26, the 8:00 AM medication was administered at 11:59 AM and the 9:00 AM medications were administered (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	between 11:50 AM and 12:23 PM. The 12:00 PM and 1:00 PM medications were administered at 2:32 PM. On 5/31/26, the 8:00 AM medication was administered at 10:59 AM and the 9:00 AM medications were administered between 10:55 AM and 11:01 AM. On 6/02/26, the 8:00 AM Oxycodone was administered at 9:23 AM, and the 12:00 PM and 1:00 PM medications were administered at 2:50 PM. Review of the medical record revealed no documentation that the physician was notified regarding the delayed administration of medications on the dates and times identified above. 3. On 6/03/26 at 11:13 AM, resident #1 stated the nurses did not tell her which medications she received. She indicated the majority of the time her morning medications were administered late. She said, Sometimes there is just one nurse and two Certified Nursing Assistants (CNAs) for the entire unit with almost 40 residents. Review of the medical record revealed resident #1 was readmitted to the facility on [DATE] with diagnoses including multiple sclerosis, obstructive and reflux uropathy (abnormal flow through the urinary system), sepsis, and major depressive disorder. Review of resident #1's quarterly MDS assessment with ARD of 3/25/26 revealed a BIMS score of 15/15, indicating intact cognition. Review of resident #1's MAR for May and June 2026 revealed the following medications were scheduled for administration:*9:00 AM: Oxycontin 20 mg, Atropine eye drops, Acidophilus, Losartan 25 mg*12:00 PM: Ropinirole 2 mg and Oxycodone 15 mg Review of the Medication Admin Audit Report for resident #1 revealed the 9:00 AM medications were administered at 10:14 AM on 5/29/26, at 11:28 AM on 5/30/26 (except Oxycontin which was administered at 10:20 AM), and between 10:35 AM and 10:42 AM on 5/31/26. The 12:00 PM medications were administered at 2:21 PM on 5/29/26 and at 2:48 PM on 6/02/26. Review of the medical record revealed no documentation that the physician was notified regarding the delayed administration of medications on the dates and times identified above. 4. On 6/03/26 at 12:27 PM, resident #5 stated some medications were given always late. She indicated one of her medications was supposed to be administered every six hours, but she received it every eight hours. She stated delays occurred at different times throughout the day. She said the facility keep(s) getting agency nurses, they get behind and it takes them forever. She further stated when she asked some nurses what medications they were administering, she was told, the same thing you received yesterday. Review of the medical record revealed resident #5 was readmitted to the facility on [DATE] with diagnoses including nontraumatic subarachnoid hemorrhage (brain bleed), spinal stenosis (narrow spaces within the spine), type 2 diabetes, and restless legs syndrome. Review of resident #5's quarterly MDS assessment with ARD of 2/22/26 revealed a BIMS score of 15/15, indicating intact cognition. Review of resident #5's MAR for May and June 2026 revealed the following medications were scheduled for administration:*8:00 AM: Lantus SoloStar 10 units*9:00 AM: Lyrica 75 mg, Nifedipine 60 mg, Humalog sliding scale insulin, Brimonidine eye drops, MiraLAX, Cyanocobalamin 500 micrograms (mcg), Aspirin 81 mg, Senokot 8.6-50 mg, Plavix 75 mg, Magnesium Oxide 400 mg, *12:00 PM: Methocarbamol 500 mg and Hydrocodone-Acetaminophen 7.5-325 mg*1:00 PM: Brimonidine eye drops and Humalog sliding scale insulin Review of the Medication Admin Audit Report for resident #5 revealed the 9:00 AM medications were administered at 10:37 AM on 5/29/26. On 5/30/26, the 8:00 AM, 9:00 AM, 12:00 PM and one of the 1:00 PM medications (Brimonidine eye drops) were administered between 2:10 PM and 2:11 PM. On 5/31/26, the 12:00 PM medications were administered between 1:58 and 1:59 PM. On 6/01/26, the 8:00 AM and 9:00 AM medications were administered between 10:04 and 10:10 AM. Review of the medical record revealed no documentation that the physician was notified regarding the delayed administration of medications on the dates and times identified above. On 6/04/26 at approximately 11:55 AM, the Unit Manager (UM) stated she frequently assisted with medication administration and was working on the medication cart that day because a nurse had called out. She indicated the facility did not have a weekend supervisor and often utilized agency nurses. She explained medications were expected to be administered within one hour before or one hour after the scheduled administration time. She stated delayed medication administration could occur when nurses were unfamiliar with the residents, unfamiliar with the facility, or required additional time to review physician orders. The UM further stated timely (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication administration was dependent on staffing circumstances and said, On a good day you can pass the medications timely. On 6/04/26 at 4:46 PM, Regional Nurse Consultant (RNC) C reviewed Medication Admin Audit Reports for residents #1, #3, #5, #13, #14, #15, #16, #17, #18, and #19 and confirmed multiple medications had been administered outside the facility's established administration time frame. She stated medications should be administered within one hour before or one hour after the scheduled administration time. RNC C indicated nurses were expected to notify the physician when medications were administered late and document the notification in the medical record. Review of the facility policy titled Staffing, effective August 2024, revealed the Administrator (NHA) and Director of Nursing (DON) were responsible for ensuring sufficient nursing staff was available to provide nursing and related services necessary for the residents to attain or maintain their highest practicable, physical, mental, and psychological well-being, as required by federal regulations. The policy further indicated projected staffing plans were to be reevaluated on an ongoing basis in response to changes in resident census, resident acuity, staffing needs, and other facility circumstances. The policy directed the facility leadership to monitor staffing on an ongoing basis and evaluate staffing daily. The policy also required staffing adjustments throughout the day based on resident census and changes in resident care needs. Review of May and June 2026 Medication Admin Audit Reports for residents #1, #3, #5, #13, #14, #15, #16, #17, #18, and #19 revealed a pattern of delayed medication administration affecting multiple residents on Unit 2 over several consecutive days. The delayed medication administration occurred despite the facility's expectation that medications be administered within one hour before or after the scheduled administration time and despite facility policy requiring ongoing evaluation and adjustment of staffing based on resident needs.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services in accordance with professional standards of practice by: failing to appropriately dispose of medications during medication administration for 1 of 2 residents reviewed during medication pass observations (#4); failing to accurately account for and document controlled substance administration and maintain security of medications for 1 of 4 residents reviewed for narcotic administration, (#11); and failing to administer medications according to physician orders and the facility's established medication administration schedule for 10 residents on 1 of 3 units reviewed, out of 19 sampled residents, (#1, #3, #5, #13, #14, #15, #16, #17, #18, and #19). Findings: Cross Reference F725, F867 1. During a medication pass observation with Licensed Practical Nurse (LPN) A on 6/03/26 at 10:05 AM, she indicated nurses were expected to administer 9:00 AM medications between 8:00 AM and 10:00 AM. While preparing medications for resident #4, a Bisacodyl tablet fell from the medication cup onto the medication cart. LPN A discarded the tablet into a trash receptacle attached to the medication cart and continued preparing medications after performing hand hygiene. LPN A administered the medications to resident #4 at 10:33 AM and informed the resident she had medications to take but did not identify the medications being administered. Following the medication pass, LPN A stated she had completed the controlled substance count with the outgoing nurse at the beginning of the shift and confirmed the count matched the Controlled Drug - Key Exchange Audit form. Observation of the audit form revealed LPN A had not signed the 7:00 AM to 3:00 PM shift verification. LPN A acknowledged she was expected to sign the form after completing the narcotic count and confirming no discrepancies. On 6/03/26 at 4:05 PM, LPN A confirmed she had discarded the Bisacodyl tablet in the trash receptacle attached to the medication cart. She stated this was a mistake and acknowledged medications requiring disposal should be discarded in the designated medication disposal container located within the medication cart. LPN A indicated she had received education regarding medication administration practices, including medication disposal procedures, during orientation approximately one month earlier. 2. On 6/03/26 at 11:52 AM, LPN B stated she completed a controlled substance count with the outgoing nurse at the beginning of her shift and compared the count to the Controlled Drug - Key Exchange Audit form. She explained nurses were expected to verify the count and sign the form when assuming responsibility for the medication cart. LPN B stated she became distracted during shift change and did not sign the form as required. She acknowledged the outgoing nurse had signed in the space designated for her signature and stated she intended to correct the error later. When informed a narcotic inspection would be conducted, LPN B stated she had administered one tablet of Norco (Hydrocodone-Acetaminophen 5-325 milligrams (mg)) to resident #11 at approximately 10:30 AM but had not yet documented the removal or administration on the Controlled Drug Record form. Review of resident #11's Hydrocodone-Acetaminophen blister pack revealed seven tablets remaining. Review of the Controlled Drug Record form reflected a count of eight tablets remaining and contained no documentation of medication administration on 6/03/26 at 10:30 AM. LPN B validated she was expected to document controlled substance removal and administration at the time the medication was administered. During an inspection of medications stored in the medication room refrigerator, LPN B left the medication cart unlocked. Upon returning to the medication cart, LPN B acknowledged the cart had remained unlocked and stated the medication carts were expected to remain locked whenever they were not under direct supervision of the nurse. 3. Review of the medical record revealed resident #1 was readmitted to the facility on [DATE] with diagnoses including multiple sclerosis, obstructive and reflux uropathy (abnormal flow through the urinary system), sepsis, and major depressive disorder. Review of resident #1's MAR for May and June 2026 revealed the following medications were scheduled for administration at 9:00 AM: Oxycontin 20 mg, Atropine (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	eye drops, Acidophilus, and Losartan 25 mg. Ropinirole 2 mg and Oxycodone 15 mg were scheduled for administration at 12:00 PM. Review of resident #1's Medication Admin (Administration) Audit Report revealed the 9:00 AM medications were administered at 10:14 AM on 5/29/26, at 11:28 AM on 5/30/26, except Oxycontin, which was administered at 10:20 AM, and between 10:35 AM and 10:42 AM on 5/31/26. The 12:00 PM medications were administered at 2:21 PM on 5/29/26 and at 2:48 PM on 6/02/26. Review of the medical record revealed no documentation the physician was notified regarding delayed administration of medications on these dates and times. 4. Review of the medical record revealed resident #3 was readmitted to the facility on [DATE] with diagnoses including paraplegia, type 2 diabetes, unstageable pressure ulcers of the bilateral buttocks, insomnia, and major depressive disorder. Review of resident #3's MAR for May and June 2026 revealed the following medications were scheduled for administration at 8:00 AM: Oxycodone 10 mg, at 9:00 AM: Amlodipine 10 mg, Aspirin 81 mg, Ascorbic acid 500 mg, Furosemide 20 mg, Gabapentin 300 mg, Oxycontin 15 mg, Senna-S 8.6-50 mg, Tizanidine 2 mg, Baclofen 20 mg, at 12:00 PM: Oxycodone 10 mg, and at 1:00 PM: Baclofen 20 mg. Review of resident #3's Medication Admin Audit Report revealed the 8:00 AM medication was administered at 10:16 AM and the 9:00 AM medications were administered between 10:16 and 10:17 AM on 5/29/26. The 12:00 PM medication was administered at 2:22 PM. On 5/30/26, the 8:00 AM medication was administered at 11:59 AM, the 9:00 AM medications were administered between 11:50 AM and 12:23 PM, and the 12:00 PM and 1:00 PM medications were administered at 2:32 PM. On 5/31/26, the 8:00 AM medication was administered at 10:59 AM and the 9:00 AM medication between 10:55 AM and 11:01 AM. On 6/02/26, the 8:00 AM medication was administered at 9:23 AM, the 12:00 PM and 1:00 PM medications were administered at 2:50 PM. Review of the medical record revealed no documentation the physician was notified regarding delayed administration of medications on these dates and times. 5. Review of the medical record revealed resident #5 was readmitted to the facility on [DATE] with diagnoses including nontraumatic subarachnoid hemorrhage, spinal stenosis (narrow spaces within the spine), type 2 diabetes, and restless legs syndrome. Review of resident #5's MAR for May and June 2026 revealed the following medications were scheduled for administration at 8:00 AM: Lantus SoloStar 10 unit, at 9:00 AM: Lyrica 75 mg, Nifedipine 60 mg, Humalog sliding scale insulin, Brimonidine eye drops, MiraLax, Cyanocobalamin 500 micrograms (mcg), Aspirin 81 mg, Senokot 8.6-50 mg, Plavix 75 mg, Magnesium Oxide 400 mg, at 12:00 PM: Methocarbamol 500 mg and Hydrocodone-Acetaminophen 7.5-325 mg, and at 1:00 PM: Brimonidine eye drops and Humalog sliding scale insulin. Review of resident #5's Medication Admin Audit Report revealed the 9:00 AM medications were administered at 10:37 AM on 5/29/26. On 5/30/26, the 8:00 AM, 9:00 AM, 12:00 PM and one 1:00 PM medications were administered between 2:10 PM and 2:11 PM. On 5/31/26, 12:00 PM medications were administered between 1:58 - 1:59 PM. On 6/01/26, the 8:00 AM and 9:00 AM medications were administered between 10:04 - 10:10 AM. Review of the medical record revealed no documentation the physician was notified regarding delayed administration of medications on these dates and times. 6. Review of the medical record revealed resident #13 was readmitted to the facility on [DATE] with diagnoses including muscle wasting and atrophy, cardiomyopathy (abnormal enlargement of the heart muscle), anxiety disorder, lymphedema (buildup of fluid called lymph in the tissues), and emphysema (respiratory disease). Review of resident #13's MAR for May and June 2026 revealed the following medications were scheduled for administration at 9:00 AM: Ferrous Sulfate 325 mg, Spironolactone 50 mg, Magnesium 400 mg, Protonix 40 mg, Sennosides 8.6 mg, Potassium Chloride 40 milliequivalent (mEq), Dorzolamide eye drops, and Hydralazine 50 mg, and at 10:00 AM: Nifedipine 60 mg. Review of resident #13's Medication Admin Audit Report revealed the 9:00 AM medications were administered at 10:15 AM on 5/29/26. On 5/30/26, the 9:00 AM and 10:00 AM medications were administered between 11:32 and 11:36 AM, and Dorzolamide eye drops were administered at 1:12 PM. On 5/31/26, the 9:00 AM medications were administered between 10:43 and 10:48 AM and the 10:00 AM medication was administered at 11:53 AM. Review of the medical record revealed no documentation the physician was (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notified regarding delayed administration of medications on these dates and times. 7. Review of the medical record revealed resident #14 was admitted to the facility on [DATE] with diagnoses including muscle wasting and atrophy, fluid overload, dysphagia (difficulty swallowing), major depressive disorder, alcoholic cirrhosis of liver, and cognitive communication deficit. Review of resident #14's MAR for May and June 2026 revealed the following medications were scheduled for administration at 9:00 AM: Spironolactone 100 mg, Thiamine 100 mg, Sertraline 50 mg, Furosemide 20 mg, Gabapentin 600 mg, and Folic Acid 1 mg, at 1:00 PM: Gabapentin 600 mg, and at 2:00 PM: Buprenorphine 8 mg. Review of resident #14's Medication Admin Audit Report revealed the 9:00 AM medications were administered at 10:15 AM and the 1:00 PM medication was administered at 2:22 PM on 5/29/26. On 5/30/26, the 9:00 AM medications were administered between 11:37 and 11:41 AM, and the 1:00 PM and 2:00 PM medications were administered at 5:04 PM. On 5/31/26, the 9:00 AM medications were administered between 10:49 and 10:50 AM. On 6/02/26, the 1:00 PM medication was administered at 2:49 PM. Review of the medical record revealed no documentation the physician was notified regarding delay administration of medications on these dates and times. 8. Review of the medical record revealed resident #15 was readmitted to the facility on [DATE] with diagnoses including aphasia (language disorder), chronic obstructive pulmonary disease, type 2 diabetes, stroke, and heart failure. Review of resident #15's MAR for May and June 2026 revealed the following medications were scheduled for administration at 9:00 AM: Spironolactone 25 mg, Empagliflozin 10 mg, Symbicort 160-4.5 mcg/Act inhaler, Apixaban 5 mg, Toprol 12.5 mg, Sertraline 100 mg, Bupropion 150 mg, and Entresto 24-26 mg. Review of resident #15's Medication Admin Audit Report revealed the 9:00 AM medications were administered between 10:17 and 10:18 AM on 5/29/26, between 12:05 PM and 12:08 PM on 5/30/26, between 11:22 AM and 11:28 AM on 5/31/26, and at 10:04 AM on 6/02/26. Review of the medical record revealed no documentation the physician was notified regarding delayed administration of medications on these dates and times. 9. Review of the medical record revealed resident #16 was readmitted to the facility on [DATE] with diagnoses including transient ischemic attack (temporary blockage of blood flow to the brain), chronic obstructive pulmonary disease, dysphagia (trouble swallowing), and cognitive communication deficit. Review of resident #16's MAR for May and June 2026 revealed the following medications were scheduled for administration at 9:00 AM: Tamsulosin 0.4 mg, Furosemide 40 mg, Citalopram 20 mg, Clopidogrel 75 mg, Aspirin 81 mg, Losartan 50 mg, Potassium Chloride 10 mEq, Docusate Sodium 100 mg, Probiotic 250 mg, and Baclofen 10 mg, and at 12:00 PM: Hydrocodone-Acetaminophen 5-300 mg. Review of resident #16's Medication Admin Audit Report revealed the 9:00 AM medications were administered at 10:16 AM on 5/29/26, between 11:42 AM and 11:46 AM on 5/30/26, and between 10:54 and 10:55 AM on 5/31/26. The 12:00 PM medication was administered at 2:22 PM on 5/29/26, at 1:16 PM on 5/30/26, at 1:06 PM on 5/31/26, and at 2:50 PM on 6/02/26. Review of the medical record revealed no documentation the physician was notified regarding delayed administration of medications on these dates and times. 10. Review of the medical record revealed resident #17 was admitted to the facility on [DATE] with diagnoses including rhabdomyolysis (rapid breakdown of skeletal muscle), alcohol abuse, metabolic encephalopathy (brain dysfunction), cognitive communication deficit. Review of resident #17's MAR for May and June 2026 revealed the following medications were scheduled for administration at 9:00 AM: Naprosyn 500 mg and Omeprazole 40 mg, at 1:00 PM: Naprosyn 500 mg, and at 2:00 PM: Folic Acid 1 mg. Review of resident #17's Medication Admin Audit Report revealed the 9:00 AM medications were administered at 10:17 AM on 5/29/26, at 12:10 PM on 5/30/26, and at 11:12 AM on 5/31/26. The 1:00 PM medication was administered at 2:23 PM on 5/29/26 and at 2:50 PM on 6/02/26. Further review revealed the Naprosyn scheduled for 1:00 on 5/30/26 was administered concurrently with the 9:00 AM dose at 12:10 PM. Review of the medical record revealed no documentation the physician was notified regarding delay administration of medications on these dates and times. 11. Review of the medical record revealed resident #18 was readmitted to the facility on [DATE] with diagnoses including type 2 diabetes, multiple sclerosis, major depressive disorder, and history of falling. Review (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of resident #18's MAR for May and June 2026 revealed the following medications were scheduled for administration at 9:00 AM: Dalfampridine 10 mg, Metformin 500 mg, Dimethyl Fumarate 240 mg, Lyrica 75 mg, Jardiance 25 mg, Fluticasone 50 mcg/Act, Benadryl 50 mg, Escitalopram 5 mg, and Neuriva supplement, at 12:00 PM: Oxycodone-Acetaminophen 10-325 mg and Methocarbamol 750 mg, and at 1:00 PM: Benadryl 50 mg. Review of the Medication Admin Audit Report for resident #18 revealed the 9:00 AM medications were administered at 10:18 AM on 5/29/26, Neuriva given at 11:29 AM on 5/30/26, 9:00 AM medications administered between 11:15 and 11:18 AM on 5/31/26, and at 10:25 AM on 6/02/26. The 12:00 and 1:00 PM medications were administered at 2:23 PM on 5/29/26 and at 2:51 PM on 6/02/26. Review of the medical record revealed no documentation the physician was notified regarding delayed administration of medications on these dates and times. 12. Review of the medical record revealed resident #19 was readmitted to the facility on [DATE] with diagnoses including muscle wasting and atrophy, chronic obstructive pulmonary disease, dysphagia, heart failure, and malignant neoplasm of main bronchus. Review of resident #19's MAR for May and June 2026 revealed the following medications were scheduled for administration at 9:00 AM: Alogliptin 6.25 mg, Aspirin 81 mg, Furosemide 20 mg, Levetiracetam 1000 mg, and Potassium Chloride 10 mEq. Review of resident #19's Medication Admin Audit Report revealed the 9:00 AM medications were administered at 10:16 AM on 5/29/26, between 12:00 and 12:01 PM on 5/30/26, and at 10:52 AM on 5/31/26. Review of the medical record revealed no documentation the physician was notified regarding delayed administration of medications on these dates and times. On 6/04/26 at 4:46 PM, Regional Nurse Consultant (RNC) C reviewed Medication Admin Audit Reports for residents #1, #3, #5, #13, #14, #15, #16, #17, #18, and #19 and confirmed multiple medications were administered outside the facility's established administration time frame. She stated medications were expected to be administered within one hour before or one hour after the scheduled administration time. RNC C reviewed the medical records and confirmed there was no evidence the physicians had been notified regarding the repeated delayed medication administrations identified above. She stated nurses were expected to communicate with the physician and document notification when medications were administered outside the established administration window. Review of the facility's Medication Administration policy dated January 2026 revealed medications were to be administered as prescribed, in accordance with physician orders, manufacturers' specifications, and accepted nursing standards of practice. The policy further required routine medications to be administered according to the established medication administration schedule and required the individual administering the medication to document administration on the resident's MAR immediately following administration. The policy also required the medication carts to remain closed and locked when not under the direct supervision of the medication nurse. Review of the facility's Medication Administration - Controlled Substances policy dated January 2026 revealed the licensed nurse administering a controlled substance was required to immediately document removal of the medication on the accountability record, administer the medication and document administration on the resident's MAR. The policy further required a physical inventory of controlled substances to be completed and documented at each shift change.		

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NAME OF PROVIDER OR SUPPLIER Titusville Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1705 Jess Parrish CT Titusville, FL 32796	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview, and record review, the facility failed to maintain a complete and accurate medical record for one of one residents sampled for wound treatments, of a total sample of 19 residents, (#3).Findings:Medical record review revealed resident #3 was admitted to the facility on [DATE] with diagnoses that included colostomy, pressure ulcers to his left heel, right and left buttock and left hip.A colostomy is a surgical opening in the abdomen to allow stool to exit the body when it cannot pass through the rectum. It connect the large intestine to the outside of the body and stool is collected in a pouch worn on the outside, (retrieved on 6/17/26 from www.hopkinsmedicine.org).Review of current physician orders revealed resident #3 had physician orders for colostomy care every shift starting 6/18/25; wound care orders every day and night shift for right great thumb on 2/16/26, wound care every night shift for a left plantar callus dated 4/20/26, wound care every night shift for sacrum and right and left buttocks dated 4/30/26, and skin prep application every shift to the bilateral heels dated 4/23/26.Review of the Treatment Administration Record (TAR) for May 2026 revealed missing documentation for the right great thumb on day shift on May 9, May 10, May 14, May 18, and May 24.Review of the TAR for May 2026 revealed missing documentation for the right great thumb for evening shift on May 5, May 7, May 8, May 27, May 28, and May 29.Review of the TAR for May 2026 revealed missing documentation for the left plantar callous, on May 9, May 19, and May 27.Review of the TAR for May 2026 revealed missing documentation for resident #3's sacrum, on May 9, May 19, and May 27.Review of the TAR for May 2026 revealed missing documentation for resident #3's right buttock, on May 9, May 19, and May 27.Review of the TAR for May 2026 revealed missing documentation for resident #3's left buttock, on May 9, May 19, and May 27.Review of the TAR for May 2026 revealed missing documentation for the resident's left and right heel, for day shift on May 1, May 9, May 10, May 18, May and 24.Review of the TAR for May 2026 revealed missing documentation for the left and right heel, for evening/night shift on May 5, May 7, May 8, May 9, May 27, May 28 and May 29.Review of the TAR for May 2026 revealed resident #3's colostomy care was not documented a total of 13 times across all three shifts. Review of the TAR's legend, an entry of the number 2 meant the resident refused and an entry of the number 9 meant other/see nurse's notes. All the TARs' missing entries had no number to explain whether the treatment was completed for resident #3, or why.On 6/04/26 at 3:05 PM, the Regional Nurse Consultant (RNC) acknowledged the holes in resident #3's record after being informed by the survey team. The RNC said if there was a hole in the Medication Administration Record or the TAR, the medication or treatment was not given or not done. She said the expectation was for the nurse to write a progress note about the resident's refusal, what the resident's reason for refusal was, education related to the refusal given to the resident and documentation the physician was informed of the refusal.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview, and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee implemented, monitored, evaluated, and revised a Performance Improvement Plan (PIP) to address identified concerns related to narcotic accountability and diversion prevention. The facility failed to ensure corrective actions were sustained after identifying repeated narcotic management concerns, resulting in continued deficiencies related to narcotic accountability, documentation, and medication management practices. Findings: Cross Reference F755 Review of a report submitted to the Agency for Health Care Administration (AHCA) on 4/14/26 for alleged misappropriation of property revealed the facility identified 28 missing Oxycodone tablets pertaining to resident #1. Following completion of the investigation, the facility determined there was a discrepancy between the number of narcotic cards received by a nurse and the number documented on the narcotic accountability records, resulting in the potential for a one-card discrepancy. In a joint interview with the Interim Administrator and the Regional Nurse Consultant (RNC) C on 6/04/26 at 2:59 PM, RNC C stated the facility initiated a PIP on 4/16/26 after identifying concerns related to potential narcotic diversion. Review of the PIP titled Narcotic Management and Narcotic Diversion Prevention included education for the Director of Nursing (DON), Unit Managers (UM), and licensed nurses regarding narcotic management and diversion prevention. The PIP also included ongoing education related to key exchange process for licensed nurses. The PIP identified system changes including the implementation of a new narcotic accountability log at the beginning of each month and daily rounds by the DON or designee to verify narcotic control records were completed. The monitoring plan included random audits of narcotic control logs weekly for four weeks followed by monthly audits for three months. Audit results were to be reviewed during monthly QAPI meetings until substantial compliance was achieved. The RNC provided audits tools dated 4/19/26, 4/21/26, 4/23/26, 4/30/26, and 5/04/26. Review of the audit tools revealed seven medication cart observations were conducted throughout the facility; however, the audit forms did not identify the shifts during which the observations occurred. The audits evaluated completion of incoming and outgoing nurses' signatures, narcotics counts, verification of individuals narcotic cards, double locking of narcotics, documentation of narcotic additions and removals, identification of discrepancies, and follow-up by the DON. RNC C stated facility management also reviewed narcotic accountability and maintained management coverage in the facility 24 hours per day for approximately six weeks following the initial incident. Review of a second report submitted to AHCA on 5/11/26 for alleged misappropriation of property on 5/11/26 revealed concerns regarding documentation of a narcotic medication administered to resident #12. The narcotic accountability records documented administration of Dilaudid 4 milligrams at 2:00 AM on 5/11/26; however, the medication administration was not documented on the Medication Administration Record (MAR). Review revealed the medication was ordered for administration at 9:00 AM and 9:00 PM. Documentation reflected the 9:00 PM dose on 5/10/26 had already been administered, making the documented 2:00 AM administration inconsistent with the physician's order. On 6/04/26 at approximately 3:10 PM, RNC C stated the facility investigated the second incident and interviewed additional residents assigned to the nurse involved. She stated no additional concerns were identified during the investigation. RNC C further stated the facility was unable to determine whether the medication had been administered and reported the nurse to the Board of Nursing for concerns related to narcotic documentation practices. RN C stated no additional Ad Hoc QAPI meeting was conducted following the second narcotic-related incident. She explained no revisions to the PIP were made and no additional audits were implemented after the second incident occurred on 5/11/26. She further stated the audits conducted under the PIP occurred during daytime hours between 8:00 AM and 5:00 PM, and not on other timeframes to incorporate the evening or overnight shifts. RNC C further reviewed resident #12's May 2026 MAR and confirmed the (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9:00 PM Dilaudid dose scheduled for 5/08/26 lacked documentation of administration. She stated this concern was not identified during the facility's investigation initiated on 5/11/26. Review of the attendance record for the 4/14/26 narcotic diversion prevention PIP revealed the Pharmacy Consultant was not listed as a participant. Review of the PIP documentation revealed no evidence the QAPI committee reviewed, revised, or expanded the PIP after the second reportable narcotic incident was identified on 5/11/26. During the course of the survey, additional concerns related to narcotic accountability and medication management practices were identified: *On 6/03/26, Licensed Practical Nurse (LPN) A failed to sign the Controlled Drug - Key Exchange Audit log after completing the beginning of shift narcotic count with the outgoing nurse. LPN A acknowledged she was required to sign the narcotic log following completion of the count. *On 6/03/26, LPN B failed to sign the Controlled Drug - Key Exchange Audit log after completing the beginning of shift narcotic count with the outgoing nurse. In addition, LPN B administered a narcotic medication to resident #11 at approximately 10:30 AM but had not documented removal of the medication on the Controlled Drug Record as of 11:55 AM. LPN B acknowledged she was required to document narcotic administration at the time the medication was removed and administered. *Review of the Controlled Drug - Key Exchange Audit log for Cart 2-A on Unit 2 revealed the 11:00 PM to 7:00 nurse signature was missing on 6/03/26 under the section Time keys given to oncoming nurse. *Review of the Controlled Drug - Key Exchange Audit log for Cart 2-B on Unit 2 revealed multiple missing signatures including the 11:00 PM to 7:00 AM shift on 6/01/26, the 3:00 to 11:00 PM shift on 6/02/26, and the 7:00 AM to 3:00 PM shift on 6/03/26 under the On-Coming Nurse Signature section. Additional missing signatures and date identified on a 11:00 PM to 7:00 AM shift in June, and the 3:00 to 11:00 PM shift on 6/02/26 in the section documenting transfer to the incoming nurses. *Review of the Controlled Drug - Key Exchange Audit log for Cart 3 on Unit 3 revealed multiple missing signatures. Missing signatures were identified for the 7:00 AM to 3:00 PM shift on 6/03/26 and 5/31/26, the 3:00 to 11:00 PM shift on 5/28/26, and the 11:00 PM to 7:00 AM shift on 5/15/26, 5/04/26 and 5/01/26. Review of the facility's Quality Assurance Performance Improvement (QAPI) Program policy, effective January 2025, revealed the QAPI Program was designed to use data driven indicators focused on resident care outcomes and quality of life. The policy documented the program would: 1) track and measure performance; 2) establish goals and thresholds for performance measurement; 3) identify and prioritize performance concerns and other issues; 4) systematically investigate and analyze underlying causes of systemic problems and adverse events; 5) develop and implement corrective actions and performance improvement activities; and 6) monitor and evaluate the effectiveness of corrective actions and performance improvement activities. The policy further indicated the Quality Assurance, Assessment, and Compliance Committee was responsible for implementing the QAPI Program through individual and committee assignments. The policy identified staffing concerns, including hiring staff, staff turnover, use of agency staff, and overtime, as quality indicators to be tracked and measured. Under the section titled Develop and Implement Corrective Actions, the policy described the Plan-Do-Study-Act process and specified once an issue was identified and prioritized, a specific corrective action plan would be developed, implemented, and monitored to measure its effectiveness. The policy further stated the Process Improvement team would continue an action if effective, modify the action if ineffective, or discontinue the action once the issue was resolved.		