STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395901	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Titusville Healthcare and Rehabilitation Center	81 Dillon Drive Titusville, PA 16354

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** 47356 Based on observations, review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to notify the physician and begin treatment timely related to a change in a resident's condition, and obtain a physician's order/clarification for the use of an assistive device for two of 17 residents reviewed (Residents R4 and R25). Findings include: Review of facility policy entitled, Change in a Resident's Condition or Status dated 3/28/24, indicated, The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): significant change in the resident's physical/emotional/mental condition. Resident R4's admission record revealed an admitted [DATE], with diagnoses that included dementia (condition with symptoms that affect memory and thinking), atrial fibrillation (irregular heart rate), and type II diabetes (condition of insufficient production of insulin). Review of a nursing note dated 7/20/24, at 6:01 p.m. indicated that the physician was faxed information regarding white patches in Resident R4's mouth. Continued review of Resident R4's clinical record revealed a nursing note dated 7/22/24, at 11:40 a.m. indicating that the physician's office was contacted regarding white patches on Resident R4's tongue and mouth. A nursing note dated 7/23/24, at 12:03 p.m. indicated an order was received for Nystatin Mouth/Throat Suspension (a medication used to treat a fungal infection in the mouth) Give 5 milliliters by mouth three times a day (8:00 a.m., 1:00 p.m., and 5:00 p.m.) for thrush swish and spit. Nursing notes dated 7/23/24, at 1:31 p.m. and 7/23/24, at 4:18 p.m. revealed that Resident R4 did not receive the Nystatin Mouth/Throat Suspension as ordered due to it not being delivered to the facility. Review of Resident R4's July 2024 Medication Administration Record revealed Resident R4 received his/her first dose of Nystatin Mouth/Throat Suspension on 7/24/24, during the 8:00 a.m. medication pass, this was approximately 86 hours after the white patches on his/her mouth and tongue were observed. (continued on next page)

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	During an interview with the Director of Nursing (DON) on 7/24/24, at 12:20 p.m. it was confirmed that there was a delay in treatment regarding Resident R4's change in condition and that nursing staff should have called the physician on Saturday 7/20/24, rather than faxing the physician with the resident condition concerns. Resident R25's clinical record revealed an admitted [DATE], with diagnoses that included status post right hip fracture and repair, heart failure, and right leg blood clots. The clinical record lacked of evidence of physician's orders, care plan interventions, nurse aide tasks, or progress notes regarding application of an abductor pillow (soft but firm foam pillow that is placed between the thighs and strapped onto the patient's legs while they are in a resting position to aid in keeping the body stable and prevents an abducting motion that could cause pain or further injury post-surgery). During an interview on 7/24/24, at 11:45 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed that Resident R25 came back from an orthopedic appointment with the pillow and that there was no physician's order for it in the clinical record. During an interview on 7/24/24, at 11:57 a.m. Nurse Aide (NA) Employee E2 confirmed that he/she has inconsistently discovered the abductor pillow between Resident R25's legs upon entering the room and removed the pillow and placed at the top of his/her closet in an effort to prevent others from using it because there was no physician's order for it. During an interview on 7/24/24, at 1:21 p.m. the DON confirmed Resident R25 did not have a physician's order for the use of an abductor pillow and the Therapy Director confirmed that the abductor pillow present in Resident R25's room was not an the appropriate size for he/she to use. During an interview on 7/24/24, at 1:35 p.m. Registered Nurse (RN) Employee E3 confirmed he/she had only seen the pillow once prior on 7/19/24. During an interview on 7/24/24, at 2:20 p.m. LPN Employee E4 confirmed he/she had only seen the pillow once prior on 7/19/24, and did not know where it came from. During an interview on 7/24/24, at 2:28 p.m. NA Employee E5 confirmed he/she was not sure how often the pillow was placed between Resident R25's legs and that if used, it was painful for the resident. During an interview on 7/24/24, at 2:35 p.m. NA Employee E6 confirmed that when he/she comes over to that hall to help the pillow is already in there, it is removed to provide care and Resident R25 doesn't like it in there. During an interview on 7/25/24, at 10:00 a.m. the Corporate Nurse Consultant confirmed there was no care plan or nurse aide tasks for the use of the abductor pillow. Observation on 7/25/24, at 10:26 a.m. revealed a pink, foam abductor pillow remained laying in Resident R25's closet. During an interview at that time, LPN Employee E1 confirmed the abductor pillow was laying in Resident R25's closet and that there was no physician's order for the pillow. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/24, at 1:00 p.m. NA Employee E7 confirmed that he/she has discovered the pillow already in place between Resident R25's legs upon entering the room. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12 (d)(2)(3) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to maintain proper care of respiratory equipment for one resident reviewed for respiratory care (Resident R210). Findings include: Facility policy entitled Departmental (Respiratory Therapy) - Prevention of Infection dated 3/28/24, indicated Infection Control Considerations Related to Oxygen Administration . Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use. Resident R210's clinical record revealed an admitted [DATE], with diagnoses that included fracture of right femur (broken bone of the upper leg), hypertension (high blood pressure), and diabetes (a health condition that causes by the body's inability to produce enough insulin). Resident R210's physician orders dated 7/12/24, revealed an order indicating to provide oxygen at 2 liters per minute via nasal cannula (oxygen tubing that has prongs that go into the nostrils and loops around the ears to secure in place to ensure adequate oxygen delivery). Observation on 7/22/24, at 11:45 a.m. revealed Resident R210's nasal cannula had a piece of tape wrapped around the oxygen tubing dated 7/17/24. The oxygen tubing was connected to the oxygen concentrator and the prongs that go into the nostrils was laying on the floor. Observation on 7/22/24, at 4:10 p.m. revealed that the oxygen tubing remained with the prongs that go into the nostrils laying on the floor. Observation on 7/23/24, at 8:28 a.m. revealed Resident R210's nasal cannula had a piece of tape wrapped around the oxygen tubing dated 7/17/24, the oxygen tubing was connected to the oxygen concentrator and the prongs that go into the nostrils was laying on the floor. During an interview on 7/23/24, at 8:41 a.m. the Director of Nursing confirmed that the nasal cannula was laying on the floor. He/she also confirmed that the nasal cannula should not be on the floor and the nasal cannula should be placed in a bag when the resident is not using it. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 211.10(d) Resident care policies

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to provide a clinical rationale and duration for the continued use of a PRN (as needed) psychotropic (affecting the mind) medication beyond 14 days for one of five residents reviewed for psychotropic medications (Resident R6). Findings include: A facility policy entitled Antipsychotic Medication Use dated 3/28/2024, indicated that PRN orders for psychotropic medications are limited to 14 days and If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. Resident R6's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and heart failure (a condition where the heart cannot supply the body with enough blood). Review of Resident R6's Medication Administration Record (MAR) revealed a physician's order dated 7/9/24, to administer Vistaril (anti-anxiety medication) 25 milligrams (mg) every eight hours as needed (PRN) for 14 days. Further review of Resident R6's MAR revealed PRN Vistaril order was revised on 7/16/24, 7/17/24, and 7/18/24. After the revision on 7/18/24, the PRN Vistaril order lacked evidence of a specified duration. Resident R6 received PRN Vistaril on 7/16/24, 7/17/24, 7/18/24, 7/19/24, 7/23/24 and 7/24/24, which was beyond 14 days from the original order date. Resident R6's Vistaril order lacked the required stop date within 14 days and a clinical rationale for continued use beyond 14 days. During interview on 7/25/24, at 9:25 a.m. the Director of Nursing revealed he/she was provided information that the PRN Vistaril did not need a duration to continue use, he/she confirmed that the information was incorrect. He/she also confirmed that the PRN Vistaril lacked the required stop date within 14 days and a clinical rationale for continued use beyond 14 days. 28 Pa. Code 211.10(d) Resident care policies 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356 Based on review of facility policies, observations, and staff interview, it was determined that the facility failed to ensure that keys to the medication cart and medication room were secured on one of five units reviewed (Unit B). Findings include: Facility policy entitled, Security of Medication Cart dated 3/28/24, indicated, The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. Facility policy entitled, Medication Storage in The Facility dated 3/28/24, indicated, Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. Observations on 7/22/24, at 1:30 p.m. in room [ROOM NUMBER] on Unit B revealed the nurse's medication cart and medication room keys were on the resident's bed and were unsecured. At that time, the Director of Nursing (DON) was called to room [ROOM NUMBER] on Unit B. The DON confirmed that the unsecured keys were for the medication cart on Unit B and the medication room. The DON confirmed that medication cart keys and medication room keys should be secured at all times and should never be left in a resident's room. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(2) Nursing services

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48496 Based on review of facility records and staff interview, it was determined that the facility failed to assure required attendance of the Infection Preventionist to Quality Assurance and Performance Improvement (QAPI) Committee meetings for two of four quarterly QAPI Committee meetings (July 2023 through December 2023). Findings include: A facility policy entitled Guardian Elder Care Quality Assurance and Process Improvement Committee dated 3/28/24, indicated the following individuals will serve on the committee . j. Infection Control Representative . and The committee will meet monthly at an appointed time. Review of the QAPI Committee Attendance Records from July 2023 through December 2023 revealed no evidence on the attendance sign-in sheets for the required QAPI meetings that the Infection Preventionist was in attendance. During an interview on 7/25/24, at 11:00 a.m. the Nursing Home Administrator confirmed the facility lacked evidence that an Infection Preventionist attended the quarterly QAPI Committee meetings as required in the quarters between July 2023 through December 2023. He/she also confirmed that the Infection Preventionist should be in attendance for the QAPI meetings as required. 28 Pa. Code 201.18(e)(1)(3) Management 28 Pa. Code 211.10(d) Resident care policies

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F 0882 Level of Harm - Potential for minimal harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 47356 Based on review of facility records and staff interviews, it was determined that the facility failed to ensure the designated Infection Preventionist (IP) attended the Infection Control Committee meetings and works at the facility focusing only on infection control at least part-time as required. Findings include: Review of facility documentation identified that the Director of Nursing (DON) fulfilled the job of the IP from November 2023 through May 2024. The DON works full-time and was unable to provide proof that additional part-time hours focusing only on infection control were completed in addition to his/her full-time DON duties. Review of Infection Control committee meetings from July 2023 through December 2023 revealed there was not anyone who attended the meetings and signed in as the IP. During an interview on 7/25/24, at 11:00 a.m. the Nursing Home Administrator confirmed the facility lacked evidence that an IP attended the meetings from July 2023-December 2023, and the DON confirmed that he/she could not provide proof that he/she completed additional part-time hours focusing only on infection control in addition to his/her full-time DON duties. 28 Pa. Code 201.18(e)(1)(3) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services