

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395901	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER Titusville Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>Based on review of facility policy and clinical records, and resident and staff interviews, it was determined that the facility failed to promote resident choices about aspects of his or her life in the facility that are significant to the resident regarding medication administration for two of 16 residents reviewed (Residents R11 and R51).</p> <p>Findings include:</p> <p>The facility policy entitled Medication Administration-General Guidelines, dated 12/11/24, indicated that medications are administered within 60 minutes of scheduled time.</p> <p>Resident R11's clinical record revealed an admission date of 3/27/23, with diagnoses that included diabetes (condition of improper blood sugar control), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and chronic obstructive pulmonary disease (a progressive lung disease with chronic respiratory symptoms).</p> <p>During an interview with Resident R11 on 6/4/25, at 10:30 a.m. the resident shared that he/she had received medications late on 5/28/25, and had filed a grievance against Licensed Practical Nurse (LPN) Employee E5. Resident R11 indicated that receiving medications at 9:30 p.m. is too late and prefers to have the medications administered closer to 8:00 p.m.</p> <p>Review of Resident R11's May Medication Administration Record (MAR) revealed that on 5/28/25, seven medications that were ordered for 8:00 p.m. were administered at 9:25 p.m.</p> <p>Resident R51's clinical record revealed an admission date of 5/23/24, with diagnoses that included protein-calorie malnutrition, anxiety, and bipolar disorder(a mental disorder with periods of depression and abnormally elevated moods).</p> <p>During an interview with Resident R51 on 6/3/25, at 11:00 a.m. the resident shared that he/she had received medications late on a few days from LPN Employee E5 and prefers to have the medications administered closer to 8:00 p.m.</p> <p>Review of Resident R51's May MAR revealed that on 5/28/25, five medications that were ordered for 8:00 p.m. were administered at 9:06 p.m. and on 5/30/25, five medications that were ordered for 8:00 p.m. were administered at 9:24 p.m.</p> <p>(continued on next page)</p>

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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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/04/25, at 1:00 p.m. the Infection Control Preventionist confirmed that Residents R11 and R51 medications were not administered timely for the above dates and in accordance with resident preferences and choices.</p> <p>28 Pa. Code 201.29 (a) Resident rights</p> <p>28 Pa. Code 201.18 (b)(1)(3) Management</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to provide oxygen according to physician's orders for one of one residents reviewed for respiratory services (Resident R209).</p> <p>Findings include:</p> <p>Review of facility policy entitled Oxygen Administration dated 12/11/24, revealed Review the physician's order . for oxygen administration. Turn on oxygen. Unless otherwise ordered, start the flow of oxygen at . and adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.</p> <p>Review of Resident R209's clinical record revealed an admission date of 5/23/25, with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), diabetes (a health condition that caused by the body's inability to produce enough insulin), and acute respiratory failure (a condition where your lungs don't exchange air properly).</p> <p>Review of Resident R209's physician's orders dated 5/23/25, revealed an order for oxygen at 6 liters/minute via nasal cannula (a thin tube with two prongs that fit into the resident's nostrils to deliver oxygen).</p> <p>Observations on 6/3/25, at 11:24 a.m., 12:50 p.m., 2:06 p.m., and again at 2:14 p.m. revealed Resident R209 sitting on their bed with supplemental oxygen in place and the oxygen concentrator liter flow set at 8 1/2 liters/minute.</p> <p>During an interview on 6/3/25, at 2:14 p.m. the Director of Nursing confirmed that Resident R209's oxygen concentrator was on and set at 8 1/2 liters/minute and was not in accordance with the physician's order dated 5/23/25, for oxygen delivery at 6 liters/minute.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on review of facility policies, observations and staff interviews, it was determined that the facility failed to appropriately discard outdated medications for two of two medication rooms reviewed (first floor and ground floor medication rooms) and failed to prevent the opportunity for potential unauthorized access of medications on one of three medication carts observed (B wing medication cart).</p> <p>Findings include:</p> <p>Review of a facility policy entitled Labeling of Medications and Biologicals dated 12/11/24, revealed that labels for multi-use vials must include the date the vial was initially opened . and all opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different . date for that opened vial.</p> <p>Review of a facility policy entitled Security of Medication Cart dated 12/11/24, revealed that medication carts must be securely locked at all times when out of the nurse's view.</p> <p>Review of manufacturer's guidelines revealed that an open vial of Tubersol (a solution used for tuberculosis testing upon admission and employment) should be discarded within 30 days after opening.</p> <p>Observation of drug storage on 6/3/25, at 12:33 p.m. of the first floor medication room revealed an open vial of Tubersol with no date indicating when the vial was open.</p> <p>During an interview with Licensed Practical Nurse (LPN) Employee E3 on 6/3/25, at the time of observation he/she confirmed that the open vial of Tubersol lacked an open date, and staff were unable to determine the discard date. LPN Employee E3 also confirmed that the vial of Tubersol should have been discarded.</p> <p>Observation on 6/3/25, at 1:17 p.m. of the ground floor medication room revealed an open vial of Tubersol with an open date of 4/25/25.</p> <p>During an interview with LPN Employee E4 on 6/3/25, at the time of observation, he/she confirmed that the open vial of Tubersol had an open date of 4/25/25 and also confirmed that the vial of Tubersol should have been discarded.</p> <p>Observation of medication administration on 6/4/25, at 8:45 a.m. revealed that LPN Employee E3 prepared medications for a resident from the B wing medication cart that was parked in the hall in front of the nurse's station. LPN Employee E3 then proceeded into the pantry to obtain a glass of milk for the resident. LPN Employee E3 left medications on top of the medication cart and did not securely lock the medication cart. LPN Employee E3 was unable to view medication cart while he/she was in the pantry.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/4/25, at the time of observation, LPN Employee E3 confirmed that the medication cart was left unlocked and with medications on top of the medication cart while it was parked at the nurse's station, which was out of view when going into the pantry. LPN employee E3 also confirmed that the medication cart was to be locked, and medications should not be left on top of the medication cart when out of view.</p> <p>28. Pa. Code 201.18(b)(1) Management</p> <p>28. Pa. Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on review of facility policies and clinical records, observations, and staff interview, it was determined that the facility failed to prevent the potential for cross contamination during a dressing change for one of three residents with pressure ulcers requiring wound care reviewed and also failed to follow acceptable infection control practices regarding enhanced barrier precautions (EBP) (Resident R109).</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Wound Care, dated 12/11/24, indicated to remove the soiled dressing, remove soiled gloves and then wash hands.</p> <p>Review of the facility policy entitled, Enhanced Barrier Precautions, dated 12/11/24, are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDRO). It also indicated that gloves and gown are to be applied prior to performing the high contact resident care activities, which includes wound care.</p> <p>Review of Resident R109's clinical record revealed an admission date of 10/11/24, with diagnoses that included paraplegia (loss of feeling in legs and lower body), pressure ulcers of sacral region, right buttock and left hip all at stage four (full thickness tissue loss with exposed muscle, tendon, ligament, cartilage or bone).</p> <p>Review of Resident R109's physician's orders dated 5/30/25, included an order to cleanse the stage four sacrum, right trochanter (hip area), left trochanter and right ischium (lower back area of the hip) pressure ulcers and apply collagen particles to the wound and cover with island dressing. Resident R109's physician's orders dated 1/06/25, revealed EBP related to a urinary catheter (tubing entering the bladder to drain urine) / MDRO. Gown and gloves for resident care.</p> <p>Observation of wound care on 6/04/25, at 10:00 a.m. revealed that Licensed Practical Nurse (LPN) Employee E1 entered Resident R109's room without donning (putting on) a gown. LPN Employee E1 removed the soiled dressing without washing hands afterwards and then continued to cleanse the wound without washing hands.</p> <p>During an interview on 6/04/25, at 10:15 a.m. LPN Employee E1 confirmed he/she did not don a gown prior to entering Resident R109's room and did not complete hand hygiene when indicated.</p> <p>During an interview on 6/04/25, at 10:45 a.m. the Infection Control Preventionist confirmed that LPN Employee E1 should have donned a gown prior to entering Resident R109's room and adhered to EBP related to wound care and catheter care and should have completed hand hygiene when indicated.</p> <p>28 Pa. Code 201.18 (b)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p>		