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	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Titusville Nursing and Rehab	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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of facility policy, review of facility documentation and clinical records, and staff interviews, it was determined that the facility failed to ensure appropriate safety measures were implemented regarding the service of hot coffee to a resident that resulted in an accident and actual harm of a second degree skin burn (a burn that damages the top layer of skin and damages the second layer of skin) for one of 20 residents reviewed (Resident R28). This deficiency is cited as past non-compliance. Findings include: The Hot Liquids Policy-Food Service policy, dated 4/23/26, states, To ensure that all hot liquids served within the facility are delivered at a temperature that balances safety and palatability, while also considering the unique needs and physical capabilities of each resident.All coffee and hot liquids will be brewed in the main kitchen.The temperature of hot liquids will be recorded and will not exceed 145 degrees at the point of service.Cups must be appropriate for the resident's ability-lightweight, easy to grip, and if necessary, fitted with lids or handles to prevent spills. Resident R28's clinical record revealed an admission date of 12/7/22, with diagnoses that included Alzheimer's Disease (a progressive disorder that affects memory, thinking, and behavior), absence epileptic syndrome not intractable without status epilepticus (seizures that cause brief sudden staring spells-that is well controlled with medications), hypertension (high blood pressure). Review of the clinical record revealed Resident R28 had a BIMS (brief interview for mental status) score of seven dated 2/20/26. The BIMS tool is used to assess cognitive function; a score of seven indicates a severe impairment. Resident R28's clinical record revealed a nursing note written by Licensed Practical Nurse (LPN) Employee E3, dated 2/26/26, at 6:34 a.m. CNA (Certified Nursing Assistant) called this writer to the room, resident spilled hot coffee on her thigh. 9cm (centimeters) by 8cm redness noted to left thigh loose skin from possible blistering gave resident Tylenol for pain. Resident R28's clinical record revealed a nursing note written by the Director of Nursing (DON), dated 2/26/26, at 8:30 a.m. Medical Director in facility and assessed resident's burn area. Resident R28's clinical record revealed a nursing note written by Licensed Practical Nurse (LPN) Employee E4, dated 2/26/26, at 2:35 p.m.Spilling coffee on lap.LT (left thigh) .LG (large) red area noted with scattered blistering. Resident R28's clinical record revealed a nursing note written by Licensed Practical Nurse (LPN) Employee E5, dated 2/26/26, at 10:30 p.m. LT one large blister has broke and others are starting to leak. The facility investigation revealed that LPN Employee E3 provided a written statement with an incident date of 2/26/26, and time of 5:25 a.m. which revealed, CNA called me to Resident R28's room. Stated a cup of hot coffee spilled on Resident R28's leg. The facility investigation revealed that CNA Employee E6 provided a written statement with an incident date of 2/26/26, and time of 5:25 a.m. which revealed, Got Resident R28 washed and dressed for the day. Asked [him/her] if he/she would like a cup of coffee, went and got one. [He/She] ended up spilling it on his/her leg. Documentation submitted by the facility, dated 2/26/26, revealed that .the coffee was obtained from the employee breakroom in a Styrofoam cup . [Resident R28] unable to say exactly what happened after being interviewed. The facility failed to ensure that Resident R28 was provided with a hot liquid served at a safe temperature, from the facility's main kitchen, was served in an appropriate container, and failed to properly supervise Resident R28 with a hot liquid causing (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 0689 Level of Harm - Actual harm Residents Affected - Few	second degree burns to his/her left thigh. This deficiency is cited as past non-compliance. On 2/26/26, the facility-initiated education for all staff to ensure that residents are receiving coffee at safe temperatures from the main kitchen, in an appropriate container, and are properly supervising residents. This plan includes the following: Immediate Suspension of CNA Employee E6. Immediate education regarding checking temperatures, obtaining hot liquids from the main kitchen, ensuring hot liquids are in an appropriate container, and that residents are properly supervised when drinking hot liquids was provided to all staff, which occurred from 2/26/26, through 3/15/26. Review of all residents at risk related to hot liquids completed by the DON and care plans updated as indicated. Interviews with CNA Employees E7 and E8, LPN Employees E4 and E9, RN Employee E10, Housekeeping Employee E11 ,Therapy Director, Activities Director, Dietary Manager, Laundry Supervisor, Medical Records Manager, and Business Manager, all confirmed the facility-initiated education and competencies starting 2/26/26, which included education on checking temperatures for hot liquids, obtaining hot liquids from the main kitchen, ensuring hot liquids are in an appropriate container, and that residents are properly supervised when drinking hot liquids. Audits were conducted to ensure residents receive hot liquids at appropriate temperatures, from the main kitchen, in an appropriate container, and are properly supervised, which occurred on all shifts and on all units from 2/26/26, through 3/19/26, with all performed appropriately. The facility has demonstrated compliance with hot liquids since 3/19/26. During an interview with the DON on 6/26/26, at approximately 12:00 p.m. and review of the facility's immediate actions, education, competencies, and audits, it was verified that the facility had implemented a plan of correction to ensure residents are free from harm/injury regarding hot liquids and had achieved substantial compliance. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to ensure that food was stored in accordance with standards for food safety and serve food in a safe and sanitary manner during tray line in the main kitchen.Findings include: Review of facility policy entitled Food Safety Requirements dated 4/23/26, indicated Staff shall adhere to safe hygienic practices to prevent contamination of food from hands or physical objects. Review of facility policy entitled Date Marking for Food Safety dated 4/23/26, indicated The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. And The marking system shall consist of, the day/date of opening, and the day/date the item must be consumed or discarded. Observations during the initial kitchen tour on 6/23/26, between 9:45 a.m. and 10:00 a.m. revealed in the walk-in refrigerator an open container of garlic with a use by date of 5/9/26. In the upright freezer there was an open bag of waffles that was not closed, four packages of hot dog buns with a best by date of 5/26/26, and four packages of English muffins which appeared freezer burnt and had no date indicating when they should be discarded. In the dry storage area, there were three open packages of pasta, one with a use by date of 6/6/26, one with no open or use by date and one with no use by date. During an interview at the time of observations the Dietary Manager confirmed the open container of garlic, hot dog buns, English muffins, and three packages of pasta were beyond their use by dates and/or lacked dates. He/she confirmed that the open bag of waffles was not properly closed to prevent contamination and that all the items should have been discarded by or before their use by date or expiration date. Observations during tray line on 6/24/26, at approximately 11:20 a.m. revealed that Dietary [NAME] Employee E2 was observed with gloved hands touching the outside of the refrigerator, countertop, oven door and the food transport cart (a cart that meal trays for residents are placed in to take out of the kitchen). He/she then picked up and placed a hamburger bun on a plate with their hands, then placed a hamburger on the bun and proceeded to pick up a slice of cheese with their hands and placed it on top of the hamburger. Dietary [NAME] Employee E2 did not remove his/her gloves and perform hand hygiene during the entire process. During an interview at the time of observations the Dietary Manager confirmed that Employee E2 touched several items then touched the resident's food with the same gloves. He/she also confirmed that Employee E2 should have removed his/her gloves, washed his/her hands and applied new gloves before touching the resident's food. 28 Pa. Code 211.6(c)(f) Dietary services 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on review of facility policy and clinical records, observations, and staff interviews, it was determined that the facility failed to receive instructions for removal of a urinary catheter (a soft plastic tubing inserted into the bladder to drain urine into a bag) in a timely manner for one of one residents reviewed for catheters (Resident R30).Findings include: Review of facility policy entitled Appropriate Use of Indwelling Catheters dated 4/23/26, indicated Indwelling urinary catheters will be used on a short-term basis., The interdisciplinary team, with the support and guidance from the physician, will assure the ongoing review, evaluation, and decision making regarding the insertion, continuation, or removal of an indwelling urinary catheter. Review of Resident R30's clinical record revealed an admission date of 4/29/26, with diagnoses that included diabetes (a health condition that is caused by the body's inability to produce enough insulin), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and chronic obstructive pulmonary disease (when your lungs do not have adequate air flow). Review of Resident R30's clinical record revealed an order from urology dated 6/9/26, instructing to remove his/her urinary catheter for a trial to void (a procedure where the urinary catheter is removed to see if the person will urinate without the urinary catheter) attempt. Monitor patient for six hours following the catheter being discontinued - if no void- straight catheter (a urinary catheter that does not remain in the patient's body) the patient. If greater that 350 ml (milliliters) of urine retained leave indwelling catheter and reach out to the urology team for the next steps. Review of Resident R30's progress notes revealed the following notes:note dated 6/9/26, at 2:37 p.m. indicating urology wanted to do a trial void noted dated 6/9/26, at 7:18 p.m. catheter was reinserted per resident's request.note on 6/10/26, at 10:50 a.m. revealed urology updated on urinary catheter and will call back with further instructions.Progress notes lacked evidence that the facility followed up with urology for further instructions for the potential removal of Resident R30's urinary catheter in a timely manner. During an interview on 6/25/26, at 12:10 p.m. Registered Nurse (RN) Employee E1 confirmed there was no evidence that the facility followed up with urology for further instructions for Resident R30's urinary catheter and on 6/26/26, at 9:30 a.m. RN Employee E1confirmed that the facility failed to follow-up with urology for further instructions regarding Resident R30's urinary catheter in a timely manner, and that the facility should have reached out to urology in a timely manner. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 211.10(c) Resident care policies