STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105791	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaney Park Health and Rehabilitation Center	215 Annie Street Orlando, FL 32806

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 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. 43192 Based on observation, interview, and record review, the facility failed to follow the physician's order for oxygen (O2) for 1 of 8 residents reviewed for O2 use, of a total sample of 12 residents, (#2). Findings: Review of resident #2's medical record revealed she was readmitted from an acute care hospital on 5/06/25. Her diagnoses included respiratory failure with hypoxia (low levels of O2 in body tissues), shortness of breath, heart failure, chronic obstructive pulmonary disease (COPD) and dementia. Review of resident #2's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date of 4/07/25 revealed her Brief Interview for Mental Status score was 4 out of 15, which indicated severely impaired cognition. The MDS assessment showed resident #2 was short of breath (SOB) or had trouble breathing when lying flat and she used O2. Review of the Florida Agency for Health Care Administration 5000-3008 Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form dated 5/06/25 revealed resident #2 was admitted to the hospital due to sepsis (life-threatening systemic response to an infection). The form noted she used continuous O2 at 2 liters per minute (LPM) via a nasal canula (NC). Review of resident #2's medical record revealed a physician's order dated 5/06/21 for O2 at 2 LPM via NC for SOB/COPD. Review of resident #2's comprehensive care plan revealed an altered respiratory status related to pulmonary disease and dependence on supplemental oxygen revised on 5/08/25. An intervention directed nurses to give O2 therapy as ordered by the physician. On 5/08/25 at 4:39 PM, during a tour of rooms with oxygen concentrators conducted with the Central Supply Coordinator, resident #2 was observed in bed, and the O2 concentrator was set at 3 LPM. On 5/08/25 at 4:59 PM, Registered Nurse (RN) A inspected the O2 concentrator for resident #2 and validated it was set at 3 LPM. RN A reviewed the physician's orders and said, It looks like the O2 order is for 2 LPM. She mentioned she verified the concentrator's setting whenever she took the resident's vital signs, but said she had not taken them yet. She indicated it was important to follow the physician's orders. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/09/25 at 1:00 PM, the Director of Nursing (DON) indicated she expected nurses to verify the O2 order in the medical record and the concentrator to ensure the rate was accurate. She mentioned nurses were supposed to follow physician's orders. A review of the facility's Oxygen Therapy policy and procedure dated November 2023 read, Oxygen is provided to residents based on physician's orders to supplement oxygen as needed per disease process.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview, and record review, the facility failed to ensure oxygen concentrators were maintained in safe, functional condition for 5 of 8 sampled residents who were oxygen-dependent, of a total sample of 12 residents, (#2, #8, #9, #10, and #11). The facility also failed to ensure that failed or potentially compromised concentrator units were promptly removed from use to avoid placing residents at risk of receiving inadequate oxygen support. Findings: On 5/08/25 at 11:30 AM, resident #2's son reported his mother used oxygen continuously. He identified an oxygen concentrator in her room that displayed a yellow light, and a sticker labeled, FAILED. He stated the equipment should have been working properly and expressed concern that families were left to identify malfunctioning equipment. On 5/08/25 at 1:36 PM, during a telephone interview, resident #1's spouse reported when the resident returned to the facility from a hospital stay in March 2025, the transport company driver informed her the oxygen concentrator was beeping and displaying a yellow light. Resident #1's spouse stated she reported the malfunction at that time to staff. She indicated she returned the next day and observed the same unit continued to beep intermittently. She stated after multiple reports, she was later informed the unit had been replaced. On 5/08/25 at 4:18 PM, the Central Supply Coordinator stated the facility had approximately twenty oxygen concentrators. She explained the oxygen concentrators were inspected and serviced monthly by an outside provider. She indicated when she was told an oxygen concentrator was not working, the Maintenance Director would inspect it and called the outside provider if needed. She validated resident #2's oxygen concentrator had a yellow light, and stated it was replaced that morning. She explained the oxygen concentrator was placed in the central supply room with a note that indicated it needed to be repaired. During a tour of rooms with oxygen concentrators conducted with the Central Supply Coordinator on 5/08/25 at 4:30 PM, she validated 4 of 14 units seen on the tour displayed yellow indicator lights; for residents #8, #9, #10, and #11. One unit had a sticker labeled, FAILED. The Central Supply Coordinator was unable to explain the meaning of the yellow light and stated she did not know who placed the sticker or when it was applied. She stated even if the green light was not illuminated, it did not necessarily mean oxygen was not being delivered. On 5/09/25 at 9:20 AM, the Nursing Home Administrator (NHA) reported that yellow lights could appear for several reasons, including poor placement. He stated nursing staff checked concentrators weekly, and maintenance responded to issues. He confirmed the vendor performed annual inspections. He provided evidence of the most recent inspection dated 9/23/2024 which showed 8 out of 15 concentrators failed and required repair or replacement. A purchase requisition dated 10/04/2024 documented the purchase of 5 new concentrators. The NHA was unable to confirm which units had been replaced or whether failed units remained in use. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/09/25 at 10:16 AM, during a telephone interview, the oxygen concentrator services' Account Manager explained a yellow light indicated caution and could signal a failure in oxygen purity. He described if the unit did not reach the required purity within 15 minutes, it was considered to have failed and should be removed from service. He emphasized failed units could not be relied on to meet residents' prescribed oxygen needs and should not remain in use. Review of the undated [NAME] 2 Series User Manual revealed features which included Oxygen Purity Indicator Lights/Fault and Power Indicator Lights. The manual indicated, the SensO2 feature monitors the purity of oxygen generated by the oxygen concentrator. If purity falls below factory preset standards, indicator lights on the control panel will illuminate. The Oxygen Purity indicator included a caution visual image and yellow light that illuminated and a telephone image, which instructed the user to call the supplier. A review of the Physical Environment policy and procedure dated August 2024 indicated, All essential mechanical, electrical, and resident care equipment is maintained in safe operating condition through the facility's Preventative Maintenance Program.