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Form Approved OMB
No. 0938-0391

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	06/05/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on observation, interview, and record review, the facility failed to conduct a medication self-administration assessment to ensure safety for 1 of 1 resident reviewed for self-administration of medication, of a total sample of 39 residents, (#74). Findings: Resident # 74 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including sequelae of cerebral infarction (stroke), anemia, heart failure, diabetes, and constipation. Review of the Minimum Data Set admission assessment with an assessment reference date of 4/29/24 revealed resident #74 had a Brief Interview for Mental Status score of 15 out of 15, which indicated she was cognitively intact. On 6/02/24 at 12:10 PM, resident #74 was observed lying in bed with her spouse sat in a chair at the bedside. A box of refresh eye drops, and a hydrocortisone 1% cream tube were noted on the resident's nightstand. Resident #74's spouse stated he put drops in his wife's eyes when she requested it. He said he applied the hydrocortisone cream to his wife's rectum due to her hemorrhoids. On 6/02/24 at 1:10 PM, the resident's bedside table was again observed with License Practical Nurse (LPN) E, the assigned nurse. She acknowledged the box of refresh eye drops and tube of hydrocortisone on the resident's nightstand. Resident #74's spouse said he brought the refresh eye drops and hydrocortisone from the previous facility to ensure she had it when needed. A review of the resident's physician orders were conducted with LPN E, which revealed no orders for the refresh eye drops or hydrocortisone found on the resident's nightstand. LPN E explained for someone to self-administer medications, they must have a physician order and a self-administration evaluation completed. LPN E stated there was no orders for the refresh eye drops or hydrocortisone cream and a self-administration evaluation had not been completed for resident #74. On 6/05/24 at 3:59 PM, the Director of Nursing (DON) stated if a resident was to self-administer medications, they had to have a physician's order. The facility would provide the resident with a lock box to store the medication safely. A self-administration evaluation would be completed, and a care plan for self-administration of medication would be initiated for the resident. The DON acknowledged those protocols were not in place for resident #74. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure for Medication Administration Self-Administration by Resident, dated 10/07, revealed residents who wanted to self -administer their medications were permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team had determined that the practice would be safe.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview and record review, the facility failed to complete a discharge Minimum Data Set (MDS) Assessment for 1 of 2 residents reviewed for resident assessments, of a total sample of 39 residents, (#69). Findings: Review of resident #69's medical record revealed she was admitted to the facility on [DATE]. Review of a Progress Note dated 1/19/24 revealed resident #69 was discharged home with her daughter and husband. Review of the MDS tab in the medical record did not show a Discharge Assessment was initiated or completed. On 6/05/24 at 3:09 PM, the Clinical Reimbursement Director reviewed resident #69's medical record and said Oh, we are missing a discharge. She explained she, .Normally ran a report at least weekly, but had not run it consistently. She mentioned resident #69's discharge assessment was 124 days overdue and concluded, It was just missed. Chapter 2 of the MDS 3.0 RAI (Resident Assessment Instrument) Manual revealed a Discharge assessment was required for all discharges. The RAI Manual indicated a Discharge Assessment, Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days). Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35086 Based on observation, interview, and record review, the facility failed to ensure Minimum Data Set (MDS) assessment was accurate for functional ability in regards to eating, vision and dental for 2 of 5 residents reviewed, of a total sample of 39 residents, (#20, and #36). Findings: 1. Resident #20's most recent admission to the facility was on 11/04/23. His diagnoses included muscle wasting, intracerebral hemorrhage, encephalopathy, dysphagia (difficulty swallowing), need for personal assistance with personal care, Parkinson's disease, and protein calorie malnutrition. Review of the resident's quarterly MDS assessment with Assessment Reference Date (ARD) of 5/04/23 revealed Section GG 0130 A for eating was coded 6 which indicated the resident was able to use suitable utensils to bring food/liquids to his mouth and swallow food/liquids placed before the resident. The prior quarterly MDS assessment with ARD date of 2/04/24 revealed Section GG 0130 was coded 1 which meant he was dependent on a helper with eating. On 6/02/24 at 12:00 PM, resident #20 was observed sitting up in a wheelchair in his room alert and oriented to person, place, and time. He was able to state where he was born and raised although his speech was garbled, and he was difficult to understand. He said he had difficulty chewing hard food or big chunks of food. Review of the Registered Dietician's (RD) note dated 4/09/24 revealed the resident was dependent on staff for his meals and liquids. Review of the Occupation Therapy (OT) discharge summary note dated 4/15/25, revealed his prior level as well as current level was maximal assistance to feed himself. Observation conducted of the lunch meal on 6/02/24 at 1:20 PM, and 6/03/24 at 1:33 PM, revealed assigned Certified Nursing Assistant (CNA) B at bedside feeding resident #20 his lunch meal. She was noted to have cut up his peanut butter and jelly sandwich and fed it to him with a fork to his mouth. She said he was not able to hold the sandwich himself. On 6/04/24 at 9:15 AM, CNA B said the resident consumed 75% of his breakfast meal with her assistance because he could not eat by himself at all. On 6/04/24 at 5:11 PM, the RD said the staff must feed resident #20 and he liked to take a drink between each bite of food. She explained because resident #20 was very particular and liked to eat pudding with the spoon upside down, she had been re-enforcing feeding techniques with the CNAs. Review of the CNA documentation in the 7 day look back period prior to 5/04/24 showed the resident needed moderated/partial assistance to totally dependent on the staff with eating ability. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/05/24 at 10:18 AM, the MDS Director verified the MDS with ARD date of 5/04/24 was an inaccurate assessment regarding the resident's ability to eat. She reviewed the OT discharge summary dated 4/15/24 and said at that time he required supervision or touching by staff when he ate. On 6/05/24 at 10:20 AM the MDS Registered Nurse (RN) said she completed the MDS assessment dated [DATE]. She said she assessed resident #20 as independent with eating because he used to eat in the dining room. The RN reviewed the CNA documentation going back 7 days prior to the assessment and said he should have been assessed as needing partial/moderate assistance with eating and not independent. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 dated October 2023 Section GG: Functional Abilities and Goals read, Intent: This section included items about functional abilities and goals .Functional status is assessed based on the need for assistance when performing self-care .GG 0130: Self-Care (cont.) Steps for Assessment 1. Assess the resident's self-care performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period Coding Instructions. When coding the resident's usual performance .Code 06, Independent: if the resident completes the activity by themselves with no assistance from a helper . When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity (e.g., eating, oral hygiene). For example, when assessing Eating (item GG 0130 A), determine the type and amount of assistance required to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident . 43192 2. Review of resident #36's medical record revealed she was admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis, type 2 diabetes, and dysphagia. Review of the Admission/Readmit: Data Collection and Baseline Care Plan dated 8/03/24 revealed resident #36 had full upper and lower dentures. The form listed glasses and dental appliance were used. Review of a care plan for nutritional problems revised on 3/14/24 revealed resident #36 was, Having difficulty chewing d/t (due to) ill-fitting dentures. Review of Social Services Progress Notes dated 5/13/24 read, Resident last seen by Optometry on 03/21/2024 and reports glasses working well. On 6/02/24 at 12:26 PM, resident #36 stated she saw the Optometrist about a month ago and was waiting to get her new glasses. She indicated she could not see well without them. She mentioned she was seen by the dentist, received her upper dentures, but was waiting for the lower ones. She explained impressions were taken. She shared they were aware of her problems with her gums, that she could not chew certain meats and vegetables because she did not have her lower dentures. On 6/04/24 at 1:25 PM, Certified Nursing Assisting (CNA) I confirmed resident #36 wore dentures, which she cleaned every day. She stated resident #36 did not wear glasses, all the time. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/05/24 at 11:26 AM, the Social Service Director (SSD) stated resident #36 was on the list to be seen by the dentist on 6/19/24. She explained resident #36 had mentioned she had her lower dentures but had not used them because they were uncomfortable. She shared resident #36 was seen by the Optometrist on 3/21/24 and expressed no concerns at that time. She indicated resident #36 wore regular eyeglasses but now, wanted bifocals. The SSD stated resident #36 was seen monthly by the hygienist and was last seen by the dentist on 11/14/23. The SSD said she had not seen the dietician's care plan dated 8/09/23 which mentioned resident #36 was, having difficulty chewing d/t ill-fitting dentures. Review of a Dental Services Patient Progress Report dated 11/14/23 read, . Adjusted lower dentures to patient comfort, but still hurts right jaw when she wears both dentures. Patient interested in new set of dentures. Review of the Patient Progress Report from hygienist dated 3/27/24 and 4/17/24 read, Full upper and lower dentures with moderate soft deposits . Placed upper denture back in patient's mouth. Appears to fit secure. Placed lower denture back in container with a denture cleansing tablet. A note dated 5/22/24 read, Full upper and lower dentures with light soft deposits . Placed lower denture back in patient's mouth. Placed upper denture back in container with a denture cleansing tablet. Review of resident #36's quarterly MDS assessment with ARD of 5/09/24 revealed she had a Brief Interview for Mental Status score of 14 out of 15 which indicated intact cognition. The assessment noted no rejection of care necessary to obtain goals for her health and well-being. Review of Section B - Hearing, Speech and Vision of the MDS assessment indicated resident #36 had adequate vision and did not use corrective lenses. Review of Section L - Oral/Dental Status of the assessment showed no issues with Broken or loosely fitting full or partial denture and . discomfort or difficulty with chewing. Review of both of resident #36's quarterly MDS assessments with ARDs of 11/11/23 and 2/09/24, revealed she had adequate vision and did not use corrective lenses. Review of the dental section showed no dental issues. Review of resident #36's admission MDS assessment with ARD of 8/10/23 revealed she had adequate vision and did not use corrective lenses. Review of Section L - Oral/Dental Status of the admission assessment showed a list of dental issues to choose from if applicable which included, A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose), B. No natural teeth or tooth fragment(s) (edentulous). The answer selected was, none of the above were present. On 6/05/24 at 2:53 PM, the Clinical Reimbursement Director explained completion of the assessment included a visit to the resident, also she talked to CNAs, nurses, and families as needed. She indicated she also referred to the Admission Data Collection Assessment and the hospital paperwork to complete the MDS assessment. The Clinical Reimbursement Director verified the medical record and confirmed the documentation showed resident #36 used glasses and upper and lower dentures. She validated the MDS assessments were not coded accurately. She mentioned she used the Resident Assessment Instrument (RAI) Manual as her guide. She stated the person who completed and signed off the assessment was attesting to the accuracy of the assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled Resident Assessment Instrument: MDS Section Completion by Discipline dated October 2023 read, The Interdisciplinary Team members participated in the Resident Assessment Instrument to assess each Resident's individual needs and strengths through an approach that assesses problems or conditions and collaboration on appropriate interventions to achieve a Resident's highest level of functioning possible and maintain their sense of individuality. Review of Section B of the MDS 3.0 RAI Manual listed steps for assessments which included asking family, caregivers and/or direct care, asking the resident about their visual abilities and testing the accuracy of the findings. Review of Section L of the MDS 3.0 RAI Manual revealed the intent was to record any dental problems present in the 7-day look-back period. The item rationale read, Poor oral health has a negative impact on quality of life, overall health, nutritional status.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview, and record review, the facility failed to provide intravenous (IV) care and services according to standards of practice and plan of care for 1 of 2 residents reviewed for IV care, out of a total sample of 39 residents, (#55). Findings: Review of resident #55's medical record revealed she was readmitted to the facility on [DATE] with diagnoses including osteomyelitis of the left ankle and foot, type 2 diabetes and pneumonia. Review of the Admission/Readmit: Data Collection and Baseline Care Plan dated 5/07/24 revealed resident #55 had IV access on the left arm. Review of resident #55's admission Minimum Data Set (MDS) assessment with Assessment Reference Date of 5/19/24 revealed she had a Brief Interview for Mental Status score of 7 out of 15 which indicated her cognition was severely impaired. The assessment noted no rejection of care necessary to obtain goals for her health and well-being. The MDS assessment indicated resident #55 had an IV access and was receiving IV medications. Review of resident #55's Physician Orders revealed she was receiving Ceftazidime 1 gram (IV antibiotic) daily for left foot infection until 6/10/24. She had additional orders in effect dated 5/08/24 for nurses to document the IV site appearance, flush normal saline every shift (3 times per day) and change the IV dressing every 7 days and as needed (PRN) when soiled and/or dislodged. Resident #55's care plan for IV medications initiated on 5/09/24 included interventions to, Check dressing at site daily. Change per facility policy/MD (medical doctor) orders. On 6/02/24 at approximately 1:30 PM and 5:15 PM, resident #55 was observed in bed. She had a transparent dressing on her left upper arm midline IV site dated 5/24/24. A midline catheter is a small, thin tube that is inserted into a vein in the upper arm or at the bend in the elbow. Its tip ends at or near the armpit (axillary) area. A midline catheter is a type of IV access. A midline catheter may be used to: . give medicines . Provide IV access for treatment that lasts 1-4 weeks (retrieved from www.elsevier.com on 6/14/24). Review of resident #55's Medication Administration Record (MAR) revealed nursing staff documented flushing the IV line and inspecting appearance every shift, day, evening and night from 6/01/24 to 6/03/24. The MAR showed the IV dressing was last changed on 5/29/24. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/03/24 at 4:27 PM, Registered Nurse (RN) H explained resident #55 had a diabetic ulcer on her left foot and was getting an IV antibiotic for a wound infection. She stated the antibiotic was recently changed because it was not effective. She indicated when she assessed the IV site, she ensured there were no signs or symptoms of infection. She stated the midline dressing must be kept intact and should be changed every 7 days. She explained she used sterile techniques to change the midline dressing, wrote the date and her initials on the dressing then documented it in the medical record. She reviewed resident #55's MAR and confirmed she documented the IV dressing was changed on 5/15/24 and 5/29/24. At 4:40 PM, RN H and surveyor visited resident #55 and inspected her IV dressing. RN H said the date on the dressing read 5/24/24. When outside the room, RN H stated the dressing should have been changed on 5/31/24. She recalled she changed when it was not due because the dressing was not intact and had ,some blood. She stated she did not realize she did not document the dressing change on 5/24/24. She could not provide an answer when asked why she documented she changed the IV dressing on 5/29/24 when she did not. She indicated she was supposed to look at the dressing and note the date. She explained that was important to prevent complications from her infection as resident #55 was immunocompromised and diabetic. On 6/04/24 at 9:01 AM, RN F stated resident #55 had a midline on her left upper arm. She indicated she flushed the line with normal saline during her shift as ordered. She mentioned she assessed the IV dressing noting it was clean and dry and had to be changed every 7 days. At 9:36 AM, RN F and surveyor inspected resident #55's IV dressing. RN H looked at the site twice and stated the dressing date was 5/24/24. She acknowledged the dressing should have been changed on 5/31/24. She acknowledged she was assigned to resident #55 and flushed her IV line on 5/31, 6/1, 6/2, and 6/3 and reflected she should have noticed the dressing needed to be changed. On 6/04/24 at 9:39 AM, the Director of Nursing (DON) stated the expectation was that nurses checked the IV site and changed the dressing every 7 days or PRN. She mentioned this was important to keep the area free of pathogens, prevent infection or reinfection. At 9:44 AM, the DON went into resident #55's room and confirmed the date on the IV dressing read 5/24/24. She indicated the nurses should have changed the IV dressing timely and RN H should have changed it yesterday as soon as she inspected it with the surveyor. Review of the facility's Dressing Change for Vascular Access Devices policy and procedures dated 8/16 revealed a purpose, to prevent local and systemic infection related to IV catheter. The policy read, Central venous access device and midline dressing changes will be done at established intervals . Transparent semi-permeable membrane dressings are changed every 7 days and PRN.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 50401 Based on observation, interview and record review, the facility had a pattern of failing to follow physician prescribed respiratory therapy orders for 1 of 2 residents reviewed for respiratory care, of a total sample of 49 residents, (#10). Findings: On 6/03/24 at 11:55 AM, resident #10's oxygen was set at 3 liters per minute (LPM) but review of the physician's orders showed the order for oxygen (O2) at 5 LPM dated 10/11/22. On 6/03/24 at 10:56 AM, the assigned Registered Nurse (RN) C, checked the order for resident #10's oxygen and confirmed it was for 5 LPM. There was also an order for O2 tubing to be changed weekly and labeled with the date. RN C went to resident #10's room and checked the resident's oxygen concentrator noting it was set for 3 LPM and the O2 tubing was not dated. She stated she had completed medication pass for this resident this morning and was supposed to check the oxygen order at that time, but confirmed she did not do so. When RN C started to change the oxygen level to 5 LPM, as per the order, the resident got very upset and started crying. The resident stated she worked hard over the last 2 years to wean herself off the oxygen to get it down to 3 LPM and did not want it to go back up to 5 LPM. Resident #10 explained nurses would adjust the oxygen level to 3 LPM as requested by the resident herself, and thought the physician was aware of this. She confirmed this had gone on for about a year, and denied ever touching the oxygen concentrator setting herself. RN C stated she was assigned to this resident 5 days/week on the day shift and confirmed what resident #10 said. RN C tested the resident's O2 saturation level which was 97%. RN C agreed the nursing staff from each shift were supposed to be checking the resident's oxygen order, but were not, or had not noticed the order was different from the actual O2 setting on the machine. She stated the nursing staff was checking the resident's 02 saturation level regularly and it had been fine. Review of the resident's Electronic Treatment Administration for the prior 6 month period showed the order for oxygen at 5 LPM was verified and documented as administered by nurses 3 shifts a day during this time. RN C notified the resident's physician and received an updated order for O2 at 3 LPM. In an interview on 06/04/24 at 11:10 AM, the Director of Nursing stated nursing was required to follow doctors' orders regarding monitoring oxygen settings, and this varied with each resident. She continued, the order for this resident was to check oxygen settings at every shift and stated she had been made aware nursing staff had charted resident #10 received 5 LPM of oxygen since October 2022.

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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. 50401 Based on observation and interview, the facility failed to store food in the freezer and walk-in refrigerator in accordance with food safety standards to prevent foodborne illness. Findings: On 6/02/24 at 10:00 AM, during the initial kitchen inspection with [NAME] D, the door into the walk-in refrigerator was found to be left open. The walk-in refrigerator temperature was 48 degrees Fahrenheit (F) on the thermometer inside. [NAME] D verified the temperature of the walk-in refrigerator and used her thermometer to measure the temperature of a carton of Mighty Shake stored inside. The temperature of the Mighty Shake was 47 degrees F. [NAME] D acknowledged the temperature was outside the acceptable range and threw away the 9 Mighty Shakes. A few minutes later, in the freezer, an unlabeled, undated, and unsealed bag of 24 sausage patties was observed. The sausage patties were stuck, frozen together and covered with ice crystals. There was also an unlabeled, undated, and unsealed bag of vegetarian burger patties. The approximately 6-8 patties on top, were frozen together in an oval-shaped mound and were also covered with ice crystals. [NAME] D confirmed the unlabeled, undated, unsealed bags of food. [NAME] D stated facility policy included that all food items should be sealed, labeled and dated once opened. She threw away both bags of food items. On 6/03/24 at 3:22 PM, the Certified Dietary Manager stated facility policy was all food items should be covered or sealed, labeled and dated when opened. She also explained the refrigerator door was very heavy and she reminded the staff regularly to ensure it was kept closed.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on observation, interview, and record review, the facility failed to implement Transmission Based precautions to prevent the spread of infection for 1 of 1 resident reviewed for isolation precautions, (#192), of a total sample of 39 residents. Findings: Review of resident #192's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included resistance to Vancomycin, acute renal failure, and Escherichia coli. The resident's Medical Certification for Medical Long Term Care Services and Patient Transfer form dated 5/12/24 listed infection control issues of Vancomycin-resistant enterococci (VRE) in the urine and Extended-spectrum beta-lactamase (ESBL) of the blood and contact Isolation Precautions. Vancomycin-resistant enterococci is a type of bacteria that is resistant to Vancomycin, a powerful antibiotic, (retrieved from www.webmd.com on 6/14/24). Extended-spectrum beta-lactamases (ESBL) are enzymes or chemicals produced by germs like certain bacteria. These enzymes make bacterial infections harder to treat with antibiotics, (retrieved from www.webmd.com on 6/14/24). Resident #192's Admission/Readmission Data Collection and baseline care plan dated 5/31/24 revealed a care plan for an actual wound with an intervention of contact precautions. Resident's #192 order summary contained a physician's order for contact precautions for a bacterial infection with a start date of 6/04/24. Contact precautions were used for patients with known or suspected infections that can be transmitted through contact. For those patients, standard precautions such as hand hygiene and personal protective equipment (PPE), etc. are needed, with the addition of limited transport and movement of patients, use of disposable patient care equipment, and thorough cleaning and disinfection strategies, (retrieved from www.ncbi.nlm.nih.gov on 6/14/24). On 06/03/24 at 11:22 AM, resident #192's room door was closed with signage that read, Contact Isolation, and a PPE caddy was also hanging from the door, filled with supplies of gloves, masks, and gowns. Upon entering resident #192's room, she stated, I was in isolation in the hospital for the urine infection I had. I told the nurse that I was in isolation in the hospital when I arrived here on Friday. Today is when they decided to wear gowns and masks. On 6/03/24 at 12:12 PM, Registered Nurse (RN) F, the primary nurse, stated the resident was on contact isolation because of bacteremia. The bacteremia diagnosis was present upon admission, and RN F confirmed resident #192 should have been placed on contact isolation upon her admission to the facility but had not been placed on it until that day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER Delaney Park Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 215 Annie Street Orlando, FL 32806	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/04/24 at 10:28 AM, RN G, stated the resident came with a package of medical records from the hospital. The documents and medication list were reviewed, then the doctor was contacted to confirm the implementation of orders. RN G explained any nurse could implement the PPE for transmission precautions. She said all PPE was available on the unit. On 6/04/24 at 2:44 PM, the Director of Nursing (DON) stated that the clinical team met to discuss each unit's admissions. A checklist was used to review the chart to ensure all orders were implemented. The checklist was not part of the medical record. She stated her expectation of the nurses was to follow orders and contact isolation should be implemented at the time the resident arrived. She also stated that PPE, signage, and all necessary equipment was available on each unit.