STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105797	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Care Nursing & Rehabilitation Center	350 South John Young Parkway Orlando, FL 32805

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646 Based on observation, interview, and record review, the facility failed to provide a secure environment to prevent a vulnerable resident from exiting the facility unsupervised for 1 of 3 residents reviewed for elopement, of a total sample of 34 residents, (#87). Findings: Resident #87 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, unspecified sequelae of cerebral infarction (stroke), personal history of pulmonary embolism, muscle weakness, unspecified mood [affective] disorder, unspecified abnormalities of gait and mobility, cognitive communication deficit, urinary tract infections, dementia in other diseases classified elsewhere mild with other behavioral disturbance, post-traumatic stress disorder, bipolar disorder and encephalopathy. Review of the Minimum Data Set quarterly assessment with assessment reference date of 2/27/25 revealed resident #87 had a Brief Interview for Mental Status score of 10/15 which indicated he had moderate cognitive impairment. The document indicated he required substantial/maximal assistance for transfers and used a wheelchair for mobility. The assessment indicated resident #87 did not use a wander/elopement alarm. Review of the medical record revealed an elopement evaluation dated 3/01/25 which indicated resident #87 was at high risk for elopement; an elopement evaluation dated 2/02/25 which indicated he was at low risk for elopement and an elopement evaluation dated 1/26/25 which indicated he was at moderate risk for elopement. A care plan for at risk for elopement due to resident #87's level of dementia was initiated 1/20/25. Interventions included to monitor location and provide supervision as needed. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/25 at 3:37 PM, Certified Nursing Assistant (CNA) C confirmed she was the assigned CNA for resident #87 on 3/01/25. She recalled seeing resident #87 around 7:00 PM. CNA C reported she observed him in the rotunda just down from the reception area between the units. She stated she believed she was headed to the kitchen and then returned to her unit. CNA C recalled going on break around 8:15 PM after making rounds. When she returned from break, she was informed resident #87 was observed outside the facility. She stated he was brought back in side and she prepared him for bed. Someone placed a wander alert bracelet on him and she was assigned to sit 1:1 with resident #87 for the rest of the shift. CNA C stated she had never worked with resident #87 before and did not know he was a risk for elopement. She recalled there was no indication on the Kardex and no one informed her of his risk for elopement before that day. On 3/09/25 at 3:55 PM, Registered Nurse (RN) A verified she was the assigned nurse for resident #87 on 3/01/25. She recalled she last saw him at approximately 8:00 PM sitting around room [ROOM NUMBER]. RN A explained she attempted to get the resident to return to his unit, but he refused. She stated she returned to her unit after she decided to give him time and would reapproach him. She recalled sometime later, resident #87 was brought back to the unit after he exited the building through the double door off the 200 unit. On 3/09/25 at 4:13 PM, CNA B recalled she worked the night of 3/01/25. She stated she went to the dayroom to get some ice for another resident. She walked over and began filling a glass when she heard a knock on the window. CNA B explained she looked out the window and saw resident #87 in his wheelchair on the sidewalk motioning for her to come to him. She stated she exited through the doors in the dayroom which led to the back courtyard and went around to side of the building to where resident #87 was sitting on his wheelchair waiting for her to let him back inside the building. CNA B reported she did not hear any door alarms prior to or at the time she exited to go outside. She stated she asked resident #87 what he was doing outside and he told her he was looking for his wife. CNA B explained that resident #87 was compliant and returned to the facility with her through the front door at approximately 8:50 PM. On 3/10/25 at 8:57 AM, the Maintenance Director pointed out the doors at the end of the 200 hallway. The doors were marked with a red sticker that read, push until alarm sounds, door will open in 15 seconds. The Maintenance Director pushed on the door and it opened. An alarm sounded. He acknowledged the doors were not locked and would open immediately if pushed. He clarified the alarms were installed after resident #87 exited the building on the night of 3/01/25. The Maintenance Director explained a wander alert system was previously installed at each door which would lock the door if a resident with a wander alert bracelet came near the door. The Maintenance Director stated the doors did not lock or alarm when resident #87 exited the facility because he did not have a wander alert bracelet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 3/10/25 at 10:26 AM, resident #87's wife confirmed she was informed that her husband exited the facility on the night of 3/01/25. She stated she was unsure which door he exited through and thought it may have been the front door. Resident #87's wife recalled she was at the facility that day, left sometime after 6:00 PM and did not return inside the facility. She explained she left her car parked in front of the facility and went shopping with her daughter, but did not tell her husband she was leaving. She explained when she left and did not tell her husband she was leaving he likely exited the facility to look for her as he could see her car still parked in the parking lot from the lobby. She stated he had never done anything like this at home. Resident #87's wife expressed his mind fluctuated at times and he had good days and bad days with his cognition. She stated she did not think he would do anything to hurt himself. On 3/11/25 at 11:21 AM, the Executive Director and the DON reviewed the facility investigation. The Executive Director expressed the investigation revealed resident #87's wife left the facility without telling her husband she was leaving. She stated resident #87 exited the facility in an attempt to locate his wife. She explained he had not exhibited any exit seeking behavior previously. She acknowledged resident had previously been identified as an elopement risk and a care plan remained active. The Executive Director verified the doors used by resident #87 were not used for entrance to the facility from the outside but were used as emergency exit doors. She acknowledged there were no alarms on the doors to alert staff to the door being breached unless the resident had a wander alert bracelet. She clarified that resident #87 did not have a wander alert bracelet at the time he exited the facility. The Executive Director acknowledged that resident #87 had been out of the facility for approximately 35 minutes without staff being aware he was not in the facility. Review of the facility's policy and procedure Resident Elopement Defined revealed an elopement occurred when a resident left the premises or a safe area without authorization and/or necessary supervision to do so. The document identified the facility would seek to prevent elopement through components which included but were not limited to regular rounds, staff supervision and interventions and environmental modification. The document indicated that only residents at high risk of elopement would be issued a wander alarm bracelet.