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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50401 Based on observation, and interview, the facility failed to ensure residents were treated with dignity by not referring to them according to their care needs, for example, as feeders. This had the potential to affect 2 of 2 residents who required assistance with dining on the East Wing, of a total sample of 34 residents. Findings: On 3/12/25 at 8:30 AM, Certified Nursing Assistant (CNA) F, was observed training CNA G, and overheard telling her that resident #15 was a feeder, so CNA G was to bring his food to him and go back to feed him when she finished passing trays to other residents. CNA G did as she was instructed by CNA F. CNA F did not explain why she called resident #15 a feeder and only acknowledged with, OK. On 3/12/25 at 4:00 PM, Registered Nurse (RN) H asked, you mean how many feeders? in response to how many residents on the East Unit were dependent on staff for eating their meals. RN H acknowledged he erroneously referred to the residents by the term, feeders and then named the two residents on the unit that needed assistance with dining. On 3/12/25 at 4:30 PM, the Director of Nursing (DON) acknowledged staff should not refer to residents with the term feeders, as it was a dignity issue. She explained the facility had provided a staff in-service on policies and procedures during meal times, including instruction to not use labels such as feeders when referring to residents, about 10 minutes prior to when RN-H had used the term.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on observation, interview, and record review, the facility failed to complete a Pre Admission Screening And Resident Review (PASARR) Level I Screen for 5 of 6 residents reviewed for PASARR that were later identified with a possible Serious Mental Illness (SMI), of a total sample of 34 residents, (#20, #42, #72, #28, and #75). Findings: 1. Review of the medical record revealed resident #20, a [AGE] year old female was admitted to the facility from an acute care hospital with diagnoses that included lack of coordination, ulcer of esophagus, hypertension, cerebral infarction (stroke), hemiplegia/hemiparesis (paralysis), major depressive disorder, unspecified psychosis, and anxiety disorder. The most recent Minimum Data Set (MDS) Quarterly Assessment with an Assessment Reference Date (ARD) of 12/29/24 noted during the look-back periods, resident #20 scored 9 out of 15 on the Brief Interview for Mental Status (BIMS) that indicated she was severely cognitively impaired. The assessment documented the resident sometimes felt lonely or isolated, for 4 to 6 days had verbal behavioral symptoms directed towards others, requires substantial/maximum staff assistance to complete Activities of Daily Living (ADL) and mobility, did not walk, was always incontinent of bladder and bowel functions, received seven insulin injections and high-risk anti-psychotic, anti-depressant, anti-platelet, and hypo-glycemic medications. No psychological therapy or discharge planning to return to the community occurred. On 3/10/25 at 10:42 AM, resident #20 was observed in the Memory Care common area sitting in a wheelchair amongst approximately 10 other residents. The resident was observed to be distressed for no obvious reason while she yelled out, Hey, hey, hey. On 3/10/25 at 1:59 PM, the resident was observed in her room sitting in a wheelchair. The resident was observed yelling out in the same manner. Review of the Admission Record noted on 12/18/16, after resident #20 was admitted , additional diagnoses were added that included: delusional disorders and pseudobulbar effect (sudden uncontrollable crying or laughing). The State Agency (MedServ Form 004 Part A, October 2015) PASARR (Pre-Admission Screen and Resident Review) Level I Screen completed by the acute care hospital on 11/19/15 documented resident #20 did not have any Suspected Mental Illness (SMI) or difficulty in interpersonal functioning. On 3/11/25 at 1:42 PM, the Social Services Director said she was responsible for completing PASARR forms for the facility. She explained, their process was that the clinical team checked and reviewed records when residents were admitted . She said if a form was missing, for example if a resident was admitted from home, she completed and submitted them electronically. She checked resident #20's medical record and confirmed there were no possible SMI diagnoses listed on the Level I Screen and stated, I don't have to do a new one; I haven't been told it has to be redone if they're not correct. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record revealed resident #42, a [AGE] year old male was admitted to the facility from a Veteran's acute care hospital on 5/10/24 with diagnoses that included moderate dementia with anxiety, affective mood disorder, major depressive disorder, cognitive communication deficit, anxiety disorder, and Chronic Post Traumatic Stress Disorder (PTSD). The most recent MDS Quarterly Assessment with an ARD of 2/11/25 noted during the look-back periods, resident #42 scored 11 out of 15 on the BIMS that indicated he was moderately cognitively impaired. The Mood Interview showed for several days, the resident felt down, depressed, or hopeless, had little energy, trouble concentrating, and sometimes felt lonely or socially isolated with no rejections of evaluation or care. The assessment noted the resident required set-up to substantial/maximum assistance to complete ADLs and functional mobility. The resident did not walk, was always incontinent of bladder and bowel functions, received high-risk anti-depressant, anti-coagulant (blood thinner), opioid, and anti-platelet (blood clot prevention) medications. There was no psychological therapy or active discharge planning to return to the community. On 3/10/25 at 9:22 AM, resident #42 was observed in his room alone, lying in bed. The resident was irritable, reluctant to answer questions and stated, they don't help me. Review of the State Agency (MedServ Form 004 Part A, March, 2017) PASARR Level I Screen completed by the acute care hospital on 5/10/24 revealed it did not list resident #42's PTSD diagnosis. On 3/11/25 at 1:45 PM, the Social Services Director checked resident #42's medical record acknowledged the PASARR did not include the PTSD diagnosis and stated, it should have PTSD on there, therefore the previous screening was incorrect. 3. Review of the medical record revealed resident #72, a [AGE] year old male was admitted to the facility from an Veteran's acute care hospital on 3/30/23 with diagnoses that included gait and mobility abnormalities, unspecified dementia with psychotic, mood, and anxiety disturbance, adjustment disorder with depressed mood, and PTSD. The most recent MDS Quarterly Assessment with an ARD of 12/31/24 noted during the look-back periods, resident #72 scored 7 out of 15 on the BIMS that indicated he was severely cognitively impaired. The assessment noted the resident required supervision to moderate assistance to complete ADLs and supervision for functional mobility and walking. The resident was occasionally incontinent of bladder and bowel functions, and received high-risk anti-depressant medications. There was no psychological therapy or active discharge planning to return to the community. The State Agency(MedServ Form 004 Part A, March, 2017) PASARR Level I Screen completed by the acute care hospital on 3/30/23 documented resident #72 did not have any SMI. On 3/09/25 at 4:30 PM, the Social Services Director checked resident #72's medical record acknowledged the PASARR was incorrect and did not include any possible mental illness diagnoses. In a joint interview with the Director of Nursing (DON) and Assistant DON on 3/12/25 at 3:36 PM, the DON said there were weekly meetings with psychiatric services, the pharmacy, social services, and nursing to discuss residents' plan of care. The DON explained any new diagnoses and treatment revisions were discussed and updated. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/12/25 at 8:43 AM, Social Services Director said she called the State Agency (SA) PASARR vendor to clarify when a new Level I Screen was required. She said she learned that a new screening was required for incorrect forms or later if possible SMI's, including PTSD were identified to determine if further evaluations were necessary to ensure residents received proper services and placement for their psychiatric diagnoses. She confirmed the facility needed to submit corrected forms for the residents. 50875 4. Review of the medical record revealed resident #28 was admitted to the facility on [DATE]. Her diagnosis included hypertension, hemiplegia, major depressive disorder, cerebral infarction (stroke), auditory hallucinations and bipolar disorder. Resident #28's Annual MDS with an ARD of 1/18/25 revealed the resident scored 15 out of 15 on the BIMS assessment which indicated she had no cognitive impairment. The assessment also indicated the resident felt depressed, had no behaviors nor rejection of care and listed diagnoses of depression, bipolar disorder and auditory hallucinations. Resident #28's Order Summary Report showed the resident had an order for Quetiapine Fumarate Tablet 75 milligrams (mg) by mouth at bedtime for bipolar disorder and Bupropion HCl tablet 150 mg by mouth two times a day major depressive disorder. On 3/10/25 at 10:50 AM, a review of resident #28's PASARR Level I Screen for Serious Mental Illness and /or Intellectual Disability or Related Conditions dated 1/15/21 incorrectly indicated no diagnoses listed in Section A for Mental Illness or Suspected Mental Illness. 5. Review of the medical record revealed resident #75 was initially admitted on [DATE] and readmitted on [DATE]. His diagnosis included dementia, delusional disorders, dysphagia (difficulty swallowing), psychotic disorders with delusions and Parkinson's disease. Resident #75's Quarterly MDS with an ARD of 12/24/24 revealed the resident scored 3 out of 15 on the BIMS which indicated he had severe cognitive impairment, displayed no behaviors and listed psychotic disorder as a diagnosis. The Plan of Care for resident #75 indicated he was at risk for adverse effects related to the use of antipsychotic medications. Review of resident #75's Order Summary Report revealed the resident had orders for Quetiapine Fumarate tablet 25 mg by mouth daily and 50 mg by mouth at bedtime for hallucinations. On 3/09/25 at 4:30 PM, a review of resident #75's PASARR Level I Screen for Serious Mental Illness and /or Intellectual Disability or Related Conditions dated 3/22/23 revealed no diagnoses listed in Section A for Mental Illness or Suspected Mental Illness. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/25 at 11:55 AM, the Social Service Director explained she was the one who reviewed the PASARR forms. She explained the process was that nurses would review the admission packet from the hospital, the clinical team would review it, then it was reviewed by medical records and finally, it was scanned into the electronic medical record. A copy was left in the hard chart as well. If a resident was admitted from home, she would complete the form. The Social Service Director would only update it if there were new behaviors which required a reassessment of a resident. The Social Service Director said she had always assumed that PASARRs from the hospital were correct. On 3/12/25 at 10:36 AM, the Social Services Director verified there were no diagnoses listed on the PASARR form for both resident #28 or #75. She confirmed the forms needed to be corrected. On 3/12/25 at 9:20 AM, the Director of Nursing (DON) said her expectation would be that the residents' diagnoses should have been listed in Section A and the PASARRs should have been updated when new diagnoses or changes occurred. The DON stated they needed to audit the whole facility for PASARR accuracy. The facility's undated policy for preadmission statements and eligibility requirements indicated that prior to admission, if the facility did not receive sufficient information to make an informed decision as to whether adequate care could be provided .the facility would transfer the resident to a more appropriate level of care. In section 1 d. Prior to admission, a screening by an outside agency was done to determine whether the individual's primary diagnosis was mental illness.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646 Based on interview, and record review, the facility failed to refer a resident with identified mental illness for a Level II Preadmission Screening and Resident Review (PASARR) evaluation and determination for 1 of 6 residents reviewed for PASARR, of a total sample of 34 residents, (#87). Findings: Resident #87 was admitted to the facility on [DATE] with diagnoses including unspecified sequelae of cerebral infarction (stroke), unspecified mood [affective] disorder, cognitive communication deficit, dementia in other diseases classified elsewhere mild with other behavioral disturbance, post-traumatic stress disorder, and bipolar disorder. Review of the Minimum Data Set (MDS) 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 his active diagnoses included non-Alzheimer's Dementia, Bipolar Disorder, post-traumatic stress disorder, unspecified mood [affective] disorder, and cognitive communication deficit. The MDS revealed resident #87 received antipsychotic medications on a routine basis. Review of resident #87's care plan revealed a behavior care plan initiated 11/07/24 which indicated he displayed agitated behavior with history of refusing care, yelling at staff, hitting, slapping and kicking. The Electronic Medical Record contained a Level I PASARR screening form dated 9/03/24 which indicated resident #87 had anxiety disorder and psychotic disorder. Review of the Level I PASARR screening form revealed resident #87 had exhibited actions or behaviors that may make him a danger to himself or others, received psychiatric treatment more intensive than outpatient care and had experienced an episode of significant disruption to his normal living situation due to the mental illness. The PASARR Screen completion section read, Individual may not be admitted to [a] Nursing Facility. Use this form and required documentation to request a Level II [PASARR] evaluation because there is a diagnosis of or suspicion of: serious mental illness. The medical record did not contain a Level II PASARR Evaluation and Determination form. On 3/12/25 at 11:09 AM, the Social Services Director (SSD) stated she and the Director of Nursing were ultimately responsible for reviewing PASARR screenings upon admission. The SSD explained the admissions department obtained the level I PASARRs and put them in the admissions packet for nursing. The clinical team then reviewed the PASARR for accuracy. The SSD confirmed resident #87's need for a Level II was missed. She acknowledged a PASARR Level II screening was not submitted for resident #87 but should have been. The facility's undated policy and procedure for Pre-Admission Assessments and Eligibility Requirements contained a list of information required prior to admission. The required information included a screening to determine if the individual had a primary diagnosis of mental illness or mental retardation. The policy and procedure indicated that an individual with mental illness or mental retardation who was not a danger to himself/herself may be admitted to the facility.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50401 Based on interview, and record review, the facility failed to ensure residents who required dialysis received services consistent with professional standards of practice including ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments. A pattern of a lack of assessments was demonstrated for 1 of 4 residents reviewed for dialysis, of a total sample of 34 residents, (# 10). Findings: Resident #10 was admitted to the facility on [DATE] with the diagnoses of end stage renal disease (ESRD) with dependence on renal dialysis, type II diabetes mellitus with hyperglycemia, essential hypertension, unspecified mood disorder, anemia of chronic kidney disease, cognitive communication deficit, dementia, encephalopathy, and abnormalities of gait and mobility. The Minimum Data Set (MDS) quarterly assessment dated [DATE], indicated the resident's Brief Interview for Mental States score was 3/15, which indicated severe cognitive impairment. On 3/11/25 at 10:31 AM, the North [NAME] (NW) Wing Unit Manager (UM) indicated the last nursing report in resident #10's dialysis chart for a dialysis visit was for Thursday 2/20/25 (19 days prior). The most recent one before that was dated 2/08/25 (12 days prior to the 2/20/25 visit). The UM acknowledged the reports were to document the residents' vital signs (vitals) and condition prior to dialysis and after she returned from dialysis treatment. He stated resident #10 was scheduled for dialysis three times per week, on Tuesdays, Thursdays, and Saturdays, so he expected nurses to complete three reports per week. He explained sometimes the resident refused to go to dialysis. For 2025, pre- and post-dialysis reports were found for the dates of 1/02/25, 1/09/25, 1/16/25, 1/31/25, 2/04/25, 2/06/25, and one with no date documented, which totaled eight reports out of a total of 17 dialysis visits during that time period. The NW Wing UM stated he was not able to find any of the missing reports in the residents' paper and electronic medical records. On 3/11/25 at 11:10 AM, the Assistant Director of Nursing (ADON) and the NW Wing UM agreed nurses were expected to chart a progress note anytime when their residents left the facility including for dialysis, and document their condition upon their return. The NW Wing UM searched for nursing progress notes in the electronic medical record for the dialysis dates Tuesday, 1/28/25, Thursday 1/30/25, and Saturday, 2/01/25, which he stated the resident had dialysis treatment. He acknowledged the nursing progress note for 1/28/25 indicated the resident left for dialysis, but did not include documentation that she returned nor her condition upon return. For the dates 1/30/25 and 2/01/25, he confirmed there were no nursing progress notes regarding the resident going to nor returning from dialysis, nor any documentation of her vitals or condition. The NW Wing UM stated it was important for the nurse to take vitals and check the resident's overall condition including the dialysis port site after they returned from dialysis to ensure they were good to go, not bleeding out, not bottomed out [low blood pressure], and were OK. After the NW Wing UM searched resident #10's electronic medical record, he stated he was not aware of any other place where nurses would document the condition of the resident before and after dialysis per procedure. He stated not finding this documentation was eye-opening to him. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 3:00 AM, the local Dialysis Center confirmed by telephone, resident #10 received dialysis treatment at their facility on 1/09/25, 1/11/25, 1/16/25, 1/18/25, 1/21/25, 1/25/25, 1/28/25, 1/30/25, 2/01/25, 2/04/25, 2/08/25, 2/11/25, 2/13/25, 2/15/25, 2/10/25, 3/04/25, and 3/08/25, a total of 17 times since the start of the year. Review of the physician orders and the electronic Treatment Administration record (TAR) indicated that upon return from dialysis, the nurse was to monitor their pressure and site dressing after four hours, and remove it if there was no bleeding present. If bleeding was present, they were to reapply the pressure dressing and re-evaluate in four hours and remove the dressing if there was no further bleeding. It added to document findings every day and evening shift every Monday, Wednesday, Friday for ESRD and every day and evening shift every Monday, Wednesday, Friday, on dialysis days. Another order directed staff to monitor dialysis shunt site for bleeding or signs of infection every shift with a start date of 3/28/24. Since the resident's scheduled dialysis days were on Tuesday, Thursday, and Saturdays, the documentation for the order for the dressing findings was not completed on dialysis days. The TAR for Monday, 1/27/25, Wednesday, 1/29/25, and Friday, 1/31 were documented as the resident's pressure and dialysis port site were checked to indicate findings after dialysis even though the resident did not have dialysis on these days. The dates of Tuesday, 1/28/25, Thursday, 1/30/25, and Saturday, 2/01/25 had an X to indicate the resident's dressing did not need to be checked even though the resident did receive dialysis on those days. The inaccurate documentation of dressing findings per physician order rendered unreliable results of resident #10's condition post-dialysis. On 3/12/25 at 4:53 PM, the ADON stated she would expect nursing staff to document on the correct date after the resident returned from dialysis and make their manager aware of the discrepancy in the dates for dialysis assessment on the TAR, so it could be corrected. The ADON also noted from the resident's vital sign documentation in the medical record, this resident's blood pressure was documented nine times in January, zero times in February, and only once in March, totaling ten times during 2025. She then looked throughout the resident's entire electronic medical record but could not locate blood pressure measurements documented in any other areas in the medical record. The ADON stated this would not meet the standards of practice for a resident with hypertension or dialysis. She confirmed the resident went to dialysis 17 times since the beginning of the year, and blood pressure should have been monitored at least 34 times, both before and after dialysis. The ADON confirmed the facility's communication form had a place on the bottom for the facility to document vitals and the resident's condition upon their return from dialysis and added that even if the bottom of the form was not completed, the expectation would be for nurses to assess the resident when they return and record their vital signs, (blood pressure, pulse, respiration, and temperature) and to check the resident's condition (the dialysis site, dialysis access, Bruit and Thrill, symptoms of bleeding and that pressure dressing was intact), into the electronic medical record system. The ADON verified this resident's vital signs and some aspects of the resident's condition were not monitored on many days the resident went to dialysis nor were vital signs completed as would routinely be expected, even on non-dialysis days. (continued on next page)

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	105797	A. Building B. Wing	03/12/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Dialysis Protocol, which the ADON stated would have to have been reviewed at a minimum in the beginning of this [AGE] year, indicated the resident should be assessed for vital signs and other conditions prior to, and after the resident returns from, dialysis treatment. The ADON stated there was a batch order for dialysis residents and even though there was no specific order for the communication tool used between the facility and the dialysis center, there was a communication practice between dialysis and all facilities that occurred because it was best practice for dialysis residents.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on observation, interview, and record review, the facility failed to provide ongoing monitoring and mitigate triggers of identified past trauma for 2 of 3 residents reviewed for trauma informed care, of a total sample of 34 residents, (#42, and #72). Findings: 1. Review of the medical record revealed resident #42, a [AGE] year old male was admitted to the facility from a Veteran's acute care hospital on 5/10/24 with diagnoses that included moderate dementia with anxiety, affective mood disorder, major depressive disorder, cognitive communication deficit, anxiety disorder, and Chronic Post Traumatic Stress Disorder (PTSD). The most recent Minimum Data Set (MDS) Quarterly Assessment with an Assessment Reference Date (ARD) of 2/11/25 noted during the look-back periods, resident #42 scored 11 out of 15 on the Brief Interview for Mental Status (BIMS) that indicated he was moderately cognitively impaired. The Mood Interview showed for several days, the resident felt down, depressed, or hopeless, had little energy, had trouble concentrating, and sometimes felt lonely or socially isolated. There were no rejections of evaluation or care. The assessment noted the resident required set-up to substantial/maximum assistance to complete Activities of Daily Living (ADL) and for functional mobility. The resident did not walk, was always incontinent of bladder and bowel functions, received high-risk anti-depressant, anti-coagulant (blood thinner), opioid (narcotic pain), and anti-platelet (blood clot prevention) medications. There was no psychological therapy or active discharge planning to return to the community. The Order Summary Report included active physician's medication orders for Donepezil (chemical inhibitor) 5 Milligrams (MG) daily at bedtime for dementia, Meclizine (antihistamine) 25 MG three times daily for vertigo (dizziness), Mirtazapine (anti-depressant) 15 MG daily at bedtime for depression, and Tramadol (opioid) 50 MG twice daily for pain. The Care Plan Report's focuses included: ADL self-care deficits, resistance to care, prefers to remain in bed most days, incontinence, nurse monitoring of anti-depressant medication adverse effects, easily upset when things don't go his way; becomes accusatory of staff when they try to provide care with an intervention that read, maintain a stable physical environment by decreasing sensory overload . The Comprehensive Care Plan did not include a Focus for PTSD. On 3/10/25 at 9:22 AM, resident #42 was observed in his room. The resident was awake while lying in bed and displayed an irritable mood. He was reluctant to answer questions and stated, they don't help me. Review of the Activities Initial Evaluation completed by the Activities Director on 5/16/24 noted resident #42's former occupation was a Veteran Army Military Police Officer. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 10:50 AM, Certified Nursing Assistant (CNA) I said she knew resident #42 well and he was frequently included in her assignment. The CNA stated, he is very agitated, refuses care; he's very jumpy, cusses you and throws things; he is not predictable; doesn't like the noise; he complains it's noisy and says close my door. The CNA said she didn't know anything about the resident's background. On 3/11/25 at 10:58 AM, the North [NAME] Unit Manager said he was in the position for approximately four months. He described resident #42 as alert with a varied mood and unpredictable behavior. The nurse stated, I don't know if he has any special issues; if they have problems they come to me. On 3/11/25 at 11:10 AM, Registered Nurse (RN) L said resident #42 was included in her assignment frequently when she worked the 7:00 AM to 3:00 PM shift. She said the resident was grumpy and didn't ask for much. The RN said she wasn't sure if the resident received any psychiatric services and stated, I'm not sure what his issues are; there's no special instructions; nothing out of the ordinary. On 3/11/25 at 1:42 PM, the Social Services Director said she was responsible for completing Trauma Informed Care assessments which were done on admission. She checked resident #42's medical record and said he triggered for PTSD on admission 10 months earlier, and he received psychiatric services. The Social Services Director explained bells, slamming doors, and overstimulation were common triggers of PTSD with veterans. Review of the PC-PTSD-5 assessment completed by the Social Services Director on 5/20/24 noted resident #42 had a positive response to past trauma events with examples that read, . A war. Seeing someone killed or seriously injured. Having a loved one die through homicide or suicide. The psychiatric provider's progress note dated 12/03/24 read, reports irritability and anger as a response to loud noises and disruptive environment at skilled nursing facility. Reports history of nightmares secondary to traumatic experiences during the Vietnam War. On 3/11/25 from 10:48 AM to 10:51 AM, resident #42's room door was observed open. Loud continuous alarms were heard at the nurses' station located just outside his room. On 3/12/25 at 8:43 AM, the Social Services Director checked resident #42's medical record and said the only PTSD screening/monitoring evaluation she conducted was completed on admission, 10 months prior. Review of the State Agency (PASARR) Level I Screen completed by the acute care hospital on 5/10/24 did not include resident #42's PTSD diagnosis. On 3/11/25 at 1:45 PM, the Social Services Director checked resident #42's medical record and said the PASARR did not include a PTSD diagnosis and confirmed, it should have PTSD on there. 2. Review of the medical record revealed resident #72, a [AGE] year old male was admitted to the facility from an Veteran's acute care hospital on 3/30/23 with diagnoses that included gait and mobility abnormalities, unspecified dementia with psychotic, mood, and anxiety disturbance, adjustment disorder with depressed mood, insomnia, and PTSD. (continued on next page)

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

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent MDS Quarterly Assessment with an ARD of 12/31/24 noted during the look-back periods, resident #72 scored 7/15 on the BIMS that indicated he was severely cognitively impaired. The assessment noted the resident required supervision to moderate assistance to complete ADLs, and supervision for functional mobility and walking. The resident was occasionally incontinent of bladder and bowel functions and received high-risk anti-depressant medications. There was no psychological therapy or active discharge planning to return to the community. The Care Plan Report's focuses included: nurse monitoring of adverse psychotropic medication effects, risk and history of falls, Long Term Care placement, ADL self-care deficits, incontinence, and at risk for changes in mood and/or behavior related to the diagnosis of PTSD with a goal for freedom from negative abrupt changes in behavior and mood. The Order Summary Report included active physician's medication orders for: Bupropion (anti-depressant) 12 Hour 150 MG once daily for PTSD, and Trazodone (anti-depressant) 100 MG daily at bedtime for insomnia. On 3/11/25 at 11:13 AM, resident #72 was observed in his room, awake, lying in bed. He said he was a [NAME] Veteran and he liked it quiet. He said he wasn't aware of any special services in regard to PTSD at the facility and stated, I would like that. On 3/12/25 at 3:58 PM, resident #72's door was open and he was observed in his room sitting in a wheelchair. The resident said he liked his door closed and stated, all I do is sit in here and watch TV, so I don't get into no kind of trouble. On 3/11/25 at 10:55 AM, CNA I said she knew resident #72 well and he preferred to stay in his room. The CNA said she was not aware of any special needs for the resident. On 3/11/25 from 11:13 AM to 11:16 AM, resident #42's room door was observed open. The resident's room was located across and down the hall approximately 30 feet away from the nurses' station. Loud continuous alarms were heard from inside the room. On 3/11/25 at 11:18 AM, RN L said resident #72 was routinely included in her assignments and she knew him well. The RN explained, she was not aware of anything out of ordinary for the resident's needs and he mostly stayed in his room. Review of resident #72's State Agency PASARR Level I Screen completed by the acute care hospital on 3/30/23 did not include the diagnosis of PTSD. The psychiatric provider's progress note dated 12/16/24 read, . He has a history of combat exposure during the Vietnam War and has been observed by nursing staff with triggers including hypersensitivity to loud noises with some hypervigilance . he reports he usually prefers to avoid triggers by staying in his room most of the day and sleeping during daytime hours.triggered by hearing screams, avoidance of skilled nursing facility environment and preferring to stay in his room, sleep and watch TV. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/09/25 at 4:30 PM, the Social Services Director checked resident #72's medical record, confirmed the PASARR was incorrect and stated, it should have PTSD. On 3/12/25 at 8:43 AM, the Social Services Director explained the facility screened for Trauma Informed Care/PTSD for residents once on admission and resident #72 was noted to have PTSD. She explained she had not conducted subsequent assessments/screens to monitor residents' triggers and stated, we should do follow-up for the Long Term Care residents; it's important to recognize PTSD because it affects their well-being. In a joint interview with the Director of Nursing (DON) and Assistant DON on 3/12/25 at 3:36 PM, the DON explained there were weekly meetings with the clinical team and psychiatry providers to discuss residents who received mental/behavioral health services. She said progress, changes in needs or services, and interventions were discussed. The DON conveyed that veterans frequently had a history of traumatic life experiences with special mental health needs, and the facility's census included a higher than average population of veterans. Review of the facility's undated standards and guidelines titled Trauma Informed Care Policy noted the facility aimed to provide an individualized supportive, safe, and healing environment for residents identified with past trauma. The policy included measures which included, . quiet space, minimizing noise . , . staff should be trained to recognize signs of distress and respond with empathy and care. , and ongoing monitoring . identify any potential triggers or trauma reactions and address them early .

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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 accordance with professional standards for food service safety, which had the potential to affect all residents who ate meals prepared in the facility's kitchen. Findings: On 3/09/25 at 9:50 AM, during the initial kitchen tour with the morning (AM) cook M, it was noted the walk-in refrigerator temperature was not written on the temperature log for today or yesterday. [NAME] M acknowledged the temperatures were not on the log and explained she was about to enter the temperature for today. In the walk-in there was a half-full bag of shredded cheese that did not have the date it was opened. There was also an unsealed, open to air, 3/4 full plastic package of sliced meat and a resealed half full plastic package of sliced deli meat which contained approximately 15 slices. Both packages were unlabeled and did not have a date to indicate what date the package was opened. There was also a previously opened package of Parmesan cheese with a manufacturer's use-by date of 2/11/25 (26 days prior). A plastic container of sour cream with an imprint of 2025-0016 on it was noted. AM cook M was unsure as to what that imprint meant and the container was not marked as to when it had been opened at the facility. The AM [NAME] M, stated she used a magic marker to date food items she opened, but acknowledged this package had none. She threw the sour cream away. The Certified Dietary Manager (CDM) arrived and took over the tour. A one-third steam table pan of leftover applesauce was dated 3/5 (four days ago) and the CDM acknowledged it should have been thrown away. There was a one-third steamtable pan of leftover corn and one of leftover gravy dated 3/4 which the CDM stated should have been thrown away previously. Two containers of beef base, and one of chicken base, were opened but undated as to when they were opened. These items were discarded. A half-filled plastic container of an unknown food item that appeared to be leftover coleslaw did not have a label to indicate the date of when it was opened or what the item was. A half used squeeze tube of whipping cream was not sealed and undated as to when it was initially opened. A previously opened box of potato salad in its original packaging, along with eight covered plates of cake slices and eight small bowls of covered fruit were noted as undated to show when they were opened or how long they had been in the cooler. 2. A few minutes later in the dry food storeroom, there were two previously opened but unsealed plastic bags of dry pasta and three pieces of unwrapped graham crackers in the box of individually-packaged graham crackers, which the CDM acknowledged. The CDM stated each person who used the food items were responsible to seal, label, and date the items to ensure they did not attract bugs or other pests and to ensure the items were fresh and safe to serve to residents. The facility's undated policy entitled Food Receiving and Storage indicated foods shall be received and stored in a manner that complied with safe food handling practices. It detailed all food stored in the refrigerator or freezer will be covered, labeled, and dated with a use by date. There was no indication in the policy as to how long different food items could be kept and utilized after they were opened.

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	105797	A. Building B. Wing	03/12/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51023 Based on interview, and record review, the facility failed to ensure coordination of hospice services for 1 of 1 resident reviewed for hospice care, of a total sample of 34 residents, (#249). Findings: Resident #249 was admitted to the facility on [DATE] following an acute care hospitalization for Congestive Heart Failure exacerbation. His diagnoses include end stage heart failure, prostate cancer, hypertension and paroxysmal atrial fibrillation. He was initially admitted to hospice on 12/03/24. On 2/21/25 the resident was transferred from home hospice to Long Term Care hospice. According to the National Institute of Health, heart failure is characterized by impairment in cardiac structure and function which results in decreased cardiac output and fluid buildup or congestion. Management of advanced heart failure centers around volume status (the amount of fluid in the body) and managing fluid overload or hypervolemia (too much fluid) (retrieved on 3/21/24 from www.nih.gov). Review of resident #249's care plan revealed a focus for receiving hospice services related to end stage heart disease which was initiated 2/28/25. The Skilled Nursing Facility Integrated Plan of Care for resident #249 between the facility and the hospice indicated the facility nurse would notify hospice regarding changes in patient status, comfort level and on new orders. A review of the resident's clinical record revealed a nurse progress note from 3/06/25 at 8:00 PM, IV infusion installed successfully. Started 50 ml [milliliters] per hour during 24 hour for hydration. Review of the resident's Electronic Medical Record (EMR) revealed an order dated 3/05/25 Sodium Chloride Solution 0.9 % use 50 milliliters/hour intravenously for 24 hours for hydration for one day. Review of resident #249's medical record revealed no documentation of hospice notification for the initiation of intravenous fluids on 3/05/25 or 3/06/25. On 3/11/25 at 4:29 PM, in a phone interview the Hospice Supervisor revealed the facility called hospice on 3/06/25 to discuss a wheelchair for the resident but there was no notification of the order for intravenous (IV) fluids being initiated. On 3/12/25 at 9:39 AM, in a phone interview with the Hospice Registered Nurse revealed that the order for IV fluids was initiated by the facility and not by hospice. She explained when she arrived to the facility on [DATE], the IV fluid was already running. Since the fluid was ordered for only one liter and the resident was 'okay' with it, all she did was document that the fluids were running. She stated that typically IV fluids were not in their goals of care when it came to hospice resident's care. On the day she was there, she got report from facility staff that he was eating or drinking without issue. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 11:19 AM, in a phone interview with the Medical Director she confirmed she ordered the intravenous fluids for resident #249. She explained she ordered the fluids due to the resident's risk for dehydration. She stated this risk was determined by an abnormal lab result, Blood Urea Nitrogen (BUN), and from talking to the certified nursing assistants (CNA) on the resident's fluid intake. She stated his BUN was 32 and confirmed this was from labs drawn on 2/20/25. She stated the reason for the delay in ordering the intravenous fluids was to give the resident a chance to rehydrate on his own. She was asked how she determined the resident's intake was inadequate when the CNA's were documenting the residents intake in the days leading up to the IV was over 1000 milliliters of fluid. She stated that she did not look at the fluid intake in his EMAR, she 'just talked' to the CNAs working. She stated she had also tried to reach out to Resident #249's family in regards to the resident's decreased fluid and food intake and the possibility of inserting a PEG tube, but the family did not answer. When asked what her procedure was for new orders when a resident is on hospice, she stated the facility will typically get the orders cleared by hospice before initiating. She confirmed that she did not notify hospice. She stated she did not even know resident #249 was on hospice and asked when services were started. On 3/12/25 at 1:13 PM, the Director of Nursing (DON) revealed she entered the order for intravenous fluids into the computer that was signed off by the nurse as administered. However, she stated she did not receive the order but rather was modifying the order put into the computer by the Medical Director. She confirmed she did not notify hospice of the IV fluid order and assumed the communication between the facility and hospice had already been done. The Skilled Nursing Facility Services Agreement between hospice and the facility dated 2/24/25 indicated the facility should immediately inform hospice of any changes in condition of a hospice patient. The agreement detailed that the hospice and the facility should communicate with one another regularly and as needed. It described that each party was responsible for documenting such communications in their respective clinical records.

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	105797	A. Building B. Wing	03/12/2025

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 51023 Based on record review, and staff interview, the facility failed to submit the Payroll Based Journal (PBJ) for the 4th quarter in the fiscal year (FY) 2024. Findings: Review of the Centers for Medicare and Medicaid Services (CMS) PBJ Staffing data report Certification and Survey Provider Enhanced Reports (CASPER Report 1705D) revealed no facility staffing data was submitted for the period of July 1,2024 to September 30, 2024 (FY Quarter 4 2024). On 3/12/25 at 5:08 PM, the Administrator acknowledged the facility was supposed to submit the PBJ staffing data and stated she was aware it had not been submitted for Quarter 4 of 2024. She explained that at that time there was a glitch in the system, and due to turnover in their Human Resources department it had not been submitted.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 45646 Based on interview, and record review, the facility failed to ensure the Quality Assessment & Assurance (QAA) / Quality Assurance and Performance Improvement (QAPI) committee conducted performance improvement activities to ensure prior improvement measures were sustained. Findings: Review of the QAPI plan effective 5/27/24 revealed the facility would use a thorough and highly organized/structured root-cause analysis approach to determine if and how identified problems may be caused or exacerbated by the way care and services were organized or delivered. The systemic actions would look comprehensively across all involved systems to prevent future events and promote sustained improvement. The facility would monitor the effectiveness of performance improvement activities to ensure that improvements were sustained. The facility had a deficiency cited at F689 during the previous recertification survey conducted 7/24/23 through 7/29/23. The facility was cited due to failure to prevent a cognitively impaired resident from exiting the facility unsupervised, and failing to provide adequate supervision and a secure environment. During the current recertification survey, the facility was again found to be in noncompliance with F689 for failing to provide a secure environment and adequate supervision when a cognitively impaired resident exited the facility through an unsecured/unalarmed door. As a result of the repeat deficiency, it was identified there was insufficient auditing and oversight to prevent the repeat citation. On 3/12/25 at 5:11 PM, the Executive Director reported the QAPI committee met monthly as well as held Ad HOC meetings when issues arose. She stated the committee used monthly reports and audits submitted by each department to identify areas of concern. She explained areas of concern were prioritized with areas affecting patient care with safety taking precedence. The Executive Director stated the committee always looked to identify a root cause to prevent the event from recurring. She stated that some type of auditing had to be put in place and documentation would be placed on the Performance Improvement Plan (PIP). The Executive Director explained she felt the previous situation was a result of a door malfunction and the current situation was different as resident #87 exited the building in an attempt to locate his wife. She did not explain how resident #87 was able to open the door without knowledge of staff if the door had been alarmed. The Executive Director acknowledged all exit doors were not alarmed after the previous elopement to ensure other residents could not exit through exterior doors that were designated as emergency exit only.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50401 Based on observation, and interview, the facility failed to provide a sanitary environment to help prevent the transmission of communicable diseases by failing to perform hand hygiene between delivering meals to 3 of 15 resident rooms in the East wing. Findings: On 3/12/25 at 8:55 AM, Certified Nursing Assistant (CNA) F, along with trainee CNA G, was observed as they entered a resident's room on the East wing that had a Contact Precautions sign at the door. The sign indicated that anyone who entered must perform hand hygiene. CNA F and CNA G were observed as they brought a breakfast tray without performing hand hygiene before they entered the room or after they left. CNA F was observed as she then entered the next resident room without performing hand hygiene. CNA F without hand hygiene, then went to the food cart, got a tray of food and brought it into a resident in another nearby room. The Director of Nursing (DON) who was in the area and observed CNAs F and G, got up from the unit nursing station and was overheard telling the trainee, CNA G to perform hand hygiene, which she then did. CNA F only nodded and stated, OK, when the observation of her and CNA G not performing hand hygiene between resident rooms was mentioned to her. At 3/12/25 at 9:34 AM, the DON acknowledged CNA G did not perform hand hygiene when she served meals to residents, but should have. She confirmed she reminded the trainee CNA to disinfect her hands between residents when she served meals. The facility's undated policy entitled Hand Hygiene and Resident Cleanliness Policy During Meal Times, indicated staff must wash hands or use hand sanitizer between residents when they delivered meal trays.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51023 Based on interview, and record review, the facility failed to provide proof of consent, refusal, or medical contraindication for pneumococcal vaccine for 3 of 5 residents reviewed for immunizations, of a total sample of 34 residents, (#20, #9, and #59). Findings: 1. Resident #20 was admitted to the facility on [DATE]. Review of her medical record revealed no documentation of consents, refusals, or medical contraindications for the pneumococcal vaccine. 2. Resident #9 was admitted to the facility on [DATE]. Review of her medical record revealed no documentation of consents, refusals, or medical contraindications for the pneumococcal vaccine. 3. Resident #59 was admitted to the facility on [DATE]. Review of his medical record revealed no documentation of consents, refusals, or medical contraindications for the pneumococcal vaccine. On 3/12/25 at approximately 6:00 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) revealed they were unable to provide a record of documentation of consent, refusal, or contraindication for administration of the pneumococcal vaccine for residents #20, #9, and #59. The DON acknowledged they could not find documentation to show if the residents had previously received the vaccination, refused it or if the vaccination was even offered. The DON explained that the previous ADON was responsible for obtaining consents from the residents or their representatives and it seemed she only documented for the Influenza vaccinations. The facility's policy titled Pneumococcal Polysaccharide Vaccine (PPV) states that all residents will be offered a Pneumococcal Polysaccharide Vaccine (PPV) upon admission and every five years thereafter or according to local health department guidelines.