STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105797	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GUARDIAN CARE NURSING & REHABILITATION CENTER	2500 W CHURCH STREET 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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop a plan of care for oxygen therapy for 1 of 1 sampled residents out of 19 residents receiving oxygen therapy (#47). Findings: Resident #47 was admitted on [DATE]. Her [DIAGNOSES REDACTED]. The minimum data set admission assessment, dated [DATE] and signed as complete on 1/02/20, noted in section O that resident had been on oxygen therapy at home and while in the facility. Review of the plans of care, dated 1/07/20, did not have a care plan for oxygen therapy, respiratory care and was not incorporated into any of the other plans of care. On 3/11/20 at 2:03 PM, the North side unit manager reviewed the plans of care and said that there was no care plan present for respiratory care or oxygen therapy.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that there was a physician's order for oxygen therapy for 1 of 1 resident reviewed out of 19 residents receiving oxygen (#47). Findings: Resident #47 was admitted to the facility on [DATE], went to the hospital on [DATE], and returned on 12/20/19. Her [DIAGNOSES REDACTED]. On 3/08/20 at 11:28 AM, resident #47 was in her bed sleeping. She wore a nasal cannula and was provided oxygen (O2) through a concentrator set at 3/liters per minute (l/min). On 3/09/20 at 9:20 AM, resident #47 was in bed with the oxygen concentrator on and set at 3 l/min. At 11:51 AM, licensed practical nurse (LPN) B was changing the portable O2 tank on the resident's wheelchair. She set the O2 at 2 l/min. On 3/10/20 at 2:50 PM, certified nursing assistant C said that she cared for resident #47. She stated that she did not touch the O2 concentrator and the O2 tank. She did not change the settings because it was the nurse's responsibility. On 3/10/20 at 10:15 AM, the concentrator was next to resident #47's bed turned off. The resident was in the hall by the nurses' station. She was wore a nasal cannula with O2 being provided by an oxygen tank on the back of her wheelchair. The tank was set at 2 l/min. On 3/10/20 at 3:04 PM, LPN B went resident #47's room. The O2 concentrator was off. She turned it on. She said the O2 was set at 3 l/ min. She stated that the order was for 2 l/min. She had not adjusted the concentrator and was not aware that it was set at 3 l/min. Review of the physician's monthly orders from December 2019 to March 2020 did not have any order for oxygen. On 3/11/20 at 2:03 PM, the director of nursing (DON) reviewed the March 2020 physician's orders and did not find an order for [REDACTED]. Review of the Hospice medication list did note oxygen at 2 l/min. On 3/11/20 at 2:05 PM, during a phone interview, the resident's Advanced Practice Registered Nurse stated she was not aware that there was no order for oxygen.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and record review, the facility failed to ensure proper cooling techniques to ensure meat balls were brought to safe temperatures within appropriate time frame. Findings: On 3/08/20 at 10:11 AM, observation of the walk-in refrigerator revealed a 6 inch () deep steam table pan that was half filled to the top with meat balls The meatballs in the center of the pan was 42.6 degrees () Fahrenheit (F). The food service director/certified dietary manager (FSD) stated that the meatballs were from supper on 3/07/20. They would have been used as an alternate on 3/08/20 and discarded within 48 hours if they were not used. She said that the kitchen closed at 8 PM. The meatballs remained in the danger zone for 14 hours. On 3/11/20 at 10:42 AM, the FSD had a log for checking temperatures for cooling food for 3/07/19. The cook on the evening shift did not note the temperature of the meat balls when he left for the night. The facility did not have a set temperature cooling log to monitor cooling of the foods at 6 hours. Improper cooling is a major factor in causing foodborne illness. Taking too long to chill PHF/TCS foods has been consistently identified as one factor contributing to foodborne illness. Foods that have been cooked and held at improper temperatures promote the growth of disease-causing microorganisms that may have survived the cooking process (e.g., spore-formers). Cooling time/temperature control for safety, food shall be cooled within 2 hours for 135F to 70F and within a total of 6 hours from 135F to 41F or less (2017 U.S. Food and Drug Administration's (FDA) Food Code Chapter 3).

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

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.