STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105377	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longwood Health and Rehabilitation Center	1520 S Grant St Longwood, FL 32750

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646 Based on interview, and record review, the facility failed to implement procedures to ensure a resident's wishes related to health care treatments and procedures at the end of life were followed and failed to honor an Advance Directive that reflected the decision to withhold Cardiopulmonary resuscitation (CPR) for 1 of 8 residents reviewed for Advanced Directives of a total sample of 8 residents, (#1). These failures contributed to resident #1 receiving CPR in violation of an explicit wish for a natural and dignified death. There was likelihood resident #1 experienced severe pain, and could have suffered broken bones, organ damage and a prolonged dying process. On [DATE] at approximately 11:48 PM, resident #1 was observed unresponsive in his wheelchair at the nurse's station. He was taken to his room where a licensed nurse initiated CPR without first verifying the resident's code status in the medical record. Emergency Medical Services (EMS) arrived at the facility at midnight and continued to provide CPR for another 20 minutes before resident #1 was transported to the hospital where he was intubated and stabilized until his wife requested life support be withdrawn. The facility failed to honor the resident's wishes not to be resuscitated and the physician order for Do Not Resuscitate. The facility's failure to honor the right to choose withholding of lifesaving interventions placed all residents with a Do Not Resuscitate Order (DNRO) Advance Directive at risk for serious psychosocial harm, physical trauma, and a prolonged, undignified death from unwanted resuscitation efforts. This failure resulted in Immediate Jeopardy starting on [DATE]. The Immediate Jeopardy was removed [DATE] based on verification of the facility's corrective actions. The scope and severity of the deficiency was decreased to a D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings: Cross reference F678. Resident #1, an [AGE] year-old male, was admitted to the facility on [DATE] with diagnoses including fracture of right femur, senile degeneration of brain, unspecified dementia, dysphagia (trouble swallowing), and chronic kidney disease stage III. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Minimum Data Set (MDS) admission assessment with assessment reference date of [DATE] revealed resident #1 had a Brief Interview for Mental Status score of ,d+[DATE] which indicated he had severe cognitive impairment. A care plan for Advance Directives was initiated [DATE] which indicated resident #1 had an established Full Code order in place and identified his wife as his proxy and emergency contact. Review of the electronic medical record (EMR) revealed a care plan minutes form from [DATE], scanned into the miscellaneous documents. The form indicated those in attendance included resident #1's wife, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). Under resident/family concern was written, change code status to DNR. Review of resident #1's EMR revealed a State of Florida Do Not Resuscitate Order (DNRO) form signed by resident #1's wife on [DATE]. A Nurses Progress Note dated [DATE] at 1:07 AM revealed Certified Nursing Assistant (CNA) A observed resident #1 was unresponsive and notified nurse. Licensed Practical Nurse (LPN) B arrived on the scene, assessed the resident and confirmed he was unresponsive. The note indicated resident #1 was immediately transferred to his room where staff initiated CPR at 11:51 PM, and emergency services were called at 11:54 PM. EMS arrived on the scene at midnight and continued to provide resuscitation efforts. Resident #1 was transferred to a nearby hospital by EMS at 12:20 AM. A Social Services progress note dated [DATE] revealed resident #1's wife was contacted regarding his change in condition. The note indicated the caller was informed by his wife resident #1 had been intubated at the hospital and expired 30 minutes after the he was taken off the ventilator. On [DATE] at 9:55 AM, the DON reported she was in the care plan meeting with resident #1's wife on [DATE]. The DON recalled she had a conversation with resident #1's wife regarding his code status. She explained resident #1 received hospice services at home prior to entering the hospital but he came into the facility as Full Code. The DON stated she explained the difference between Full Code and DNR to the resident's wife who then decided she wanted resident #1 to be a DNR. She then called the Social Service Assistant (SSA) and informed her of the wife's wish to be a DNR. The DON recalled the wife then signed the DNRO form. She stated she told the ADON to contact the doctor and to update resident #1's code status in the EMR. The DON recalled Licensed Practical Nurse (LPN) B called her in the middle of the night to inform her of the code. She explained she questioned LPN B because the wife had signed the DNRO form earlier that day. LPN B informed the DON that resident #1 was listed as Full Code in the EMR. The DON explained she spoke to the ADON later that morning who stated she had forgotten to update the EMR with the change in resident #1's code status. She confirmed LPN B should have checked the EMR and the Code Status Binder to confirm the code status per facility policy. The DON acknowledged resident #1 was a DNR at the time CPR was performed. In a phone interview on [DATE] at 12:32 PM, the ADON confirmed she was in the care plan meeting on [DATE]. She recalled resident #1's wife wanted him to be a DNR and she went with the SSA to sign the DNRO form. She acknowledged the DON told her the wife signed the form and asked her to update the EMR with the new code status. The ADON recalled she was busy with another staff member and had asked the DON to remind her. She explained the DON did not remind her and she forgot to update the EMR. The ADON explained any nurse could have updated the EMR with the new code status. She said she did not know why someone else did not do it. (continued on next page)

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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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on [DATE] at 10:14 AM, the SSA stated she was called into the care plan meeting and was told resident #1 had a DNRO form at home. The SSA informed resident #1's wife she had a DNRO form in her office that could be signed and would be activated that day. She explained resident #1's wife signed the form. The SSA reported she uploaded a scan of the form to the EMR and placed a copy in the Code Status Binder on the code cart on the unit on the afternoon of [DATE]. She stated the following morning she was told resident #1 was found unresponsive and the nurses provided CPR. Once she got to the facility, the SSA discovered resident #1's code status had not been updated in the EMR. On [DATE] at 8:54 AM, LPN B stated she was assigned to resident #1 on the night of [DATE]. She recalled seeing resident #1 in his wheelchair by the nurse's station. LPN B reported as she was rounding, she heard another staff member announce a Code Blue. She stated resident #1 had been found unresponsive and she assisted with getting him to his room and into the bed. LPN B stated she asked for someone to check his code status and heard someone reply he was a Full Code. She explained she asked again if he was a Full Code, and the person said it again. LPN B reported she then began chest compressions at 11:51 PM. She stated she alternated compressions with other nurses until EMS arrived. LPN B recalled she then went outside the room to verify the resident's code status for herself when she first switched off with another nurse. LPN B stated the code cart was in the resident's room. She acknowledged she did not check the Code Status Binder located on the cart to verify resident #1's code status. She reported EMS arrived at midnight and took over CPR. She stated EMS continued chest compressions through the time they transported resident #1 to the hospital at 12:20 AM. In a phone interview on [DATE] at 3:05 PM, LPN C confirmed she worked the night of [DATE]. She stated she heard another nurse call a Code Blue from the other wing and ran over to assist. LPN C recalled she assisted getting resident #1 into bed. She did not recall who started the chest compressions but stated she did participate in providing CPR to resident #1. She stated she thought LPN B checked resident #1's code status but was not aware of where she got the information. LPN C acknowledged she did not verify resident #1's code status as CPR was already in progress. In a phone interview on [DATE] at 2:32 PM, Registered Nurse (RN) D confirmed she was working the night of [DATE]. She recalled hearing a Code Blue called on the opposite unit and ran to that unit. RN D stated when she arrived at resident #1's room, LPN B and LPN C were already there. She explained she saw LPN B performing chest compressions. RN D reported that she alternated with LPN B and LPN C to perform CPR on resident #1. She stated she thought the code status had been confirmed since CPR was already in progress. RN D recalled she saw resident #1 was identified as Full Code in the EMR but acknowledged she did not check the Code Status Binder on the code cart to verify. (continued on next page)

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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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on [DATE] at 12:02 PM, resident #1's wife confirmed she signed the DNRO on [DATE] during a care plan meeting at the facility. She explained her husband received hospice care previously at home and had been a DNR. She stated the facility called her sometime during the night after she had signed the new DNRO to inform her of the Code Blue and that her husband was being sent to the hospital. Resident #1's wife stated she did not know why they performed CPR since their wishes were for DNR. She reported the hospital called her on [DATE] at approximately 1:00 AM to update her on her husband's status. She told them she did not want her husband to be intubated. She explained the hospital staff informed her he had already been intubated. Resident #1's wife stated she went to the hospital that morning and talked with a doctor in order to get the tube removed. She recalled two doctors had to sign off and the tubes were removed around 10:00 AM. She explained she sat with her husband, holding his hand until he passed away a short time later at 10:30 AM. Resident #1's wife explained she had signed the DNRO because she did not want to prolong his life and did not want him to suffer. She stated her husband did not want to suffer either. On [DATE] at 11:13 AM, the Administrator stated the DON called her on [DATE] at approximately 12:, d+[DATE]:45 AM to inform her of CPR being provided to resident #1. She explained an investigation was initiated that morning. The Administrator reported the ADON failed to update the EMR with the correct code status. She acknowledged the nurses should have verified resident #1's code status in the EMR and Code Status Binder on the code cart before initiating CPR. The Administrator verified this resulted in resident #1 being provided life saving measures against his wishes. The Facility's policy and procedure for Advanced Directives and Code Status dated [DATE] read, It is the policy of the facility to honor Advanced Directives, Code Status and Do Not Resuscitate Orders in accordance with Stated and Federal Regulations. Review of the immediate corrective measures implemented by the facility revealed the following, which were verified by the survey team: *On [DATE] a medical record audit was completed for current residents to ensure DNR forms were present in the electronic medical record for residents with DNR orders. *On [DATE] through [DATE] current licensed nurses were educated on resident's rights regarding treatment and Advanced Directives by the Director of Nursing/delegate. * 40 out of 41 total licensed nurses received education; 98% of nurses: On [DATE] 10 out of 41 nurses completed the education, 24% of nurses, On [DATE] an additional 29 of 41 nurses completed their education, 71% of nurses. On [DATE] an additional 1 of 41 nurses completed the education, 2%. 1 remaining licensed nurse to receive education upon return from leave and prior to working next shift. *New hire nurses at the facility will receive the above education during orientation and prior to working an assignment. (continued on next page)

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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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*On [DATE] through [DATE] current licensed nurses participated in mock code drills: *18 out of 41 total Licensed Nurses participated in mock code drills; 44% of nurses: On [DATE] 11 out of 41 nurses participated in mock code drills, 27% of nurses. On [DATE] 7 out of 41 nurses participated in mock code drills, 17%. 23 remaining licensed nurses to participate in mock code drills upon return from leave and prior to working next shift. *New hire nurses at the facility will participate in a mock code drill during orientation and prior to working an assignment. *On [DATE] through [DATE] residents and/or responsible parties for current residents residing in facility were interviewed by Social Services/Delegate to validate current physician orders for code status reflect resident and/or responsible party's current wishes for code status. Code status updated, if applicable based on interviews conducted. *Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting on [DATE] completed with Medical Director, Administrator, and additional Interdisciplinary team (IDT) members on the adherence to CPR policy and policy and procedure for Resident Rights Regarding Treatment and Advance Directives and a review of the root cause analysis was completed. *As part of the ongoing Quality Assurance Assessment (QAA) process, an ad hoc QAPI was conducted on [DATE] that included the Medical Director, Administrator, Director of Nursing and additional IDT members to review the plan viability on the Advance Directives process, code process and results of audits. No discrepancies or concerns were noted related to Advanced Directive code status standards and guidelines. Interviews conducted on [DATE] with 10 licensed nurses across all shifts indicated they were knowledgeable of Advance Directives and where to verify the code status in the EMR and the code status binder prior to providing CPR. The surveyors validated the education with attendance sheets for Code Blue drills and in-services. Review of QAPI audits revealed daily Code Blue drills were conducted per performance improvement plan. The resident sample was expanded to include four additional residents, three who elected DNR status and one with Full Code status. Interviews and record reviews revealed no concerns for residents #2, #3, #4, #5, #6, #7, and #8 related to Advance Directives.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646 Based on record review, and interview, licensed nurses failed to follow the facility's policy and procedure for Cardiopulmonary Resuscitation (CPR) related to verification of resuscitation or code status in an emergency for 1 of 8 residents reviewed for Advanced Directives, of a total sample of 8 residents, (#1). On [DATE] at approximately 11:48 PM, resident #1 was observed unresponsive in his wheelchair at the nurse's station. He was taken to his room where a licensed nurse initiated CPR without first verifying the resident's code status in the medical record. Emergency Medical Services (EMS) arrived at the facility at midnight and continued to provide CPR for another 20 minutes before resident #1 was transported to the hospital where he was intubated and stabilized. The facility failed to honor the resident's wishes not to be resuscitated and physician's order for Do Not Resuscitate. The facility's failure to ensure staff followed procedures related to honoring an Advanced Directive to withhold CPR contributed to resident #1 suffering unwanted, aggressive resuscitation efforts and placed all residents who had valid DNROs at risk for serious injury/impairment/prolonged death. This failure resulted in Immediate Jeopardy starting on [DATE]. The Immediate Jeopardy was removed on [DATE]. The scope and severity of the deficiency was decreased to a D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings: Cross reference F578. Resident #1, an [AGE] year-old male, was admitted to the facility on [DATE] with diagnoses including fracture of right femur, senile degeneration of brain, unspecified dementia, dysphagia (difficulty swallowing), and chronic kidney disease stage III. Review of the Minimum Data Set admission assessment with assessment reference date of [DATE] revealed resident #1 had a Brief Interview for Mental Status score of ,d+[DATE] which indicated he had severe cognitive impairment. Review of the electronic medical record (EMR) revealed a care plan minutes form dated [DATE] scanned into the miscellaneous documents. The form indicated those in attendance at the meeting included resident #1's wife, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). Under resident/family concern was written, change code status to DNR. Review of resident #1's EMR revealed a State of Florida Do Not Resuscitate Order (DNRO) form dated [DATE] that was signed by the resident's wife and his attending physician. The document showed the resident representative's signature under the statement, Being informed of my right to refuse cardiopulmonary resuscitation (CPR), including artificial ventilation, cardiac compression, endotracheal intubation and defibrillation, direct that CPR be withheld or withdrawn from me. The physician's statement read, I direct the withholding or withdrawal of CPR from the patient in the event of the patient's cardiac or respiratory arrest. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1's EMR contained a physician order dated [DATE] which read, Full Code. The Facility's policy and procedure for Advanced Directives Code Status dated [DATE] read, It is the policy of the facility to honor Advanced Directives, Code Status and Do Not Resuscitate Orders in accordance with State and Federal regulations. The form indicated a resident's code status should be verified by the physician's order tab in the EMR and the corresponding form should be visualized in the code status binder. A Nurse's Progress Note dated [DATE] at 1:07 AM, revealed Certified Nursing Assistant (CNA) A observed resident #1 was unresponsive and notified the nurse. Licensed Practical Nurse (LPN) B arrived on the scene, assessed resident #1 and confirmed he was unresponsive. The note indicated resident #1 was immediately transferred to his room and staff initiated CPR at 11:51 PM and emergency services were called 11:54 PM. Emergency Medical Services (EMS) arrived on the scene at midnight and continued to provide resuscitation efforts. Resident #1 was transferred to the hospital by EMS at 12:20 AM. On [DATE] at 9:55 AM, the DON reported she was in the care plan meeting with resident #1's wife on [DATE]. The DON recalled she had a conversation with resident #1's wife regarding his code status. The DON stated she explained the difference between Full Code and DNR to the wife who then decided to sign a DNRO. The DON explained she asked the Social Services Assistant (SSA) to assist the wife with the DNRO and directed the Assistant Director of Nursing (ADON) to contact resident #1's physician and to update the EMR. She recalled Licensed Practical Nurse (LPN) B called her in the middle of the night to inform her of the code. The DON state she questioned LPN B because the wife had signed a DNRO form. LPN B informed her resident #1 was listed as Full Code in the EMR. The DON acknowledged the EMR had not been updated and resident #1 was a DNR at the time CPR was performed. In a phone interview on [DATE] at 12:32 PM, the ADON confirmed she attended the care plan meeting on [DATE]. She recalled resident #1's wife signed a DNRO. She acknowledged the DON told her to contact the doctor and update the EMR with the new code status. The ADON stated she was busy with another staff member and asked the DON to remind her. She explained she forgot to update the EMR. The ADON stated any nurse could have updated the EMR with the new code status. In a phone interview on [DATE] at 10:14 AM, the SSA confirmed she met with resident #1's wife who signed a DNRO form on [DATE]. The SSA reported she uploaded the form to the EMR and placed a copy in the Code Status Binder on the crash cart on the afternoon of [DATE]. She stated the following morning she was told resident #1 coded and the nurses provided CPR. Once she got to the facility, the SSA discovered the code status had not been updated in the EMR. On [DATE] at 4:09 PM, Certified Nursing Assistant (CNA A) confirmed she was the assigned CNA for resident #1 on [DATE]. She recalled resident #1 was in his wheelchair at the nurse station and he was not moving or breathing. She notified a nurse who called a code blue. CNA A reported staff responded to the call, and she assisted in getting resident to his room and into bed. She explained she stepped outside the room and the nurses took over. CNA A stated she did not know who verified resident #1's code status or who started resuscitation efforts. She did recall seeing the crash cart in the room but did not know who brought it. (continued on next page)

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 8:54 AM, LPN B stated she was assigned to resident #1 on the night of [DATE]. She described the sequence of events on [DATE], the day resident #1 received CPR. She recalled hearing another staff member announce a Code Blue. LPN B stated she observed resident #1 was unresponsive at nurse station and she assisted with getting him to his room and into the bed. LPN B explained she asked for someone to check code status and heard someone say he was a Full Code. She asked again if he was a Full Code, and the person said it again. LPN B reported she then began chest compressions at 11:51 PM. She stated she switched off with other nurses until EMS arrived at midnight. LPN B recalled she went outside the room to verify resident's code status for herself when she first switched off with another nurse. LPN B stated the crash cart was in the resident's room. She acknowledged she only checked the computer and did not check the Code Status Binder to verify resident #1's code status. She reported EMS took over CPR when they arrived. LPN B stated EMS continued chest compressions until 12:20 AM when they transported resident #1 to the hospital. In a phone interview on [DATE] at 3:05 PM, LPN C confirmed she was working the night of [DATE]. She stated she heard another nurse calling a Code Blue from the other wing and ran over to assist. LPN C recalled she assisted getting resident into bed. She did not recall who started chest compressions but stated she did participate in providing CPR to resident #1. She stated she was sure LPN B checked resident #1's code status. She reported LPN B came back to the room and stated he was a Full Code. She did know how LPN B verified the code status. LPN C acknowledged she did not verify resident #1's code status as CPR had already started. In a phone interview on [DATE] at 2:32 PM, Registered Nurse (RN) D confirmed she was working the night of [DATE]. She recalled hearing a code blue called on the opposite unit and ran to that unit. RN D stated when she arrived LPN B and LPN C were already in resident #1's room. She explained she saw LPN B performing chest compressions. RN D reported that she traded off with LPN B and LPN C to perform CPR. She stated she thought code status had been confirmed since CPR had been started. RN D recalled she later saw resident #1 was a full code in the EMR. She acknowledged she did not check before CPR began and did not check the Code Status Binder on the crash cart to verify. In a phone interview on [DATE] at 12:02 PM, resident #1's wife confirmed she signed a DNRO on [DATE] during a care plan meeting. She stated the facility called her sometime during the night and informed her of the code and her husband being transferred to the hospital. Resident #1's wife stated she did know why they did that since he was a DNR. She reported the hospital called her on [DATE] at approximately 1:00 AM to update her on resident #1's status. She told the caller she did not want her husband to be intubated. She explained the caller informed her he had already been intubated. Resident #1's wife stated she went to the hospital that morning and had to talk with a doctor to get the tube removed. She recalled two doctors had to sign off and the tubes were eventually removed around 10:00 AM. She stated she went into the room and sat with her husband holding his hand until he passed away at 10:30 AM. Resident #1's wife explained she had signed the DNRO because she did not want to prolong his life and did not want him to suffer. She stated her husband did not want to suffer either. On [DATE] at 11:13 AM, the Administrator stated the DON called her on [DATE] around 12:,d+[DATE]:45 AM and informed her of CPR being provided to resident #1. She explained an investigation was initiated that morning. The Administrator reported that resident #1's wife had signed a DNRO and the ADON failed to update the EMR with the correct code status. She acknowledged the nurses should have verified resident #1's code status in the EMR and Code Status Binder on the crash cart per policy. The Administrator verified this resulted in a resident with a DNR being provided CPR. (continued on next page)

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the immediate corrective measures implemented by the facility revealed the following, which were verified by the survey team: *On [DATE] through [DATE] current licensed nurses were educated on facility's CPR policy and on procedure for performing a code to include confirmation of resident code status prior to initiating CPR. Post test and code procedure competencies completed to validate comprehension. *39 of 41 total licensed nurses received education; 95% of nurses: On ,d+[DATE] ,d+[DATE] 10 out of 41 nurses completed the education, 24% of nurses, On [DATE] an additional 29 of 41 nurses completed their education, 71% of nurses. 2 remaining licensed nurse to receive education upon return from leave and prior to Working next shift. *New hire nurses at the facility will receive the above education during orientation and prior to working an assignment. *On [DATE] through [DATE] current licensed nurses participated in Mock Code Drills: *18 of 41 total licensed nurses participated in mock code drills; 44% of nurses On [DATE] 11 out of 41 nurses participated in mock code drills, 27% of nurses, On [DATE] 7 out of 41 nurses participated in mock code drills, 17%. 23 remaining licensed nurses to participate in mock code drills upon return from leave and prior to working next shift. *New hire nurses at the facility will participate in a mock code drill during orientation and prior to working an assignment. *Ad Hoc QAPI on [DATE] completed with Medical Director, Administrator, Director of Nursing and additional IDT members on the adherence to CPR policy and checking the residents code status prior to initiating CPR. Interviews conducted on [DATE] with 10 licensed nurses across all shifts indicated they were knowledgeable of Advanced directives and where to verify the code status in the EMR and the code status binder prior to providing CPR. The surveyors validated the education with attendance sheets for code blue drills and in-services. Review of QAPI audits revealed daily code blue drills were conducted per performance improvement plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105377	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longwood Health and Rehabilitation Center	1520 S Grant St Longwood, FL 32750

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The resident sample was expanded to include four additional residents, 3 who elected DNR status and 1 with Full Code status. Interviews and record reviews revealed no concerns for residents #2, #3, #4, #5, #6, #7, and #8 related to Advanced directives. Based on the facility's corrective actions, the survey team determined the immediate jeopardy was removed [DATE].