

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to adhere to proper infection control practices related to transmission-based precautions for 2 of 7 residents reviewed for infection control, out of a total sample of 48 residents, (#81, and #29) and maintain a complete antibiotic stewardship program. The facility also failed to adhere to proper infection control practices related to hand hygiene and personal protection equipment (PPE) use. Findings: 1. Review of resident #29's medical record revealed she was originally admitted to the facility on [DATE] with diagnoses including myasthenia gravis (an autoimmune condition that causes skeletal muscle weakness), sequelae of cerebral infarction, osteoarthritis, and fibromyalgia (chronic condition that causes pain in muscles and soft tissues all over the body). The Minimum Data Set (MDS) admission assessment with Assessment Reference Date of 8/13/25 revealed resident #29 had a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. On 9/29/25 at 11:24 AM, resident #29 stated she was diagnosed with flu and strep throat the previous Friday. She explained she first became ill around a week ago, and when she could not eat or swallow, she called her primary care physician (PCP) located outside the facility and scheduled an appointment. She stated she saw the PCP on the previous Friday and was prescribed Amoxicillin and another medication for the flu which she did not receive until Sunday. Resident #29's room was not identified for isolation, and no personal protection equipment was observed outside or inside her room. Review of an After Visit Summary form dated 9/26/25 revealed resident #29 was diagnosed with influenza type B and sore throat. The document showed medications Oseltamivir, Amoxicillin and Fluticasone were ordered. Review of resident #29's medical record revealed a Psychotherapy Progress Note dated 9/27/25 which read, in part, . Patient very sick with upper respiratory infection. She presents weak looking and weak appearing. She is planning on calling her son to drop off soup and tea. On 10/02/25 at 5:25 PM, the Director of Nursing (DON) stated resident #29 did not give a copy of the After Visit Summary to the nurse when she returned from the appointment on 9/26/25. The DON explained a nurse found the form the next day in resident #29's room during rounds. The DON indicated the medications were entered into the system on 9/27/25 with the first doses given at 8:00 AM on 9/28/25. The DON could not confirm if the assigned nurse on 9/26/25 contacted the PCP's office after resident #29 returned from the appointment for post-visit summary and instructions. The DON validated no documentation regarding the After Visit Summary was found in resident #29's (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: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	medical record. Review of resident #29's physician's orders revealed no orders for Droplet Precautions until 10/02/25, six days after the diagnosis of influenza. 2. On 10/01/25 at approximately 9:05 AM, Sitter G was observed exiting room B-14 while wearing gloves and talking with another staff member in the hallway. On 10/01/25 at 9:10 AM, Sitter G was observed as she re-entered room B-14 wearing the same gloves. Sitter G stated she was going to transfer a meal tray to the bedside table but had to inform the Certified Nursing Assistant (CNA) about something that needed immediate attention. Sitter G acknowledged she was supposed to remove the gloves and sanitize her hands before exiting the room but did not do so. 3. On 10/01/25 at approximately 5:10 PM, CNA H was observed stepping out of room B-11 holding a soiled bag while still wearing gloves. CNA H entered the soiled utility room, discarded the soiled bag and exited a few minutes later still wearing gloves. CNA H then removed the gloves, discarded them in a trash can located by the nurse's station and washed her hands with soap and water in the bathroom near the nurse's station. On 10/01/25 at 5:20 PM, CNA H explained she had provided a shower for a resident in room B-11 and changed the bed sheets afterward. She shared she usually kept her gloves on until after she discarded the bag in the soiled utility room. She validated that a few moments earlier she had kept the gloves on until after she exited the soiled utility room. She said she had received infection control training and knew that removing gloves before exiting a resident's room was required but was confused about what to do when carrying soiled bags. She stated removing gloves before leaving the room would require her to use her bare hands to hold the bag, which she was uncomfortable doing. On 10/02/25 at 11:52 AM, the Assistant Director of Nursing (ADON) stated infection control education had been provided to all staff including reminders about glove removal before leaving a resident's room. He shared for staff who did not feel comfortable holding a soiled bag with bare hands, staff had the option to use paper to hold it or double bag it, especially if dripping could occur. He confirmed wearing gloves from a resident's room to the hallway was considered a break in infection control. He mentioned he was not informed about resident #29's flu diagnosis until recently, when she was started on isolation. Review of the Transmission-Based (Isolation) Precautions policy and procedure revised on 8/15/22 revealed the facility's intent to take appropriate precautions to prevent transmission of pathogens, based on the pathogen's mode of transmission. The policy stated nursing staff would place residents with suspected or confirmed infectious diarrhea, influenza, or symptoms consistent with a communicable disease on transmission-based precautions/isolation empirically while awaiting confirmation. The policy revealed signage including instructions of specific PPE to be placed conspicuously outside the resident's room. Review of the Infection Prevention and Control policy and procedure revised on 8/15/22 revealed the facility would establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections in accordance with accepted national standards and guidelines. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities by the Centers for Disease Control included, Ill residents should be placed on droplet precautions with room restriction and be excluded from participating in group activities . (Retrieved from www.cdc.gov on 10/06/25.) 4. Resident #81 was admitted to the facility on [DATE] from the hospital. The Comprehensive Minimum Data Set assessment dated [DATE] indicated diagnoses including dementia, and end stage renal disease. Review of resident #81's physician orders revealed an order for Ertapenem sodium solution reconstituted 1 gram to be given intravenously (IV) every 24 hours for urinary tract infection for six days starting on 9/26/25. Review of laboratory results for resident #81 revealed on 9/19/25 a complete blood count (CBC) with differential was drawn and the resident's white blood cells (WBC) were 23.2 cells per microliter (K/uL). The normal range for WBC's is 3.8 to 10.8 K/uL and an elevated level could indicate an infection. The resident also had a urinalysis and culture with reflex drawn. A physician note dated 9/26/25 at 2:25 PM, revealed the resident's urine culture was positive for Klebsiella pneumonia. The physician documented the resident was started on an antibiotic 1 gram daily for five days which the physician indicated was discussed with the Assistant Director of Nursing (ADON) who was also the IP. Extended-spectrum beta-lactamase-producing (ESBL) Enterobacterales are resistant to common antibiotics and require complex treatment. One of the ESBL-producing Enterobacterales includes Klebsiella pneumoniae. These bacteria can cause infections in places such as the urinary tract and bloodstream, and can cause increased mortality and hospitalization, (retrieved from www.cdc.gov on 10/10/25). On 9/30/25 at 10:41 AM, the Infection Preventionist (IP) confirmed the was responsible for monitoring all residents who received antibiotics and any residents with devices such as IVs and foley catheters in the facility. He explained he monitored residents with devices because they increased the resident's risk for infection. The IP stated he was unsure if resident #81 had any devices such as an IV. He recalled there were two residents in the facility who had IV's, but he could not remember if resident #81 was one of them. Enhanced Barrier Precautions is an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve the use of a gown and gloves during high-contact resident care activities to prevent infections in vulnerable people, (retrieved from https://www.cdc.gov on 10/10/25). On 10/02/25 at 2:16 PM, the Infection Preventionist was observed in resident #81's room without gloves or a gown, preparing to administer intravenous (IV) medication. The resident was sitting on the right side of his bed with the room divider curtain on his right side. Above the resident's bed was a sign which indicated the resident was on Enhanced Barrier Precaution. The IP was seen to don gloves at that time and begin to prepare and administer the IV medication. The IP brushed himself against the resident, his wheelchair and the resident's curtain in order to hang the IV antibiotic medication on the IV pole behind the resident. The IP finished preparing and administering the medication, removed his gloves and performed hand hygiene with alcohol sanitizer before he exited the room. He did not wear (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a gown during the entire time he was in resident #81's room providing care. On 10/03/25 at 12:19 PM, the IP stated he had been in the position for three months and had never worked as an IP before. He explained his titles and responsibilities included the Assistant Director of Nursing, Staff Educator and occasionally worked on the floor when needed. He confirmed he had read the infection control policies when he started in the position and had a short training session with an IP from a sister facility. He explained the IP position was vacant when he started and the position had been vacant for a while. The IP confirmed that resident #81 was on enhanced barrier precautions and acknowledged he did not wear a gown when he administered the resident's IV medication but should have. Review of the facility's policy and procedure for Transmission-Based Precautions (TBP) revised 8/15/22 revealed that signage that included instructions for use of specific PPE would be placed in a conspicuous location outside the resident's room with either the CDC category of TBP or to see the nurse before entering the room. The document indicated the order for transmission-based precautions/isolation should specify the type of precaution and reason for the transmission-based precaution. Review of the facility's policy and procedure for Infection Prevention and Control Program (ICPC) revised 8/15/22 revealed a resident with an infection or communicable disease would be placed on transmission-based precaution as recommended by the current CDC guidelines. The facility did not have a policy dedicated to Enhanced Barrier Precautions. 5. On 9/30/25 at approximately 10:45 AM, the IP acknowledged part of his role as the IP was to track and monitor antibiotic use. He confirmed that part of the monitoring included verifying antibiotics were given for a full course and that residents did not miss any doses. He explained if a resident missed a dose, the physician should be notified to verify if the course of the antibiotics should be extended. The IP stated the expectation for an unavailable antibiotic was for staff to check the emergency supply kit to see if it was available there and notify the physician to obtain an order for an alternative medication if it was not available. Review of the resident #81's electronic medication administration record (EMAR) for September 2025 revealed the physician ordered antibiotic medication Ertapenem sodium solution was not administered on 9/26/25 with an administration note that read, Waiting on pharmacy delivery; on 9/28/25, the medication was not administered and an administration note indicated that a midline IV was ordered and the physician was aware; and on 9/29/25, the medication was not administered and an administration note read, Waiting on pharmacy. In a phone interview on 10/11/25 at 11:15 AM, the Pharmacy Manager clarified that Ertapenem could be administered through a peripheral line if the duration was for less than 10 days. He stated that from his records there was no issue with the medication being unavailable to the facility. He verified that four doses of the antibiotic medication were delivered to the facility on the 9/26/25 for resident #81. The Pharmacy Manager noted that Ertapenem Intramuscular (IM) 1 gram was available in the emergency supply kit as an alternative if there had been an issue with an available IV site for delivery of the medication. On 9/30/25 at 10:45 AM, the IP and Director of Nursing (DON) confirmed there was no documentation on 9/26/25 or 9/29/25 that the physician was notified that resident #81 missed doses of the medication. The IP stated he did not realize the resident did not receive multiple doses of his (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	antibiotic as ordered. On 10/01/25 at 6:00 PM, the IP stated he had not participated in the medication regimen review since he started. He acknowledged he had not performed antibiotic audits during the last month and stated it fell through the cracks. On 10/03/25 at 1:09 PM, the DON stated that she believed the reason the nurses did not administer the antibiotic medication was because staff were unsure if the Ertapenem could be given through a peripheral line. She explained the staff were waiting until a midline was inserted to administer the medication. The DON clarified the staff must have thought pharmacy was responsible for inserting the midline which was why they documented they were waiting on pharmacy. She acknowledged that staff should have called the pharmacy to verify if the medication could be given through a peripheral line if they were unsure. The DON verified that part of her role was to oversee the IP and make sure aspects such as antibiotic stewardship were implemented. The DON explained that management was focused on other facility issues and had not realized aspects of the infection control program were not being performed. Review of the facility's policy and procedure for Antibiotic Stewardship Program revised 8/23/2022 revealed the antibiotic stewardship program included protocols and a system to monitor antibiotics. The document indicated that antibiotic use would be monitored during each monthly medication regimen review when the resident had been prescribed or was taking an antibiotic. Random audits of antibiotic prescriptions were to be performed to verify completeness and appropriateness.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on interview, and record review, the facility failed to maintain an effective Quality Assurance and Performance Improvement (QAPI) program by not identifying and addressing repeated deficiencies and by not ensuring complete monitoring documentation for corrective action plans. The deficient practice resulted in a pattern of unresolved quality concerns and had the potential to affect more than a limited number of residents by not ensuring consistent monitoring and follow-up of identified problems. Findings: On a previous recertification survey dated 4/12/24, Centers for Medicare & Medicaid Services (CMS) Enforcements were issued that included F0584 (Safe/Clean/Comfortable/Homelike Environment), F0842 (Resident Records - Identifiable Information), and F0880 (Infection Prevention & Control). On 10/03/25 at 2:30 PM, the Nursing Home Administrator (NHA) explained that their QAPI program included non-compliance assessments/review, and identification of identified problems reported by each department during their monthly regular and Ad Hoc (when needed) meetings. She recalled the last monthly meeting was held on 9/25/25, and the last Ad Hoc meeting was held on 8/25/25 for a change in the facility's NHA. The NHA explained that a four-step process was used to identify what issues the committee decided to work on that included identification of the problem, investigation for the root cause, development of a correction plan, and tracking of progress and trends for one year which was the facility's practice. On 10/03/25 at approximately 2:45 PM, a joint review of the facility's QAPI binder and Performance Improvement Plans (PIPs) since the last recertification was conducted with the NHA and Director of Nursing (DON). Documentation of monitoring for previously identified deficiencies was incomplete or missing. For example, in February 2025, the facility identified Dietary Department concerns. The facility conducted an Ad Hoc QAPI meeting where the committee developed a PIP to correct the issue. When asked to review the monitoring documentation and audits, the NHA and DON were unable to locate the records. The NHA stated, the Certified Dietary Manager's last day was last Wednesday; she had a PIP for Dietary concerns, and she kept them separate. From 9/29/25 to 10/03/25, a recertification and complaint survey was conducted, and deficient practice was again identified for F0584 (Safe/Clean/Comfortable/Homelike Environment), F0842 (Resident Records - Identifiable Information), and F0880 (Infection Prevention & Control). The facility did not implement an ongoing, systematic QAPI program to ensure that identified problems were corrected and prevented from recurring. The failure of the facility to maintain complete monitoring documentation and address repeated deficiencies demonstrated that the QAPI program was not effective. Review of the facility's undated standards and guidelines titled, 2025 Quality Assurance & Performance Improvement (QAPI) noted the program's intentions included multiple resources and best available evidence to ensure their data collection tools and monitoring systems were in place and consistent for, proactive analysis. The program outlined identification and prioritization of problems and opportunities based on performance indicator data, resident and staff input, and other information. Projects were used to determine gaps or patterns in care systems that could result in quality problems and/or identification of opportunities to make improvements. The document indicated that all QAPI goals and action plans were to be stored in the QAPI binder.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct medication self-administration assessment to ensure safety for 1 of 1 resident reviewed for self-administration of medications, out of a total sample of 48 residents, (#68). Findings: Resident #68 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, end stage renal disease, type 2 diabetes mellitus with diabetic neuropathy, and major depressive disorder. A review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of 6/30/25 revealed resident # 68 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated he was cognitively intact. The assessment indicated he did not exhibit any behaviors and did not reject care. A review of resident #68's electronic medical record revealed no physician's order for self-administration of medications and did not contain an assessment for self-administration of medications. A review of the Medication Administration Audit report showed Licensed Practical Nurse (LPN) B administered the scheduled 9:00 AM medications at 10:15 AM on 9/29/25. On 9/29/25 at 11:19 AM, resident #68 was observed sitting up in bed watching television. A medication cup which contained pills was noted on his bedside table. Resident #68 explained the nurse left the cup there because he usually takes a while to swallow the pills. On 9/29/25 at 11:21 AM, LPN B confirmed he was the assigned nurse for resident #68 and had administered his medications. He confirmed resident #68 was not allowed to self-administer his own medications. LPN B accompanied the surveyor to the resident's room and observed the medications on the bedside table. He explained that he saw resident #68 lift the medication cup to his mouth but got distracted by the roommate. LPN B acknowledged he should have stayed and watched the resident take all of his medications. On 9/29/25 at 11:29 AM both the A wing Unit Manager (UM) and the Director of Nursing (DON) were at the nurse's station and were made aware of the situation. The A wing UM stated that it was unacceptable for LPN B to leave the medications with resident # 68 and should have stayed with the resident. The A wing UM explained she was not aware that resident #68 wanted to self-administer his medications. The DON clarified that there were no residents in the facility who were assessed for self-administration of medications. She stated that her expectation was for LPN B to have stayed and watched resident #68 take his medications. Review of the facility's policy and procedure for Medication Administration revised in October 2023, revealed in section 15 of their policy explanation and compliance guidelines that staff were directed to Observe resident consumption of medication. The facility's policy and procedure for Resident Self-Administration of Medication, implemented in November of 2020, read, A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary maintenance services to ensure a homelike environment in 3 of 32 rooms in the B- wing, (rooms #13, #14, and #17). Findings: On 9/29/25 at 11:20 AM, broken window blinds were noted in room [ROOM NUMBER]. On 9/30/25 at 11:28 AM, resident #19, in room [ROOM NUMBER], stated the clock on the wall had been without a battery for five days. He mentioned he informed the staff, but they had not fixed it, so he could not tell how long he waited for his call light to be answered. Later, on 10/01/25 at 9:17 AM, resident #19 stated his clock was still not working. On 9/30/25 at 12:25 PM, broken window blinds were noted in room [ROOM NUMBER]. On 10/02/25 at 10:01 AM, the blinds in rooms #13 and #17 were still broken, and the wall clock in room [ROOM NUMBER] remained nonfunctional. On 10/02/25 at 1:38 PM, the Maintenance Director stated he was responsible for the maintenance of the building, including residents' rooms. He indicated he performed routine inspections of residents' rooms and repaired items as needed. He explained staff entered work orders in their electronic system (TELS), which he or his assistant checked multiple times daily. He stated they did not maintain records of their room inspections. The Maintenance Director emphasized the importance of keeping residents' rooms in good condition for their comfort and dignity. At approximately 1:44 PM, observations of the above-mentioned rooms were conducted with the Maintenance Director, who acknowledged the findings. Later, at 2:58 PM, the Maintenance Director reviewed the TELS report for the above-mentioned rooms and confirmed the issues had not been previously identified. On 10/02/25 at 1:47 PM, Housekeeper F was cleaning room [ROOM NUMBER] and stated she verbally reported her findings from cleaning residents' rooms to maintenance. She acknowledged the broken window blinds and stated she had not reported them to the Maintenance Director because she had not noticed them earlier. She mentioned it was important for residents to have their rooms clean and orderly so they could feel good and welcome. She added she would not like her own home to be dirty or have broken items. The facility's policy titled Safe and Homelike Environment revised on 4/11/23 read, . the facility will provide a safe, clean, comfortable, and homelike environment, . The form revealed general considerations of reporting any furniture in disrepair to Maintenance promptly and reporting unresolved environmental concerns to the Administrator.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate care and services according to professional standards for monitoring and management of an intravenous (IV) therapy site for 1 of 2 residents reviewed for IV access, (#81), and failed to provide appropriate care and services according to professional standards for medication administration for 1 out of 2 residents, (#87), out of a total sample of 48 residents. Findings: 1. Resident #81 was admitted to the facility on [DATE] from an acute care hospital following a fall. He was admitted with diagnosis including fracture of sacrum, fracture left pubis, fracture right ilium, essential tremor, cognitive communication deficit, Parkinson's with dyskinesia, and dementia. On 9/30/2025 at 10:18 AM, resident #81 was observed in his wheelchair in the dining room. He was noted to have a short peripheral intravenous line (IV) to his left forearm which was undated and a single lumen midline to his left arm hanging down from his sleeve. Resident #81 lifted his sleeve to reveal a midline dressing dated 9/29/25. Resident #81 could not recall why he needed the IVs. A short peripheral intravenous line is a catheter, up to three inches long, inserted into one of the superficial veins of an extremity. A midline catheter is longer than 3 inches and is inserted into the upper arm through a larger vein of the upper extremity with the catheter tip located at or near the level of the axilla and distal to the shoulder. (retrieved from www.infusioninstitute.com on 10/06/25). Review of laboratory results for resident #81 revealed on 9/19/25 a complete blood count (CBC) with differential was drawn and the resident's white blood cells (WBC) were 23.2 thousand cells per microliter (K/uL). The normal range for WBC's were 3.8 to 10.8 K/uL and an elevated level could indicate an infection. The resident also had a urinalysis and culture with reflex drawn and the urinalysis per physician was unremarkable. A physician note dated 9/26/25 revealed the resident's urine culture was positive for Klebsiella pneumonia and he was started on an antibiotic 1 gram daily for five days which was discussed with the Assistant Director of Nursing (ADON). Resident #81's physician orders revealed an order for Ertapenem 1 gram intravenous every 24 hours for UTI for six Days with a start date of 9/26/25. Review of resident #81's progress notes revealed a note from 9/27/25 at 11:51 PM, stating a 22 gauge IV was inserted into the left forearm after one successful attempt which the resident tolerated well. The IV antibiotic was started. Review of the physician's orders for resident #81 revealed no order for insertion of a peripheral IV line and no orders to monitor the IV insertion site, flush the line with normal saline, or change the dressing. Review of resident #81's physician orders revealed an order to insert a midline for antibiotic therapy with a start date 9/29/25 which was administered at 12:49 PM. There were no orders to monitor the midline IV site, flush the line with normal saline, or change the dressing. On 9/30/25 at 10:31 AM, Licensed Practical Nurse (LPN) A confirmed that resident #81 had a peripheral IV to his left forearm which did not have a date and a midline to his left upper arm which was dated 9/29/25. She reviewed the physician orders and verified there were no orders for the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	midline nor the peripheral IV to be flushed, monitored, or have the dressings changed. On 9/30/25 at 10:45 AM, the Director of Nursing (DON) confirmed there were no physician orders to monitor, flush or change the dressing of the peripheral IV nor to monitor, flush or change the dressing to the midline IV. She explained the nurses were expected to add those orders whenever a resident had an IV site. She was unable to explain why those orders were not obtained. Review of the facility's policy for Intravenous Therapy revised 8/02/22 revealed the facility would adhere to accepted standards of practice regarding infusion practices. The document indicated that IV dressings would be changed every 72 hours unless otherwise ordered by the physician. Staff were directed to check IV sites every four hours or as per facility protocol and as needed for signs and symptoms of infection or inflammation. 2. Resident #87 was admitted to the facility on [DATE] with diagnosis including chronic obstructive pulmonary disease, dysphagia, dry eye syndrome of unspecified lacrimal gland and chronic kidney disease. Review of the Minimum Data Set (MDS) annual assessment with an assessment reference date (ARD) of 7/23/25 revealed resident #87 was cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15 out of 15. The document indicated she had impaired vision. Review of resident #87's electronic medical record (EMR) revealed a physician's order for Lubricating Plus Eye Drops Ophthalmic Solution 0.5 % (carboxymethylcellulose sodium) and nurses were instructed to instill two drops in both eyes every 12 hours for dry eyes. On 9/29/25 at 11:04 AM, resident #87 was observed in bed. She reported that she had not received her eye drops as ordered. On 10/02/25 at 11:38 AM, Registered Nurse (RN) C verified she was the assigned nurse for resident #87 and had administered her eye drops. RN C presented a blue and white box from her cart which read generic eye lubricant without the resident's name or date on the box. RN C confirmed that she administered the eye drops to resident #87 that morning and knew the eye drops belonged to her even though the box did not have her name on it. RN C reviewed the physician's order and verified the order was for Lubricating Plus Eye Drops Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium). She acknowledged the generic lubricating eye drops which she administered earlier were not the eye drops that were prescribed. She explained she did not realize she had administered the wrong ones. RN C stated she should have verified the medication prior to administration and was sorry that she administered the wrong medication. On 10/02/25 at 11:45AM the Unit Manager (UM) for the A Wing acknowledged resident #88 received the wrong eye drops and stated that the facility had the correct medication in the stock room. The A Wing UM expressed she did not understand the reason generic eye drops were even in the medication cart because the resident did not receive the generic drops. The UM confirmed RN C and other nurses required education on medication administration. On 10/02/25 at 12:04 PM, the DON acknowledged resident #87 received the wrong eye drops. The DON shook her head and stated she could not understand why the nurse did not give the correct eyedrops. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure on Medication Administration revised October 2023, revealed in section 10 of the policy's explanation and compliance guidelines, the nurses were instructed to Review MAR [medication administration record] to identify medication to be administered.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** Based on interview, and record review, the facility failed to develop a trauma-informed care plan based on a resident's past experiences and preferences to mitigate triggers that could cause re-traumatization, for 1 of 1 resident reviewed for abuse, of a total sample of 48 residents, (#29). Findings: Review of resident #29's medical record revealed she was originally admitted to the facility on [DATE] with diagnoses including myasthenia gravis (an autoimmune condition that causes skeletal muscle weakness), sequelae of cerebral infarction, osteoarthritis, an fibromyalgia (chronic condition that causes pain in muscles and soft tissues all over the body). The Minimum Data Set admission assessment with Assessment Reference Date of 8/13/25 revealed resident #29 had a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. On 9/29 at 11:24 AM, resident #29 reported she had a problem with a male resident on 9/06/25. She presented a partial copy of a grievance form filed on the day of the incident. She stated the staff were not watching the male resident, and he entered her room. She explained a Certified Nursing Assistant (CNA) had left the male resident sitting in a chair in her room and walked away. She stated the male resident then got up from the chair, moved toward her, pushed her bedside table aside, and sat at the edge of her bed. She stated she screamed and yelled while the male resident cursed. She described feeling terrified and uncertain about what he might do to her. Resident #29 shared she had previously survived an attempted murder, and the event triggered memories of that trauma. She stated she felt defenseless because she could not stand or use her hands. She reported no staff were in her room and when they arrived, they laughed and told her it was okay. She stated the entire unit must have heard her screams. She indicated the staff eventually removed the male resident. She shared a manager later visited her and explained what had occurred. She indicated she was informed the male resident was on a one-to-one supervision, but she said she still did not feel safe. She questioned, Was he trying to have sex? What would he do to me? and shared staff often did not respond quickly when she pressed her call light. Resident #29 also reported suffering from post-traumatic stress disorder. Review of resident #29's comprehensive care plan revealed it did not include a focus on trauma-informed care. Review of a Grievance/Complaint Report filed by resident #29 on 9/06/25 read, Resident stated male resident entered her room approximately 11:45 AM and sat in chair by her door shouting . The form showed resident #29 was informed about changes made to supervise the male resident, but she remained upset that he had entered her room. Review of resident #29's Social Services - Trauma-Informed Care Evaluation dated 8/10/25 revealed affirmative responses for the following questions, Has anyone ever made or pressured you into some type of unwanted sexual contact? If the event happened, did you think your life was in danger or you might be seriously injured? and . were you seriously injured. Her identified triggers for potential re-traumatization was self. Review of resident #29's medical record included a Psychotherapy Progress Note dated 9/13/25 which read, . She shared a recent experience when another resident entered her room and she was triggered. Her traumas of almost getting killed three times by her ex-partners. She said it took staff intervention to calm her down and Hydroxyzine . A Psychotherapy Progress Note dated 9/20/25 indicated, . She shared traumas she encountered while growing up and many traumas as an adult that have impacted her life experiences. All of those adverse experiences have been catalysts to her current response to the environment and hypervigilance. On 10/01/25 at 2:42 PM, during a telephone interview, CNA J recalled resident #29 was screaming and visibly upset when a male resident sat on her bed. She stated her and other staff removed the male resident from resident #29's room. On 10/01/25 at 4:37 PM, the Assistant Business Office Manager stated she was the Manager on Duty on 9/06/25. She recalled being informed resident #29 requested to speak with a manager. She indicated resident #29 told her a male resident had entered her room, which made her very upset. She mentioned resident #29 explained she was startled due to her history of sexual abuse. The Assistant Business Office (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manager said resident #29 was extremely irate and may have received medication afterward to calm her down. On 10/02/25 at 2:24 PM, LPN I reported overhearing resident #29 screaming while passing medications on 9/06/25. She recalled entering resident #29's room where she observed three staff members struggling to remove the male resident who was sitting at the edge of resident #29's bed. LPN I indicated she assisted staff in removing him. She stated resident #29 shared she was fearful due to prior traumatic experiences with males. On 10/01/25 at 4:49 PM, the Social Services Director (SSD) stated she had completed a psychosocial evaluation on 8/10/25 in which resident #29 shared her history of sexual abuse and trauma. The SSD stated she referred the resident for psychological services and counseling. The SSD acknowledged she should have developed a trauma-informed care plan but became focused on providing immediate support instead. The SSD acknowledged the 9/06/25 incident was another opportunity the facility had to update the care plan to address trauma as a focus area. Review of the facility's policy Trauma Informed Care revised on 7/27/22 revealed the intent to provide care and services which met professional standards and used approaches that were culturally competent, accounted for experiences and preferences and addressed the needs of trauma survivors by minimizing triggers and/or re-traumatization. The guidelines included identifying a resident's history of trauma and triggers and developing and implementing individualized care plan interventions. The policy read, Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the residents care plan.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure pharmacy recommendations were implemented in a timely manner for 1 of 5 residents reviewed for Unnecessary Medication Regimen Review, out of a total sample of 48 residents, (#19). Findings: Review of the medical record revealed resident #19 was admitted to the facility on [DATE] and readmitted from an acute care hospital on 4/22/25. His diagnoses included type 2 diabetes mellitus (DM), hemiplegia (one-sided paralysis) and hemiparesis (one-sided muscle weakness) following a cerebral infarction, atrial fibrillation, and heart failure. A review of resident #19's Recommendation Outcomes form dated 8/25/25 showed the pharmacist identified several medications that could cause hypoglycemia: Glimepiride 2 milligrams (mg) orally (PO) every morning for DM, Metformin 1000 mg PO twice a day, Humulin 70/30 injection 20 units before meals (AC), Trulicity injection 2 mg subcutaneous once weekly, and Humalog sliding scale to be used AC and at bedtime. The pharmacist recommended adding a hold parameter for the Humulin 70/30 order, stating Resident has a high risk of hypoglycemia due to the additive effects of multiple Diabetes meds. A handwritten note by the Director of Nursing (DON) dated 8/29/25 read, T.O. (telephone order) Hold for parameter blood glucose below 150. The physician agreed and signed the order on 8/29/25. Review of resident #19's physician's orders revealed an order dated 2/19/25 for Humulin 70/30 to inject 20 units AC. The order was discontinued on 9/23/25 at 1:56 PM and a new order for Humulin 70/30 to inject 15 units AC was started on 9/23/25 at 4:30 PM. The physician's orders, however, did not include a parameter to hold the insulin if the resident's blood glucose (BG) was below 150. The active orders confirmed this parameter was not officially added until 10/01/25. Review of resident #19's care plan, revised on 2/05/25, with a focus on diabetes management, noted he was at risk for both hyperglycemia and hypoglycemia. The goal was to minimize complications related to hyper/hypoglycemia. Interventions instructed nurses to Administer medications as ordered. Review of resident #19's Medication Administration Record (MAR) for August and September 2025 showed Humulin 70/30 was scheduled three times daily at 6:30 AM, 11:30 AM, and 4:30 PM. Documentation revealed nurses administered 28 doses of Humulin 70/30 between 8/31/25 and 9/22/25 despite the physician's hold order for BG levels under 150. Resident #19's BG level ranged between 87 and 148 on days administered outside of parameters. A review of resident #19's Pharmacist's Recommendation to Prescriber form dated 6/27/25 revealed the resident had PRN (as needed) orders for non-acute pain management: Hydrocodone- APAP 5-325 milligrams (mg) every 4 hours (Q4H) PRN and Morphine solution 20 mg/milliliters (mL) Q4H PRN for pain, shortness of breath (SOB), or respiratory distress. The pharmacists recommended adding a pain scale to these PRN orders. Review of resident #19's physician's orders revealed an order dated 6/11/25 for Hydrocodone 5-325 mg Q4H PRN pain, which was discontinued on 10/01/25. A new order entered the same date read Hydrocodone-acetaminophen 5-325 mg Q4H PRN for non-acute pain. The Morphine 20 mg/mL 5 ml Q4H PRN Pain/SOB/Respiratory distress non-acute pain dated 4/23/25 was also discontinued and reentered on 10/01/25. Neither of these orders included the pain scale recommendation from the pharmacist. On 10/02/25 at 6:43 PM, the DON confirmed resident #19's pharmacy recommendations and physician order for Humulin 70/30 were not followed. She stated she updated the orders on 10/01/25 after reviewing them and realizing the recommended parameters had not been entered. The DON reported she believed nurses were following sliding scale parameters used for Humalog insulin and assumed the same applied to Humulin, even though the hold order was not added as recommended by pharmacy. A review of the facility's Medication Administration policy and procedure, revised on 10/2023, read, Medications are administered by licensed nurses, . as ordered by the physician and in accordance with professional standards of practice, .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the medical record reflected documentation of an incident between residents and follow-up assessments for 1 of 1 residents reviewed for abuse, out of a total sample of 48 residents, (#29). Findings: Review of resident #29's medical record revealed she was originally admitted to the facility on [DATE] and readmitted on [DATE] from an acute care hospital. Her diagnoses included myasthenia gravis (an autoimmune condition that causes skeletal muscle weakness), sequelae of cerebral infarction, osteoarthritis, an fibromyalgia (chronic condition that causes pain in muscles and soft tissues all over the body). The Minimum Data Set (MDS) admission assessment with Assessment Reference Date of 8/13/25 revealed resident #29 had a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. On 9/29/25 at 11:24 AM, resident #29 reported she had a problem with a male resident on 9/06/25. Resident #29 showed a partial copy of a grievance form filed on the day of the incident. She stated a Certified Nursing Assistant (CNA) left the male resident sitting in a chair in her room and walked away for a moment. She recalled the male resident got up, came near her, pushed her bedside table aside, and sat at the edge of her bed. She stated she was screaming while the male resident was cursing. She said she was terrified and did not know what he would do to her. Resident #29 shared a man had previously tried to kill her and this incident triggered those memories. She explained due to her medical conditions, she could not stand or use her hands and therefore felt defenseless. She stated staff entered her room a few minutes later and eventually removed the male resident from her room. She indicated she received a visit from a manager after the incident and she explained what happened, and the manager filed a grievance on her behalf. She said her nurse came after the incident and obtained her blood pressure (BP) which was 162/90 and that it had never been that high before. Review of resident #29's medical record did not reveal any documentation about the incident on 9/06/25 or the BP of 162/90. Review of resident #29's Progress Notes revealed a psychotherapy note dated 9/13/25 which read in part, Patient is being followed due to history of anxiety and depression with new onset of acute stress reaction. She shared a recent experience when another resident entered her room and she was triggered. Her traumas of almost getting killed three times by her ex-partners. She said it took staff intervention to calm her down and Hydroxyzine. On 10/01/25 at 4:37 PM, the Assistant Business Office Manager stated she was the Manager on Duty on 9/06/25 and met with resident #29 after the incident. She said resident #29 was visibly upset because a male resident had entered her room and sat on her bed. The Assistant Business Office Manager indicated resident #29 told her she had history of sexual abuse, and the incident caused her distress. The Assistant Business Office Manager stated she informed resident #29 the issue was being addressed and completed the grievance form. The Assistant Business Office Manager stated she believed resident #29 received a medication to calm her down after the incident. On 10/02/25 at 2:24 PM, Licensed Practical Nurse (LPN) I stated on 9/06/25, while passing medications, she heard resident #29 screaming and went to her room to check on her. She recalled seeing three staff members and a male resident sitting at the edge of resident #29's bed. She indicated the staff were having trouble removing the male resident from the room, so she assisted. LPN I stated she asked resident #29 if she was hurt and resident #29 told her the male resident did not touch her. LPN I said resident #29 refused a head-to-toe assessment. LPN I indicated resident #29 shared she was fearful because of prior experiences with males. When asked about documentation of the incident or assessment that day, LPN I said she did not recall entering any notes in the medical record. LPN I acknowledged the incident should have been documented but did not remember doing so. On 10/02/25 at 11:52 AM, the Assistant Director of Nursing (ADON) stated he was working on 9/06/25 and was informed by LPN I about the incident involving resident #29 and the male resident. The ADON shared he spoke with (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Longwood Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident #29 and completed a grievance form because she was upset. He explained he reassigned the male resident to one-to-one supervision but did not enter any notes regarding the incident in resident #29's medical record. Later at 4:30 PM, the ADON stated the facility's expectation was for accurate documentation in the medical record, including resident's refusals. On 10/2/25 at 5:25 PM, the Director of Nursing (DON) validated resident #29's medical record did not include the incident on 9/06/25 and acknowledged it should have been documented. Review of the facility's Documentation in Medical Record policy and procedure revised on 8/25/22 read, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. The guidelines listed directed licensed staff and interdisciplinary team members to document all assessments, observations, and services in the medical record in accordance with state law and facility policy.		