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	02/19/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure that physician ordered medications were not left unattended at residents' bedside for 1 of 2 residents, reviewed for quality of care, of a total of 4 sampled residents, (#1).Findings:On 2/19/26 at 12:27 PM, a medication cup with four pills (one yellow tablet, one pink tablet, one white tablet, one pink and gray capsule), and one six-ounce clear plastic cup with clear liquid and a spoon inside of it was sitting on resident #1's bedside table with his lunch tray. Resident #1, alert to person, place and time, explained the medications in the cup were his 9:00 AM medications previously left by the nurse. He said the clear plastic cup with clear liquid was his MiraLAX that was also left at bedside by the nurse. On 2/19/26 at 12:51 PM, assigned Licensed Practical Nurse (LPN) A, stated she did not know where the medications left on the bedside came from. She mentioned the medications were not there when she administered the resident's 9:00 AM medications. The nurse stated she didn't usually leave medications at residents' bedsides but explained she left resident #1's 9:00 AM liquid stool softener (MiraLAX) on his bedside table in a clear six-ounce plastic cup. On 2/19/26 at 12:54 PM, the Director of Nursing (DON) acknowledged the cup with the medications on resident #1's bedside table, then took the cup from resident #1's bedside table and stated that he would investigate what the medications were. Review of resident #1's current physician orders revealed he had orders for Aspirin oral capsule 81 milligrams (mg) - give 1 tablet by mouth in the morning for PAD (peripheral artery disease) - start date 10/25/25 9:00 AM, Flomax capsule 0.4 mg - give 1 capsule by mouth in the morning for benign prostatic hyperplasia - start date 12/24/25 at 9:00 AM, Losartan potassium tablet 25 mg - give 1 tablet by mouth one time a day for hypertension (high blood pressure) - start date 10/25/25, 9:00 AM, MiraLAX oral packet 17 grams - give 17 grams by mouth one time a day for constipation - start date 10/25/25 at 9:00 AM, and Oxybutynin chloride extended release 24 hour, 10 milligram tablet - give 1 tablet by mouth one time a day for overactive bladder - start date 11/27/25 at 9:00 AM. Review of the facility's Medication Administration Record (MAR) revealed that resident #1's 9:00 AM, medications were documented as given by LPN A, on 02/19/26 at 9:00 AM, in conflict with the medications observed still in a cup on resident #1's bedside table. On 2/19/26 at 2:25 PM, the DON stated he spoke to the physician by phone to verify resident #1 medications. He stated the 4 medications in the medication cup were Aspirin 81 mg, Flomax 0.4 mg, Losartan 25 mg, Oxybutynin 10 mg, and the clear liquid in the cup was MiraLAX. The DON confirmed these medications were resident #1's medications scheduled for 9:00 AM, still sitting on the bedside table three and a half hours later at 12:27 PM. Review of the facility's policy revised October 2023, entitled Medication Administration, indicated that medications were administered by licensed nurses, or other staff who were legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines #15, indicated for staff to observe resident consumption of medication, and #19 (continued on next page)

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, Report and document any adverse side effects or refusals.