STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105518	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winter Garden Rehabilitation and Nursing Center	12751 W Colonial Drive Winter Garden, FL 34787

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 - Some	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 interview, and record review, the facility failed to provide pharmaceutical services, consistent with professional standards of practice, to ensure safe medication administration for three residents reviewed for anticonvulsant medications, of a total sample of 10 residents, (#1, #2, and #3).Findings:1. Review of the medical record revealed resident #1 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (one-sided weakness and paralysis) following a cerebral infarction (stroke), epilepsy, dementia, dysphagia (trouble swallowing) and type 2 diabetes mellitus.Review of a physician progress note on 1/13/26 revealed the resident had an episode of unresponsiveness to voice or light touch and he would only open his eyes to a strong rub on the chest bone. The resident was sent to the hospital for further evaluation.The hospital ?After Visit Summary' dated 1/13/26 to 1/19/26 listed his diagnosis as a breakthrough seizure. Review of the resident's discharge medication revealed the resident's previous anticonvulsant medication of Primidone 250 milligrams (mg) was stopped and Brivaracetam 100mg in the morning and at bedtime was started.Review of the Electronic Medication Administration Record (EMAR) revealed a physician order for the anti-seizure medication Brivaracetam 100mg with a start date of 1/20/26. Review of the EMAR revealed the resident did not receive the medication for 20 of the 24 scheduled doses in January 2026 and 14 of 37 scheduled doses in February 2026. The charting code associated with these missed doses correlated to Medication on order from pharmacy/MD (physician) aware. The medication was discontinued on 2/19/26.Review of the residents' electronic medical record revealed no documentation related to the notification of the physician, subsequent orders nor monitoring for seizure activity. Review of the medical record also revealed no documentation by the physician related to the knowledge of multiple missed doses of the anticonvulsant medication.2. Review of the medical record revealed resident #2 was admitted to the facility on [DATE] with a primary diagnosis of epilepsy without status epilepticus (long seizures). The resident also had additional diagnosis including type 2 diabetes mellitus, heart failure, cognitive communication disorder, and dysphagia.Review of the resident's physician orders revealed orders for the anti-seizure medications Cenobarmate 25mg daily, Depakote DR 250mg twice daily, Lacosamide 100mg twice daily and Levetiracetam 1000mg twice daily.Review of the EMAR revealed physician orders for the anti-seizure medications Cenobarmate 25mg daily with a start date of 1/07/26 and Lacosamide 100mg twice a day with a start date of 1/06/26. Review of the EMAR of January 2026 revealed the resident did not receive 13 of the 20 scheduled doses of Cenobarmate 25mg and 7 of 26 doses of Lacosamide. Review for February 2026 revealed the resident did not receive 13 of 24 scheduled doses of Cenobarmate and 5 of 44 doses of Lacosamide. The charting code associated with these missed doses correlated to Medication on order from pharmacy/MD aware. The medication was discontinued on 2/28/26.Review of the resident's electronic medical record revealed no documentation related to the notification of the physician, subsequent orders nor monitoring for seizure activity. Review also revealed no documentation from the physician related to the knowledge of multiple missed doses of the anticonvulsant.3. Resident #3 was admitted to the facility on [DATE] with diagnosis including quadriplegia (paralysis from neck down), vascular dementia, spinal stenosis, and seizures. Review of (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's physician orders revealed an order for the anti-seizure medication Levetiracetam 100mg/milliliters (ml) to administer 5ml twice daily with a start date of 11/15/23. Review of the EMAR revealed the resident did not receive the medication for 6 doses out of 39 doses in May 2026. The charting code associated with these missed doses correlated to Medication on order from pharmacy/MD aware.Review of the resident's electronic medical record revealed no documentation related to the notification of the physician, subsequent orders nor monitoring for seizure activity. Review of the record also revealed no documentation from the physician related to the knowledge of multiple missed doses of the anticonvulsant.On 5/20/26 at 1:50 PM, the Director of Nursing (DON) acknowledged residents #1, #2, and #3 did not receive multiple doses of their seizure medications. She stated her expectation was for nurses to notify the physician when a medication was unavailable and document any orders that may follow. She said the nurses must also notify the resident and resident representative if indicated for the missed doses.On 5/21/26 at 12:27 PM, a phone interview with the residents' attending physician revealed he was not aware the residents did not receive multiple doses of their seizure medications. He stated his expectation was for nurses to notify him when they did not have a medication for a resident and for the nurse to document the conversation and any subsequent new orders. He said he would also expect nurses to monitor for any seizure activity during the time frame a seizure medication was not given. He stated if he was aware of the missed dose, it would be documented in his physician notes in the resident's clinical record.Review of the facility policy titled Physician Orders revised January 2024 revealed physician orders should be followed as prescribed and if not followed, it should be recorded in the resident's medical record during that shift. The policy indicated the physician should be notified and the responsible party as needed.