STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105301	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Hills Health and Rehabilitation Center	1350 Sleepy Hill Rd Lakeland, FL 33810

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed to promptly notify the physician of laboratory testing results for two (Residents #1 and #2) of two residents sampled. Findings included: Review of Resident #2's admission Record revealed the resident was admitted on [DATE] and included diagnoses of unspecified fracture of left acetabulum subsequent encounter for fracture with routine healing, unspecified fracture of right talus subsequent encounter for fracture with routine healing, and essential (primary) hypertension. Review of the primary care physician note dated, 10/2/25, for Resident #2 showed the resident had been in a motor vehicle accident resulting in a left acetabulum fracture and right talus fracture. The objective data gathered by the physician showed bilateral lungs were clear to auscultation (CTA), no shortness of breath (SOB) or dyspnea on exertion (DOE). The plan was for Staff to report any new or worsening issues, complications, or symptoms to provider via SBAR (Situation, Background, Assessment, Recommendation). Review of the Advanced Practitioner Registered Nurse (APRN) visit notes, dated 10/9 and 10/14 showed Resident #2 was alert and oriented x4, lungs were clear on auscultation with no signs and/or symptoms (s/s) of shortness of breath, and was on room air. Review of Resident #2's primary care physician note dated 10/17/25 at 10:36 a.m. showed the resident informed the physician I couldn't breathe and had complaints of difficulty breathing and dyspnea with exertion or activity. The physician noted the resident was currently on two liters of oxygen, described feeling angry, and denied any previous history of pulmonary problems. The physical examination revealed lungs were clear to auscultation (CTA) with crackles and rales noted, and dyspnea was noted. The cardiovascular assessment showed an irregular rate and rhythm. The assessment and plan was for staff to obtain a stat chest x-ray, check D-dimer level and additional blood work, and order a complete blood count (CBC) and comprehensive metabolic panel. Review of a nursing note dated 10/17/25 at 9:49 a.m. revealed the physician had seen Resident #2 with complaint of shortness of breath (SOB) and anxiety. The recommendation was for a stat chest x-ray (CXR), D-dimer, and nebulizer treatments. (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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's laboratory results showed blood was collected for a stat D-dimer on 10/18/25 at 10:00 a.m., received at 1:36 p.m. and reported at 7:06 p.m. The results showed a high value of 10.53 (normal range 0.00-0.50). The results report revealed, D-dimer levels reflect breakdown of blood clots specifically cross-linked fibrin (fibrinolysis). D-dimer is low in healthy people and can be elevated in the presence of deep vein thrombosis (DVT) and pulmonary embolism (PE). D-dimer elevation is NONSPECIFIC since it may be elevated in other conditions including (but not limited to) pregnancy, elderly, malignancy, post-surgery, trauma, heart disease, and in hospitalized patients. Review of Resident #2's progress notes did not show the physician was notified of D-dimer results received on 10/18/25 at 7:06 p.m. until 10/20/25 at 10:51 a.m. Review of Resident #2's progress notes from 10/16 to 10/20/25 included the following: - 10/16/25 at 8:45 a.m. the resident was alert and oriented to person, place, time, and situation, lung sounds were within normal limits (WNL) and used no respiratory devices. - 10/17/25 at 11:05 a.m. the resident was alert and oriented to person, place, time, and situation. The resident had shortness of breath (SOB) while lying flat and on exertion, breathing was shallow, and use of oxygen and nebulizer treatments. The note showed no new lab/medication/treatment orders had been received. - 10/17/25 at 2:36 pm. showed the physician was notified of Resident #2's chest x-ray. - 10/17/25 at 11:59 p.m. the resident had lung sounds within normal limits (WNL), no respiratory devices, and no new laboratory/medication/treatment orders had been received. The note did not include any other comments. - 10/18/25 at 7:36 p.m. showed the resident's lung sounds were WNL, effort was normal, and oxygen was in use. The note revealed no new lab/medication/treatment orders had been received. - No progress note regarding status of resident was completed on 10/19/25. - 10/20/25 at 10:51 a.m. revealed D-Dimer 10.35 sent to MD and orders to send to local acute care facility for computed tomography scan (CT) of lungs as the resident was having SOB even after breathing treatments and on oxygen. Review of Resident #2/s care plan showed the resident was on anticoagulant therapy related to limited mobility due to fracture (fx) of left acetabulum and right talus. The nursing staff were to observe/document/report as needed (PRN) adverse reactions of anticoagulant therapy which included shortness of breath (SOB). (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Staff A, Licensed Practical Nurse (LPN) and the Assistant Director of Nursing (ADON) on 12/3/25 at 12:20 p.m. Staff A, LPN thought phlebotomy comes to the facility between 3:00 a.m. to 5:00 a.m. and are not scheduled to come on Saturday night/Sunday morning, unless a stat (immediately or at once). Laboratory (labs) testing was scheduled for the next draw (date) and physicians will tell staff if they want testing drawn stat. If a lab is ordered stat, staff call the laboratory, staff do not draw labs. Staff A stated laboratory results are in the computer and sometimes the results are faxed. Staff A stated the prior nurse would inform the oncoming nurse if they were drawn. There is also, book showing if the phlebotomist came in., the 11:00 p.m. to 7:00 a.m. shift nurse completes a to-do list of who, what lab tests need to be completed. The phlebotomist reviews the to-do list and signs off if labs are drawn. Staff A said two (2) copies of the lab requisition forms are printed out. One is placed in the lab book under the date to be drawn, there was a daily list of draws in the book to be done, and the 11-7 shift printed it (daily list) out for the phlebotomist. When results are received back to the facility, they are either sent to or called to the physician. The ADON stated the facility does not use a daily log of labs to be drawn, the phlebotomist brings a list of draws to be checked off as completed. During an interview on 12/3/25 at 1:07 p.m. Staff A, LPN reported Resident #2 had been in a MVA with non-surgical left hip and right ankle fractures. Staff A, LPN believed the resident's chest x-ray was negative and the physician ordered nebulizer treatments and did not believe the D-dimer was stat. Staff A, LPN reported putting the orders into the system and reported the orders to the oncoming nurse. Staff A, LPN stated as the orders had been received on Friday 10/17, the D-dimer would have been drawn on Saturday a. m. Staff A stated being curious on Monday (10/20/25) and saw the results of D-dimer was 10 something so the staff member called the physician and was told to send the resident to the hospital. Staff A stated the results had not been relayed to the physician earlier because he did not hesitate to send the resident out. Staff A, LPN stated not working the weekend but if results had been received the nurse on duty should have called the physician, Staff A stated the resident was short of breath and symptomatic, at time of transfer to the hospital. During an interview on 12/3/25 at 3:21 p.m. the Director of Nursing (DON) stated the expectation was once a nurse received (laboratory) orders from the physician they were transcribed into the electronic medical record. The orders go to the laboratory vendor, a printed requisition was put in the lab book, and at that point alert & oriented residents or family members are informed of the labs and are provided with education. When lab results are received back, staff are to contact the physician, some physicians will review results before staff are able to review them, and any additional orders will be transcribed. The DON stated staff don't make the decision regarding differentiating if the physician needs to know (if normal), it's his order so he can review. Staff were to inform the physicians that the results of labs were available for review. A review of Resident #2's D-dimer results was conducted showing one result had been received on 10/18 at 2:52 p.m. and one on 10/18 at 7:06 p.m. The DON stated the nurses should have notified the physician (prior to 10/20/25) and documented the notification. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone interview was conducted with Resident #2's primary care physician (PCP) on 12/4/25 at 11:10 a.m. The physician stated the expectation was if (labs) are ordered, when results come in staff were to notify him the results are in. The physician explained many times that he is not aware of when results come in due to different facilities having different (lab) companies and reporting times. The PCP reported at some point being notified of Resident #2's D-dimer results as he ordered the resident to be sent to the hospital but did not remember when or by whom. The physician stated the resident was on an anticoagulant, but a pulmonary embolism (PE) was considered but couldn't determine if it was that or due to the acute trauma (MVA). The physician was unable to locate the specific information regarding the time of notification. Review of Resident #1's admission record revealed an admission date of 11/13/2025. Resident #1 was admitted to the facility with diagnosis to include diabetes mellitus type 2, heart disease, other behavioral disturbance, adult failure to thrive, parkinsonism, severe protein-calorie malnutrition, persistent mood disorders, major depressive disorder, and anxiety disorder. Review of Resident #1's lab results revealed, collection date 10/08/2025 04:00, received 10/08/2025 10:34, reported 10/08/2025 11:50. Results: 74.3 (within range). Reviewed on 11/12/2025 16:41. Review of Resident #1's progress notes revealed: 10/07/2025 Nursing Note: New orders to get a valproic acid level (Depakote labs) on 10/08/2025. New orders put in at this time. No documentation was found related to the physician being notified or reviewing the result of valproic acid level. Review of Resident #1's Psychiatry subsequent note dated 10/09/2025, revealed, reason for today's encounter: Today, I saw the patient as it was reported to me that patient is unstable requiring psychiatric assessment and to assess tolerability and effectiveness after recent medication changes.A.) Summaries of the past notes: 10/09/2025: Patient anxious. I attended interdisciplinary psychotropic gradual dose reduction meeting. Discontinued Ativan.10/02/2025: patient has mood disorder. Patient was very agitated and physically aggressive. ordered Depakote labs. C.) Summaries of previous abnormal lab results: No labs since 03/25/2025. There was no documentation related to the review of valproic acid (Depakote labs). During an interview on 12/03/2025 at 3:21 p.m., the Director of Nursing (DON) stated the psych provider is good at reviewing their labs. He reviewed Resident #1's nurse progress notes and psych notes and acknowledged there was no documentation of the valproic acid (Depakote labs) being reviewed. Review of the policy titled Details of the Process related to: Laboratory Test/Diagnostic Policy/Procedure, dated 5/17/25, revealed: Policy: The facility will track ordered labs and diagnostic procedures and promptly notify the residents physician or nurse practitioner or physician's assistant of results of resident lab results and diagnostic procedure findings. The resident and/or resident representative will also be made aware of lab and diagnostic procedure results. Details of the process included the following: . (continued on next page)

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