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	04/30/2026

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

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure access to vision services for one (Resident #73) of one resident reviewed for communication and sensory problems.Findings included: On 4/27/2026 at 1:13 p.m., an interview was conducted with Resident #73 in her room. Resident #73 stated she would like to visit an ophthalmologist (eye doctor). She said staff told her she was placed on a list months ago. She does not know why they have not followed up with her on this request. She said she can see with her current glasses but due to her glaucoma she would like an examination. A review of Resident #73's admission Record showed Resident #73 was admitted to the facility on [DATE] with a diagnosis including but not limited to glaucoma. A review of Resident #73's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition and showed she uses corrective lenses. Review of Resident #73's active Care Plan dated 7/25/25 revealed Resident #73 has impaired visual function related to Glaucoma. The interventions for this care plan state to observe, document and report as needed any signs or symptoms of acute eye problems. On 4/29/2026 at 12:46 p.m., an interview was conducted with Staff A, Certified nursing assistant (CNA). Staff A, remembers there was an eye doctor that would see the residents here, and she is not sure if they currently still have this process in place. She said, if a resident reported they needed to see an eye doctor, she would report this to her nurse. Staff A said, if she recalls accurately the Unit Manager would handle the arrangements to see an eye doctor. On 4/29/2026 at 12:54 p.m., an interview was conducted with Staff B, Licensed Practical Nurse (LPN). Staff B said, Resident #73 did request a couple months ago that she would like to see an ophthalmologist. Staff B looked for a logbook to report this, could not find the logbook for vision care needs. Staff B said they didn't have a Unit Manager at the time, so she reported this to the previous Director of Nursing (DON). On 4/29/2026 at 12:54 p.m., an interview was conducted with the interim Director of Nursing (DON). The DON stated the process for a vision exam is to notify the nurse or supervisor first. Then determine if the resident would prefer the in-house optometrist, or if an outpatient appointment is needed. The DON stated they have two staff members that will handle appointment arrangements and transportation. The DON said, she is not aware of Resident #73 requesting to have a vision appointment for over two months. The DON acknowledged the process did not get the outcome expected for Resident #73. Review of the Resident Rights Policy with no revision date revealed the following. Policy: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility must protect and promote the rights of the resident. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, and reprisal from the facility.

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent residentˆtoˆresident altercation for five (Residents: #20, #51, #126, #185, #192) of five residents reviewed. This failure resulted in three resident-to-resident physical altercations on one (500-unit) of five units. Findings Include:1. On 04/27/2026 at 10:52 AM, an observation was made of two residents yelling at each other in the dining room of the 500 units. An activities aid was sitting at the table with the two residents. A nurse and the medical records coordinator responded to the situation, after two minutes of the argument. At the same time, Resident #20 had walked over to resident #185, who was sitting in a wheelchair and watching television (TV). Resident #185 was in the middle of the dining room, and Resident #20 poked and shoved the right side of Resident #185's head near the ear. Staff continued to assist the other two residents, who were continuing to argue. Resident #20 then walked from the middle of the dining room to the far right of the dining room. Resident #20 walked around other residents and went over to resident #126. Resident #126 had been sitting in a chair on the far right of the room. Resident #20 began speaking unintelligible words, while looking and pointing at Resident #126. Resident #126 yelled go back, go back, go back, while having his arms up in front of his face and pointing away from Resident #20. Staff then began to walk over to Resident #20 and stood next to the resident while Resident #20 was pointing at Resident #126. Resident #20 then slapped Resident #126 on the right arm. During an interview on 04/27/2026 at 11:08 AM, Staff Z, Certified Nursing Assistant (CNA), stated sometimes Resident #20 gets aggravated. Staff Z stated having seen Resident #20 go over to Resident #126 and try to engage in conversation. Staff Z stated Resident #126 hollered at Resident #20 to go away, and Resident #20 hit Resident #126. Staff Z stated after sundown, residents get more aggressive. During an interview on 04/28/2026 at 2:17 PM, Staff CC Nurse Practitioner, stated Resident #20 was always confused and anxious. During an interview on 04/29/2026 at 09:57 AM, the Recreational Director stated, no I do not think so, when asked if one staff member is enough to keep 24 residents engaged. During an interview on 04/29/2026 at 10:24 AM, Staff EE, CNA, stated definitely having a hard time meeting job duty task. Staff EE stated, there is not enough staff. Staff EE stated she can't provide the level of care to a resident that she would like to, due to being pulled into the dining room. Staff EE stated Resident #20 is very caring and likes to touch people. Staff EE stated resident #126 is very vocal and stated, she retaliated against that. During an interview on 04/29/2026 at 11:11 AM, Staff FF, CNA, stated it's hard, there have been times when we have been short. During an interview on 04/29/2026 at 11:26 AM, Staff V, Registered Nurse (RN), stated if the residents aren't engaged in activities, they may begin to wander, and some may become aggressive due to an unknown reason. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/29/2026 at 5:16 PM, Staff GG, Licensed Practical Nurse (LPN), stated residents wander into each other's rooms often on this unit. During an interview on 04/29/2026 at 5:23 PM, Staff O LPN, Unit Manager, stated all she knew was that Resident #126 yelled at Resident #20, which is what he does all the time. Staff O stated, no there is not enough supervision. During an interview on 04/30/2026 at 8:40 AM, Staff HH, LPN, stated the staff members were told to make sure residents don't go into each other's room. Staff H stated the residents wander into each other's rooms, frequently. Staff H stated activities help keep residents from wandering into each other's rooms. Staff H stated sometimes they need more assistance and sometimes not. Sometimes we're short-staffed. During an interview on 04/30/2026 at 9:38 AM, Staff EE, CNA, stated Resident #20 touches other residents quite often, like quite often. Staff EE explained believing that wandering poses no safety risk to residents. During an interview on 04/30/2026 at 9:49 AM, Staff II, CNA, stated when residents wander, they could get hit, they could get pushed out. Staff II stated wandering does happen quite often down here. During an interview on 04/30/2026 at 10:354 AM, Staff JJ, Activities, stated there were two residents having a verbal interaction leading up to the time Resident #20 hit Resident #126. Staff JJ stated this is the reason she did not attempt to assist Resident #20, prior to Resident #20 slapping Resident #126. Record review of Resident #20's medical record revealed the resident was admitted to the facility on [DATE]. Medical diagnosis included: unspecified dementia, unspecified severity, without behavioral, disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, and brief psychotic disorder. Review of Resident #20's physician orders revealed the resident had been ordered Rivastigmine Tartrate Oral Capsule 3 milligram (MG), one capsule was to be given two times a day for dementia, dated 01/03/2026. Seroquel oral tablet 50 MG, one tablet, was to be given by mouth at bedtime for brief psychotic disorder, dated 04/21/2026. Review of Resident #20's Minimum Data Set, dated [DATE], revealed a Brief Interview Minimum Status (BIMS) of 00, which meant severe impairment in cognition. Review of Resident #20's progress note revealed the resident had been seen on 04/28/2026 by psychiatry. The resident had a resident-to-resident altercation as the aggressor. Resident #20 was unstable, requiring psychiatric assessment. Review of resident #20's care plan revealed a focus: Resident #20 is on a secured unit related to impaired cognitive function/dementia or impaired thought processes related to diagnosis of dementia. The goal was for the resident to be able to communicate basic needs on a daily basis through next review date. Interventions included: cue, orient, and supervise as needed. Review of Resident #126's medical records revealed the resident was admitted to the facility on [DATE]. Medical diagnosis included: unspecified dementia, unspecified severity, without behavioral (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	disturbance, psychotic disturbance, mood disturbance, anxiety, and vascular dementia, moderate with agitation. Review of orders for Resident #126 revealed, an order for Seroquel oral tablet, (Quetiapine Fumarate) give 12.5 mg by mouth at bedtime for brief psychosis, dated 04/22/2026. Review of Resident #126's Minimum Data Set, dated [DATE], BIMS of 11, which means moderate cognitive impairment. Review of resident #126's care plan revealed a focus: Resident #126 is on the secured unit due to his impaired cognitive function/dementia or impaired thought processes related to diagnosis of dementia, without disturbance. The goal was for the resident to maintain current level of cognitive function through next review date. Interventions included: cue, orient, and supervise as needed, and the resident needs assistance with all decision making. During an interview on 04/30/2026 at 1:10 PM, the interim Director of Nursing, (DON), stated there was an interaction between Resident #20 and Resident #126. The DON stated Resident #126 yelled at Resident #20 and Resident #20 then hit Resident #126. The DON stated in a memory care unit there will be residents with mental conditions and behaviors. The DON stated the expectation is for staff to ask for help if they need it. Stated staff should be able to monitor those residents. The DON stated, it could have been preventable, I wouldn't feel great if someone smacked me or slapped me. The DON stated there are some residents who cannot say whether they are alright with being touched or not. During an interview on 04/30/2026 at 1:30 PM, the Nursing Home Administrator (NHA), stated the residents in the 500-unit need to be observed by staff. The NHA stated resident safety is ensured by staff observations. 2. On 04/29/2026 at 4:55 PM, an observation was made of Resident #51 wondering near B hall door at end of the 500-unit. On 04/29/2026 at 4:59 PM, an observation was made of Resident #51 attempting to go into room [ROOM NUMBER], which was not the resident's room. Resident #51 then went to the end of the hall and began to speak to the other residents and continued to wander. On 04/29/2026 at 10:47 AM an interview was conducted with Resident #51's family member. The family member stated there have been many incidents that occurred since Resident #51 was admitted to the facility from a lack of supervision in the unit. The family member stated they noticed Resident #192 trying to call Resident #51 into their room, so the family member had asked staff to keep an eye on Resident #192 because of this and Resident #192 repeating to attempt to enter Resident #51's room. Resident #51's family member said Resident #192 would always search out Resident #51. Resident #51's family member stated the assault occurred at nighttime, and at the time aides were observed changing residents and providing care but could not recall where the nurses were. During an interview on 04/29/2026 at 4:41 PM, Staff KK, CNA, stated we are all responsible for watching the residents, most residents stay around the dining room. Staff KK stated she would periodically check on residents who are elsewhere. Staff KK stated, I don't know, how often I check on the residents. Staff KK stated normally has 20 or more residents to supervise in the dining room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Staff KK stated television is the main activity. Staff KK stated day to day, residents wander into each other's room. Staff KK stated recalling Resident #51's family reported the incident where the family member found Resident #51 in another resident's room, to the nurse in charge. Staff KK stated it is not dangerous for residents to go into each other's rooms. Staff KK explained not knowing what is being done to prevent the situation from happening again, although the Resident #192 is no longer at the facility. Staff KK stated if it were her, she would fight like hell. During an interview on 04/29/2026 at 5:23 PM, Staff O, Licensed Practical Nurse, Unit Manager, stated having been told by Resident #51's family member in 03/2026, that Resident #51's family member was looking for Resident #51 and walked into Resident #192's room and saw Resident #192 groping Resident #51's breast. Staff O stated, he was feeling up her breast. Staff O stated earlier in the year, Resident #192 had a similar situation in which he had touched another resident sexually and inappropriately. Staff O stated after each incident, Resident #192 had not remembered what he had done. Staff O stated after the first incident we thought it was a one-time incident. Staff O stated the facility staff had hoped it was a one-time incident. Staff O stated she would have been upset, had this happened to a loved one. We placed Resident #192 on 1:1 for everyone's safety after each incident. Then reevaluated as appropriate. During an interview on 04/30/2026 at 8:54 AM, Staff V, RN stated having been told to keep an eye on Resident #192. Staff V stated Resident #192 had a habit of touching himself. Staff V stated the facility was aware of Resident #192's sexual desires. Staff V stated this happened in February or March. During an interview on 04/30/2026 at 9:02 AM, Staff FF, CNA, stated residents typically go at each other during the 3:00 PM to 11:00 PM shift. Staff FF stated, I would not feel safe with my parents on this unit. Staff FF stated, I don't think they (the staff) are fully watching the residents like they (the staff) are supposed to. Staff F stated wandering is dangerous for residents. Staff FF stated, if a resident is in another room with the doors closed you don't know what is going on. Staff F stated of supervision, They could use more, I mean I only have two eyes. During an interview on 04/30/2026 at 9:12 AM, Staff F, CNA, stated Resident #192 had been touching himself from the beginning of being placed in the 500-unit. Staff F stated, not believing they are providing enough supervision to prevent residents from going into each other rooms. During an interview on 04/30/2026 at 9:38 AM, Staff EE, CNA stated, anything can happen when you allow a resident to wander. During an interview on 04/30/2026 at 9:59 AM, Staff O, LPN, UM stated for both incidents involving Resident #192, the female residents wondered into Resident #192's room. Staff O stated, they will go into another room, it does happen sometimes. Review of Resident #51's medical record revealed the resident was admitted to the facility on [DATE]. Medical diagnosis included, heart failure, senile degeneration of the brain, dementia without behavioral disturbance, and anxiety. Review of Resident #51's physician orders revealed an order for the resident to be admitted to hospice, dated 01/22/2026. There was an order for a wander management bracelet, dated 03/22/2026. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #51's Minimum Data Set, dated [DATE], revealed BIMS was 00, which meant the resident did not have the ability to answer the questions. This showed the resident did not have the ability to recall season, location, names, and faces and the resident has a long-term memory problem. Review of resident #51's care plan revealed a focus: Resident #51 is an elopement risk/wanderer related to impaired safety awareness. Resident #51 has diagnosis of dementia. The goal was for Resident #51 to not leave the facility unattended. Interventions included: distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. A focus showed: Resident #51 has an alteration in neurological status related to senile degeneration of brain, dementia, dysphagia, anxiety, history of cerebrovascular accident. On 4/29/2026 at 5:06 PM an interview was conducted with the facility's psychiatric provider over the phone. The psychiatric provider revealed that the incident that occurred has a high potential of negatively affecting and being a trigger if Resident #51 had been sound of mind and not consenting to the act. A review of Resident #192's admission record revealed an admission date of 01/14/2025 with diagnoses to include Alzheimer's disease, major depressive disorder, unspecified dementia, anxiety disorders, and cognitive communication deficit. Resident #192 had a discharge date of 04/08/2026. A review of Resident #192's Quarterly Minimum Data Set (MDS) assessment, dated 4/8/26, revealed a BIMS of 6/15, indicating Resident #192 has severe impairment. Behaviors section revealed that Resident #192 scored a 2 for wandering, presence and frequency, meaning behavior of this type occurred 4 to 6 days during the seven day look back period. A review of Resident #192's Care Plan revealed the resident can be sexually inappropriate at times related to a diagnosis of dementia. Staff is to redirect, distract and provide alternative activities. Resident #192 is also care planned for being an elopement risk and wanderer related to impaired safety awareness. On 04/29/2026 at 10:39 AM an interview was conducted with Staff F, CNA for Resident #192. Staff F, CNA stated she would hear about Resident #192's inappropriate sexual behaviors but never witnessed them. On 4/30/2026 at 11:39 AM an interview was conducted with Staff I, LPN. Staff I, LPN stated Resident #192 had a habit of touching themselves, and she knew to knock loudly on the door before entering. Staff I, LPN stated it depended on the time of the day and the nature of the residents to determine if there was enough staff to provide supervision in the locked unit. Staff I, LPN said the care staff does what they can with the staff they have on a regular basis, but to have additional staff would be a relief to help provide additional supervision of residents. On 4/30/2026 at 1:45 PM an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated that despite Resident #192 having the same type of incident three weeks prior, the resident was not seen as the aggressor. Resident #192 was not displaying any abnormal behaviors, and it was determined the resident could be removed from 1:1 care. This decision was made by the psychiatric provider and primary care provider (PCP). The NHA stated even though Resident #192 was not displaying sexual behaviors after the first incident, the facility still should have been monitoring Resident #192. The NHA stated the care staff should have been checking on Resident #192 more often than the usual rounds, due to his behaviors. The NHA said at the time of the incident with Resident (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	#51, the staff on duty did not know how Resident #51 got into Resident #192's room, and there is no staff who were able to say they saw the two residents in the room together. The NHA stated one nurse was down Hall A charting but does not know where the nurse for Hall B was at the time of the incident. The NHA stated the care staff were responsible for supervising the halls of the unit. A review of the facility's Abuse, Neglect, Exploitation & Misappropriation policy revealed the following: It is the policy of the facility to take appropriate steps to prevent abuse (be it verbal, sexual, physical, or mental), neglect, exploitation and misappropriation and the occurrence of an injury of an unknown source, and to ensure that all alleged violations of Federal and/or State laws are reported immediately to the Administrator, the Risk Manager, the Social Services Director, and the Director of Nursing. The facility shall make all reasonable efforts to determine the cause of the suspected maltreatment and take corrective action consistent with the investigation findings to eliminate any ongoing danger to the resident or other residents. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Neglect: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is ware of or should be aware of goods and services that a resident requires, but the facility fails to provide them to the resident resulting in or may result in physical harm. Person centered care: For purposes of this subpart, person centered-care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. Sexual abuse: Sexual abuse is non-consensual sexual contact of any type with a resident. The facility must determine whether the resident(s) have the capacity to consent to sexual activity.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure medication error rate was not greater than 5%. A total of 27 opportunities were observed with 2 errors constituting an error rate of 7.41%. Findings included:1. On 04/29/2026 at 8:34 AM a medication observation was conducted with Staff C, Licensed Practical Nurse (LPN) for Resident #131. Staff C dispensed the following medications:-Amlodipine 2.5 mg (milligram) -1 tablet-Aspirin 81mg chewable -1 tablet-Zyrtec 10mg -1 tablet-donepezil 5 mg -1tablet-Famotidine 10mg -4 tablets-Losartan 25 mg -1 tabletStaff C, LPN confirmed the tablets prior to administration.Review of Resident #131's admission Record showed she was admitted to the facility on [DATE] with diagnoses to include: cerebral atherosclerosis, vascular dementia, dementia, and hypertension. Review of Resident #131's active orders showed:-Donepezil HCl (hydrochloride) Tablet 5 mg; Give 10 mg by mouth one time a day for dementia.2. On 04/29/2026 at 4:30 PM a medication observation was conducted for with Staff D, LPN for Resident #194.Staff D obtained a blood glucose level of 234. Staff D then dispensed the Humalog KwikPen and turned the dial to show 3 units. Staff D, LPN stated she does not prime the pen prior to administration. Staff D administered the dose in the left lower abdomen and held dose knob for approximately 2 seconds.Review of Resident #194's admission Record showed he was admitted to the facility on [DATE] with diagnoses to include diabetes mellitus type 2.Review of Resident #194 active orders showed: -HumaLOG KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (milliliter) (Insulin Lispro) Inject as per sliding scale: if 0 - 110 = 0 units for blood sugar less than 70 notify physician; 111 - 149 = 1 units; 150 - 199 = 2 units; 200 - 249 = 3 units; 250 - 299 = 4 units; 300 - 349 = 5 units; 350 - 399 = 6 units ; 400+ = 6 units for blood sugar greater than 399 give 6 units and notify physician, subcutaneously before meals and at bedtime for DM (diabetes mellitus).On 04/30/2026 at 1:00 PM an interview was conducted with the Interim Director of Nursing (DON). She said she has not provided education to staff regarding insulin pen priming. She was not able to provide a proper demonstration of how to prime an insulin pen. DON said it was necessary to prime an insulin pen to provide the resident with the correct dose of insulin. Reviewed with DON regarding findings of the medication administration observations. The DON confirmed the correct dose of milligrams should have been administered, and the nurse should have primed the insulin-pen.Review of the manufacturer's KwikPen U-100 instructions for use 3mL single-patient-use pen found on the manufacturer's website at: https://uspl.lilly.com/humalog/humalog.htm#ug1 showed the following:Step 5: Priming your Pen. Prime before each injection.-Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the Pen is working correctly.-If you do not prime before each injection, you may get too much or too little insulin.Giving your injectionStep 11:-Insert the needle into your skin.-Push the dose knob all the way in.-Continue to hold the dose knob in and slowly count to 5 (5 seconds) before removing the needle.Review of the Policy Administering Medications with a revision date of April 2019 showed: Medications are administered in a safe and timely manner, and as prescribed. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record reviews and interviews, the facility failed to provide timely laboratory services for one (Resident #130) of three residents reviewed.Findings included: Review of Resident #130's admission record revealed an admission date of 5/2/2024. Diagnosis includes but not limited to fracture of the lower end of right radius, nondisplaced fracture of right ulna styloid, chronic diastolic heart failure, and convulsions. Review of Resident #130's progress notes revealed a nursing note on 3/13/2026 at 10:11 p.m. showing Resident #130 had swelling of the right arm and right hand, felt hard and a little warm to touch. The resident's cast was removed from this arm on 2/19/2026 from a previous fracture. The note also said Resident #130 had range of motion within normal limits (ROM WNL), hospice and facility physician were notified. Review of Resident #130's progress notes revealed a nursing note on 3/14/2026 at 6:15 a.m. that a new order was placed for a venous ultrasound of the right upper extremity. Review of Resident #130's progress notes revealed a nursing note on 3/15/2026 at 9:56 p.m. that stated a call was placed to a mobile radiology vendor regarding Resident #130's doppler that was ordered. The facility was told someone would visit that same day however they had not come to do the venous doppler. Review of the procedure results showed on 3/17/2026 at 11:01 a.m. Resident #130 had an occlusive radial deep venous thrombosis. Review of Resident #130's care plan showed Resident #130 was at risk of cardiac complications. There was an intervention to notify physician of significant abnormalities and observe/document/report any color/warmth of extremities. During an interview on 4/30/2026 at 1:40 p.m. Staff Q, Certified Nursing Assistant (CNA) stated swelling was to be reported to the nurses right away who will then check on the resident. During an interview on 4/30/2026 at 1:42 p.m. Staff P, Licensed Practical Nurse (LPN) stated change in condition, such as swelling, was to be reported immediately. This included night shift nurses as there is an on call physician. Staff P did not know why there was a delay in testing after swelling was found on Resident #130's arm. Staff P said if radiology was ordered through a vendor and they did not show up, the facility would follow up with the vendor within that same shift. During an interview on 4/30/2026 at 12:48 p.m. the Director of Nursing (DON) stated swelling in residents with a history of chronic heart failure was to be reported right away. If this occurred during night shift, staff should not wait until morning to report it. The DON said if an outside vendors was to conduct a procedure but had not shown up yet, staff must call again to find out, what happened. Nurses are to confirm with the doctor and ensure the test(s) are ordered stat. The DON said she was unsure why there was a delay in care especially if there was swelling involved. Review of the facility's LPN position description revealed a Basic function: To deliver nursing care to residents of this facility. Essential Function: .3. Makes observations and reports pertinent information related to the care of the resident. The Coordination of Care: 1. Co-workers are informed of changes in residents conditions or of any other changes occurring on the unit. 2. Information is relayed to other members of the health care team (LE., physicians.)Review of the facility's Registered Nurse (RN) position description revealed a Basic Function: To plan and deliver nursing care to patients/residents requiring long-term of rehabilitative care. Essential Functions:.7. Maintains knowledge of necessary documentation requirements. The Coordination of Care: 1. Co-workers are informed of changes in residents conditions or of any other changes occurring on the unit. 2. Information is relayed to other members of the health care team (LE., physicians.)

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	04/30/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to serve food in accordance with professional standards for food service safety related to one of one dish washing machines was not operated per its specifications. Findings included: On 4/27/2026 at 9:45 a.m. the kitchen was toured with the Certified Dietary Manager (CDM), and the Regional Dietary Manager. The CDM stated the kitchen operates a low temperature dishwashing machine. The CDM further stated the machine's operation includes wash temperatures to reach at least 140 degrees Fahrenheit (F), and the final rinse temperature to reach at least 120 degrees F. The CDM continued to state the machine provides a chemical sanitizer and with a litmus test strip for chemical sanitizer testing to reach 50 - 100 parts per million (ppm). On 4/27/2026 at 10:02 a.m. an observation of the dishwashing machine room occurred with the CDM. Staff were already utilizing the machine and were running soiled crates of dishes through the dishwashing machine. On 4/27/2026 at 10:03 a.m. an interview and observation with a Staff J, Dietary Aide (DA) occurred. Staff J, DA stated they have been operating the machine since 9:30 a.m. and have run many crates of dishes through the machine. Staff J was observed spraying soiled dishes with a water hose and setting up dishes and trays in crates. He then was observed to run the crates of soiled dishes and trays through the machine to be cleaned. On the other side of the machine, Staff K, DA was observed receiving the crates of dishes/trays from the clean side of the dish machine. Staff J and K confirmed the dish machine wash temperatures should reach 140 degrees F., and the rinse temperatures should reach 120 degrees F. On 4/27/2026 at 10:04 a.m. a crate of meal trays was put through the machine. The wash temp reached above 140 degrees, and the rinse temp reached above 130 degrees. Staff K conducted the sanitizer testing utilizing litmus paper test strip. Staff K placed the test strip in an area of pooled water, on one of the trays that was just washed. The white colored test strip did not change color and remained white. Staff K, DA proceeded to get another strip, repeated the process and the same outcome occurred. Staff J, DA pushed a priming button on the sanitizer dispenser and ran another crate of trays through the dish machine. On 4/27/2026 at 10:08 a.m. Staff J, DA put a crate of dishes through the dish machine. The wash temp reached above 140 degrees F, and the rinse temp reached above 120 degrees F. [NAME] this demonstration, there was a crate of bowls and plates that ran through the entire wash and rinse cycle, and the dishes were observed with food debris remaining. Staff K, DA picked out the soiled dishes and placed them in a soiled rack but took the rest of the plates and put them in the clean area. A chemical sanitizing test was not demonstrated since dishes came out of the machine still soiled. On 4/27/2026 at 10:12 a.m. a crate of meal trays was put through the dish machine. The wash temp reached above 140 degrees F., and the rinse temp reached above 130 degrees F. Staff K and Staff U, Assistant Dietary Manager (ADM) both placed a separate litmus test paper strip on a wet side of the washed meal trays. The strips did not change color and remained white. This indicated there was no chemical sanitizer getting into the machine, and the dishes. The CDM stated the litmus paper chemical sanitizer test strip should have turned a medium to dark purple color which would indicate PPM of 50 -100. The color grid could be verified on the test strip bottle. On 4/30/2026 at 4:00 p.m. the Nursing Home Administrator provided the Dish Machine Use policy and procedure with a date of 6/2025 for review. The policy revealed; Dishware, eating utensils, and meal trays are washed and sanitized by use of the mechanical dish machine. The policy interpretive and implementation section revealed;The following guidelines will be followed when dishwashing:Wash hands before and after running dishwashing machine, and frequently during the process.Flatware:Presoak the flatware.Run the flatware through the dishwashing machine in a pallet.Wash the flatware in the utensil holder with eating end pointed upward.Presoak dishes or pots that contain dried or burnt food.Do not overcrowd racks.Use overhead spray to remove loose food particles.After running items through entire cycle, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	allow to air-dry.Clean dish machine after each meal.Dish machine chemical sanitizer temperature and concentration will be as follows: Type of solution = Chlorine, Minimum concentration = 50-100 ppm, Minimum temperature = 120 degrees F. or as per manufacturers recommendation.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to implement and maintain an effective infection control program related to 1) cleanliness and maintenance of the laundry room, 2) educate staff on hand hygiene and personal protective equipment required for the prevention of spreading Clostridioides difficile (C. diff) after two (#41 and #91) of two residents tested positive for the highly contagious bacteria and two (#1 and #39) of two sampled residents were actively being tested for the bacteria and 3) provide Pneumococcal immunization for one (R#20) of five residents sampled for the administration of vaccinations.Findings included: On 4/29/26 at 10:13 a.m. the facility laundry room was observed with the Housekeeping Director (HD) and the Nursing Home Administrator (NHA). The observers entered the clean area of the laundry area. The HD stated the area was swept multiple times a day. The observation revealed wire shelving units to the right of the doorway (facing from door into area) with miscellaneous bed linens folded and plastic bags filled with unknown objects. The bottom shelf appeared to be fuzzy with gray dust/lint-like material, under the unit was wadded up paper and dust, in front of the unit was a piece of blue plastic. An opened personal-sized bottle of purified water was observed sitting amongst folded linens. The HD observed the bottle and stated it should not be there. The area to the left of the door revealed a folded piece of white terry cloth with 2 pieces of dust/lint like substance attached to it. The HD took the item down, unfolded it and stated the pieces were part of the writing on the material. A continued observation with the HD showed the 2 pieces of substance continued to be attached to the material and was not part of the writing in black marker. Several flakes of a white/cream colored material littered the floor under the air duct. On the ceiling next to air duct were 2 areas showing previous repairs had been completed and the seams of the repair appeared wet and joint tape was hanging down from the ceiling. The HD stated the area had started leaking yesterday from the [NAME] fixing the roof. A dusty slipper and bits of plastic were observed under a white plastic shelving unit parked against the wall. The HD reported folding occurred on the 2 metal tables in the area, one to the right of door and the other to the left. On the left table inside a crate sitting on a dark colored dusty towel was a bottle of peach air fragrance. The HD stated the bottle should not be on the table.Observation was conducted of a room containing two washing machines. The outside of both washers was covered with fuzzy gray dust/lint material. On the floor between the wall and first washer was dusty terra [NAME] tiles with a blue rubber-type glove and remnants of white paper-like material. The conduit beside and behind the washers had the same fuzzy gray material attached to them. A fan attached to the wall behind the washers had a piece of opaque plastic inside the cage and the cage was covered with the gray fuzzy material. Next to the second washer on the floor was plastic hangers, a bag of pillows, and wadded up white linens. The HD stated they had used the blankets to soak up the water leaking from the roof in the folding area and confirmed the items should not be left on the floor next to the washer. The conduit running from electrical boxes to the ceiling had dust attached to them. The HD stated staff swept the floor every shift but did not wipe down the outside of washers. The third room of the laundry area contained one washer, metal lockers, and a sink. The gasket between the frame and drum of washer had white paper and brown crumbs of an unknown substance. On the floor next to the washer and in front of the lockers was a black plastic comb, on the other side of the washer behind an overflowing trash bin was a wadded-up blanket, and between the bin and sink on the floor was pieced of white wadded-up pieces of paper. The exhaust fan above the area was covered with the fuzzy gray material and had an opaque piece of plastic inside the cage. The sorting area contained multiple large plastic black bags stacked along the back wall and on top of a linen cart. Staff Q, laundry aide (LA) reported not knowing what was in the bags. Staff Q open one and stated pillows were in them. The staff member was asked to demonstrate how to fold a blanket. The staff member obtained an unfolded blanket, dragged a corner of it on the floor, held the blanket against self, and folded it into a neat square. Immediately (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following Staff Q, LA demonstration, the NHA informed the HD the staff member would need further education on how to fold the blanket, to include not dragging it on ground nor touching the staff members unprotected clothing. On 4/30/26 at 11:12 a.m. an observation was made of the laundry area containing one washer, metal lockers, and sink. The fan on wall near sink continued to be covered with gray fuzzy material and opaque plastic was still located within the blade cage. The facility failed to provide a policy regarding cleanliness of laundry room. 2.During an interview on 4/30/26 at 12:00 p.m. the Interim Director of Nursing/Infection Preventionist (DON/IP) reported the facility had two (R#91 and R#41) confirmed cases of Clostridioides difficile (C. diff) and one (R#1) resident was currently being tested for it. The line listing for April showed two residents were positive for C. diff and did not include information related to the third resident (R#1). The IP stated hand hygiene was to be done with soap and water instead of alcohol-based hand rub (ABHR) for C. diff. The IP reported no re-education on hand hygiene had been started for staff regarding the use of soap and water for C. diff but would start. The IP stated not knowing what constituted as an outbreak. Review of the April 2026 Infection Control Log did not reveal Resident #1 and Resident #39's information. Review of Resident #41's clinical record showed a stool sample had been obtained on 4/20/26. On 4/23/26 the results showed positive for the bacteria C. difficile. Review of monthly infection control log for the 300-hall showed Resident #41 was admitted on [DATE] with an onset of C. diff on 4/20/26 and the antibiotic Vancomycin (Vanco) started 4/22/26. Review of Resident #91's clinical record showed the resident was admitted to the secured unit on 10/14/25. The record showed a stool sample had been obtained on 4/16/26 and the sample tested positive for C. Diff Toxins A& B. The results were reported on 4/18/26 to the facility. Review of the monthly infection control log for the 500-hall (Resident #91's unit) showed the onset of infection was 4/14, culture was taken on 4/16 and the antibiotic vancomycin (Vanco) was started on 4/19/26. Review of Resident #1's clinical record showed the resident was admitted on [DATE] and moved to the secure unit on 1/8/26. Review of Resident #1's laboratory results showed the resident had tested positive for the bacteria, C. Difficile. Review of the monthly infection control log for the 500- hall showed Resident #1's information had been added after the interview with the IP on 4/30/26. The log showed Resident #1 had been tested on [DATE] with positive results. The resident started on the antibiotic Vanco on 4/30/26. Review of Resident #39's progress note dated 4/28/26 at 12:49 p.m. showed Resident #39 was alert and oriented. A note dated 4/28/26 at 2:27 p.m. revealed the resident had complaints of diarrhea, and an as needed (prn) dose of anti-diarrheal medication had been administered and the physician ordered STAT (to be completed immediately) blood work to include complete blood count (CBC) and comprehensive metabolic panel (CMP). The notes showed on 4/29/26 at 11:03 a.m. the physician had ordered the facility to check stool for C. Diff. The notes showed Resident #39 received another dose of anti-diarrheal medication on 4/29/26 at 8:45 p.m. A note on 4/30/25 at 7:05 a.m. revealed staff had been unable to collect a stool sample overnight due to no bowel movements. The notes showed on 4/30/26 at 10:16 am., Resident #39 was moved to the 300-hall without a documented reason. Review of Resident #39's clinical record showed the resident resided on the 400-hall since 1/31/25 and had moved to the 300-hall on 4/30/26. Review of the monthly infection control log for 300 and/or 400-hall, dated 4/15 - 4/30/26 did not reveal Resident #39 was being tested for an infection and if a culture had been obtained. 3.Review of Resident #20's vaccine consent form, dated 1/3/26 showed the legal representative had chosen for the resident to receive the pneumococcal, respiratory syncytial virus (RSV), and shingles vaccinations. Review of Resident #20's admission Record revealed the resident was admitted on [DATE] with diagnoses not limited to unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, moderate recurrent major depressive disorder, and brief psychotic disorder. Review of Resident #20's January 2026 Medication Administration Record (MAR) did not show the consented vaccinations had been ordered and/or administered. Review of Resident #20's progress notes, dated 1/3 to 1/5/26 did not reveal the resident refused the vaccinations and/or the legal representative had rescinded the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consent. During an interview on 4/30/26 at 12:00 p.m. the Interim Director of Nursing/Infection Preventionist (DON/IP) reported the facility does not offer RSV or shingles vaccinations. The IP reported not knowing why the resident did not get vaccinated (at time of consent) with pneumococcal vaccine. The DON/IP said if a resident refuse (staff) should retry, contact the family and physician, and document (the refusal). Review of the policy - Pneumococcal Vaccine, revised August 2016, showed All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The interpretation and implementation revealed the following:1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contradicted or the resident has already been vaccinated.2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission.4. Pneumococcal vaccines will be administered to residents (unless medically contradicted, already given, or refused) per our facilities physician-approved Pneumococcal vaccination protocol.5. Residents/ representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each residence medical record indicating the date of the refusal of the pneumococcal vaccination.6. For residents who received the vaccines, the date of the vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the residence medical record. Review of the policy - Infection Prevention and Control Program, undated, revealed And in infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.1. The IPCP is developed to address the facility-specific infection control needs and requirements identified in the facility assessment and the infection control risk assessment. The program is reviewed annually and updated as necessary.2. The program is based on accepted national infection prevention and control standards.The elements of the IPCP included but not limited to:1. Coordination and Oversight d. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Some examples of committee reviews may include:3. Surveillance and reporting b. Surveillance tools are used for identifying the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infection, monitoring adherence to infection prevention and control practices, and dictating unusual pathogens with infection control implications.4. Antibiotic Stewardshipa. Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities.b. Medical criteria in standardized definitions of infections are used to help recognize and manage infections.6. Outbreak Management a. Outbreak management is a process that consists of: (1) determining the presence of an outbreak; (3) preventing the spread to other residents; (6) educating the staff and the public;7. Prevention of Infection a. Important facets of infection prevention include:(3) Educating staff and ensuring that they adhere to proper techniques and procedures;9. Monitoring Employee Health and Safetya. The facility has established policies and procedures regarding infection preventions and control among employees, contractors, vendors, visitors, and volunteers, including:b. Those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment.(1) The facility provides personal protective equipment, checks for its proper use, and provides appropriate means for needle disposal.