Florida State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 120096	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Florida, 33810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	INITIAL COMMENTS A complaint survey for complaint numbers 2025017193 and 2025017430, was conducted at Valencia Hills Health and Rehabilitation Center on . Deficiencies were identified at the time of survey. Complaint numbers 2025017430 had deficiencies cited at N201.	N0000		/2025
N0201 SS = E	Right to Adequate and Appropriate Health Care CFR(s): 400.022(1)(l), FS (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record reviews, observations, and interviews the facility failed to ensure two (Residents #1 and #2) of two residents sampled, received appropriate and adequate healthcare services related to the delay of notification of laboratory results to the ordering provider. Findings included: Review of the policy titled Details of the Process related to: Laboratory Test/Diagnostic Policy/Procedure, dated , 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: …	N0201	N201 Right to Adequate and Appropriate Health Care Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. F773 Lab Services Physician Order/Notify of Results 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #1, the lab was reviewed by the physician no changes made to current , order. Physician progress note completed that labs were reviewed for resident #1 and no changes made. Resident #2 discharged from the facility. 2. How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. Other current residents with lab orders in the last 30 days from , were reviewed by the DON/Nursing Administration team to ensure review of lab results and physician notification with documentation was completed. 3. What measures will be put in place or what systematic changes will you make to ensure that deficient practice does not occur.	/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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N0201 SS = E	Continued from page 1 4. The designated nurse is responsible for completing a lab requisition based on the lab in diagnostic report or verifying the diagnostic procedure , , has been made as part of the order review for the shift. The ordered lab is automatically parked on the lab vendor "lab log" she per the requisition as part of the electronic process. The "lab log" sheet will be printed and placed in the corresponding date in the lab binder after the lab and diagnostic report record report. The date/ time and location of the diagnostic procedure will be noted in the medical record. 5. The completed lab requisitions are printed according to the date the lab is to be done and placed in the lab binder along with the lab log on each unit. 6. Once the ordered lab specimen is drawn or is collected by the , , the , is to initial the lab log sheet. 7. When the lab results come from the lab, the receiving nurse is to note the date the results were received on the log and notify the resident's physician of the values. 8. The nurse contacting the physician notes the date the physician was contacted on the lab log and whether any new orders were received. New orders received are entered electronically and notification is documented in the medical record. 10. Designated nurse will review lab log sheets daily to verify protocol is followed. 11. The designated nurse will utilize the lab tracking log to monitor for return of lab results for a specified date and/ or ongoing tracking for labs that require a longer process for evaluation and resulting. Any discrepancies will be reviewed with the medical practitioner for notification and follow-up. Review of Resident #2's Admission Record revealed the resident was admitted on and included diagnoses of unspecified of left acetabulum subsequent encounter for with routine healing, unspecified of right talus subsequent encounter for . . with routine healing, and essential (primary) , , . Review of the primary care physician note dated, , for Resident #2 showed the resident had been in a motor vehicle accident resulting in a left acetabulum and right talus . The	N0201	Continued from page 1 Nurse leadership staff will be educated by the DON/designee regarding daily lab order review, and timely notification to physicians of results with supporting documentation by . Education completed by DON/designee to the licensed nurses regarding daily review of lab orders and timely notification of lab results reported to the physician of results with supporting documentation by . Education completed by the DON/designee to physicians for review of labs and notation that the lab was reviewed by . 4. How will the corrective actions be monitored to ensure the practice will not recur; what quality measures will be put into place? Random audits of lab orders, physician notification of lab results, and supporting documentation will be completed by the DON/designee on 20 residents, weekly x4 weeks then monthly x2 months. The results of the random audits will be presented to the QAPI committee monthly x3 months and as needed for review and follow-up recommendations as indicated.	

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N0201 SS = E	Continued from page 2 objective data gathered by the physician showed were clear to auscultation (CTA), no ( ) or , 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 and showed Resident #2 was alert and oriented x4, were clear on auscultation with no signs and/or symptoms (s/s) of , and was on room air. Review of Resident #2's primary care physician note dated at 10:36 a.m. showed the resident informed the physician "I couldn't breathe" and had complaints of difficulty breathing and , with exertion or activity. The physician noted the resident was "currently on two liters of ", described feeling angry, and denied any previous history of , problems. The physical examination revealed were clear to auscultation (CTA) with crackles and rales noted, and , was noted. The assessment showed an irregular rate and rhythm. The assessment and plan was for staff to obtain a stat , check D-dimer level and additional work, and order a , ( ) and comprehensive panel. Review of a nursing note dated at 9:49 a.m. revealed the physician had seen Resident #2 with complaint of ( ) and , . The recommendation was for a stat , ( ), D-dimer, and treatments. Review of Resident #2's laboratory results showed was collected for a stat D-dimer on 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 clots specifically cross-linked fibrin (fibrinolysis). D-dimer is low in healthy people and can be elevated in the presence of , ( ) and , , (PE). D-dimer elevation is NONSPECIFIC since it may be elevated in other conditions including (but not limited to) , , , elderly, malignancy, post-surgery, , and in hospitalized patients. Review of Resident #2's progress notes did not show the physician was notified of D-dimer results received on at 7:06 p.m. until at 10:51 a.m. Review of Resident #2's progress notes from to	N0201		

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N0201 SS = E	Continued from page 3 included the following: - at 8:45 a.m. the resident was alert and oriented to person, place, time, and situation, sounds were within normal limits (WNL) and used no devices. - at 11:05 a.m. the resident was alert and oriented to person, place, time, and situation. The resident had ( ) while lying flat and on exertion, breathing was shallow, and use of and treatments. The note showed no new lab/medication/treatment orders had been received. - at 2:36 pm. showed the physician was notified of Resident #2's . - at 11:59 p.m. the resident had sounds within normal limits (WNL), no devices, and no new laboratory/medication/treatment orders had been received. The note did not include any other comments. - at 7:36 p.m. showed the resident's sounds were WNL, effort was normal, and 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 . - at 10:51 a.m. revealed D-Dimer 10.35 sent to MD and orders to send to local acute care facility for computed scan (CT) of as the resident was having even after and on . Review of Resident #2/s care plan showed the resident was on related to limited mobility due to (fx) of left acetabulum and right talus. The nursing staff were to observe/document/report as needed (PRN) adverse reactions of which included ( ). An interview was conducted with Staff A, Licensed Practical Nurse (LPN) and the Assistant Director of Nursing (ADON) on at 12:20 p.m. Staff A, LPN thought , 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	N0201		

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N0201 SS = E	Continued from page 4 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 , 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 , 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 shift printed it (daily list) out for the , . When results are received 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 , brings a list of draws to be checked off as completed. During an interview on at 1:07 p.m. Staff A, LPN reported Resident #2 had been in a MVA with non-surgical left , and right ankle . Staff A, LPN believed the resident's , was negative and the physician ordered 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 , the D-dimer would have been drawn on Saturday a.m. Staff A stated being curious on Monday ( ) 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 and , , at time of transfer to the hospital. During an interview on 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 , 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	N0201		

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N0201 SS = E	Continued from page 5 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 at 2:52 p.m. and one on at 7:06 p.m. The DON stated the nurses should have notified the physician (prior to) and documented the notification. A telephone interview was conducted with Resident #2's primary care physician (PCP) on 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 , but a , (PE) was considered but couldn't determine if it was that or due to the acute (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 . Resident #1 was admitted to the facility with diagnosis to include type 2, , other behavioral disturbance, adult , severe protein-calorie , persistent , major , and . Review of Resident #1's lab results revealed, collection date 04:00, received 10:34, reported 11:50. Results: 74.3 (within range). Reviewed on 16:41. Review of Resident #1's progress notes revealed: Nursing Note: New orders to get a level (labs) on . New orders put in at this time.... No documentation was found related to the physician being notified or reviewing the result of level. Review of Resident #1's subsequent note dated , revealed, reason for today's encounter: Today, I saw the patient as it was reported	N0201		

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N0201 SS = E	Continued from page 6 to me that patient is unstable requiring , , assessment and to assess tolerability and effectiveness after recent medication changes…A.) Summaries of the past notes: : Patient . I attended interdisciplinary , , , gradual dose reduction meeting. Discontinued … : patient has . Patient was very agitated and physically aggressive…. ordered , labs…. C.) Summaries of previous abnormal lab results: No labs since …. There was no documentation related to the review of , (, labs). During an interview on 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 , (, labs) being reviewed and their should be. Class III	N0201		

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F0000	INITIAL COMMENTS A complaint survey for complaint numbers, 2025017193 and 2025017430, was conducted at Valencia Hills Health and Rehabilitation Center on . The facility was not in compliance with Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities. Complaint number 2025017430 had deficiencies cited at F773.	F0000		/2025
F0773 SS = E	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse , in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse , of laboratory results that outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is NOT MET as evidenced by: 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 and included diagnoses of unspecified of left acetabulum subsequent encounter for with routine healing, unspecified of right talus subsequent encounter for with routine healing, and essential (primary) .	F0773	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. F773 Lab Services Physician Order/Notify of Results 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #1, the lab was reviewed by the physician no changes made to current , order. Physician progress note completed that labs were reviewed for resident #1 and no changes made. Resident #2 discharged from the facility. 2. How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. Other current residents with lab orders in the last 30 days from , were reviewed by the DON/Nursing Administration team to ensure review of lab results and physician notification with documentation was completed. 3. What measures will be put in place or what systematic changes will you make to ensure that deficient practice does not occur. Nurse leadership staff will be educated by the	/2026

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F0773 SS = E	Continued from page 1 Review of the primary care physician note dated, , for Resident #2 showed the resident had been in a motor vehicle accident resulting in a left acetabulum and right talus . The objective data gathered by the physician showed were clear to auscultation (CTA), no ( ) or , , 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 and showed Resident #2 was alert and oriented x4, were clear on auscultation with no signs and/or symptoms (s/s) of , and was on room air. Review of Resident #2's primary care physician note dated at 10:36 a.m. showed the resident informed the physician "I couldn't breathe" and had complaints of difficulty breathing and , , with exertion or activity. The physician noted the resident was "currently on two liters of , ", described feeling angry, and denied any previous history of , problems. The physical examination revealed were clear to auscultation (CTA) with crackles and rales noted, and , was noted. The assessment showed an irregular rate and rhythm. The assessment and plan was for staff to obtain a stat , check D-dimer level and additional work, and order a ( ) and comprehensive panel. Review of a nursing note dated at 9:49 a.m. revealed the physician had seen Resident #2 with complaint of ( ) and . The recommendation was for a stat , ( ), D-dimer, and treatments. Review of Resident #2's laboratory results showed was collected for a stat D-dimer on 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 clots specifically cross-linked fibrin (fibrinolysis). D-dimer is low in healthy people and can be elevated in the presence of ( ) and , (PE). D-dimer elevation is NONSPECIFIC since it may be elevated in other conditions including (but not limited to) , , , elderly, malignancy, post-surgery, , , and in hospitalized patients. Review of Resident #2's progress notes did not show the	F0773	Continued from page 1 DON/designee regarding daily lab order review, and timely notification to physicians of results with supporting documentation by . Education completed by DON/designee to the licensed nurses regarding daily review of lab orders and timely notification of lab results reported to the physician of results with supporting documentation by . Education completed by the DON/designee to physicians for review of labs and notation that the lab was reviewed by . 4. How will the corrective actions be monitored to ensure the practice will not recur; what quality measures will be put into place? Random audits of lab orders, physician notification of lab results, and supporting documentation will be completed by the DON/designee on 20 residents, weekly x4 weeks then monthly x2 months. The results of the random audits will be presented to the QAPI committee monthly x3 months and as needed for review and follow-up recommendations as indicated.	

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F0773 SS = E	Continued from page 2 physician was notified of D-dimer results received on at 7:06 p.m. until at 10:51 a.m. Review of Resident #2's progress notes from to included the following: - at 8:45 a.m. the resident was alert and oriented to person, place, time, and situation, sounds were within normal limits (WNL) and used no devices. - at 11:05 a.m. the resident was alert and oriented to person, place, time, and situation. The resident had ( ) while lying flat and on exertion, breathing was shallow, and use of and treatments. The note showed no new lab/medication/treatment orders had been received. - at 2:36 pm. showed the physician was notified of Resident #2's . - at 11:59 p.m. the resident had sounds within normal limits (WNL), no devices, and no new laboratory/medication/treatment orders had been received. The note did not include any other comments. - at 7:36 p.m. showed the resident's sounds were WNL, effort was normal, and 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 . - at 10:51 a.m. revealed D-Dimer 10.35 sent to MD and orders to send to local acute care facility for computed scan (CT) of as the resident was having even after and on . Review of Resident #2/s care plan showed the resident was on related to limited mobility due to (fx) of left acetabulum and right talus. The nursing staff were to observe/document/report as needed (PRN) adverse reactions of which included ( ). An interview was conducted with Staff A, Licensed Practical Nurse (LPN) and the Assistant Director of Nursing (ADON) on at 12:20 p.m. Staff A, LPN thought 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	F0773		

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F0773 SS = E	Continued from page 3 (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 , 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 , 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 shift printed it (daily list) out for the , . When results are received 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 , brings a list of draws to be checked off as completed. During an interview on at 1:07 p.m. Staff A, LPN reported Resident #2 had been in a MVA with non-surgical left , and right ankle . Staff A, LPN believed the resident's , was negative and the physician ordered 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 , the D-dimer would have been drawn on Saturday a.m. Staff A stated being curious on Monday ( ) 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 and , , , at time of transfer to the hospital. During an interview on 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 , staff	F0773		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0773 SS = E	Continued from page 4 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 at 2:52 p.m. and one on at 7:06 p.m. The DON stated the nurses should have notified the physician (prior to) and documented the notification. A telephone interview was conducted with Resident #2's primary care physician (PCP) on 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 , but a , (PE) was considered but couldn't determine if it was that or due to the acute (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 . Resident #1 was admitted to the facility with diagnosis to include type 2, , other behavioral disturbance, adult , severe protein-calorie , persistent , major , , and . Review of Resident #1's lab results revealed, collection date 04:00, received 10:34, reported 11:50. Results: 74.3 (within range). Reviewed on 16:41. Review of Resident #1's progress notes revealed: Nursing Note: New orders to get a , level (, labs) on . New orders put in at this time…. No documentation was found related to the physician being notified or reviewing the result of , level.	F0773		

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F0773 SS = E	Continued from page 5 Review of Resident #1's , , subsequent note dated , revealed, reason for today's encounter: Today, I saw the patient as it was reported to me that patient is unstable requiring , , assessment and to assess tolerability and effectiveness after recent medication changes…A.) Summaries of the past notes: : Patient . I attended interdisciplinary , , , gradual dose reduction meeting. Discontinued . . : patient has . Patient was very agitated and physically aggressive…. ordered , labs…. C.) Summaries of previous abnormal lab results: No labs since …. There was no documentation related to the review of , (, labs). During an interview on 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 , (, labs) being reviewed. Review of the policy titled Details of the Process related to: Laboratory Test/Diagnostic Policy/Procedure, dated , 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: … 4. The designated nurse is responsible for completing a lab requisition based on the lab in diagnostic report or verifying the diagnostic procedure , . has been made as part of the order review for the shift. The ordered lab is automatically parked on the lab vendor "lab log" she per the requisition as part of the electronic process. The "lab log" sheet will be printed and placed in the corresponding date in the lab binder after the lab and diagnostic report record report. The date/ time and location of the diagnostic procedure will be noted in the medical record. 5. The completed lab requisitions are printed according to the date the lab is to be done and placed in the lab binder along with the lab log on each unit. 6. Once the ordered lab specimen is drawn or is	F0773		

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F0773 SS = E	Continued from page 6 collected by the , , the , is to initial the lab log sheet. 7. When the lab results come from the lab, the receiving nurse is to note the date the results were received on the log and notify the resident's physician of the values. 8. The nurse contacting the physician notes the date the physician was contacted on the lab log and whether any new orders were received. New orders received are entered electronically and notification is documented in the medical record. 10. Designated nurse will review lab log sheets daily to verify protocol is followed. 11. The designated nurse will utilize the lab tracking log to monitor for return of lab results for a specified date and/ or ongoing tracking for labs that require a longer process for evaluation and resulting. Any discrepancies will be reviewed with the medical practitioner for notification and follow-up.	F0773		