

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/03/2026
NAME OF PROVIDER OR SUPPLIER  Valencia Hills Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  Based on interviews and record reviews, the facility failed to accurately reconcile an anti-psychotic medication per their policy, for one resident (#5) out of three residents sampled. Findings included: A record review of Resident #5's admission record showed an original admission date of 01/27/2023 with a readmission date of 01/12/2026 with diagnoses to include but not limited to major depressive disorder, generalized anxiety disorder and other specified persistent mood disorders. A record review of Resident #5's hospital discharge medication list dated 01/12/2026 at 08:46 a.m., revealed a current order of an antipsychotic medication Lurasidone, (also known as Latuda) 20 milligram (mg) oral tablet to be given with supper. Review of Resident #5's electronic medical record (EMR) revealed on date 01/12/2026 when the resident readmitted to the facility, there was no new medication listed on the Order Summary Report signed by the facility doctor on 01/13/2026. An admission progress notes dated 01/12/2026 on page thirty-seven under medication reconciliation and the hospitals recommended list, it revealed that there was no medication recommended by hospital. Review of physician orders on readmission revealed the order for Latuda 20 mg had not been entered and was not administered until 01/14/2026. On 1/12/2026 and 01/13/2026 the medication Latuda was not administered. A progress note dated 01/20/2026 revealed that on 01/14/2026 Latuda was initiated from hospital discharge paperwork. On 02/03/2026 at 7:15 p.m., an interview was conducted with the Director of Nursing (DON), she said the expectation is when a resident is readmitted, the admitting nurse should call the doctor and verify the medication on discharge paperwork from the hospital and then review the readmit medications and receive new orders and make notes on any changes. An interview on 02/03/2026 at 8:00 p.m., with Resident #5's Psychiatrist revealed he did not know and was not notified Resident #5 had missed two days of the antipsychotic medication. The psychiatrist stated it was important for medications to be administered as ordered. Review of an undated facility policy titled, Medication Reconciliation, showed the following policy statement: Medication reconciliation is the process of reviewing the medication orders brought from the hospital and noting any that need to be clarified due to being unclear or missing certain required information. Note any order received from the hospital that need to be clarified. Review all medication with the physician when obtaining admission orders. Review medications as appropriate when the resident returns from ER visits or physician appointments.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  105301	Facility ID:  105301  If continuation sheet Page 1 of 9

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observations, interviews and record review of the facility's Shift to Shift Controlled Medication count sheets, the facility did not ensure accurate documentation of controlled substances count logs for three carts (200-A, 100A - and 100-B) out of ten medication carts. On 02/03/2026 at 9:25 a.m., an observation was made of the medication cart identified as cart 200-A. A review of cart 200 -A's narcotic book showed the Shift-to-Shift Controlled Medication Count with no entry for this morning's count. Staff G, Licensed Practical Nurse (LPN) who was assigned to the 200-A medication cart stated she forgot to mark the number of total narcotic cards, but the count was correct. On 02/03/2026 at 9:59 a.m., an interview was conducted with Staff C, LPN. Staff C, LPN, stated during shift change, two nurses, the off coming shift nurse and the oncoming nurse, must count the narcotic cards in the Shift-to-Shift Controlled Medication Count as well as each individual residents' narcotic medication. Both nurses will sign the Shift-to-Shift Controlled Medication Count. Staff C, LPN, stated if a resident was discharged or a medication was discharged, the medication card (s) would stay in the narcotic box in the medication cart until the Director of Nursing (DON) would remove the card after verifying with another nurse as a witness. Staff C, LPN, stated there have been times when she was asked to bring discharged narcotics to the DON's office located on the 400 hallway. Staff C, LPN was able to state there was a previous concern about a missing narcotic pill but could not recall when. Staff C, LPN stated the supervisor was involved but they were able to figure out the nurse forgot to sign it out and the event was confirmed by the resident involved. On 02/03/2026 at 10:28 a.m., an interview was conducted with Staff A, Registered Nurse (RN). Staff A, RN stated the narcotic count was correct this morning during shift change and stated he would not have taken over the medication cart if the count was wrong. Staff A, RN stated usually if the count is off, it is because the shift before nurse forgot to document when removing a medication or if pharmacy delivers narcotics, she/he forgot to add them to the Shift-to-Shift Medication Count. Staff A, RN stated he had heard about a narcotic pill missing from a resident a few months ago on the 300-hallway side. Staff A, RN stated he had heard the supervisor was involved but could not state he knew the outcome. On 02/03/2026 at 10:40 a.m., after the interview with Staff A, RN an observation was made of Staff A, RN walking to Staff B, LPN at the end of the 100 B hallway. Staff B, LPN was in the process of medication administration when Staff A, RN was observed in a brief conversation and then walked away from Staff B, LPN. A brief interview was conducted with Staff B, LPN, where Staff B acknowledged Staff A, RN, gave her his medication cart keys while Staff A, RN, went on break. On 02/03/2026 at 11:40 a.m., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated when the pharmacy delivers narcotics, the nurse who received the medication will verify the prescription with the delivery person, sign their yellow copy and sign the delivery individual's phone confirming delivery. The nurse will place the prescription with another nurse acting as a witness in the narcotic book for the individual resident and adjust the Shift-to-Shift Controlled Medication Count. The ADON stated narcotics discontinued for various reasons will remain in the locked narcotic box in the medication cart until the DON will remove with verification from another nurse acting as a witness. The ADON stated if a nurse leaves for a break and relinquishes keys to their co-worker, the expectation would be for the nurses to count the narcotics before and after the nurse returns to their cart. The ADON stated she was not aware of any diversion for narcotics since her five months tenure. The ADON stated there was one minor incident in which the morning count was off, but the situation was resolved as soon as the investigation began. The ADON stated the Shift-to-Shift Controlled Medication Count were reviewed by the ADON and the former DON. The ADON stated there are ten</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>noted: An entry was made on 11/23/25 of the night shift total narcotic count of 30 followed by an entry of the day shift on 11/24/25 with an entry of 29 with no entry in the comment section. Followed by the same day 11/24/25 night shift for a total count of 32 with no entry in the comment section. An entry was made on 11/30/25 on the night shift for a total narcotic count of 37 followed by the next shift (day) for a total narcotic count of 36 with no entry in the comment section. An entry was made on 12/05/25 of the evening shift for a total of 38, followed by no total entry for the night shift, followed by the day shift for 12/06/25 for a total of 34 with no comments on how the total went from 38 to 34. The count continued as 34 until 12/07/25 when -1 card was removed for a total of 33 evening shift followed by the next entry 12/07/25 night shift the count went to 37 with no entry in the comment section. An entry was made on 12/20/25 of the evening shift for a total of 31 narcotic cards, followed by the night shift for a total of 29 after a comment of -1 card, -1 card; however, count went to 27 the following day shift for a total of 27 with no entry in the comment section. An entry was made on 12/23/25 of the day shift for a total of 30 narcotic cards followed by the evening shift for a total of 29 with no entry in the comment section. An entry was made on 12/25/25 of the day shift for a total of 32 narcotic cards followed by the evening shift on 12/25/25 for a total of 31 narcotic cards with no entry in the comment section. An entry was made on 1/04/26 of the day shift for a total of 38 narcotic cards followed by the evening shift removing a card documented in the comment section for a total of 37 narcotic cards, the count continues as 37 through the night shift and a new Shift to Shift Controlled Medication Count was started. The count of 37 was not reviewed as continued to the next page. Instead on 01/5/26 on the day shift the count was documented as a start of 36 and a comment made of a removal of one card followed by the next shift (evening) of a count of 35 with no entry in the comment section. The evening shift documented the removal of one card for a total of 34 narcotic cards followed by the next shift (day) for 1/6/26 day shift with illegible documentation of a number and multiple scratched out entries for total narcotic cards. Finally, the next shift (evening) had the number 35 entered for total number of narcotic cards. On 02/03/2026 at 11:40 a.m., an interview was conducted with the ADON related to the observations made of narcotic book 100/A and 100/B. The ADON stated she has not had any concerns with narcotics. The ADON stated if there was a concern the pharmacy would bring it to their attention due to increased demand for delivery of narcotic prescriptions. The ADON stated there was one incident she could recall of a missing narcotic pill but was quickly resolved by the two nurses and the Risk Manager. The ADON acknowledged the areas of concern when the narcotic binders were reviewed but the ADON stated if a concern was present, the pharmacy would bring to the administration, and an investigation would start immediately with notification to include law enforcement. The ADON stated she had not received any complaints from residents regarding not getting their medication or increased pain. On 02/03/2026 at 12: 03 p.m., an interview was conducted with Staff A, RN. Staff A, RN stated he knew the count was correct before he went on a break and gave his keys to the other nurse, but he stated he counted when he returned, the count was correct, but the binder was in the ADON's office to document. He stated he did not document. On 02/03/2026 at 1:35 p.m., a telephone interview was conducted with the pharmacist account manager. The pharmacy account manager stated [pharmacy ] will make sure their [automatic pharmacy medication dispenser] is working properly and medication carts are functioning. On 02/03/2026 at 3:20 p.m., an interview was conducted with Staff D, LPN/UM related to the observations made of narcotic book 200/A. Staff D, LPN/UM viewed ledgers and stated there were areas for improvement. Staff D, LPN/UM stated the ledgers have narrow entry space and stated this could be part of the problem. Staff D, LPN/UM stated she will review the Shift-to-Shift Controlled Medication Count in the mornings for her</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>designated units. Staff D, LPN/UM agreed today's ledger was not completed and asked Staff G, LPN the oncoming day shift nurse why the ledger was incomplete. Staff G, LPN stated she had forgotten. Staff D, LPN/UM completed the Shift-to-Shift Controlled Medication Count with this surveyor. On 02/03/2026 at 6:15 p.m., an interview was conducted with the ADON, DON, Nursing Home Administrator (NHA) and the Risk Manager related to concerns reviewed with the ADON and Staff D, LPN/UM for three narcotic books. The NHA stated concerns may be from not adding or subtracting accurately but added she was not clinical. The ADON present stated she agreed with observations of the narcotic books with inaccuracies but stated if there were truly narcotic cards missing the pharmacy would alert the facility. On 02/03/2026 at 6:30 p.m., a telephone interview was conducted with the pharmaceutical consultant. The consultant stated the facility has independently hired the consultant pharmacy to fulfill the requirements from a federal and state standpoint. The consultant stated job functions included monthly medication review for all residents, checking medications for expiration dates, verify destruction of medication, but they do not check narcotics other than to ensure the process of destroying them. A review of the facility's undated policy titled, 4.0 Schedule II Controlled Substance Medication, revealed a general information statement: To provide guidelines for facilities to follow relating to the handling of controlled substances within the facility. Controlled substances or handled by the facility and [pharmacy] in a manner that promotes proper storage and compliance with state and federal guidelines. H. Dispensing of Controlled Dangerous Substances (CDS) 5. When a CDS medication is administered, in addition to following proper procedure for the charting of medications, the nurse must document on the declining inventory sheet the date of administration, the quantity administered, the amount of medication remaining and his/ her initials. 6. And inventory count of all CDS medications stored on each nursing unit shall be performed at each change of each shift by both the incoming and outgoing nurse. Both nurses are responsible for the count and must sign the inventory count form. I. Storage of Controlled Dangerous Substance 1. All CDS medications will be stored under double lock, separate from all other medications. 2. The keys to locked areas that store CDS medications must always be in the possession of a licensed nurse that meets the criteria for handling CDS medications as per facility policy and procedure. A review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation, with no effective or revision date, showed the following policy statement: It is the policy of this 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 Service Director, and the Director of Nursing. If the alleged violation involves neglect, misappropriation of resident property, exploitation, or injuries of unknown source and involves no serious bodily injury, it must be reported no later than 24 hours. 2. Training: Upon hire, each new employee shall be informed of what constitutes ANE and the reporting requirements, including their obligation to report and how to report. Training shall include definitions of abuse (verbal, sexual, physical, and mental), neglect, exploitation, injuries of unknown source, and our policy and procedure regarding ANE. Every employee shall receive training, no less frequently than annually, on the requirements of the facility's policy and procedures on ANE and the requirements of their Federal and State laws. 3. Prevention: The facility encourages residents and families, and requires staff to report concerns, incidents, and grievances without fear of retaliation and is provided feedback, when possible, on these reports. The facility identifies, corrects, and intervenes in situations of alleged abuse, neglect, and exploitation and focuses on the following areas for prevention: g. maintenance of inventory of resident's property 4.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Identification: Reporting suspected maltreatment is required of all staff. All incidents will be reviewed by the facility's Quality Assurance Committee for detection of patterns and/ or trendsIf the alleged violation involves neglect, misappropriation of resident property, exploitation of injuries of an unknown source and involves no serious bodily injury, it must be reported no later than 24 hours.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>Based on observations, interviews, record review, and review of the facility's Plan of Correction (POC), the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) Committee effectively implemented and monitored corrective actions to prevent recurrence of deficient practices. The facility had previously been cited under F 755 during a complaint survey conducted on 2/3/26 and developed a Plan of Correction with a completion date of 3/2/26. The review showed the facility did not fully implement or sustain the corrective actions identified in the Plan of Correction. Findings Included: A review of in-service/training by the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) showed education with the following objectives was started on 2/3/26: -Narcotic shift to shift documentation (count sheet)-Add and remove in the comment section.-Must be signed at the time of the count-Narcotic count when received from pharmacy. The in-service training record showed the education was provided between 2/3/26 and 3/2/26 for all nurses except the nurses on vacation or leave of absence. A review of a form titled Risk Management/Quality Improvement: Data Collection Form showed an audit form with the following goal: To ensure compliance with proper documentation on narcotic shift count sheets. An audit reviewed each of the medication carts for the following: -Narcotic verification log completed each shift by on-coming and off-going nurse.-Controlled substance inventory completed with no omissions and/or discrepancies noted-Inventory count matches on hand supply.-Random count of three narcotics completed and accurate to disposition documentation. A review of the facility's audit results showed 100% compliance; however, documentation showed the corrective actions from the Plan of Correction had not been consistently implemented in practice. On 3/9/26 at 7:40 a.m. the 100 B medication cart Controlled Medication Inventory Sheet (CMIS) was reviewed with Staff L, Registered Nurse (RN). Incomplete documentation of narcotic counts between 3/2/26 and 3/9/26 was identified. Staff L, RN agreed with the finding and said, Someone forgot to write down the name of the medication. On 3/9/26 at 7:34 a.m. the 200 A medication cart CMIS was reviewed with Staff M, Licensed Practical Nurse (LPN). Incomplete documentation of narcotic counts completed between 3/2/26 and 3/8/26 was identified. Staff M, LPN said there was No need to complete the resident's name on the CMIS. On 3/9/26 at 7:30 a.m. the 200 B medication cart CMIS was reviewed with Staff N, RN. Incomplete documentation of narcotic counts completed between 3/2/26 and 3/8/26 was identified. Staff N, RN said she did not receive recent education from the facility about narcotic management. On 3/9/26 at 6:50 a.m., the 400 A medication cart CMIS was reviewed with Staff O, RN Unit Manager. The total narcotic card count was documented as 23 cards and there were 22 narcotic cards in the cart. Staff O, RN, Unit Manager (UM) said the resident's name should be documented on sheet and she would investigate the issue to determine the reason. On 3/9/26 at 7:00 a.m., the 400 B medication cart CMIS was reviewed with Staff Q, LPN. Staff Q, LPN said at the beginning of each shift he performs a narcotic count. He said the off-going nurse calls out the remaining amount of medication and the oncoming nurse counts the pills to verify the count. Staff Q, LPN stated when medication cards are received or removed, the information should be documented on the CMIS. He said all entries should be completed and accurately documented when entered on the inventory sheet. (Photographic Evidence Obtained) During a follow-up interview on 3/11/26 at 12:41 p.m., Staff O, RN stated staff told her they forgot to document the removal of one narcotic card from the 400 A medication cart. During an interview on 3/10/26 at 3:58 p.m. a review and discussion of the POC was conducted with the Nursing Home Administrator and the DON. The NHA said the Quality Assurance and Performance Improvement (QAPI) committee meets ad hoc and on the third Wednesday of the month. The attendees include the Medical Director, members of the Interdisciplinary Team (IDT), and department leaders such as</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>dietary and housekeeping. A review of two forms titled internal risk management and quality assurance performance improvement program meeting minutes showed the committee meeting met on 2/18/26 and 3/10/26. The NHA said during the meetings CMS Form 2567 was reviewed, and corrective actions were discussed and identified. The DON said education had been provided to all nurses on the proper process and required documentation for completing the Controlled Medication Inventory Sheet (CMIS). A review of a facility policy titled administrator/risk management-quality management showed the following: Vision Statement: This facility will create a caring and nurturing environment, focused on professionalism and excellence in service delivery. The facility strives to be the provider of choice as well as the employer of choice in our community. Mission statement: This facility's mission statement is to provide Quality Focused Care, One Resident at a Time. To that end we will:-Recognize each resident as an individual with unique needs and preferences-Offer choices and support resident decision making-Honor and respect each resident's dignity and rights Provide a supportive environment that promotes comfort-Utilize resources effectively-Communicate with our residents, their families, health care professionals, and the community related to services provided Purpose: Through Quality Assurance and Performance Improvement (QAPI), the facility will take a proactive approach to continually improving care and services for our residents. The facility will involve residents, staff, and other partners to realize our vision of being both the provider and the employer of choice in this community. To do this, all employees will participate in ongoing QAPI efforts to support our mission of providing quality focused care, one resident at a time. Guiding Principles:-The facility will use QAPI to make decisions and improve the day-to-day operations-QAPI will include all employees, every department, and all services provided-QAPI focuses on systems and processes, rather than individuals,-The facility will have a culture that encourages, rather than punishes, staff who identify errors or system breakdowns-The facility will support performance improvement by encouraging our staff to support each other as well as to be accountable for their own professional performance and practice-The facility will make decisions based on data, which will include the input and experiences of caregivers, residents, health care partners, families, and other stakeholders-The facility will set goals for performance and measures progress toward those goals-The desired outcome of QAPI in the facility is the improved quality of care and the enhanced quality of life for our residents Scope: The broad types of care and services provided by the facility that have an impact on clinical care, quality of life, resident choice, and care transitions .pharmacy services, nursing services Policy: The Administrator is responsible for the Quality Assessment and Assurance Committee for the facility. The facility will have an internal Quality Assurance and Performance Improvement Program designed to provide a comprehensive approach to ensuring high quality care and services The QA&amp;A Committee, referred to as the QAPI Committee, will meet at least monthly and will utilize the 5 Elements of QAPI which are: Design and scope - ongoing program and is comprehensive, dealing with the full range of services offered by the facility. The QAPI program will address all systems of care and management practices, aiming for safety and high quality while emphasizing autonomy and .Governance and Leadership - the governing body (administration of the facility) develop a culture of seeking input from facility staff, residents, and families while assuring adequate resources to conduct QAPI efforts. QAPI will be a priority and will include setting expectations around safety, quality, rights, choice, and respect by balancing safety with resident-centered rights and choice Feedback, Data Systems and Monitoring the facility will put systems in place to monitor care and services through the use of multiple sources. Feedback systems will incorporate input from staff, residents, families, and others. Performance Indicators will monitor a wide range of care and outcomes and findings will be compared to benchmarks or</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/03/2026
NAME OF PROVIDER OR SUPPLIER  Valencia Hills Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>targets established for performance. Performance Improvement Projects (PIP's) involves gathering information systematically and intervening for improvement with a written work plan by the project team and a timeline. Systemic Analysis and Systemic Action the facility will model and promote systems thinking, practice root cause analysis and take action at the systems level. Composition and Duties of the QAPI Committee: The facility Administrator and Department Leaders will create an environment that promotes quality improvement and involves all caregivers. The residents, families and staff will be encouraged to bring quality concerns forward to the Committee without fear of reprisal. The Committee will be expected to build effective teamwork among departments and caregivers, emphasizing effective communication across shifts and between departments. The Committee is comprised of: Medical Director, Administrator (serving as Chairperson), Director of Nursing, Risk Manager. The Committee will identify opportunities for improvement as well as recommend, implement, monitor and evaluate changes. The Committee will address all systems of care and management practices, aiming for safety and high quality while emphasizing autonomy and choice in daily life for residents. It utilizes the best available evidence to define and measure goals. The Committee will obtain data from multiple sources, including Performance Indicators which are benchmarked. and will incorporate input from staff, residents, families, and others as appropriate. The Committee will charter Performance Improvement Projects (PIP's) to provide concentrated efforts to address a particular problem areas identified in one part of the facility or facility wide. The facility conducts PIP's to examine and improve care or services by gathering information systematically to clarify issues and intervening for improvement. The facility will be proficient in the use of Root Cause Analysis to determine how Identified problems may be caused or exacerbated and will look across all Involved systems to prevent future events and promote sustained improvement. programs. Once the root cause has been established, changes or corrective actions tightly linked to the root cause will be implemented. These changes or corrective measures should offer long term solutions to the problem, and must be achievable, objective, and measurable. The Committee will review Performance Improvement Projects each month to monitor and provide feedback to sustain continuous improvement.</p>		