From:7275521162

J 7. 17:40 #054 P.005/054

		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 08/07/201 M APPROVEI D: 0938-039
STATEMENT OF DEFIDIENCIES AND PLAN OF CORRECTION (X1) PROVIDENSUPPLIERICLIA IX2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION NUMBER: A SUIL DING			(X3) DA	TE SURVEY		
		105884	B. WING		01	C 5/26/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
EXCEL	REHABILITATION AND	HEALTH CENTER		2811 CAMPUS HILL DR TAMPA, FL 33612		
(X4) ID PREFIX TAG	FEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING IMPORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS) COMPLETION DATE
F 000	INITIAL COMMENT	s	F O	00		
	SKILLED NURSING	3 FACILITY		Preparation and submission of This plan of correction does not		
	COMPLAINT INVES			Constitute and admission or agreement by the provider of the		
	CCR#2015005834	vas conducted on		truth of the facts alleged or correctness of the conclusions set forth on the statement of		
		was identified at F-155 S/S: 4 S/S: J; F-281 S/S: J; F-282		deficiencies, the plan of correction is prepared and submitted solely because of the requirement		
	Substandard Quality F-224 (J)	of Care was identified at		under State and Federal law. This plan of correction will serve as the Facility's allegation		
	A Partial Extended S	survey was conducted on		of substantial compliance.		
	The Administrator was Jeopardy on	as informed of the Immediate at 5:31 PM.				
	It was determined the was removed on	at the immediate Jeopardy				
	not in compliance wi	and Health Care Center is th 42 CFR Part 483, ng Term Care Facilities.				
	Amended	per CMS to add F-520 (J)				i c
F 155 SS≍J	483.10(b)(4) RIGHT ADVANCE DIRECTI	TO REFUSE; FORMULATE VES	F 15	5		
			Ac	Cepted		

Any deficiency state-first glinglight an estarisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sefequants provide glinglight-protection to the pasients. (Be instructions.) Except for nursing promes, the findings stated above are disclossible 90 days following the date of survey whicher or not a plan of ororection is provided. For nursing promes, the structions, and plans of correction are disclossible 41 days following the date of survey whicher or not a plan of ororection is provided. For nursing promes, the above findings and plans of correction are disclossible 41 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.

Factlity 1D: 62932

LABORATORY DIRECTOR'S Q

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

OMB NO. 0938-0391 (X3) DATE SURVEY A. BUILDING COMPLETED ^ 105984 B. WING NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33612 (X4) (C SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION

F 155 Continued From page 1

PREFIX

TAG

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION

This REQUIREMENT is not met as evidenced

Based on resident record review, review of the " Advance Directives * facility policy (Revised 2008) and interviews with the resident's father, the facility's nursing, medical, administrative staff, and Medical Director it was determined that the facility failed to protect the rights of a resident to have Cardio _...(initiated in the event of for one (#1) of 7 sampled residents of 81 residents identified

as having Full Code status, according to the Advanced Directives List, provided by the facility and dated The facility did not initiate on Resident #1, who was 66 years old and had not expressed wishes to have withheld nor had his Health Care Proxy expressed wishes

to be withheld if he was found unresponsive On , the resident was found unresponsive and absent of pulse and

, less than 24 hours after admission.

F 155

PREFIX

TAG

1. Resident #1 Expired at the facility on . Advance Directives has been discussed with Resident's #2 and #4 and Advance directives have been implemented per their request. All required documents have been signed by the resident/responsible party as of 6-26-2015

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY

2. A review was completed for advance directives on this included a review of current full code. and physician orders. A review was also be completed by that all residents received in writing their rights to formulate advance directives according to their wishes or that of their respective responsible parties. A Review has also been completed for completion of the Admissions Agreements and will be completed by identified areas of concern have been addressed. All current residents advance directives are being acknowledged per their request.

AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

EXCEL REHABILITATION AND HEALTH CENTER

105004

STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DO TAMPA, FL 33612

COMPLETED 06/26/2015

SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USE IDENTIFYING INFORMATIONS

in PREFIX TAG

B. WING

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION

F 155 Continued From page 2

The facility did not initiate as per the resident's wishes and his Health Care Proxy's wishes. The facility falled to honor the resident 's Advance Directives and he without the opportunity to be by receiving the services of Additionally, the facility failed to protect the right to form an Advance Directive for 2 (#2, #4) of 6 sampled residents out of a total of 29 residents listed as a full code and recently admitted (after , 2015) in regards to residents who were documented as a full code on their medical

The failure to perform when Resident #1 was found unresponsive resulted in findings of Immediate Jeopardy which were removed , and the severity and scope was

record but wished to have a

reduced to a D Findings include:

order (1

1. A review of Resident #1 's medical record Social Service Admission Evaluation Tool document dated at 5:32 AM (Thursday) included the following information: the resident . had resided with his father in the cast, was a high school graduate and had been in the Marines for 10 years. It also included the questions with corresponding answers written in capital letters. Does the resident have advanced directives? INCAPACITY & HC (health care) PROXY ON CHART; Does the resident have a legal representative? YES, (the resident s father 's name and phone number); What is the resident 's code status? FULL CODE, It was Electronically signed by Employee G

F 155

3. The facility's policy and procedures for Advance Directives,-

and Do Not

Orders have been reviewed and revised as necessary by the OAPI Committee on Licensed Nursing staff has been reeducated related to Advance Directives

. Code Blue Roles and

Responsibilities on thru 6-25-15. Re-education will be provided again and will be completed by . The Social Services Department and Admissions Department has been re-educated on completion of the Admission Agreement and Documentation in the medical

/- /2015 17:42 #054 P. /

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES				PRIN	TED: 08/07/2015
CENT	ERS FOR MEDICARI	& MEDICAID SERVICES				F	ORM APPROVED
ND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ALTIPLE CO	NSTRUCTION		NO. 0938-0391 DATE SURVEY COMPLETED
		105884	B. WIN	3		- 1	С
NAME OF	PROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE		06/26/2015
EXCEL	REHABILITATION AND	WEATTH AFFIRM		2811 C	AMPUS HILL OR		
					A. FL 33612		
(X4) ID PREFIX	SLMMARY STA	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ib		PROVIDER'S PLAN OF CORRECT	71011	
TAG	REGULATORY OR US	C DENTIFYING INFORMATION	PREF	ix	(EACH CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
F 155	Continued From pag		F 1	55 re	cord regarding resident Ac		
	Review of Resident	#1 's closed medical record,	, ,	Di Di	rectives. Education was pr	vance	
	to include demograp	hic / face sheet indicated he		by	the Staff Development	ovided	'
	was initially admitted	to the facility on		c,	and stan Development		1
	readmitted on	and most recently illty from the hospital on		20	ordinator/DON/ Administr	ator	ſ
	Wednesd	ay, for skilled services with		801	d Nurse Consultant. When	а	- 1
	diagnoses that include	led but not limited to:		163	ident is admitted to the fa	cility	i
		L D and		the	Licensed Nursing staff wi	1	i
	Review o	of the Physician 's Order			uire with the		
	Sheet (POS) dated physician on	and signed by the		res	ident/responsible party if	they	- 1
		revealed under Special "Full" (handwritten).		nav	e current advance directiv	es. If	1
		· ·		tne	resident has advance dire	ctives	1
	Per the hospital disch	arge summary for Resident		and	the copies are available t	1ey wi	9
	#1 dated :: P admitted to the emerg	atient was a		pe t	placed in the medical reco	d and	1
,		lency the hospital fallure, HCAP		ımp	lemented. If copies of the		
(Healthcare-associate	d A		resi	dent's advance directives	ere no	t
á	advance VF	RE (-Resistant		avai	lable the nurse will reque:	t the	
E	Enterococci) (Methicillin-resistant	and		resid	dent/responsible party to		1
- }	\ During	his hospital stay, a		prov	ide copies to the facility a	t their	1
à	onsultation was perfo	rmed on due to		earli	est convenience. Resident		
h	aving noted stools the	at were positive for occult		wish	ing to implement advance		
	Laboratory data	revealed hemodiahin of		direc	tives will be referred to the	16	- 1
n	atient was with	t of 335 indicating the		Socia	Il Services department for		- 1
		tlent did not show any		turth	er discussion. The nurse w	rill)	1
s	ans of active	: at the time		docu	ment in the resident's me	dical	1
R	ecommendations incl	uded continue tube		recor	d that this discussion has	aken	i
Te St	edings as lolerated; n	nonitor the hemoglobin needed basis. Resident		place	 Admissions will be review 	ved at	
77	Was discharged from	the boenital and		the D	ally Clinical Meeting to ass	ure	- 1
tra	ensferred to the skiller	i nursing facility on		that t	he resident's advance		ı
	j.			direct	ives have been addressed	bv	l
				the fa	cility per their request and	that	1
A	eview of the Nursino	Admission Evaluation		any to	llow up has been complet	ed	- 1
To	ol dated at	3:00 PM revealed: patient		Curre	nt residents who do not he	We	1
45-2561(0	2-99) Previous Versions Obsolu			advan	ce directives will have a re		1
		DIR EVENT ID: USQX11	'	discus review	sion at their quarterly care	at i	Pego 4 of 213

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DEDARTMENT OF

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER			06/26/2015
	105884	8. WING	C
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
274771 W. W. AS ASS. C		<u> </u>	MB NO. 0938-039
CENTERS FOR MEDICARE	& MEDICAID SERVICES		FORM APPROVE
ACLUATION OF DEVELY	ANU HUMAN SERVICES		MINIED: 08/0/1201

EXCEL REHABILITATION AND HEALTH CENTER

2811 CAMPI/S HILL OF

TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FUIL)
REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID ID PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE PREFIX (EACH GORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY

F 155 Continued From page 4

arrived via stretcher from hospital with - and ... The resident has advance directives upon admission? NO. Are advance directives in the chart? NO. Activities of Daily ... required for bed mobility, transfers; dressing; and personal hygiene. Alert to person and non-verbal, skin pale, warm and dry. Patient not verbal with this nurse, but can make faces for pain. regular and audible, pulse rate equal and Breath sounds clear in place. Has referrals for Physical Occupational and Speech Signed by Employee C. a Licensed Practical Nurse (LPN)

A review of the Admission Minimum Data Set (MDS) assessment dated revealed under Section C (Patterns): Staff Assessment for Mental Status: Short term memory: memory problem. Long term memory: memory problem. skills for Daily Decision Making: severely Under Section D (Mood): Staff Assessment: feeling or appearing down, depressed, hopeless. Trouble falling or staying asleep or sleeping too much; Feeling tired or having little energy, Trouble concentrating. Under Section G (Functional of one person assistance required for bed mobility and dressing; total dependence required for eating and personal hygiene. Under Section H (Bowel): Always of bowel and Under Section I (Active Diagnoses): failure . Under Section K (Swallowing and Nutritional Status): Height 66 "; weight 111 pounds; loss of 5% or more in the last month or loss of 10% or more in last 6 months-yes;

Feeding tube. Under Section M (Skin Conditions):

F 155

4. This area of care will be monitored by the DON/Social Services Director/Admissions Coordinator weekly times four weeks and then monthly times three months. This will also be over seen by the Administrator and the OAPI Committee

-3/- //2015 17:44 #054 P.O. /--

CENTE	RTMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: FORM APPROVED OMB NO. 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIER	105884	B. WING		C 06/26/2015
	REHABILITATION AND	HEALTH CENTER		STREET ADDRESS, CITY, STATE, Z 2811 CAMPUS HILL DR TAMPA, FL 33812	IP CODE
(X4) ID PREFIX YAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFI TAG		ION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 155	Continued From pag	e 5	F 1	155	
	A risk of developing Section Q (Resident Expects to remain in	's Overall Expectation): this facility; by family.			:
; ((f	i, pulse or amount of frothy salive extremities cool to to attending physician) rom (covering physic elease body. Call to uneral home receiver	ed to Certified NA). Resident noted with no Noted large a on face and chest. Upper			
e '1' ree as in har this che ex	onducted with the AB or be resident when he sa taking care of him she took a mployee called off. S. verbal, he required to admitted from the he sked to recall the eve sked to recall the public that AB or AB OLDN stated, which she she medication think he is gone, I was the control touch. He from the resident she was the she was the she was the she was the she the she the she the she the she the she the she the she the she the she the the the the the the the t	shift because another he stated the resident was notal care and had been spital that day. When nits that happened on esident #1 sworking the night shift, ! now not a round 5:45 e halfway and said, "! In Resident #1."			

7=17 117:45 #054 P. /.-

	DEPARTMENT OF HEA	LTH AND HUMAN SERVICES			PRINTED: 08/07/201
	CENTERS FOR MEDIC	ARE & MEDICAID SERVICES			FORM APPROVE
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII	TIPLE CONSTRUCTION	OMB NO. 0938-039
	MAD PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	(X3) DATE SURVEY COMPLETED
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		105884	8. WING		С
į	NAME OF PROVIDER OR SUPPL	JER		STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/2015
İ	EXCEL REHABILITATION	AND HEALTH CENTED	- 1	2811 CAMPUS DR	
ŀ		THE HEREIN CENTER	- 1	TAMPA, FL 33612	
ı	(X4) ID SUMMARY PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECT	
		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(BACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
	F 155 Continued From				
			F 15	55	
	had and I di	dn t see a . Honestly when	2		
	saw the resider	nt after the CNA called me he	*		
	anything I could a	h, I don 't know if there was do for him. At that point I made			
	the decision to n	of code him; because he was			
	and stiff I di	id not know how long he had			
	been like that. Th	e physician covering for the			
	attending physicia	an was called, and informed of			
	the resident's	. The ADON was asked if			
	she saw a 🗆 o	order on the medical record, she			i
	stated, " after loc	king at the chart, no. " When			
	asked if she had i	received training on how to			i
	respond when a r	esident is found without vital			1
	compressions and	we are supposed to do chest disend someone to check on			i
	status	sano someone to check on			1
		was asked if she knew how to			
	determine code st	atus, she stated, if a resident is			
	unresponsive, I an	n supposed to check the pulse			
	and call for some	one else to check the chart for			ı
	orders. I will	a call code blue and bring the			1
	crash cart. We have	ve a yellow book at the nurses '		•	1
	station with all the	forms. If the recident ic o			1
	new admission it n	nay be necessary to look in the			1
	resident 's advance	d how the nurse is notified of a e directives, including			
	She states "It is to	he nurse 's responsibility to			1
	check the chart on	every resident, so they know			
	status, If so	meone finds someone			
	unresponsive, they	have to wait until someone			1
	checks the yellow t	look or the chart to see if they			
	are UNK or not. W	hen asked what she would do			1
		in a resident is found			1
	- Dut	there is no Advance directive			i
	she had had any ten	ld do a Code." When asked if slining since the event, she			1
	stated ves one-on-	one with the Director of			
		THE DIRECTOR OF			

Nursing (DON) on , advance directives, Code Blue, and mock drills. The DON reviewed

08/07/2015 17:45 #054 P.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/07/2015

CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII,	ILTIPLE CONSTRUCTION DING	(XS) DATE SURVEY COMPLETED
	105884	S. WIN)	C 06/26/2015
NAME OF PROVIDER OR SUPPLIER EXCEL REMARK ITATION AND	HEALTH CENTED		STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR	

EXCEL REHABILITATION AND HEALTH CENTER

2311 CAMPUS HILL DR
TAMPA, FL 33612

IXA) ID
PROVIDERS PLAN OF CORRECTION
PREFIX
(EACH DEFICIENCY MUST BE PRECEDED BY FILL
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REGULATORY OR LSC IDENTIFYING INFORMATION)

TAG
CRUSS-REFERENCY OT HIS APPROPRIATE
DEFICIENCY)

F 155 Continued From page 7

with me when we are supposed to do a code.

On at approximately 5.00 PM an interview was conducted via lelephone, with Employee A, the CNA, who found Resident if unresponsive. She stated she no longer worked for the facility. Employee A stated she was making rounds before she went home and found Resident if I not breathing. She called for the nurse to check on him. The ADON responded and checked on the resident. The ADON said, rie was gone. "Employee A stated that the ADON did not of

() on Resident #1 and that she did not recall anything else about the resident.

at 1:15 PM an Interview was conducted with Employee G a Social Services Assistant regarding Resident #1 's Social Service Admission Evaluation Tool dated timed 5:32 AM, approximately 13 minutes prior to the resident's . When asked, Employee G stated he probably filled in the information based on prior admissions. He stated he was going to speak with the resident 's family and he confirmed that the resident had a health care proxy and a Determination of Incapacity. He confirmed that the resident was a Full Code on previous admissions and remained a Full Code because there was not a signed medical record. He stated that his plan was to call the family and inform them of their right to formulate an advance directive for the resident. He further stated that the facility procedure in regards to advance directives required the Admissions Department to speak to residents on admission, advance directives are then addressed in the Nursing Admission Assessment and the Social Services Department reviews the

F 155

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DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 08/07/2015
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED
	VT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T		OMB NO. 0938-0391
	OF CORRECTION	DENTIFICATION NUMBER		ILTIPLE CONSTRUCTION	(X3) DATE SURVEY
			A. BUILD	DING	COMPLETED
		105884	B. WING		c
NAME OF	PROVIDER OR SUPPLIER	103884	D. WING		
			1	STREET ADDRESS, CITY, STATE, ZIP CODE	
EXCEL	REHABILITATION AND	HEALTH CENTER	- 1	2811 CAMPUS HILL DR	
				TAMPA, FL 33612	
(X4) ID PREFIX	SUMMARY STAT	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT!	ON IXE
TAG	REGULATORY OR LS	C IDENTIFYING INFORMATION)	PREFU		ORE COUNTRION
		•	750	DEFICIENCY)	PRIATE DATE
F 155	Continued From pag	ge 8	F 1:	55	
	information with the	resident and/or the family.			1
		•			1
		20 PM an interview was			1
	conducted with the S	ocial Services Director			1
	(SSD) regarding Res	ildent #1. Per the SSD, she			ľ
	spoke to the resident				ì
	he was readmitted or				ĺ
	that his parents were	making the decisions			
		nd were designated as his			
	She stated that the fa	cision Makers at that time. other was given information			1
	in records to formula	ting an advance directive.			1
	SSD states, " If he w				1
		m the paperwork. " She			1
	also stated that she h	ad not spoken to the father			1
	when the resident wa	s admitted on			ľ
	She stated that the Re	esident was designated as a			
	Full Code since his or	riginal admission in of			1
	2014 and had never t	nad a paper in his			
	medical record.				
	0				1
	On at 12:40	PM, a telephone interview			i
		esident #1 's father. He			i
		the Marines; he got an I had to have surgery. He			1
	stated the recident the	ed by himself for a while.			
		ing with his didfriend " . He			1
		nd they sent him to the			
	tursing home. When				ı
	expecting his, hi	e stated, he " could not			1
	are for him anymore.	that 's why he went to the			
r	ursing home. " He w	as wearing diapers and			1
c	ouldn 't dress himsel	f anymore, "I couldn't			1
h	andle him anymore. "	He went to the hospital			1
a	nd then the nursing h	ome; he " was in and out			
0	f the nursing home. "	think he in the			ĺ
n	ospital, no, the nursin	g nome, I get			
S)	omeumes, I couldn' t	do anything with him. " He			
- "	as naving problems t	reathing, they put him on			1

From:7275521162

- 7 7 17:47 #054 P.014/054

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 08/07/2019 FORM APPROVED
STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105884	8. WING		С
NAME OF	E OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY.		STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/2015	
	REHABILITATION AND			2811 CAMPUS HILL DR TAMPA, FL 33612	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST 8E PRECEDED BY FULL C IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECT: (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COURTERON
F 155	Continued From pag	ne 9	F 15	55	
	. The last tim hospital, and then so was	e I saw him he was in the meone called and said he		~	
	policy statement: "A respected in accorda facility policy." Polici implementation, sect admitted to our facility Director (SSD) or des information to the result in the result of the re	d 2008), revealed a dware directives will be noe with state law and protection and ion. "I. When a resident is y, the Social Services signee will provide written ident concerning medical care, society or reliable to medical or of the right to formulate on the right to formulate on the right to formulate or any written Policy Interpretation and on." 5.1 in accordance with ms and guidellines ectives, our facility has citives as preferences citives as or fererences trians and include, but are includes to the right of the r			
A	irectives Acknowledo	's Admission age 31 of 39 Advanced ement with the following that I do not have to sign			

or implement an Advanced Directive in order to

/2015 17:47

#054 P 015/054

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/07/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OME NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING_ COMPLETED 105884 R. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR

TAMPA, FL 33612 SUMMARY STATEMENT OF PREICIENCIES (X41 (D th PROVIDER'S PLAN OF CORRECTION PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FUL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)

F 155 Continued From page 10

be a resident at this Healthcare Center 1 understand that I may implement an Advanced Directive at any time during my stay in the facility. It is also my understanding that I may ask at any time to review Advanced Directive information or my Advanced Directive (s) and ask questions (may have concerning them. I may revoke any Advanced Directive (s) at any time that I have made. I understand the facility's staff cannot give legal advice, but can answer questions concerning Advanced Directives. I have the following designations(s) and my copies have been provided to Health Care Center. A line was drawn through the blank spaces in front of all the choices which were: Living Will or Direction to Withhold Life Sustaining Procedures,

Yellow HRS Form Health Care Surrogate, Health Care Proxy. Durable Power of Attorney, Financial Power of Attorney, Medical Power of Attorney, Guardian Financial or Medical, Anatomical Gift, Other: Physician Statement of Incapacity, Funeral Home Selection. The form was initiated by the resident and witnessed by Employee H on

Review of the resident 's Admissions paperwork revealed a second form titled Advanced Directives Acknowledgement (no page number) with the residents initials beside the sections 1, I have been given written material about my right to accept or refuse medical and surgical treatments and my right to form Advanced Directives, 2, I understand that I am not required to have an Advanced Directives in order to receive medical treatment at this health care facility and 3. I understand that the term of any Advanced Directives that I have executed will be followed by the health care facility, physicians and my caregivers to the extent permitted by the

F 155

.3/ 17:48 #054 P.016/064

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 08/07/2019 FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD	LTIPLE CONSTRUCTION	OMB NO. 0938-039-
		105884	B. WING	_	С
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/2015
EXCEL	REHABILITATION AND	HEALTH CENTER		2811 CAMPUS HILL DR TAMPA, FL 33612	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S BLANCE CORRECTO	D. D.C.
Fr.	of the following state of the following state of the following state of facility. Inderstand physicians at this fac the term on my Advance Directive and advanced interest of the state of	uss with: Please Check one ments: I have executed an did will provide a copy to the half will not be able to follow need Directives until in the staff, or I have not a Directive for the staff, or I have not a Directive for the staff or I have not an order to the staff or I have a dispined by the resident and sentiative Employee H and sentiative Employee H and sentiative Employee H and and readmitted to the and readmitted to the His admission paperwork entation that his Active et, his father, was given the province of the sentiation that his Active et, his father, was given to the fecility. 's physician orders dated Code Status of Full Code. 's medical record was discharged to the and readmitted on on paperwork circl nor active the and readmitted on on paperwork circl nor intential half with Medical her, was given information. There was no There	F1		
the	admission nanerum	knowledgement " form in			

readmission to the facility.

3/

- / 72016 17:49

#064 B

1 . - 1 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 105884 B. WING NAME OF PROVIDER OR SUPPLIES 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA. Ft. 33612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAP DEFICIENCY F 155 Continued From page 12 E 155 Review of Resident #1 's complete medical record including the closed record revealed no form was present Further review of Resident #1 's medical record revealed a document titled Activated Medical Decision Maker signed by the resident 's father and mother and witnessed by two signatures on . The document included the following language: The Determination of Incapacity form has been completed on . I do hereby attest that I am at least or older and am willing to become involved in the above stated resident 's health care decisions. I have maintained regular contact and am familiar with the resident 's activities, health, religious and moral beliefs, so that I can make health care decisions, including withholding/withdrawing life prolonging decisions that would be the decisions the resident would have made, if capable, I am willing to produce clear and convincing evidence upon request. I understand that my role has become active and accept my responsibility. which is one of the following Medical Decision Maker designations; checked were Proxy and A parent of the resident.

revealed a Determination of Incapacity document dated and signed by his attending physician. It included the following language: As attending physician for the above stated resident (Resident #1). I have evaluated and determined the above stated resident tacks the capacity to give informed consent to make medical decisions and does not have the reasonable medical probability of recovering mental and physical capacity to directly exercise rights.

Review of Resident #1 's medical record

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER A. BUILDING _ COMPLETED C 105884 B. WING 06/26/2015 NAME OF PROVIDER OR SUPPLIES STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33612 (YALIF SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1981 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETION TAG TAG DEFICIENCY F 155 Continued From page 13 F 155 at 5:15 PM an interview was conducted with the Director of Nursing (DON) when asked if she was familiar with Resident #1 she stated, "yes." When asked about the day Resident #1 , she stated, "When I came in about 5:30 AM the (ADON) stated that Resident #1 had passed. I asked the (ADON) if she had performed the (ADON) said no I stated to the (ADON) that she, should have called a code and the (ADON), and stated she did not do it. I educated the (ADON) right then and there regarding our policy. The policy states, we have to start a code no matter what, on a Full Code resident. I interviewed (Employee A) who stated she was making her rounds, and the resident didn't look right, she shook him, and he was not responding, so she got the nurse." The DON stated. "The chart revealed the resident was a Full Code. " The DON stated. "I knew he was a full code because he had been here for so long. The DON stated "the (ADON) decided on her nurse pronounced him

at 5:00 PM an interview was conducted with the Nursing Home Administrator (NHA). When asked if she could recall the events that happened on , the day Resident #1 she stated the DON informed her that the ADON had found the resident unresponsive and did not perform stated in her opinion the ADON should have looked at the chart and initiated

at 2:40 PM, a telephone interview was conducted with the covering physician who received the call regarding Resident #1 on She stated she was covering for the

but doesn't attending physician on

From:7276521162

/ / 17:50 #064 P.019/054

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				FOR	D: 08/07/201
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F 155	Continued From pag	ge 14	F 1	55			
	patients. When aske resident was a Full (s she stated she covers 1000 ad if she was informed the Code and he was not sted, "I apologize, but I don'					
	interview was condu- attending physician, resident had multiple issue:						
	He was thin and look a patient. He was bar was not called the da						
	so, probably when the Normally if a patient of their chart, would	" I found out the next day or a funeral home called me, " does not have a on d be initiated and 911 called, the nurse would start					
	fa :wasnotont On at12:0	he chart. " 0 PM, an interview was					
1	conducted with the M f his expectation was on a Full Code reside the done. " He has be almost 4 years. " If the	edical Director. When asked for a nurse to perform int, he stated, "should en the Medical Director for e resident was					
	inresponsive they have or all non- reside						
r C	evealed she was a n (Friday gainst medical advice	dical record for Resident #2 admitted originally) discharged on e and was re-admitted on () from the hospital,					

SINTEME	NT OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	Towns and		FORM APPROVED OMB NO. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	ALTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	REHABILITATION AND			2811 CAMPUS HILL DR TAMPA, FL 33612	
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F 155	Continued From pag	ge 15	F 1	55	
	Interview of Mental S indicating the resider Review of Resident # dated (Frit Directives Acknowled Frit Directives Acknowled Frit Code or was signed by the reserve of Resident # revealed an Admission 5: admitted fristory of lung ; arrive	assment revealed a Briefi islatus (BIMS) score of 13; it was infact. 22 s Admission Agreement day) revealed an Advanced gement form. All blanks on signify that the resident had lon and designeded a choice were not filled in. The form ident on (Tuesday). 2 s medical record in Evaluation Tool dated or (remission);			
v 5 5 6	; assist with by walking, dressing, toile athing; assistive devi- ections. Living will, Or birectives Explained w. Review of Resident #2 rst admission) revealed mission Evaluation.	gan Donor and Advance rere all blank, 's medical record (for her			
re co to Re se	any years; no advano isident makes her ow ode; mood; antici 4 weeks, signed by t	ned directives at this time; not decisions at this time; full pated length of stay for 2 he SSD. 's medical racord (for her talled an Admission			

Facility ID: 62932

(Thursday):

COMPLETION

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#054 P. 15 'n

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES MEDICAID SERVICES		PRINTED: 08/07/2015 FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>

EXCEL REHABILITATION AND HEALTH CENTER

2811 CAMPUS HILL DR TAMPA, FL 33612 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

F 155 Continued From page 16

F 155

. status post . smoker lung ; advance directives - no: is the advance directives noted in the chart and communicated to staff - no; independent in hed mobility. for transfers. dressing, toileting, personal hygiene, upper arms; alert and oriented x 3.

Review of Resident #2 's medical record revealed a Social Service Admission Evaluation at 5:32 PM: Tool dated female; no advanced directives at this time: resident makes her own decisions at this time; full mood; anticipated discharge 4 weeks to home with son and daughter-in-law.

Review of the resident 's medical record revealed a 2015 Physician Order Sheet. under Code Status, there was a blank line. Neither Full Code nor were written on the line provided to designate the Code Status.

Review of Resident #2 's medical record revealed a Discharge Summary dated at 10:55 AM: resident left the facility Against Medical Advice (AMA) resident 's son was in the facility and took resident home. Resident able to make her decisions independently and had no , signed by the SSD.

Review of Resident #2 's medical record revealed a nursing progress note dated at 6:58 PM: resident admitted from hospital with admitting diagnosis of status post , lung collection stated findings as follow: old and new noted on the upper extremities and lower extremities lung sounds clear to auscultation: bowel sounds heard all 4 quads; abdomen

--/ 7 -- 18:31 #054 R 099

CENT	ERS FOR MEDICARE	AND HUMAN SERVICES			PRINTED: 08/07/2015 FORM APPROVED
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	LTIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
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F 155	Continued From pag	ie 17	F 1	56	
	non-distended orien Unit manager.		,,,	55	
	AM an interview was 2. She was observed bedside. When the n wishes for if ne want . After con the resident was ask directives, she stated about that. "When a she stated, "don't my family to suffer the	vant that. " "Don 't want			
	conducted with the St Resident #2. " like I st spoke with her (Resid directives and she do have a son. She does decisions for her. SSI directives acknowled	9 PM an interview was 5D. She stated in regards to howed you yesterday, I lent #2) about advance esn' t have any. She does in' t want her son to make o was informed the advance sement form in Resident #2' interview and in' t know that.			
6 8 8 6 1 1	conducted with the NF Corporate Nurse (CN) should be documenting advance directives in a of the electronic progra that for Resident #2 th	PM an interview was IA, the DON, and the The NHA stated that SS g discussions regarding a progress note. On review ass notes it was revealed ere was no documentation s notes, and The NHA			

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				PRINTED: 08/07/201
I STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	Town	_		OMB NO. 0938-039
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NAME OF	PROVIDER OR SUPPLIER		-	Ť	STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/2015
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					TAMPA, FL 33612	
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F 155	Continued From pag			_		
			F 1	55	5	
	following	t re-admission found the				
	Social Services Assis	ocial Service Director and stant together went to speak				
,	with the resident abo	ut advanced directives.				
	Resident stated she i	does not have any advanced				
	directives at home. D	lo Not Resuscitation ()				
	order was explained.	Resident was agreeable at				
,	his time to sign order. Signed by	order. Will follow up with				
	order, signed by	y 55U.				
3	. Review of the me	dical record revealed				
F	lesident #4 was an	male admitted on				ł
د	(Friday) fron	n the hospital with				1
	lagnoses that include ematoma.					
	ronic kidnev	, anemia and				I
						ı
R	eview of Resident #4	's medical record, on				
	, since adm	nission (1
re	vealed there was no	form in the record.				ĺ
R	eview of Resident #4	's Admission Agreement				i
da	ited resident	s Admission Agreement saled an Advanced				
Di	rectives Acknowledo	ement form signed by the				1
rea	sident 's daughter. A	ul the blank lines on the				1
tor	m for initials to signil	fy that the daughter had				1
rec	Pelved the Information Full Code or with	n and designating a choice				
ui	run code of ; We	ere not filled in.				
Re	view of the resident	s medical record				
rey	ealed an undated Ph	Ivsician Order Sheet				
pag	ge 1 of 2; under Code	6 Status, there was a				1
bla	nk line. Neither Full (Code nor ! were				1
Sta	tten on the line provid tus.	ded to designate the Code				- 1
						I
Rev	iew of Resident #4 '	s Admission Evaluation				i

--/ /2015 18:32 #0\$4 P.02 /...

& MEDICAID SERVICES			PRINTED: 08/07/20 FORM APPROV
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
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		STREET ADDRESS CITY STATE 20 CORE	06/26/2015
HEALTH CENTER	- 1		
		TAMPA, FL 33612	
	ID PREFI) TAG		
(Sunday) (admission date disarrived via wheel chair sist included "advanced mt appears to be capable of cistions at this time; only ring a translator, requires bed mobility, transfers, I personal hygiene; skin is as poor balance and needs are and ambulation; liet, aller to person, place on the time memory not good of for several ar. continent of and assist for ambulation; and assist for ambulation; and assist for ambulation; and	F 15	55	:
sment revaaled a Brief tus () score of 6, ervice Admission (Monday) revealed; n Puerto Rico, lived in when came to live with unced directives on file at nily visits daily; planning			
	HEALTH CENTER ELEVATO PDESIGNATION BY STANDARD	A MEDICAID SERVICES (AT) PROVORDISUPPLESS (AT) PROVORDISUPPLESS (AT) PROVORDISUPPLESS (AT) PROVORDISUPPLESS (BETTER ATTON NUMBER: A BULL B. WING HEALTH CENTER TEMENT OF DESIGNATION (Sunday) (admission date of a trived via wheel chair sis included (Sunday) (admission date of arrived via wheel chair sis included (Sunday) (admission date of arrived via wheel chair sis included (Formally included) A MEDICAID SERVICES (AT) PROVIDES/PURPLENDAY (AT) PURPLENDAY (AT) PU	

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DEPARTMENT OF HEALT	H AND HUMAN SERVICES			PRINTED: 08/07/2
CENTERS FUR MEDICAR	E & MEDICAID SERVICES			FORM APPROV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIED/CLIA	Lower	The same of the sa	OMB NO. 0938-03
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EXCEL REHABILITATION AND	HEALTH CENTER	- 1	2811 CAMPUS HILL DR	
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		140	CROSS-REFERENCED TO THE APPRI DEFICIENCY	OPRIATE DATE
			72.13.13.17	
F 155 Continued From page	ge 20	F 15	-	
Further review of Re	esident #4 's medical record	F 10	15	
revealed the resider	it went back to the hospital for			
a rollow up visit on	and count one wints			
there. The record inc	cluded a document of a			
verbal report given to	the facility nurse from the			
nospital nurse titled	"Nurse to Nurse " 18			
included the following	2 documentation			
(Saturday, 8 days aft	er admission) "the resident"			
sname", /Do N	lot Intubate (DMI)			
Diagnoses, fatigue, id	ow hemoglobin.			
, chronic kid	Iney			
	clinic, 2 units of			
i, aler	t, oriented,			
Review of the Nurse				
of 11:45 AM (Saturday	s notes revealed			
resident admitted from	y, 8 days after admission),			
diagnosis of fatigue se	the nospital with a			
hemoglobin, and	scondary to low			
administrand social-				
family via ambulation	was transferred with his wheelchair, Limited English,			
spoken. /DNIs etc	wheelchair, Limited English, Itus noted. Skin has some			
abnormal findings right				
from hospital stated th	temple noted; nurse			
/	was ordered for bone			
shave/	Further review of the nurse			
s notes revealed	at 2:30 PM			
attending physician wa	s called by the supervisor			
Supervisor updated phy	vsician on re-arimit No			1
new orders; it is okay to	resume previous orders.			1
				i
On at 12:20 PM	(Thursday, 13 days after			1
aurinssion and 5 days a	fter returning from			1
overnight stay at hosnits	al) an intendeut use			1
conducted with Residen	t#4 'c daughter lathau			1
asked if the lacility had a	anoken with hor recording			
ing rating 2 sovance di	rectives one stated we			
no one had spoken with	her on admission,			1

or on

Facility ID: 62932

She stated she took

From:7275521162

W 7 = 18:34 #054 P.026/054

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 08/07/201: FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	CTIPLE CONSTRUCTION	(X3) DATE SURVEY
	105884	B. WING		c
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/2015
EXCEL REHABILITATION AND			2811 CAMPUS HILL DR TAMPA, FL 33612	
PREFIX FEACH DEFICIENCY &	EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL DIDENTIFYING INPORMATION)	PREFI TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	
F 155 Continued From page		F 1	46	
directives due to his c physician stated we m DNI. We (the far weekend after his wish decided that a or want him to be comfor respect his wishes. On at 1.00 conducted with the NN Corporate Nurse (CN), the Corporate Nurse (CN), the Corporate Nurse (CM) and a directives A with blank ines. The N admission agree Advanced Directives A with blank ines. The N admissions representa making sure the admissions grade to refer the other through the resident present their resident in the resident was admitted or Sunday if the nursing discuss advance directive of simily, the NI-NI-S tate the facility staff that per #4 's daughter, she stat with her regarding advar her brother in Puero Ric Attorney (POA). The NIN Nurse (CN) confirmed the	ooke with her about advance nondrition. The hospital any need to think about minity discussed the to the hospital. We refer is what we wanted; we fable. I would like to the hospital. We refer is what we wanted; we fable. I would like to IPM an interview was IA, the DDN, and the IPM and IPM were shown Resident ment packet, including the cknowledgement form. He verified that including the cknowledgement form, the very set including the cknowledgement form; the very set including the cknowledgement form; the very set including the resident and or family resident; swishes and to this work of the resident and or family resident; swishes and to this. When asked if a in Friday right, Saturday is staff were supposed to ves with the resident and d, "Yes." Also informed interview with Resident and d, "Yes." Also informed interview with Resident ed, no one has sopten need directives, and that to is the medical Power of A, DDN and Corporate last the "DNN were notes and nurse to rurse at they should have the			

one. The Corporate Nurse stated, "We have 5

#- 7 - 18:34 #084 P.02"7 _

CENT	ERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FOR	ED: 08/07/20 RM APPROVE
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) D	IO. 093 -039
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NAME OF	PROVIDER OR SUPPLIER	103084	B. WING		- 1	
	REHABILITATION AND			STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR TAMPA, FL 33612		
PREFIX TAG		EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDERS BLANCE CORRES		COMPLETION DATE
FR nd a affront DD space space space had been been been been been been been bee	assessment period. I should be document advance directives in of the electronic prog that for Resident #4 in from SS in the progrethis. On at 1:4. Conducted with the SS advance directives at 2:4. Conducted with the SS advance directives at Sesions #4 is admissiblank. She stated. Von at apprinteries was conducted stated that the SS dep Daughter of Resident #4 inceptacity certification. I device of the paper work together capacity certification stevies of Resident #4 severed of Social Service of Resident #4 inceptacity certification. I device of Resident #4 inceptacity certification in the Social seak with the resident paper work to service of the Social seak with the resident procedures. I service of Social Service of Soci	noe directives during the The NHA stated that SS ng discussions regarding a progress note. On review rests notes it was revealed rere was no documentation as notes and the verified of the NHA verified on the NHA verified of the NHA verified on the NHA verified of the NHA verified on the NHA verified on the NHA verified of the NHA verified of the NHA verified of the NHA verified on the NHA verified of the NHA verified of the NHA verified on the NHA verified of th	F15			

s daughter stated that she discussed with the entire family and family was agreeable to sign

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER

105884

(X2) MULTIPLE CONSTRUCTION A. BUILDING

PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 06/26/2015

COMPLETION

NAME OF PROVIDER OR SUPPLIES EXCEL REHABILITATION AND HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL OR TAMPA, FL 33612

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION

10 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY

F 155 Continued From page 23

order for her father. SSD explained process ar signing , such as signing incapacity form. Health Care Proxy form and after that, Will follow up with order.

at 5:00 PM an interview was conducted with the NHA. In regards to the facility response to the incident of Resident #1 not receiving when necessary she stated. " We started an Investigation and a Quality Assurance Performance Plan (QAPI) immediately. We sent the ADON home for the day on suspension. We reviewed the policy and procedures for advance directives . Code Blue Roles and Responsibilities, and the Emergency Procedure

. We interviewed the staff regarding their ability to verbalize the process. We normally complete an audit of the advance directives and orders monthly. The SSD initiated an

immediate audit for Advance Directives and for the entire resident population and it was completed by , 2015. We were monitoring / reviewing the charts of residents who expired. We started in-service training regarding advance directives and and called a Code Blue Drill. Multiple interviews of the staff were initiated to ensure the direct staff knew about advance directives. and when to call a code Training was conducted in for the entire facility. The DON did immediate in-servicing with the ADON and we completed a Federal report. We have been conducting weekly QA meetings regarding the event. These meetings will continue weekly through and then occur monthly." When asked when staff training had been conducted prior to the last couple of months, she stated, "we do it routinely and new hires get it at orientation." When asked how the facility audits the employee records for current she stated.

F 155

B. WING

FORM CMS-2567(02-99) Previous Versions Obsplete

Event (D: J5QX11

Facility ID: 62932

If continuation sheet Page 24 of 213

/_ / _ 18:36 #054 P.028/054

DEPARTMEN	IT OF HEALT	HAND HUMAN SERVICES					
CENTERS E	D MEDICAD	E & MEDICAID SERVICES				PRINTED: 08/07/20)1
STATELENT OF THE	NEDICAR	E & MEDICAID SERVICES				FORM APPROV	Eί
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	I TIDI E CO	NSTRUCTION	OMB NO. 0938-03	9
The Con	RECTION	IDENTIFICATION NUMBER:	A. BUIL	DETIFEE CO	NETRUCTION	(X3) DATE SURVEY	
		1	A BUIL	DING		COMPLETED	
		105884	1			1 c	
NAME OF PROVID		105884	B. WIN	s		1	
WHE OF FROMO	ER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	06/26/2015	
SYCE! DEUAD		HEALTH CENTER		1 2044 0	ADDITION OF THE CORE		
CAULL NEIME	ILITATION AND	HEALTH CENTER			AMPUS HILL DR		
(X4) ID	***************************************			TAMPA	FL 33612		
PREFIX (I	ATE PRIMMUS LOUDING HOA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	10		PROVIDER'S PLAN OF CORRECT!		
TAG RE	GULATORY OF	SC IDENTIFYING INFORMATION	PREF	tx			
		PO IDENTIFE TING INFORMATION)	TAG		AND OWNER THE MENUED TO THE APPRO	D BE COMPLETION PRIATE DATE	4
					DEFICIENCY)	THE STATE	
							_
F 155 Contin	lued From pag	ge 24		155			1
" the i	luman Pacou	rce (HR) manager does an		100			
audit.	which include:	ce (Firk) manager does an					
inthe-	WINCH MULUGE	reviewing cards."					1
vvnen	asked if the e	vent had been presented to					-1
the QA	committee w	ith an action plan she stated.					1
Yes "							1
On	the N	A provided a " QA Book ", it					1
contair	ned the Quality	Assurance Performance					ļ
Improv	ement Plan fo	r review. The tool was					1
dated	ond:	signed by the Quality					1
	on to own in all	signed by the Quality					ı
Masura	nce learn inch	uding the Medical Director on					1
	A review	of the information provided					1
reveale	d policy revisi						1
							1
Directiv	es " which inc	cludes " Code Blue Roles					ı
and Re	sponsibilities *	and "Emergency					ı
Proced	Ire -	and Emergency					l
Review	of these route	ions revealed the following					ı
relevan	changes 18416	Code Blue Roles and					
Bassa	- Changes, 1	Love Blue Roles and					ı
respon	sibilities (no	effective date): " In the					ı
	at a resident i						l
. tr	e person disc	overing the should					
immedia	ately notify a n	urse of the situation, A					
leamma	te should pag	e overhead that there is a					Ĺ
Code Bl	ue and the loc	ation of the code All				-	
available	teammates a	are responsible to respond					
to a Con	e Blue Pane	The nurse is responsible to					
immedia	tely assess th	e resident to determine if				- 1	
the resid	ant is in						
		The				i	
(CSIUDIN	s medical rec	ord will be obtained to				1	
determin	e if the reside	nt has a () document					
in their re	cord. (may ch	eck YELLOW BINDERS					
at each r	urses station	for status) if the				í	
is noted	hen there will	be no further interventions				1	
impleme	nted as per the	resident's advance				1	
directives	. If there is no	in the medical				1	
record the		e initiated on the resident				i	
		for the implementation of				1	
00.00	ne regident Ti	he nurse assigned to the					
tacidani u	diente se the 1	TEAM LEADER of the				1	
Lesingli A	um ant as tub i	CAN LEADER Of the				1	

DEPARTMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 08/07/201
CENTERS FOR MEDICARI	F & MEDICAID SERVICES			FORM APPROVE
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-039
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		ATIPLE CONSTRUCTION	(X3) DATE SURVEY
		A. BUR.	DING	COMPLETED
	105884		_	l c
NAME OF PROVIDER OR SUPPLIER	10384	B. WING		05/25/2045
			STREET ADDRESS, CITY, STATE, ZIP COI	OF COLUMN
EXCEL REHABILITATION AND	HEALTH CENTER		2811 CAMPUS HILL DR	
(X4) ID SUMMARY STA			TAMPA, FL 33612	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	iO	PROVIDER'S PLAN OF CORR	ECTION
TAG REGULATORY OR LE	C IDENTIFYING INFORMATION	PREF	CROSS-REFERENCED TO THE AP	
			DEFICIENCY)	
F 155 Continued From pag	25			
	fied Nursing Assistants who	F 1	55	
are certified ma	ay be directed to assist with			
at the direction	of the purpo. "			
THE GROOM	of the flutte.			
On signs	ature sheets were provided			
for the following in-se	prvices, dated			
	6/7, and			
	n mock "Code Blue " drills			
were done on ,	, Ali			
occuments that were	provided to the survey team			1
the in continuation	nparison was made between			
of all employees. The	re sheets and the master list comparison revealed that			
	of licensed nurses and 97%			
	if had completed the training.			i
	rias completes are stanting,			1
Interviews with the fac	cility staff regarding			ľ
advanced directives.	and Code Blue drills			
were conducted in ord	der to verify staff knowledge.			1
The following relevant	t interviews were obtained:			
On at 4:24	PM, an interview was			
she worked full time o	yee C a nurse; she stated in the 7:00 AM -3:00 PM			j
shift She stated she b	nad been part of a mock			1
Code Blue drill a coun	le of months ago and that."			1
we just had an in-servi	ice on where to find the			- 1
forms, in the velt	ow book." When asked			1
how she would respon	d If a CNA said a resident			į.
was unresponsive she	stated she "would check			i
the book I would	eone at the desk check			
the book, I would determined if the reside	initiate until			1
would stop . "	ent had a order then f			
On at 4:32 F	M an Interview was			
conducted with Employ	ee D a nurse, who stated			1
she worked full time on	the 7:00 AM -3:00 PM			
shift. She stated she ha	d training on			
advanced directives an	d participated in mock			

Fram:7275521162

/. /2015 18:37 #054 P.031/054

DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 08/07/2019 FORM APPROVED
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BURLD	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	105884	B. WING		С
NAME OF PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/2015
EXCEL REHABILITATION AND H	HEALTH CENTER	1	2811 CAMPUS HILL DR TAMPA, FL 33612	
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OFFICIENCY)	DRE COMPETION
She also stated unresponsive; I would someone to go to I would stop I w family, if they were a funli the paramedics of until the paramedics of conducted with Employ she usually worked as at 11:00 PM shift. She somentation they discuss orders. She had to monits on advance direction of the she will be shown to the she will be shown to the she will be shown to the she were a shown to the she were a she will be she will be shown to the she were a she will be	months ago and again in "iff found someons start shout for book. If they were a build call the physician and ull code I would keep going ome." Man interview was yee E a nurse, she stated needed on the 3:00 PM tated that during sed advance directives and raining in the last couple of ectives and did a mock and a model of the start of the sta	F1		

signs, call for crash cart. Call another person to

/ /2015 18:38 #054 P.032/054

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 105884 Ċ 8 WING NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX 10 PROVIDER'S PLAN OF CORRECTION (XS) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 155 Continued From page 27 F 155 right away, and if found they were a would stop compressions. During the interview conducted on 5:15 PM with the DON she stated that what she would expect that if a resident was found unresponsive and had a Full Code status the nurse should start She was asked If a nurse should start prior to finding out about order. She stated. "The nurse should know if the resident is a or not before they start . If the nurse starts and finds out the resident is a the nurse can ston That is what I was told during my class. When asked if that was in the facility policy, she stated, " It is not in our policy, so I do not teach that in the in-service classes. " The DON was informed that 3 out of 7 nurses interviewed so far stated they would start when they found an unresponsive resident and then stop found the resident was a She was asked if the facility conducted training since the event. She stated " yes, we started in after the event and we have given in-services again recentiv. " This training covered advance directives. The training is also being done on orientation. She stated, "We did the training for the whole month of we had to get everybody. And then we just did it again. In addition, a Quality Assessment Performance Improvement (QAPI) was started. the day of the event. The Quality Assurance (QA) committee was informed. We did training with the CNAs and nurses and also preformed mock code blues. " When asked if training had been performed in the past, stated, "Yes, the

in-service is done yearly and during orientation. " In addition, the DON was also asked, how the facility audits the employee records for current

CENTERS FOR MEDIC	ALTH AND HUMAN SERVICES ARE & MEDICAID SERVICES			PRINTED: 08/07/201 FORM APPROVE
STATEMENT OF DÉFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	105884	B. WING		С
NAME OF PROVIDER OR SUPPL	IER		STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/2015
EXCEL REHABILITATION	AND HEALTH CENTER	- 1	2811 CAMPUS HILL DR	
			TAMPA, FL 33612	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFO TAG	PROVIDER'S PLAN OF CORRECTY (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	
F 155 Continued From	page 28	F 15		
, she stated	. "When we have new employed	FI	10	
stärting Human i	Resources (HR) sees the card			
and then the AD	The second section			
" When asked if	re supposed to be certified, the facility had audited the			
employee record	s for current , she stated "			
Yes, the ADON a	udits : monthly and HR does DON stated the SS department			
monitors, audits t	he advance directives, and			
reviews ord	ers monthly. The DON stated			
the event had bee	on presented to the Quality			
and plan of corre	committee and an action plan tion was put into place. The			
DON completed t	he Federal report and reported it			1
to the corporate n	urse. The DDN stated "The			1
codes, and file a f	to do education, and do mock			1
	•			i
On at 2	PM, an interview was			
the content of the	NHA and the DON to review training in-services. The NHA			
and DON stated, v	ve went over the following			1
policies: polici	y (which included what to look			1
for, orders as	nd book, where to find the ace Directive policy and Code			1
Blue policy (descri	oed a mock code blue, if staff			
walk in on an unre	Sponsive resident what you			1
would do), and the	Emergency procedure policy. sentation and every nurse			
received a packet.	The expectation was for			1
nursing / CNA staff	to receive training by the first			1
QAPI meeting. By I	he first OAPI we were almost			1
of 8 nurses on	ern regarding interviews with 4 and by the			1
surveyor which reve	aled the nurses would start			
prior to knowing	10 the resident 's code etatus			
was discussed. The	DON stated, "That is not led to do. " The NHA and the			1
DON stated they wo	uld begin retraining the			
	C			1

7-7 - 18:39 #054 P. 7--

CENT	ERS FOR MEDICARE	AND HUMAN SERVICES	_				FORM	06/07/201 APPROVE 0938-039
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		ONSTRUCTION		(X3) DAT	E SURVEY PLETED
		105884	B. WING	:			1	С
NAME OF	PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, I	710.0000	06/	26/2015
EXCEL	REHABILITATION AND	NEALTH CENTER			CAMPUS HILL DR	EIP CODE		
			- 1	TAME	A. FL 33612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION;	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	FION SHOULD THE APPROPE	DP.	COMPLETION DATE
F 155	Continued From pag	ne 29	F 1	er.				
	nursing staff that day			35				
	conducted with the N (CN). When asked w Procedure for advan- last reviewed, the Ch procedure for advan- : was revi- ", after the further stated that the .was also update Blue Roles and Resp	ce directives and were a stated "the Policy and be directives and updated on event with Resident #f. He Emergency Procedure add which included the Code onsibilities.						
: : : : : : : : : : : : : : : : : : :	reviewed for retraining regarding advance discode blue drills. The Nataff with the exceptio unavailable had receive the NHA verified that extern to work until the etraining. On interview etraining, the nurses Policy and Procedures and Emergency Processing Emergency Processing staff members and expensional Emergency Processing Staff members and Emergency Processing Staff members and Staff	ectives, and IIIAA verified that all nursing n of one employee that was red the in-service retraining. It is employee will not y have received the will was confirmed after the were able to verbailize the it. Advance Directives, dure: and Code Blue, cited with 21 out of the 31 on fmembers interviewed bolicy and able to verbailize the						
c	onducted with the NH	PM an interview was A. She was asked how the sure that residents had						

Advance Directives which accurately reflected

PAGE .3/...

3/./ 18:40 #054 F.035/054

CENT	ERS FOR MEDICARE VT OF DEFICIENCIES	AND HUMAN SERVICES			PRINTED: 08/07/201 FORM APPROVE OMB NO: 0938-039
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY
		DESTRUCTION NOT NOT NOT NOT NOT NOT NOT NOT NOT N	A. BUIL	DING	COMPLETED
		105884	B. WING	G	С
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	5
EXCEL	REHABILITATION AND	HEALTH CENTER		2811 CAMPUS HILL DR	
		_		TAMPA, FL 33612	
PREFIX TAG		FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFI TAG	FIX (EACH CORRECTIVE ACTION SHITE	
F 155	Continued From pag	ne 30'			
		first 14 days of admission	F 1	155	
	since Residents #2	and #4 's advance directives			
	had not been addres	sed and they were both			
	recently admitted. S	he stated she met with the			
	SS department and s	said that all residents			
	admitted in the last 2	weeks or since			
	and the reviewed re	garding advance directives dibe documented in the			
	progress notes. Whe	n asked how the facility was			
	going to address blar	iks in the Advance Directive			
	Acknowledgement to	rm she stated the Regional			
	Business office will de	a complete audit of our			1
	admissions for compl	etion; will audit immediately			i
	correctly and complet	ork is being filled out ely.			
	On the fac	cility provided the following letterhead and dated			
	signed by	the NHA:			i
	Social Service: In rega	ards to assuring that			1
- 1	esidents are given the	e opportunity to			1
	iscuss/choose an ad	vance directive, 100% of all			1
	admissions from 6/1/2	015 forward have been or of Social Services and a			
,	cviewed by the Direct	or or social services and a ng same has been added to			
i	hese records as an a	idendum to the initial			
a	issessment done at th	e time of the admission			1
-	dmissions Contract:	n regards to assuring that			1
T.	esidents are given the	opportunity to			1
9	dmissions contracts f	rance directive, 100% of all			1
	ave been reviewed by				
Ċ	oordinator to ensure	completion of all forms			
ir	cluding the advanced	Directive			
~	cknowledgement.				
0		AM an interview was			1
C	anducted with the NH	A and the Corporate Nurse			1
(0	N). They slated they	had initiated an audit on			1

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIED

AND PLAN OF CORRECTION

18:41 #054 P.036/054

DEPARTMENT OF HEALTH AND HUMAN SERVICE CENTERS FOR MEDICARE & MEDICAID SERVICE

(X1) PROVIDER/SUPPLIER/CLI

IDENTIFICATION NUMBER 105884

ŝ		FORM APPROVED
	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	B. WING	C 06/26/2015
	STREET ADDRESS, CITY STATE ZIP CODE	00/20/20/15

EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DO TAMPA, FL 33812 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 413 PROVIDER'S PLAN OF CORRECTION TAG PREEN (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION TAG DEFICIENCY)

F 155 Continued From page 31

all admissions since The SS department revisited each resident and wrote a progress note for each medical record to provide documentation. The Admissions department went through all admission paperwork for residents admitted on forward to make sure paperwork is correct and to review the advance directives section for completion. All incomplete forms were addressed with the resident last night or this morning. The Admissions department has been re-educated by the NHA regarding completion of admission agreement forms, with attention to the resident rights portion and advance directives, including not leaving blanks and having correct dates. The NHA stated she would review advance directive paperwork on all new admissions. They also stated that the Admissions department will do an audit of the paperwork for all admissions for the next three months. They said that after three months they would begin a monthly random audit that would be discussed at the QA meetings. They further stated that at the time of admission. the nurse will verify advance directives and document on a progress note. All new admissions will be reviewed at the daily clinical meeting and advance directives will be a focal point at that time; this will occur on the weekends as well. Social services will continue to assist the resident with development of advance directives and will document on a progress note. They stated that each resident 's advance directives will be discussed at their 14-21 day and quarterly care plan meetings. The expectation is that if a resident wants anything changed between the 14 day care plan and quarterly care plan meetings they will approach the facility staff or if staff notices a change in condition that it will be

F 155

re-addressed with resident

				77015 18:41	#054 P.037/054
CEN	ERS FOR MEDICARE	AND HUMAN SERVICES			PRINTED: 08/07/2015 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		105884	B. WING		С
NAME O	F PROVIDER OR SUPPLIER		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	STREET ADDRESS, CITY, STATE, ZIP CODE	06/28/2015
	REHABILITATION AND			2011 CAMPUS HILL DR TAMPA, FL 33812	
(X4) ID PREFIX TAG		EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEPICIENCY)	
F 155	Continued From pag	e 32	F 1	55	
SS=J SS=J r iii f v o e tt ir tt	reduced to a D. 448.3 10(b)(s) - (10), 4 483.10(b)(s) - (10), 4 RIGHTS, RULES, SE The facility must inform and in writing in a lang understands of his or regulations governing responsibilities during facility must also provinotice (if any) of the S § 1919(s)(s) of the Act made prior to or upon resident's stay. Receig any amendments to it, writing. The facility must informentitled to Medicaid be a defined to the nurse sident's stay. Receigness and services that callity services under thich the resident may their items and services that of or which the resident and services that callity services under the resident may their items and services that of or which the resident we items and services that call the services and services that of the resident we items and services that of the resident we items and services.	to be removed on cope and severity was as 19(b)(1) NOTICE OF RVICES, CHARGES in the resident both orally jugged that the resident her rights and all rules and resident conduct and the stay in the facility. The det the resident with the resident conduct and the stay in the facility. The det the resident with the state developed under Such notification must be admission and during the admission and during the admission and during the state developed under Such notification must be acknowledged in the state of		Resident #1 Expired at the facili 3-12-15. Advance Directives has been discussed with Resident's 1 and #4 6-25-15 and Advance directives have been implemente per their request. All required documents have been signed by resident/responsible party as of 6 26-2015.	#2 ed
at	the time of admission	each resident before, or and periodically during			

Facility 10: 82832

1A:49 #054 B

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDIC STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PRINTED: 08/07/2015

CENTERS FOR MEDICARE	& MEDICAID SERVICES		FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER	195884	B. WING	C 06/26/2015

EXCEL REHABILITATION AND HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR TAMPA, FL 33812

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR I.SC IDENTIFYING INFORMATION) (X4) ID TAG

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

COMPLETION

F 156 Continued From page 33

the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section:

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident , neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

F 156

2. A review was completed for advance directives on this included a review of current full code. physician orders. A review was also be completed by to assure that all residents received in writing their rights to formulate advance directives according to their wishes or that of their respective responsible parties. A Review has also been completed for completion of the Admissions Agreements and will be completed by identified areas of concern have been addressed. All current residents advance directives are being acknowledged per their request.

From:7275521162

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 08/07/201
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-039* (X3) DATE SURVEY COMPLETED	
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NAME O	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/2015
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F 156	Continued From pag	e 34	F 15	6	
	The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to recoalve refunds for previous payments covered by such benefits.		3.	res Not ry 	
initiate in accordance with thei Agreement, on Resident #1, a The resident had a current physician documenting his code status as "Fi meaning that he wanted if foun unresponsive.		by review, review of clinical in with the facility staff, inclined and family it was citify falled to implement procedures for Advanced (for a constant). It was been started to the constant of 81 residents		Directives, Code Blue Roles a Responsibilities on 6-23-15 thru 25-15. Re-education will be provided again and will be completed by The Socia Services Department and Admiss Department has been re-educate on on completion of the Admission Agreement and Documentation in the medical record regarding resident Advance Directives. Education was provide by the Staff Development Coordinator/ODN/ Administrator	6- ions ed
c u le	On Reside presponsive, without ess than 24 hours afte	int #1 was found o pulse or r admission. The Facility es of the resident to be		and Nurse Consultant. When a resident is admitted to the facility the Licensed Nursing staff will	

services to prolong his life.

. The facility failed to honor Resident

#1 's advance directives and denied the resident

the opportunity to receive emergency lifesaving

inquire with the

Facility ID: 62932

resident/responsible party if they

have current advance directives. If

From:7275521162

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CEN	ERS FOR MEDICAR	AND HUMAN SERVICES & MEDICAID SERVICES				APPROVE
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F 15	Continued From pa	ge 35	F 1	56		
Additionally, the facility failed to implement the Advance DirectIves policy for 2 (#2, #4) of 8 sampled residents out of a total of 28 residents listed as full code and recently admitted (after 1, 2015). Residents #2 and #4 wished to have a 1 but it was documented as a full code in their medical records. The failure to honor and carry out the expressed wishes to receive resulted in findings of Immediate Jeopardy which were removed on and the severity and scope was reduced to D. Findings Include:			the resident has advance directi and the copies are available the be placed in the medical record implemented. If copies of the resident's advance directives are available the nurse will request tresident/responsible party to provide copies to the facility at the ariliest convenience. Resident wishing to implement advance directives will be referred to the Social Services department for further discussion. The nurse will document in the resident's medicine record that this discussion has tax place. Admissions will be reviewed	y will and not he neir		
,	policy statement: "A respected in accorda facility policy." Policy Implementation, sead admitted to our facility Director (SSD) or des information to the reserright to make decision including the right to a surgical treatment, an advance directives." admitted to our facility inquire of the resident, nembers, about the e dvance directives."	April 2008), revealed a dvance directives will be noe with state law and retreet in the presence of the properties of th		the Daily Clinical Meeting to assurt that the resident's advance directives have been addressed by the facility per their request and than y follow up has been completed. Current residents who do not have advance directives will have a rediscussion at their quarterly care reviews.	e	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED 105884 B. WING NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG COMPLETION DATE: DEFICIENCY F 156 Continued From page 36 F 156 governing advance directives, our facility has defined advanced directives as preferences 4. This area of care will be monitored regarding treatment options and include, but are -Indicates by the DON/Social Services not limited to: b. that, in case of Director/Admissions Coordinator 10 fallure, the resident, legal guardian, health care proxy, or weekly times four weeks and then representative (sponsor) has directed that no monthly times three months. This (. . .) or other will also be over seen by the life-saving methods are to be used " Administrator and the QAPI A review of the facility policy: " Emergency Committee. Procedure:) " (Revised 2011), documented the policy statement: "Personnel have completed training on the Initiation of 1/Basic Life Support (BLS) in victims of sudden Policy and Interpretation and Implementation: " is defined as inadequate resulting in insufficient flow throughout the body (pulselessness), 2. Sudden (SCA) is a leading cause of in adults. 3. Victims of : many initiatly have pasping or may even appear to be having a . Training in BLS includes recognizing the presentations of SCA, 4. The likelihood of recovering from SCA due to an acute event (such as) differs substantially from the likelihood of recovering that the end result of multi-system failure and advance irreversible or conditions. 5. Depending on the

may be increased if

underlying cause, the chances of surviving SCA

upon collapse. 6. Any unnecessary interruptions in chest compressions (including longer than necessary pauses for rescue breathing)

reversible situations, early delivery of a

Facility ID: 62932

is initiated immediately

effectiveness. 7. In potentially

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	De	ermine if the residen	t has existing advance					- 1

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DEPARTMENT OF HEALTH	AND HUMAN SERVICES			POINTED: SOME
CENTERS FOR MEDICARE	& MEDICAID SERVICES			PRINTED: 08/07/2015 FORM APPROVED
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T		OMB NO. 0938-0391
AND PLAN OF CORRECTION	DENTIFICATION NUMBER	A. BUIL	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	105884	B. WING	1	c
NAME OF PROVIDER OR SUPPLIER				06/26/2015
EVCEL BEHARM PARISH			STREET ADDRESS, CITY, STATE, ZIP CODE	
EXCEL REHABILITATION AND	HEALTH CENTER		2811 CAMPUS HILL DR TAMPA, FL 33612	
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES			
	MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		10.00
F 156 Continued From pag	- 10			
disenting Man 1 M	Je 39	F 1	56	ł
onectives. It so, mitte	ate the process of obtaining a			1
resident with informa	record. If not, provide the ation on his/her right to have			1
advance directives a	nd initiate the process of			
establishing them. "	Documentation: "the			1
following information	should be recorded in the			1
resident 's medical r	ecord: 3. All relevant			i
assessment data obt	ained during the procedure.			
				-
2 Bentannet de Bant				
2. Review of the Resi	page 31 of 39 Advanced			į
Directives Acknowled	gement with the following			1
(anguage:) understan	nd that I do not have to sign			
or implement an Adva	anced Directive in order to			1
be a resident at this h	lealthcare Center, I			1
understand that I may	implement an Advanced			1
Directive at any time of	during my stay in the facility			ì
It is also my understar	nding that I may ask at any			
time to review Advance	ed Directive information or			
my Advanced Directive	e (s) and ask questions (1
may have concerning	them. I may revoke any			1
made Lunderstond th) at any time that I have			1
give legal advice, but of	e facility 's staff cannot			
concerning Advanced	Directives I have the			
following designations	(s) and my copies have			
been provided to Healt	th Care Center. A line was			1
drawn through the blan	k spaces in front of all the			1
choices which were: Li	ving Will or Direction to			1
Withhold Life Sustainin	g Procedures,			
1	Yellow HRS Form			1
Health Care Surrogate	Health Care Proxy,			ì
Ourable Power of Attor	ney, Financial Power of			1
Attorney, Medical Power	er of Attorney, Guardian			ŀ
Financial or Medical, A	natomical Gift, Other;			ł
Selection The form we	Incapacity, Funeral Home			-
Sciection, The form wa	s initialed by the resident			ì

7-17 18 19:47

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 105884 B. WIME NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY STATE ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRESTA TAG PLETION DATE TAG DEFICIENCY) F 156 Continued From page 40 E 156 Review of the resident 's Admissions paperwork revealed a second form titled Advanced Directives Acknowledgement (no page number) with the Residents initials beside the sections 1. I have been given written material about my right to accept or refuse medical and surgical treatments and my right to form Advanced Directives, 2, I understand that I am not required to have an Advanced Directives in order to receive medical treatment at this health care facility and 3. I understand that the term of any Advanced Directives that I have executed will be followed by the health care facility, physicians and my caregivers to the extent permitted by the law. The form continues with: Please Check one of the following statements: I have executed an

Review of Resident #1 's medical record revealed the resident was discharged to the hospital on and readmitted to the facility on i. His admission paperwork did not include documentation that his Active Medical Decision Maker, his father, was given information on Advance Directives. There was no " Advanced Directives Acknowledgement 1 form in the admission paperwork for the resident 's

Advance Directive and will provide a copy to the facility. I understand that the staff and the physicians at this facility will not be able to follow the term on my Advanced Directives until I provide a copy of it to the staff; or I have not executed an Advanced Directive and do not wish to discuss Advanced Directives further at this time. The spaces to check either statement were blank. The form was signed by the resident and the Admissions Representative Employee H and

readmission to the facility.

dated

08/ .7. .5 18:48 #054 P.046/054 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 105884 C B. WING NAME OF PROVIDER OR SUPPLIES STREET ADDRESS, CITY, STATE, ZIP CODE FXCEL REMABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33812 (X4) IO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION In TAR PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG COMPLETION DATE DEFICIENCY F 156 Continued From page 41 F 156 Review of Resident #1 's physician orders dated revealed a Code Status of Full Code Review of Resident #1 's medical record revealed the resident was discharged to the hospital on and readmitted on (Wednesday). His admission paperwork did not include documentation that his Active Medical Decision Maker, his father, was given information on Advance Directives. There was no "Advanced Directives Acknowledgement " form in the admission paperwork for the resident 's readmission to the facility. Review of Resident #1 's complete medical record including the closed record revealed no) form was present. Review of Resident #1 's closed medical record, to include demographic / face sheet, indicated he was initially admitted to the facility on readmitted on and most recently readmitted to the facility from the hospital on for skilled services with diagnoses that included but not limited to:), and neview of the Physician's Order Sheet (POS) dated and signed by the physician on revealed under Special Needs; Code Status: "Full " (handwritten). Per the hospital discharge summary for Resident #1 dated : Patient was a admitted to the emergency the hospital

with acute

(Healthcare-associated

Facility ID: 62932

failure, HCAP

) and

. VRE /

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#054 P.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0936-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER (X3) DATE SURVEY A BUILDING COMPLETED 105884 C NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS. CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL 1D PROVIDER'S PLAN OF CORRECTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAC COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 156 Continued From page 42 F 156 -resistant 1. During his hospital stay, a consultation was performed on due to having noted stools that were positive for occult Laboratory data revealed hemoglobin of 8.5 and a platelet count of 335 indicating the patient was with occult () loss. The patient did not show any signs of active at the time. Recommendations included continue tube feedings as tolerated; monitor the hemoglobin and transfuse on an as needed basis. Resident #1 was discharged from the hospital and transferred to the skilled nursing facility on A review of the Nursing Admission Evaluation Tool dated at 3:00 PM revealed: patient arrived via stretcher from hospital with . The resident has advance directives upon admission? NO. Are advance directives in the chart? NO. Activities of Dally Livina: required for bed mobility; transfers; dressing; and personal hygiene. Alert to person and non-verbal, skin pale, warm and dry. Patient not verbal with this nurse, but can make faces for pain, regular and audible, pulse rate equal and Breath sounds clear. in place. Has referrals for Physical Occupational and Speech Signed by Employee C. a Licensed Practical Nurse (LPN) A review of Resident #1 's medical record, Social Service Admission Evaluation Tool document at 5:32 AM (Thursday) included the following Information: the resident was

08/07/2015 18:49 #054 P.

CENTERS FOR MEDIC	ALTH AND HUMAN SERVICES ARE & MEDICAID SERVICES			PRINTED: 08/07/201 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MU A. BUILL	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	105884	B. WING		C
NAME OF PROVIDER OR SUPP	JER .			06/26/2015
EXCEL REHABILITATION	AND HEALTH CENTER		STREET ADDRESS. CITY, STATE, ZIP CODE 2611 CAMPUS HILL DR TAMPA, FL. 33612	
	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC (DENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S DI ANI OS COCIDE	
F 156 Continued From	page 43	F 1		
marmis for it you questions the capital letters, Didectives? INCA PROXY ON CI-M. Elegal representation is name and pho resident is name and pho resident is not established and the capital is name and pho resident is code: Electronically sign. A review of the Ac (MDS) assessment for M memory. memory problem. Decision Making: Section D (Mood); appearing down, dialling or staying at Feeling tired or han concentrating. Und Status): assistance requires total dependence represonal hygiene. Bowel): Always Under Section I (Ac and untrinound statupounds; loss of 15% loss of 15% oss os 15% oss os 15% oss of 15% oss os 15% oss of 15% oss os 15% oss of 15% oss os 15% oss of	Patterns). Staff ental Status: Short term problem. Long term memory: aktills for Daily severely . Under Staff Assessment: feeling or epressed, hopeless. Trouble sleep or sleeping too much: ring fittle energy. Trouble der Section G (Functional of one person for bed mobility and dreasing: aquired for esting and Inder Section H (of howell and			

Fram:7276521162

18:50

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DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES			DD (ACT)	ED: 08/07/20
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			FOR	RM APPROVE
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDERSUPFLIERICLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	OMB N	IO. 0938-039
		105884	1		"	C
NAME O	PROVIDER OR SUPPLIER	703004	8. WING		ه ا	6/26/2015
			ı	STREET ADDRESS, CITY, STATE, ZIP CODE		0/20/2015
LACEL	REHABILITATION AND	HEALTH CENTER	- 1	2811 CAMPUS HILL DR		
(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES		TAMPA, FL 33612		
PREFIX		MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
F 156	Continued From pag	e 44		-		
	AM: " this nurse call	ed to Certified	F 15	6		
	Nursing Assistant (Ci	NA). Resident noted with no				
	, puise or	Noted large				
	amount of frothy salis	a on face and cheef Unear				
	extremities cool to to	service, return call received				
	from (covering physic	ian) Order received to				
	release body. Call to 1	amily (Mother) name of				
	Tuneral home received	. Family declined to come				
	Nursing (ADON).	the Assistant Director of				
	Further review of Resi	dent #1 's medical record				ı
	revealed a document i	itled Activated Medical				- 1
	Decision Maker signat	by the resident's father				1
	The docum	ised by two signatures on ent included the following				
	language: The Determ	ination of incapacity form				i
	nas been completed or	1 I do hereby				I
	attest that I am at least	or older				- 1
	and am willing to become	me involved in the above				1
ì	maintained repular con	th care decisions. I have fact and am familiar with				
	ne resident 's activities	s health religious and				- 1
F	noral beliefs, so that I a	can make health core				1
	lecisions, including with	holding/withdrawing life				- 1
p si	rolonging decisions the	at would be the decisions				
W	illing to produce clear	e made, if capable. I am and convincing evidence				
u	pon request. I underst:	and that my role has				
٥	ecome active and acce	an my responsibility				
w	nich is one of the follow	wing Medical Decision				- 1
Pi	aker designations: che arent of the resident.	cked were Proxy and A				

Review of Resident #1 's medical record revealed a Determination of Incapacity document

and signed by his attending

From:7275521182

08/. V . 3 18:50 #054 P. V___.

STREET ADDRESS. CITY. STATE 2P CODE AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIES EXCEL REMBILITATION AND HEALTH CENTER TAG BUILDING CROSS. REFERENCED TO THE APPROPRIATE F 156 CONTINUED FOR DAYS THE PROPERT OF DEFICIENCIES OF PROVIDER OR AND PLAN OF CORRECTION RESULATION TO FLAS DEPARTMENT OF DEFICIENCIES A Intending physician for the above stated resident (Resident #1). I have evaluated and determined the above stated resident lacks the capacity to give informed consent to make medical decisions and does not have the reasonable medical probability of recovering mental and physical capacity to directly exercise rights. On at approximately 5:00 PM an intenview was conducted wit stelephone, with Employee A stated share was making owneds before she went home and found Resident #1 not breathing. She called for the fastient Employee A stated that the ADON did not do ()) on Resident #1 and that she did not recall anything else about the resident. On at 1:00 PM an interview was conducted with the ADON did not do ()) on Resident #1 and that she did not recall anything else about the resident ADON stated, I was working the night shift, I had finished medication pass and around 5:45 AM, the CNA was in the hallway and said, "I think he is gone." I went in Resident #1 in his upper	DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 08/07/201
AND PLAN OF CORRECTION DENTIFICATION NUMBER 105884	STATELIEN	OF PERIODICANO	A MEDICAID SERVICES			FORM APPROVE
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Resident #1 and that she did not recall anything else about the resident. On at 1:00 PM an interview was conducted with the ADON, the nurse assigned to the resident when he DN, the nurse assigned to the resident when he . She stated that she was taking care of him for the first time on a he took a shift because another employee called off. She stated the resident wasn i vertal. he required total care and had been readmitted from the haspital that day. When asked to recall the events that happened on the call the events that happened on the ADON stated, I was working the night shift, I had finished medication pass and around 5:45 AM, the CNA was in the nallway and said, "I think he is gone. I went in Resident #1 to the call the event finished medication pass and and said, "I think he is gone. I went in Resident #1 to	Fr	nninues A stated the	ald, "He was gone,"			1
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conducted with the ADON, the nurse assigned to the resident when he . She stated that she was taking care of him for the first time on			M an interview was			ı
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asked to recall the events that happened on the day Resident #1 the ADON stated, I was working the night shift, I had finished medication pass and around 5.45 AM, the CNA was in the hallway and said, "I think he is gone. I went in Resident #1 s checked thing for rules and the said."	****	erbai, ne required to	tal care and had been			1
the ADON stated, I was working the night shift, I had finished medication pass and around 5:45 AM, the CNA was in the hallway and said, "I think he is gone. I went in Resident 41 is checked thing for wife medication in the said of the	200	ed to receil the	pital that day, When			1
the ADON stated, I was working the night shift, I had finished medication pass and around 5:45 AM, the CNA was in the hallway and said, "I think he is gone. I went in Resident #1 's checked him for rules and the control of the	651	neve and received	is that happened on			į.
nai ninshed medication pass and around 5.45 AM, the CNA was in the nailway and said, "1 think he is gone. I went in Resident #1 's	the.	ADON stated I was	working the sinks at it.			
AM, the CNA was in the hallway and said, " ! think he is gone. I went in Resident #1" s	nad	finished medication	hace and around five			I
Checked him for rules and	AM.	the CNA was in the	hallway and sold " !			1
CRECKED him for oules and						1
very cool to touch. He felt a little stiff in his unper	cnec	CKRD him for nules a	ad L. '			i
	very	cool to touch. He fe	it a little stiff in his upper			

./ - /2015 16:51

#054 P.051/054

DEPARTMENT OF H CENTERS FOR MED	ICARE & M	HUMAN SERVICES EDICAID SERVICES			PRINTED: 08/07/201 FORM APPROVE
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105884	B. WING		c
NAME OF PROVIDER OR SUI	PPLIER			STREET ADDRESS. CITY, STATE, ZIP CODE	06/26/2015
EXCEL REHABILITATIO				2811 CAMPUS HILL DR TAMPA, FL 33612	
		T OF DEFICIENCIES BE PRECEDED BY FULL ITIFYING INFORMATION)	PREFO TAG	PROVIDER'S BLANCE CORDER	
F 156 Continued Fro	m page 46		F 15		
extremities, Hi	is lower extr	emities had sort of	F 16	00	
4	The resident	had white feether nower			
atoung his mo	uth. There v	was nothing I could do			
iornim." Whe	n asked if s	he looked at the chart			
tora orda	er, she state	d I looked at his show			
arter i called th	e doctor to	tell him the resident			
nao landi	didn't see.	3 Honosthumbon			
I saw me reside	ent after the	CNA called me he			
was cool to fou	ch. I don ' t	know if there was			
anything I could	do for him	At that point I made			
the decision to	not code hir	n: because he was			
and strit; I	did not knov	v how inno he had			
been like that. T	he physicia	n covering for the			
attending physic	dan was cal	lled, and informed of			
the resident is	. The A	ADON was asked if			1
she saw a	order on the	e medical record eta			i
stated, after lo	oking at the	chart no " Whon			1
asked it she had	received tr	Bining on how to			i
respond when a	resident is:	found without vital			i
signs she stated	. We are sur	prosed to do chart			ĺ
compressions as status.	nd send son	neone to check on			
	wns acked	if she knew how to			1
determine code	platue cho	stated, if a resident is			1
unresponsive I a	SID SUDDOCA	d to check the pulse			1
and call for some	tone also to	check the chart for			1
orders I wil	la call code	blue and bring the			
trasn cart. We ha	ave a vellou	pook at the nurses .			1
station with all the	form	s. If the resident is a			1
		essary to look in the			1
chart. When ask	ed how the i	rures is notified at a			1
resident s advan	ce directive	s ipriudina			1
sne states, "It is	the nurse 's	e responsibility to			
cneck the chart of	1 EVERY PESIC	dent so they know			1
status, " If s	ameone fini	de camacan			1
unresponsive, the	v have to wa	ait until compone			1
checks the yellow	book or the	charl to can if they			j
are ornot v	Vhen asked	what she would do			1
in non-di-		SILE MOUIL GO			

Event ID: JSOX11

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DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 08/07/2015
OTATION.	AS FUR MEDICARE	& MEDICAID SERVICES			FORM APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	LIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105884	B. WING		c
NAME OF	PROVIDER OR SUPPLIER				06/26/2015
EVORE	NEW 2011			STREET ADDRESS. CITY, STATE, ZIP CODE	
EXCEL	REHABILITATION AND	HEALTH CENTER		2811 CAMPUS HILL DR	
(X4) ID	A10			TAMPA, FL 33612	1
PREFIX	(FACH DESIGNAL	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	Ð	PROVIDENCE PLANT	
TAG	REGULATORY OR LS	MOST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	TAG		
F 156	Continued From pag	e 47			
		here is no Advance directive	F 1	56	1
	Sine stated " Lucust	do a Code. " When asked if			- 1
	she had had any troit	ning since the event, she			
	stated yes, one-on or	ne with the Director of			1
	Nursing (DON) on	advance directives.			i
	Code Blue, and mack	drills. The DON reviewed			
	with me when we are	supposed to do a code.			- 1
	mon me	supposed to do a code.			į.
	On at 19:44	PM, a telephone interview			1
١	Vas conducted with R	esident #1 's father. He			1
	lated his son was in	the Marines; he got an			1
á	neurysm in there and	had to have surgery. He			
	tated the resident live	ed by himself for a while,			1
ē	nd then he started by	ing with his girlfriend. He			1
v	ent to the hospital on	ing with his girithend. He id they sent him to the			
n	ursing home. When a	o mey sent nim to the			
e	xpecting his he	stated, he "could not			1
č	are for him anymore	that 's why he went to the			1
D.	ursing home " He w	as wearing diapers and			1
C	ouldn't drass himself	anymore, "I couldn't			
h	andle him enumers "	He went to the hospital			
ar	nd then the nursing by	ome; he "was in and out			1
of	the nursing home. "	I think he was in and out			1
ho	spital, no, the nursing	home last			1
sc	metimes. Loculdo 11.	do amidhina with till a si			1
wa	s having problems by	eathing, they put him on			
	. The last time I	saw him he was in the			
no	Spital, and then some	one called and said he			1
wa	s ;	Cite cause and said 10			
On		M an interview was			1
cor	iducted with Employe	P.G. a Social Social			ļ
AS	istant regarding Resi	dent #1 ' e Social Camilla			1
					1
tim	9d 5:32 AM, approxim	nately 13 minutes prior to			i
					1
stat	ed he probably filled i	n the information based			- 1
on a	rior admissions. He	stated he was going to			İ
spe	ak with the resident	s family and he			

31-7 18:53

#054 P. ./... DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (XZ) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING COMPLETED 105984 c B. WING NAME OF PROVIDER OR SUPPLIED 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX IQ PREFIX REGULATORY OR LSC IDENTIFYING INFORMATIONS TAG TAG COMPLETION DEFICIENCY F 156 Continued From page 48 F 156 confirmed that the resident had a health care proxy and a Determination of Incapacity. He confirmed that the resident was a Full Code on previous admissions and remained a Full Code because there was not a signed in the medical record. He stated that his plan was to call the family and inform them of their right to formulate an advance directive for the resident. He further stated that the facility procedure in regards to advance directives required the Admissions Department to speak to residents on admission, advance directives are then addressed in the Nursing Admission Assessment and the Social Services Department reviews the Information with the resident and/or the family. On at 1:20 PM an interview was conducted with the Social Services Director (SSD) regarding Resident #1. Per the SSD, she sooke to the resident's father on he was readmitted on . She confirmed that his parents were making the decisions regarding his care and were designated as his Activated Medical Decision Makers at that time. She stated that the father was given information in regards to formulating an advance directive. SSD states, "If he wanted him to be a would have mailed him the paperwork." She also stated that she had not spoken to the father when the resident was admitted on She stated that the resident was designated as a Full Code since his original admission in 1 of 2014 and had never had a paper in his medical record.

Facility ID: 62932

, the day Resident

at 5:00 PM an interview was conducted with the Nursing Home Administrator (NHA). When asked if she could recall the events

#054 P. ... /__.

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 08/07/201
	ERS FUR MEDICARE NT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO	TIPLE CONSTRUCTION	FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		105884	B. WING		С
		HEALTH CENTER EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR TAMPA, PL 33612 PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCES TO THE APPRI DEFICIENCY)	
or residence of the second of	#1 she her river to the control of t	stated the DON informed ad found the resident I not perform : The NHA	F18	66	

conducted with the Medical Director, When and If his expectation was for a nurse to perform on a Full Code resident, he stated, should be done. He has been the Medical Director for almost 4 years. If the resident was unresponsive they have to do ... Code Blue is

residents. "

From:7275521162

.../_..7 17:\$4 #065 P.___/_

		AND HUMAN SERVICES				ED: 08/07/2019 RM APPROVED
		& MEDICAID SERVICES				VO. 0938-039
TATEMEN IND PLAN	ITATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			JLTIPLE CONSTRUCTION DING	(X3)	DATE SURVEY COMPLETED
		105884	B. WING	3	1.	C 06/26/2015
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZI	PCODE	
EXCEL	REHABILITATION AND	HEALTH CENTER		Z811 CAMPUS HILL OR TAMPA, FL 33612		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	IX (EACH CORRECTIVE ACTIO	ON SHOULD BE HE APPROPRIATE	(XS) COMPLETION DATE
	interview was conductated in the visual resident had multiple issue (), and he was thin and lood a patient. He was thin and lood a patient. He was the was not called was conceived by when the Normally if a patient would be converted with the was not called and the work of the was not called and the work of the was not called with the was not called with the was not called the was not called the was not considered with the was not considered with the was not considered. She state the was a full Companies when asked was a full Companies was a full Companies with the was a full Companies. When asked considered was a full Companies was a full Companies with the was not considered with the was not con	proximately 10.00 AM, an order with Resident #1 is. The physician stated the a problems including; multiple 4. The physician stated the a problems including; multiple 4. If the did not look well at all. led 90. He was new to me as ck and forth to the hospital. I by he the physician if found out the next day or led tuneral home called me. The does not have a more than the chart. The chart. PM, a telephone interview he covering physician who writing Resident #1 on but doesn't she stated she covers 1000 if she was informed the ode and he was not ed., "I apologize, but I don't ed.,"	F1	1156	,	
1	liagnoses that include ematoma, hronic kidney					
d C	ated reviewed reviewed rectives Acknowledges rectives Acknowledges rectives and rectives and rectives rectives and rectives and rectives rectives and rective and rective	4 's Admission Agreement, ealed an Advanced pement form signed by the All the blank lines on the Ify that the daughter had				

1/

08/.../ - 17:55 #056 P. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 08/07/2015 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED 105884 B. WING NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REMABILITATION AND HEALTH CENTER 2811 CAMPUS NILL OF TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX ID TAG COMPLETION TAI DEFICIENCY) F 156 Continued From page 51 F 156 received the information and designating a choice of Full Code or were not filled in. Review of the resident 's medical record revealed an undated Physician Order Sheet page 1 of 2: under Code Status, there was a blank line. Neither Full Code nor written on the line provided to designate the Code Status. at 12:20 PM an interview was conducted with Resident #4 's daughter, When asked if the facility had spoken with her regarding her father 's advance directives, she stated, no no one had spoken with her on admission or on She stated she took ner rather to the hospital on and the staff at the hospital spoke with her about advance directives due to his condition. The hospital physician stated we may need to think above /DNI. We (the family) discussed the the weekend after his visit to the hospital. We decided that a order is what we wanted; we want him to be comfortable. I would like to respect his wishes. Review of Resident #4 's medical record, on , since admission (revealed there was no form in the record Review of Resident #4 's Admission Evaluation Tool dated (Sunday) (admission date of) revealed: arrived via wheel chair from hospital; diagnosis included

hematoma and chronic kidney

girectives - NO; resident appears to be capable of making healthcare decisions at this time; only

advanced

#055 P. ./. .!

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105884	B. WING		C 06/26/2015	
	PROVIDER OR SUPPLIER REHABILITATION AND	HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR TAMPA, FL. 33612		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		D BE COMPLETION	
F 156	dressing, tolleting a pale, warm and dry, assist of 1 with transmechanically alterer and situation; patier per family, diagnosis years; rate reg bowet, no pain, limit, side rais for bed moran LPN. Review of the Resid	or bed mobility, transfers, ind personal hyglene; skin is has poor balence and needs sfers and ambulation; diet, alter to person, place to long term memory not good to off for several puter, continent of and assist for ambulation; 1/4 biblity, signed by Employee C,	F1	56 .		

Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 6: indicating severe

Review of the Social Service Admission Evaluation Tool dated (Monday) revealed: male born in Puerto Rico, Ilved In

Puerto Rico until when came to live with other daughter; no advanced directives on file at this time; Full Code; family visits daily; planning for Long Term Care

A review of the nursing progress notes revealed the following relevant entries. at 2:47 PM: patient admitted via wheelchair from hospital; patient transported by family. Alert and oriented x 2; Speaks Spanish only: Daughters at bedside.

Further review of Resident #4 's medical record revealed the resident went back to the hospital for a follow up visit on and spent one night there. The record included a document of a verbal report given to the facility nurse from the hospital nurse titled "Nurse to Nurse". It included the following documentation. (Saturday, 8 days after admission) "the resident"

FORM CMS-2967(02-99) Previous Versions Obsolete

Event ID: JSQX11

Fecility IO: 62932

If continuation sheet Page, 53 of 213

-21-1	 17:57	#055	₽.

DEPARTMENT OF HEALTH AND HUMAN CENTERS FOR MEDICARE & MEDICAID			PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEPICIENCIES (X1) PROVIDERS AND PLAN OF CORRECTION IDENTIFICAT		MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5884 S. W	ING	C 06/26/2015
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY.	STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENT	ren	2811 CAMPUS HILL DR	
EXCENTIONALITY OF AND REALTH CEN	IER	TAMPA, FL 33612	
(X4) ID SUMMARY STATEMENT OF DEFIC PREFIX (EACH DEFICIENCY MUST BE PRECED TAG REGULATORY OR LSC IDENTIFYING IN	DED BY FULL PR	ÉFIX (EACH CORREC AG CROSS-REFEREN	PLAN OF CORRECTION (X8) TIVE ACTION SHOULD BE COMPLETION ICED TO THE APPROPRIATE DATE EFFCIENCY)
F 156 Continued From page 53		F 156	
s name ", /Do Not Intubate (130	
Diagnoses, fatigue, low hemoglobi			
, chronic kidney			l
	nic. 2 units of		
, alert, oriented.			
	r admission), , with a , with a red with his imited English, kin has some noted; nurse with for bone w of the nurse wof the nurse solo: attending sor. admit. No		
On at 1:00 PM (Thursda after admission and 5 days after ret overright stay at hospital): an inter-conducted with the NHA, the DON; Corporate Nurse (CN). The NHA, the DON is corporate Nurse (CN). The NHA which the CN were shown Resident 44 is agreement packet, including the AdD piractives Acknowledgement form, vines. The NHA verified that the admission agreement packet was without any blanks. The NHA verified admissions representative was responsible for not be admissions representative was suppreview the advance directive acknowledgement advance directive acknowledgement and the control of the contr	urning from few was and the e DON and admission ranced with blank issions raking sure s complete that the ssed to		

with the resident and or family member regarding the resident 's wishes and to protect their

DEPAR	TMENT OF HEALTH	AND HUMAN SERVA	CES				Pi	RINTED:	08/07/2015 PPROVED
CEIAIL	INS FUR MEDICARE	& MEDICAID SERVICE			_		0		938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMB	CUA IER;	(X2) MU A. BUILD		ONSTRUCTION		(X3) DATE : COMPL	SI MANUAL V
		105884		B. WING				С	
NAME OF	PROVIDER OR SUPPLIER			·	PTDE	ET ADDRESS. CITY, STATE, ZIP CI			
EVer		,					DDE		
CAUEL	REHABILITATION AND	HEALTH CENTER		ı		CAMPUS HILL DR			
(X4) (D	C) Shippers				(AM	PA, FL 33612			
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FU		ID		PROVIDER'S PLAN OF COR	RECTION		(95)
TAG	REGULATORY OR LE	C IDENTIFYING INFORMATIC	IN)	TAG	×	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)			DATE
F 156	Continued From pag	ne 54		F 1					
		n asked if a resident w		F 1	56				- 1
	admitted on Friday n	light, Saturday or Sund	28						- 1
	the nursing staff wer	e supposed to discuss	аул						
	advance directives w	ith the resident and or	familie						- 1
	the NHA stated, ves.	Also informed the facil	libritsy,						- 1
	staff that per intervier	w with Resident #4 's	n.y						- 1
	daughter, she stated	. no one has spoken w	th her						- 1
	regarding advance di	rectives, and that her							- 1
	brother in Puerto Rio	o is the medical Power	of						i
	Attorney (POA). The	NHA, DON and CN							
	confirmed that the	/DNI were included i	n the						- 1
	progress notes and n	urse to nurse note. The	e						- 1
	NHA stated that they	should have the medic	al						- 1
	POA information in th	e record if there is one	The						
	Corporate Nurse state	ed, "We have 5 days	o						- 1
9	discuss advance direc	ctives during the							- 1
	assessment period."	The NHA stated that S	35						
	should be documenting	ng discussions regardin	ig						
3	invance directives in	a progress note. On re	view						- 1
	hat for Besides #4	ess notes it was revea	led						1
6	rom SS in the progress	ere was no documenta as notes, the NHA verif	ation						ľ
ti	nis.	ss notes, the NHA vert	led						
	on at 1:49	PM an interview was							1
¢	onducted with the SS	D. SSD was informed	the						- 1
3	dvance directives ack	moviednement form in	1						- 1
R	esident #4 's admiss	ion agreement nanket	woe						- 1
bi	ank. She stated, "W	ell I wouldn't know the	at."						- 1
٥			ĺ						1
		oximately 3:30 PM an							
et et	coview was conducte	d with Employee G. H.	B						- 1
D:	and the 35 department	artment spoke with the 4 and she wants to be							1
he	aith care proxy and h	and she wants to be							1
he	r father Employee C	have a initiated for stated they are getting							1
the	paperwork together	and writing on the	}						1
inc	capacity certification f	one waiting on the							1
	-p	rom trie brigateian.							

/-.7 . 17:58 #055 P.007/051

CENTERS FOR N	EDICARE	AND HUMAN SERVICES				FOR	ED: 08/07/201
STATEMENT OF DEFICIE AND PLAN OF CORRECT	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION	(X3) E	IO. 0938-039 PATE SURVEY OMPLETED
		105884	8. WING			- 1	С
NAME OF PROVIDER OF	SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL REHABILITA	TION AND	HEALTH CENTER		281	1 CAMPUS HILL DR MPA. FL 33612		
PREFIX (EACH	DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION:	ID PREFIX TAG	(PROVIDERS PLAN OF CORRECTIVE ACTION SHO CRREFERENCED TO THE APPLOEFICIENCY)	MAGRE	COMPLETION DATE
revealed a dated admission from overn Service Dr. Assistant w daughter at daughter st directives a her siblings advanced () orde Resident #4 discussed was agreed was agreed was agreed was agreed was foren and order. 4. Review of revealed she review of revealed she on medical advi	Resident (a) and (b) a	#4 's medical record #4 's medical record #4 's medical record #4 's medical record #5 PM (13 days after #6 PM (13 days after	F1	56			
Review of the	resident '	s medical record					- 1

revealed a 2015 Physician Order Sheet.

Fro :7975521162

J_7 . 17:59 # P.008/051

STATEMEN	T OF DESIGNACIES	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
14147.44		105884	B. WING		C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/2015
EXCEL	EHABILITATION AND	HEALTH CENTER		2811 CAMPUS HILL DR	
(X4) ID	CI MALANDA OTTO	EMENT OF DEFICIENCIES		TAMPA, FL 33612	
PREFIX TAG		EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT) (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	B 04 (A2)
F 156	Continued From pag	e 56	F 1	56	
	Neither Full Code no	here was a blank line, r were written on the mate the Code Status.	r 1.	50)
t c a s s n R sin	AM an interview was 2. She was observed bedside. When the re wishes for if nee wishes for if nee wishes for if nee wishes for if need and he receives, she stated, bout that. "When as he stated, "don't w y family to suffer thir aview of the Resider noe admission revea the record.	ant that, " "Don't want ough that, " t #2's medical record led there was no form		÷.	
hoo was ba see Dir Rec Eva stree state adv	st admission) reveals of dated 'History cold dated 'History spiral', weight 94 pool it assist with because it says that weight 94 pool it will bring; assistive device the says assistive device of Resident #2 and admission) reversituation Tool dated to be post ance directives - no a	via stretcher from dist height, 5' 6"; alert; i mobility, transfers, ng, personal hygiene and ewith a walker. The an Donor and Advance re all blank. s medical record (for her aled an Admission			

#055 P

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/ . / . . . 17:59

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING c 105884 a wind NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ces PREFIX COMPLETION TAG DEFICIENCY F 156 Continued From page 57 F 156 independent in bed mobility. Extensive assistance for transfers, dressing, toileting, personal hygiene: on upper arms: alert and oriented x 3. Review of the resident 's Data Sel (MDS) assessment revealed a Brief Interview of Mental Status () score of 13 indicating the resident was intadt. Review of Resident #2 's medical record (for her first admission) revealed a Social Services Admission Evaluation Tool assessment dated at 4:09 PM: lived with granddaughter for many years; no advanced directives at this time: resident makes her own decisions at this time: full mood; anticipated length of stay for 2 to 4 weeks, signed by the SSD. Review of Resident #2 's medical record (for her second admission) revealed a Social Service Admission Evaluation Tool dated PM: female; no advanced directives at this time: resident makes her own decisions at this time; full code; mood; anticipated discharge 4 weeks to home with son and daughter-in-law, signed by the SSD Review of Resident #2 's medical record revealed a nursing progress note dated at 6:58 PM: resident admitted from hospital with admitting diagnosis of weakness , status post 1, luna . Data collection stated findings as follow: old and new noted on the upper extremities and lower

extremities lung sounds clear to auscultation: bowel sounds heard all 4 quads; abdomen non-distended oriented to

. signed by the

#055 P -/ 1 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED MB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED C 105884 R WIND NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, PL 33612 /X4\ 10 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) !D PROVIDER'S PLAN OF CORRECTION PREFIX (X5) WPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F 156 Continued From page 58 F 156 Review of Resident #2 's medical record revealed a Discharge Summary dated at 10:55 AM: resident left the facility Against Medical Advice (AMA) Resident 's son was in the facility and took resident home. Resident able to make her decisions independently and had no , signed by the SSD at 1:00 PM an interview was conducted with the NHA, the DON, and the Corporate Nurse (CN). The NHA stated that SS should be documenting discussions regarding advance directives in a progress note. On review of the electronic progress notes it was revealed that for Resident #2 there was no documentation from SS in the progress notes, and the NHA verified this at 1:49 PM an interview was conducted with the SSD. She stated in regards to Resident #2, " like I showed you yesterday, I spoke with her (Resident #2) about advance directives and she doesn't have any. She does have a son. She doesn't want her son to make decisions for her, SSD was informed the advance directives acknowledgement form in Resident #2" s admission agreement packet was blank. She stated, "Well I wouldn't know that. Review of Resident #2 's medical record revealed Social Service Progress Note dated at 2:39 PM; which was a week after Resident #2 's latest re-admission, found the following notation: Social Service Director and Social Services Assistant together went to speak with the resident about advanced directives. Resident stated she does not have any advanced

directives at home. Do Not

Facility ID: 62932

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	-7- / - 18:01 #c	056 P. I/
		,
	F	NTED: 08/07/2015 ORM APPROVED
(X2) MU A. BUILI	LTIPLE CONSTRUCTION (X	3 NO. 0938-0391 3) DATE SURVEY COMPLETED
B. WING		С
	STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/2015
	2811 CAMPUS HILL DR TAMPA, FL 33612	
ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTION ACTION SHOWS DO	COMPLETION E DATE
F 1	56	

08/ 1/ 18:02

From:7275521162

#055 P. / DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED DENTIFICATION NUMBER A. BUILDING C 106904 B. WING 06/26/2015 NAME OF PROVIDER OF SUPPLIES STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL OR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID ID PROVICER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (K5) COMPLETION TAG REGULATORY OR USC IDENTIFYING INFORMATION! DEFICIENCY F 156 Continued From page 60 F 156 audit, which includes reviewing When asked if the event had been presented to the QA committee with an action plan she stated. "Yes ' On the NHA provided a " QA Book " it contained the Quality Assurance Performance Improvement Plan for review. The tool was daled and signed by the Quality Assurance team including the Medical Director on A review of the information provided revealed policy revisions dated for Directives " which includes " Code Blue Roles and Responsibilities " and " Emergency Procedure -Review of these revisions revealed the following relevant changes: "Code Blue Roles and Responsibilities " (no effective date): " In the event that a resident is found in the person discovering the . should immediately notify a nurse of the situation. A teammate should page overhead that there is a Code Blue and the location of the code. All available teammates are responsible to respond to a Code Blue Page. The nurse is responsible to immediately assess the resident to determine if the resident is in resident 's medical record will be obtained to determine if the resident has a () document in their record. (may check YELLOW BINDERS

record then

at each nurses station for

directives, if there is no

is noted then there will be no further interventions implemented as per the resident 's advance

status) if the

In the medical

is to be initiated on the resident Nurses are responsible for the implementation of on the resident. The nurse assigned to the resident will act as the TEAM LEADER of the

08/ / 18:02 #065 P. // _1

ATEMEN	IT OF DEFICIENCIES	& MEDICAID SERVICES			N SMO	O. 0938-03
D PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING	(X3) E	ATE SURVEY OMPLETED
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AME OF	OF PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE		16/
CEL	REHABILITATION AND	HEALTH CENTER		2811 CAMPUS HILL DR TAMPA, FL 33612		
X4) ID REFIX TAG	LEACH DEFICIENCY	Tement of deficiencies MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREPID TAG	PROVIDER'S PLAN OF CORPER		COMPLETIO DATE
- 156	Continued From pag	70 ft	_			
	code eltration Code	ge 01	F 15	56		
	are certified ma	fied Nursing Assistants who by be directed to assist with of the nurse. "				
	On signa	sture sheets were provided				
	for the following in-se	ervices, dated				
		6/7, and				
	in additio	n mock "Code Blue " drills				
	were done on :	. 5/28, All				
	documents that were	provided to the survey team				
	were reviewed. A con	nparison was made between				
	ine in-service signatu	re sheets and the master list				
,	as of 91%	comparison revealed that				
		of licensed nurses and 97% fixed completed the training.				
1	nterviews with the fac					
	dvanced directives,	and Code Blue drills				
, v	vere conducted in ord	ter to verify staff knowledge.				
,	ne rollowing relevant	Interviews were obtained:				
		PM, an interview was				
	he worked full time a	yee C a nurse; she stated in the 7:00 AM -3:00 PM				
si	hift She stated the b	rifie 7:00 AM -3:00 PM and been part of a mock				
C	ode Rhie drill a count	le of months ago and that "				
w	e just had an In-send	ice on where to find the				
	forms, in the velle	ow book, " When asked				
h	ow she would respon	d if a CNA said a resident				
W	as unresponsive she	stated she "would check				
th	e resident, have som	eone at the desk check				
th	 book, I would 	initiate until l				
de	stermined if the resident	ent had a order then I				
Or		M an interview was				
CO	nducted with Employ	PR D a nurse who stated				
sn	e worked full time on	the 7:00 AM -3:00 PM				
SHI	ft. She stated she ha	d training on				

advanced directives and participated in mock

CENT	ERS FOR MEDICARE	AND HUMAN SERVICES				FO	ED: 08/07/2 RM APPRO	VEC
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3)	NO. 0938-0 DATE SURVEY COMPLETED	
		105884	B. WING	3			C	
l .	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		06/28/2015	
EXCEL	REHABILITATION AND	HEALTH CENTER	- 1		11 CAMPUS HILL DR			
(X4) ID	SUMMARY STAT	TEMENT OF DEFICIENCIES		TA	MPA, FL 33612			
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F 156	Continued From pag	ne 62	F 18					
	Code Blue drills a fe	w months ago and again in	F 16	50				- 1
	J. She also state	d " If I found someone						
	unresponsive; I would someone to go to							
		book. If they were a vould call the physician and						- 1
	family. If they were a	full code I would keen noing						- [
	until the paramedics	come. "						
	On at 4:40	PM an interview was					1	-
	conducted with Emple	OVER E a miree she stated						- 1
	she usually worked a:	S needed on the 3:00 PM						
	-11:00 PM shift. She	stated that during ssed advance directives and						- 1
	orders. She had	training in the last counts of						
	months on advance d	irectives and did a mock						1
	Code Blue drill also, if	a resident was found led she would, " check the						1
	'esident, yell for help,	and send someone to get						1
	nore neip. I would sta	rt ! There is a						1
	started and find	meone to check. If I have						1
	hen I would stop. I wo	out the resident is a						
H	new if they were a	or not."						
	at 7:22 AM	an interview was						
c	onducted with Employ	ree F a nurse he stated he						1
u	Sually worked the 11-6	00 PM -7:00 AM chie Lic						
re	tated "We had a Mod	ck Code Blue training ad a class on advance						1
Q.	rectives and"	The training included:						
m	laking sure we have a	dvance directives, if						i
	sident is specified specif	seak with the family, check						
Pi	DA is in the chart also	form, make sure a He was asked what he						1
w	ould do if he found an	Unrechangius resident be-						
51	ared this lassess for	breathing cell a code						
ca	ii somebody by name	to call 911. Check Vital						1

signs, call for crash cart, Call another person to

form. I would start compressions

08/07/2015 18:04 4055 -

					-035 F.	-
DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 08	in zona
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APP	20112U1
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 093	38-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SUI	RVEY
		1	A. BUILD	ING	COMPLET	/E0
		105884	a. WING		l c	
NAME OF	PROVIDER OR SUPPLIER	10064	u. WING		06/26/2	015
			- 1	STREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL F	REHABILITATION AND	HEALTH CENTER	- 1	2811 CAMPUS HILL DR		
				TAMPA, FL 33612		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT	TION	
TAG	REGULATORY OR LE	C IDENTIFYING INFORMATION	PREFIX	EACH CORRECTIVE ACTION OUR	UE COM CO.	(X5) PLETION
			IAG	CROSS-REFERENCED TO THE APPR DEFICIENCY	ROPRIATE I	DATE
F 156	Continued From pag	ie 63				
	right away, and if for	and they were a	F 15	DØ		
	stop compressions.	and they were a . would				
	The Territoria					
	During the Interview	conducted on at				
	5:15 PM with the DO	N she stated that what she				
	would expect that if a	resident was found				
	unresponsive and ha	d a Full Code status the				
	nurse should start	. She was asked if a				
	nurse should start	prior to finding out about				
	a resident 's or	der. She stated. "The nurse				
	should know if the re:	sident is a or not before				
	they start . If the	nurse starts and finds				
	out the resident is a	, the nurse can stop.				- 1
	That is what I was told	during my class."				- 1
,	rvnen asked ir that wa	as in the facility policy, she				i
	hat in the leasantes	r policy, so I do not teach lasses. " The DON was				- 1
ii ir	oformed that 3 and of	lasses. The DON was				- 1
	tated they would star	7 nurses interviewed so far				- 1
	nresponsive resident	t when they found an				- 1
fe	ound the resident was					- 1
th	e facility conducted	a She was asked if raining since the event.				- 1
S	he stated "yes, we s	started in , after the				- 1
e	vent and we have giv	en in-services again				- 1
re	cently. " This training	O COVERED DESIGN OF				- 1
ac	dvance directives. Th	e training is also being				- 1
90	one on orientation. S	he stated. "We did the				- 1
tra	sining for the whole n	onth of herouse				1
W	e had to get everyboo	ly And then up just all to				- 1
ag	lain. In addition, a Oi	INITY Accessment				- 1
Pe	normance Improven	nent (OAPI) was started				- 1
Int	and of the event. The	ne Quality Assurance (QA)				
ÇO CN	minitee was informe	d. We did training with the				
Ki.	une and nurses and a	also preformed mock code				- 1
nei	ies. " When asked if rformed in the past, s	training had been				1
jn-r	service is done was a	rated, " Yes, the and during orientation."				- 1
în a	addition, the DON wa	s also asked, how the				
		~ wise asked, HOW IDE				- 1

. ./ . ./ . . 18:04 #055 P. /

	DEPARTMENT OF HEALTH				PRINTED: 08/07/201 FORM APPROVEI OMB NO. 0938-039
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105884	B. WING		C 06/26/2015
l	NAME OF PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	
	EXCEL REHABILITATION AND			2811 CAMPUS HILL DR TAMPA, FL 33612	
	PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD RE COMPLETION
	F 156 Continued From pa	ge 54	F 1	56	
	starting Human Res and then the ADON that. All nurses are: "When asked if the employee records (rest and it on hire." The DO monitors, audits the reviews orders the reviews orders the reviews orders the summand plan of correction and plan of correction and plan of correction and plan of correction to the corporate nurs direction i gol was to codes, and file a feditorial conducted with the National Conducted National Conducte	supposed to be cariffied. I facility had audited the or current she stated to current she stated to mount of the stated to mount of the stated the SS department advance directives, and monthly. The DCN stated presented to the Quality minttee and an action plan in was put into place. The Federal report and reported the Pederal report and reported the e. The DCN stated, "The do education, and do mock eral report." A, an interview was HA and the DON to review ining in-services. The NHA went over the following whitch included what to look book, where to find the DI rective policy and Code 1 a mack code blue, if staff policy resident what you mergency procedure policy tation and every rurse expectation was for receiver training by the first first OAP live were simost terms of the competition of the process of the policy training by the first first OAP live were simost.			
	QAPI meeting. By the	first QAPI we were almost regarding interviews with 4			

of 8 nurses on

∍and

surveyor which revealed the nurses would start prior to knowing the resident's code status was discussed. The DON stated, "That is not what they were Irained to do." The NHA and the DON stated they would begin retraining the

by the

From:7275521162

/ . 1/2015 18:05 #055 P. 7_ :

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2015 FORM APPROVED OMB NO 0938-0301

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DA	TE SURVEY
		105884	B. WING		05	C /26/2015
	HABILITATION AND	HEALTH CENTER	28	reet address, city, state, zip o 111 Campus Hill Dr Ampa, Fl. 33612	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE

F 156 Continued From page 65 nursing staff that day.

> at 1:00 PM an interview was conducted with the NHA and the CN. When asked when the Policy and Procedure for advance directives and were last reviewed. the CN stated "the Policy and procedure for advance directives and reviewed and updated on " after the event with Resident #1. He further stated that the Emergency Procedure : was also updated. which included the Code Blue Roles and Responsibilities

- 6. Record reviews and interviews revealed the following corrective action was taken:
- in-service signature sheets were reviewed for retraining of the nursing staff, recarding advance directives code blue drills. The NHA verified that all nursing staff with the exception of one employee that was unavailable had received the in-service retraining. The NHA verified that this employee will not return to work until they have received the retraining. On interview it was confirmed after the re-training, the nurses were able to verbalize the Policy and Procedures: Advance Directives. and Emergency Procedure: and Code Blue Interviews were conducted with 21 out of the 31 nursing staff members on and . All staff members interviewed were familiar with the policy and able to verbalize the correct procedure
- On at 3:40 PM an interview was conducted with the NHA. She was asked how the facility was going to ensure that residents had Advance Directives which accurately reflected

F 156

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J5QX11

Facility ID: 62932

If continuation sheet Page 56 of 213

From:7275521162

./ .. /_ 18:05

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 08/07/2015

F 156 Continued From page 56 their wishes in their first 14 days of admission since Readenth F 158 their wishes in their first 14 days of admission since Readenth F 158 their wishes in their first 14 days of admission since Readenth F 158 their wishes in their first 14 days of admission since Readenth F 158 their wishes and #4 s advance directives had not been addressed and they were both recently admitted. She stated she mer with the SS department and said that all residents admitted in the tast 2 weeks or since would be reviewed regarding advance directives and the reviews would be documented in the progress notes. When asked how the facility was going to address blanks in the Advance Directive Acknowledgement form she stated the Regional Business office will do a complete audit of our admissions for completion; will audit immediately to ensure the paper work is being filled out correctly and completely. On the facility provided the following note written on facility leterhead and dated signed by the NHA: Social Service: In regards to assuring that residents are given the opportunity to discuss/choose an addendum to the initial assessment done at the time of the admission. Admissions Contract in regards to assuring that residents are given the opportunity to discuss/choose an addrendum to the initial assessment done at the time of the admission. Admissions Contract in regards to assuring that residents are given the opportunity to discuss/choose an advance directive. 100% of all admissions contracts from to have been reviewed by the Director of the province of the prov	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					D. 0938-0391
19884 B. WING STREET ADDRESS, CITY, STATE ZP CODE						ONSTRUCTION	(X3) DA	MPLETED
INME OF PROVIDER OR SUPPLIER EXCEL REHABILITATION AND HEALTH CENTER STREET ADDRESS, CITY, STATE, 2P CODE 2311 CAMPIA, FL 33612 FROUDERS PLANDER COMPRECTION (SOUTH CONTINUED TO SEPTICE PROPERTY ON THE PROPERTY OF THE PROPERTY ON THE PROPERTY ON THE PROPERTY ON THE PROPERTY OF THE PROPERTY ON THE PROPERTY ON THE PROPERTY ON THE PROPERTY ON THE PROPERTY ON THE PROPERTY ON THE PROPERTY ON THE PROPERTY ON THE PROPERTY OF THE PROPERTY ON THE PROPERTY OF THE PROPERTY ON THE PROPERTY OF THE PROPERTY ON THE PROPERTY ON THE PROPERTY OF THE PROPERTY ON THE P			105884	B. WING	3			-
F 156 Continued From page 56 their wishes in their first 14 days of admission since Residents #2 and #4 's advance directives had not been addressed and they were both recordly admitted. She satisfied his met with the progress notes. When asked how the facility was going to admissions. When asked how the facility was going to address office will do a complete audit of our admissions for completion, will sudif immediately to ensure the page rowr is being filled out correctly and complete patient. On the facility provided the following note written on facility letterhead and dated signed by the NHA. Social Service: In regards to assuring that residents are given the opportunity to discuss/choose an addressed office will admissions from have been reviewed by the Director of Social Services and a progress note regarding same has been added to these records as an addendum to the initial assessment done at the time of the admission. Admissions Contract in regards to assuring that residents are given the opportunity to discuss/choose an addendum to the initial assessment done at the time of the admission. Admissions contracts from to have been reviewed by the Director of Social Services and a progress note regarding same has been added to these records as an addendum to the initial assessment done at the time of the admission. Admissions contracts from to have been reviewed by the Admissions in the Admissions done at the progress from the progress fro			HEALTH CENTER	-	2811	CAMPUS HILL DR		W/20/2015
their wishes in their first 14 days of admission since Readedins 142 and 24° s advance directives had not been addressed and they were both recently admitted. She stated she me with the SS department and said that all residents admitted in the tast 2 weeks or since would be reviewed regarding advance directives and the reviews would be documented in the progress notes. When asked how the facility was going to address blanks in the Advance Directive Acknowledgement form she stated the Regional Business office will do a complete audit of our admissions for completion; will audit immediately to ensure the paper work is being filled out correctly and completely. On the facility provided the following note written on facility, letethead and dated signed by the NHA: Social Service: In regards to assuring that residents are given the opportunity to discuss/choose an advance directive, 100% of all admissions from have been reviewed by the Director of Social Services and a progress note regarding same has been added to these records as an addendum to the initial assessment done at the time of the admission. Admissions Contract: In regards to assuring that residents are given the opportunity to discuss/choose an addendum to the initial assessment done at the time of the admission. Admissions Contract: In regards to assuring that residents are given the opportunity to discuss/choose an advance directive, 100% of all admissions contracts from to have been reviewed by the Director of byte Admissions	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
Coordinator to ensure completion of all forms including the advanced Directive Acknowledgement. On at 9:50 AM an interview was conducted with the NHA and the Clinical Nurse		their wishes in their since Residents #2 had not been addre creantly admitted. \$S department and carefully admitted. \$S department and admitted in the last would be reviewed us and the reviewed us admitted to the state of the reviewed us admitted to the reviewed us admitted to the reviewed us admitted to the reviewed us the reviewed by the Direction of the reviewed by the Direction of the reviewed by the Direction of the reviewed to the residents are given it discussions Contract done at Admissions Contract where the reviewed us the reviewed us the reviewed us the reviewed of the reviewed us the review of the reviewed us the review of the r	first 14 days of admission and 44 's advance directives seed and they were both his stated she met with the said that all residents were both as a state of the said that all residents (ab education of the said that all residents (ab education of the said that all residents (ab education of the said that all residents and said of the said that all residents with a said that the said that all residents with a said that mandalately work is being filled out teley. addity provided the following y letterhead and dated yithe NHA: pards to assuring that he opportunity to dvance directive, 100% of all have been tor of Social Services and a ling same has been added to addend un to the initial of the said of the s	F	1156			

/ / 18:07

/ 18:07 #055 /

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2015 FORM APPROVED OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X31 DATE SURVEY DENTIFICATION NUMBER: COMPLETED A. BUILDING ^ 105884 S WING 06/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID 10 PROVIDER'S PLAN OF CORRECTION COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAC DESICIENCY F 156 Continued From page 67 F 156 all admissions since The SS department revisited each resident and wrote a progress note for each medical record to provide documentation. The Admissions department went through all admission paperwork for residents admitted on forward to make sure paperwork is correct and to review the advance directives section for completion. All incomplete forms were addressed with the resident last night or this morning. The

Admissions department has been re-educated by the NHA regarding completion of admission agreement forms, with attention to the resident rights portion and advance directives, including not leaving blanks and having correct dates. The NHA stated she would review advance directive paperwork on all new admissions. They also stated that the Admissions department will do an audit of the paperwork for all admissions for the next three months. They said that after three months they would begin a monthly random audit that would be discussed at the QA meetings. They further stated that at the time of admission. the nurse will verify advance directives and document on a progress note. All new admissions will be reviewed at the daily clinical meeting and advance directives will be a focal point at that time; this will occur on the weekends as well. Social services will continue to assist the resident with development of advance directives and will document on a progress note. They stated that each resident's advance directives will be discussed at their 14-21 day and quarterly care plan meetings. The expectation is that if a resident wants anything changed between the 14 day care plan and quarterly care plan meetings they will approach the facility staff or if staff notices a change in condition that it will be

re-addressed with resident.

08/... 18:07

18:07 #055 P.L...(/__)

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PRINTED: 08/07/2015 FORM APPROVED

GENTERS FOR MEDICARE & MEDICAID SERVICES			MB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED
				С
	105884	8. WING		06/26/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
EXCEL REHABILITATION AND HEALTH CENTER		1	2811 CAMPUS HILL DR TAMPA, FL 33612	
(XA) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE	BE COMPLETION

F 156 Continued From page 68

F 156

Based on this information the Immediate Jeopardy was found to be removed on and the scope and severity was reduced to a D.

F 224 483.13(c) PROHIBIT
SS=J MISTREATMENT/NEGLECT/MISAPPROPRIATN

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and ______ of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced

Dispatch or review of resident medical and admission records, review of facility policies and procedures and interview with facility staff, a resident's family member, the attending physician, and the Medical Director, it was determined the facility falled to horn or the advance directives of one (Resident #1) of 7 sampled residents of 81 residents identified as having Full Code orders according to the Advance Directive Audit Tool, provided by the facility and dated

The staff did not fulfill a care taking.

of providing goods and services
necessary to avoid physical harm or mental
anguish consistent with their ", Neglect
and ______ " policy and procedure (no date).

On _______, Resident #1, a ______ | male, was found unresponsive, without pulse or

F 224

 1. Resident #1 Expired at the facility on 3-12-2015. The family and physician were notified of the resident's passing.

DEELCIENCY

 A review was completed for advance directives on , this included a review of a current full code, and physician orders. Also a review was completed by to assure that all residents have received in writing their right to formulate advance directives according to their wishes or that of their respective responsible parties. Any identified areas of concern have been addressed, Policies and Procedures for . Neglect and Advance Directives, Implementation of

and Do Not Orders are currently implemented and resident wishes for advance directives are being honored by the facility staff.

and Neglect was

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/07/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION A. BUILDING COMPLETED 105884 A WING

NAME OF PROMOSE OF SUPPLIES

EXCEL REHABILITATION AND HEALTH CENTER

(X4) (D PREFIX SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR TAMPA FI 33612

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(XS) COMPLETION

06/26/2015

F 224 Continued From page 69

iess than 24 hours after admission. The resident had a current physician order documenting his code status as "Full" meaning that he wanted unresponsive. The facility failed to honor Resident #1 's wishes regarding his advance directives to be and denied the resident the opportunity to receive emergency lifesaving services to prolong his life. The facility failed to follow their policy and procedure. In regards to, its "Advance Directives" (Revised 2008), "Emergency Procedure-

(Revised _____ 2011) and " _____, Neglect and _____ " (no date).

Failure of the facility staff to provide the services necessary to honor and fulfill the expressed wishes of the resident to receive findings of Immediate Jeopardy which were removed on /2015 and the severity and scope was reduced to D

Findings include:

1. A review of the facility policy: " : Neglect Prevention and Prohibition (Not dated), revealed a Standard: "The prevention and prohibition of . neglect and . To an environment within the facility which promotes resident well-being, safety and , neglect, involuntary and the misappropriation of property for all residents 1 i. "Furthermore, each resident has the right to

be free from corporal punishment, and involuntary . Residents must not be subjected to by anyone, including but not limited to: facility staff, other residents, consultants or volunteers, staff of other agencies

F 224

3. Policy and Procedure for

in

PREFIX

TAG

reviewed by the QAPI Committee on and approved by the committee. Staff reeducation was provided regarding the policy for Directives, -Pulmonany . All re-education will be completed by

i. This was provided by the ADON/Staff Development Coordinator. Mock Code Orills have continued per our previous QAPI Plan, the most recent being 7-5-15. The facility will continue to implement Mock Code Drills weekly for a total of four weeks. The drills will them be provided on a quarterly basis. , Neglect and Allegations of will continue to be reported according to regulatory requirements.

4. This area of care will be monitored by the Director of Nursing/Designee weekly times four weeks and then monthly. A Data Collection Toll will be utilized for the monitoring. This will also be over seen by the Administrator/QAPI Committee for ongoing compliance.

15

From:7275521162

/ ... / 18:09 #055 P.02 /

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/07/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMO FTEN 105884 8. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR TAMPA, FL 33612

EXCEL REHABILITATION AND HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (X4) (D Ð PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION! TAC COLGE STION TAG PATE DEFICIENCY)

F 224

F 224 Continued From page 70

serving the resident, family members or legal quardians, friends or other individuals. " II, " Each resident has the right to be free from mistreatment, neglect and misappropriation of property. This includes the facility's identification of residents whose personal histories render them at risk for abusing other residents, and development of intervention strategies to prevent occurrences, monitoring for changes that would trigger behavior and reassessment of the interventions on a regular basis. Definitions: 7. " Neglect: means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness, (42 CFR 488,3011 Procedures

- 1. Screening: " a. The facility screens potential employees for a history of , neglect or mistreating residents as defined by the applicable requirements a 483.13 @ (1) (ii) (A) (B) This includes attempting to obtain Information from previous employers and /or current employers and checking with the appropriate licensing boards and registries. Screening is done on all employees prior to hire."
- 2. Training:" a. Each team member is scheduled to attend a general prientation session, b. Fach team member is offered and asked to attend a facility in-service where the information is reviewed as needed throughout the year. c. each team member is notified that a mandatory "
- Prevention " in-service is scheduled on an annual basis. This In-service includes: 1. Appropriate interventions to deal with aggressive and / or catastrophic reactions; 4. What constitutes , neglect and misappropriation of resident property.
- 3. Prevention: Every effort is made on behalf of the resident to prevent . This includes an

Event ID: ISOX11

Facility IO: 62832

If continuation sheet Page 71 of 213

From:7275521162

v v - 18:09 #055 F.023/051

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED c 105884 B. WING NAME OF PROVIDER OR SUPPLIED 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REMABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33812 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES GACH DEFICIENCY MUST BE PRECEDED BY FULL 10 PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION TAG DEFICIENCY F 224 Continued From page 71 F 224 analysis of: a. Features of the physical environment that may make and/or neglect more likely to occur, such as secluded areas of the facility, b. the deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that staff assigned have knowledge of the Individual residents ' care needs. C. the supervision of staff to identify inappropriate behaviors, such as ...ignoring residents while giving care,and d. the assessment, care planning and monitoring of residents with needs and behavlors which might lead to conflict or neglect, such as resident with communication . those that require heavy nursing care and/or the totally dependent on staff. Each team member reads and signs the " Resident Rights " upon employment. A copy of the resident rights is given to each team member within his/her probationary period of employment. This information is reviewed on an annual basis by the Social Services staff in an all-staff in-service Identification: Each team member is encouraged to atlend a mandatory " Prevention in-service on an annual basis. This in-service includes methods to identify events, such as of residents, occurrences, patterns, and trends that may constitute and to determine the direction of the Investigation, Investigation: the Social Services Manager is the facility appointed designee who is the staff member responsible for the initial reporting investigation of alleged violations and reporting

results to proper authorities. The facility policy for

immediately to the attention of the immediate

is for it to be brought

--/- /2015 18:10 #055 P.024/051

PAGE _3/._

DEPAI	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINT	ED: 08/07/201
ISTATEME	NT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES	(X2) ML	ULTIF	PLE CONSTRUCTION	OMB I	RM APPROVE IO. 0938-039
		IDENTIFICATION NUMBER:	A. BUE	DING	3	(X3) (DATE SURVEY OMPLETED
NAME OF	PROVIDER OR SUPPLIER	105884	B. WING			Ι.	C 96/26/2015
	REHABILITATION AND	HEALTH GENTER		1	STREET AODRESS. CITY. STATE, ZIP CODE 2811 CAMPUS HILL DR TAMPA, FL 33612		0/26/2015
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	PREF	DX.	PROVIDER'S PLAN OF CORRECTED ACTION SHOUND CROSS-REFERENCED TO THE APPR DEPICIENCY)		COMPLETION DATE
: : : : : : : : : : : : : : : : : : :	uesignee, the DON,	who is the facility appointed and the Administrator, notify the appropriate in and the Administrator, notify the appropriate in the nature of the allegation in the analysis of the allegation in the analysis of the analysis of the application, and until it is the facility will report all 4000-96 , and all is to the state appropriate and the application, and the application of the application	F2	2224			

08/ . 14-11 #065 P.025/081

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING _ COMPLETED c 105894 8. WING NAME OF PROVIDER OR SUPPLIER 06/26/2016 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2611 CAMPUS HILL DR TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE IYE TAG REGULATORY OR LSC IDENTIFYING INFORMATION COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 224 Continued From page 73 F 224 Per the Nurse 's Notes dated AM: " this nurse called to Certified Nursing Assistant (CNA). Resident noted with no , pulse or . Noted large amount of frothy saliva on face and chest. Upper extremities cool to touch. Call placed to (attending physician) service, return call received from (covering physician). Order received to release body. Call to family, (Mother), name of funeral home received. Family declined to come to facility. " Signed by the Assistant Director of Nursing (ADON) at 1:00 PM an interview was conducted with the ADON, the nurse assigned to the resident when he . She stated that she was taking care of him for the first time on ; she took a shift because another employee called off. She stated the resident wash t verbal, he required total care and had been readmitted from the hospital that day. When asked to recall the events that happened on , the day Resident #1 the ADUN stated. I was working the night shift. I had finished medication pass and around 5:45 AM, the CNA was in the hallway and said, "I think he is gone. I went in Resident #1's checked him for pulse and very cool to touch. He felt a little stiff in his upper extremities. His lower extremities had sort of . The resident had white frothy stuff around his mouth. There was nothing I could do for him. " When asked if she looked at the chart

, Honestly when

order, she stated, I looked at his chart after I called the doctor to tell him the resident and I didn't see a

I saw the resident after the CNA called me he was cool to touch, I don't know if there was

06/26/2015

STATEMENT OF DEFICIENCIES

. . / / 18:12

#055 P.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

(X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION DENTIFICATION NUMBER A. BUILDING 105884

B. WING

F 224

NAME OF PROVIDER OR SUPPLIER EXCEL REHABILITATION AND HEALTH CENTER

STREET ADDRESS, CITY, STATE ZIP CODE 2811 CAMPUS HILL DR TAMPA. FL 33612

SUMMARY STATEMENT OF DEFICIENCIES (X4) (D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) m TAG PREFIV TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

F 224 Continued From page 74

anything i could do for him. At that point I made the decision to not code him; because he was and stiff: I did not know how long he had peen like that. The physician covering for the attending physician was called, and informed of the resident 's The ADON was asked if she saw a order on the medical record, she stated. " after looking at the chart, no. " When asked if she had received training on how to respond when a resident is found without vital

compressions and send someone to check on When the ADON was asked if she knew how to determine code status, she stated, if a resident is unresponsive, I am supposed to check the pulse and call for someone else to check the chart for

signs she stated, we are supposed to do chest

orders. I will a call code blue and bring the crash cart. We have a yellow book at the nurses station with all the forms. If the resident is a new admission it may be necessary to look in the chart. When asked how the nurse is notified of a resident 's advance directives, including she states. " It is the nurse 's responsibility to check the chart on every resident, so they know

status." If someone finds someone unresponsive, they have to wait until someone checks the yellow book or the chart to see if they or not. When asked what she would do in a situation wherein a resident is found

but there is no Advance directive sne stated, "I would do a Code," When asked if she had had any training since the event, she stated yes, one-on-one with the Director of Nursing (DON) on . advance directives. Code Blue, and mock drills. The DON reviewed with me when we are supposed to do a code.

at approximately 5:00 PM an

7 18:12

DEFICIENCY

#055 P.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING 105884 A WING NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33612 (X4) (D SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) iD TAG

F 224 Continued From page 75

interview was conducted via telephone, with Employee A, the Certified Nursing Assistant (CNA), who found Resident #1 unresponsive. She stated she no longer worked for the facility. Employee A stated she was making rounds before she went home and found Resident #1 not breathing. She called for the nurse to check on him. The ADON responded and checked on the resident. The ADON said, "He was gone. Employee A stated that the ADON did not do

100 Resident #1 and that she did not recall anything else about the resident

at 5:00 PM an interview was conducted with the Nursing Home Administrator (NHA). When asked if she could recall the events that happened on , the day Resident she stated the DON informed her that the Assistant Director of Nursing (ADON) had found the resident unresponsive and did not . The NHA stated in her opinion the ADON should have looked at the chart and initiated

On at 5:15 PM an interview was conducted with the Director of Nursing (DON) when asked if she was familiar with Resident #1. she stated, "yes." When asked about the day Resident #1 she stated, "When I came in about 5:30 AM the (ADON) stated that Resident #1 had passed. I asked the (ADON) if she had performed , the (ADON), said, no. I stated to the (ADON) that she, should have called a code and the (ADON), and stated she did not do it. I educated the (ADON) right then and there regarding our policy. The policy states, we have to start a code no matter what, on a Full Code resident. I interviewed (Employee A) who stated

TAG F 224

FORM CMS-2567(02-99) Previous Varsions Obsolete

Evant ID: JSQX11

Facility ID: 62932

if continuation sheet Page 76 of 213

From:7275521162

../- V... 18:13 #055 P. /

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING COMPLETED 105884 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION 10 (EACH DEFICIENCY MUST BE PRECEDED BY FUI (XS) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY

F 224

F 224 Continued From page 76

she was making her rounds, and the resident didn't look right, she shook him, and he was not responding, so she got the nurse. " The DON stated. "The chart revealed the resident was a Full Code. " The DON stated. " I knew he was a full code because he had been here for so long. The DON stated "the (ADON) decided on her own not to do . The DON, stated " the nurse pronounced him

On at 12:40 PM. a telephone interview was conducted with Resident #1 's father, He stated his son was in the Marines; he got an aneurysm in there and had to have surgery. He stated the resident lived by himself for a while, and then he started living with his girlfriend. He went to the hospital and they sent him to the nursing home. When asked if they were expecting his , he stated, he "could not care for him anymore, that 's why he went to the nursing home. " He was wearing diapers and couldn't dress himself anymore. "I couldn't handle him anymore. " He went to the hospital and then the nursing home, he " was in and out of the nursing home. " I think he hospital, no, the nursing home, I get sometimes. I couldn't do anything with him." He was having problems breathing, they put him on . The last time I saw him he was in the

hospital, and then someone called and said he at 12:00 PM, an Interview was conducted with the Medical Director. When asked if his expectation was for a nurse to perform on a Full Code resident, he stated.

be done. " He has been the Medical Director for almost 4 years. " If the resident was

FORM CMS-2567(02-99) Previous Versions Obsolete

was

Event ID: ISOVIA

Facility ID: 62932

If continuation sheet Page 77 of 213

08/07/2015 18:14

#055 P.029/051

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/BUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY DENTIFICATION NUMBER A. BUILDING COMPLETED c 105884 B. WING . NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL OR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33812 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F 224 Continued From page 77 F 224 unresponsive they have to do . Code Blue is for all nonresidents On at approximately 10:00 AM, an Interview was conducted with Resident #1 's attending physician. The physician stated the resident had multiple problems including; multiple issues,

"He did not look well at all.), and He was thin and looked 90. He was new to me as a patient. He was back and forth to the hospital I was not called the day he the physician covering was called. " I found out the next day or so, probably when the funeral home called me. Normally if a patient does not have a their chart. would be initiated and 911 called My expectation is that the nurse would start lfa was not on the chart. st 2:40 PM, a telephone interview was conducted with the covering physician who received the call regarding Resident #1 on She stated she was covering for the attending physician on , but doesn't remember the call as she stated she covers 1000 patients. When asked if she was informed the resident was a Full Code and he was not she stated, "I applogize, but I don " Review of the Resident #1 's Admission Agreement revealed; page 31 of 39 Advanced Directives Acknowledgement with the following language: I understand that I do not have to sign or implement an Advanced Directive in order to be a resident at this Healthcare Center. I understand that I may implement an Advanced Directive at any time during my stay in the facility.

It is also my understanding that I may ask at any

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICAR	E & MEDICAID SERVICES		OI	FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDH	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	B. WING_		C 06/26/2015
NAME OF PROVIDER OR SUPPLIER EXCEL REHABILITATION AN			STREET ADDRESS. CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR TAMPA, FL. 33612	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	ACITA PAICO BE

F 224 Continued From page 78

F 224

time to review Advanced Directive information or my Advanced Directive (a) and ask questions I may have concerning then. I may revoke any Advanced Directive (a) at any time that I have made. I understand the facility's staff cannot give legal advice, but can answer questions concerning Advanced Directives. I have the following designations(s) and my copies have been provided to Health Care Center. A line was drawn through the blank spaces in front of all the choices which were: Living Will or Direction to Wilthhold Life Sustaining Procedures.

Health Care Surrogate, Health Care Proxy, Durable Power of Attorney, Financial Power of Attorney, Medical Power of Attorney, Guardian Financial or Medical, Anatomical Gift, Other: Physician Statement of Incapacity, Funeral Home Selection. The form was initiated by the resident and witnessed by Employee H on

Yellow HRS Form

Review of the resident 's Admissions paperwork revealed a second form titled Advanced Directives Acknowledgement (no page number) with the resident 's initials beside the sections 1. I have been given written material about my right to accept or refuse medical and surgical treatments and my right to form Advanced Directives, 2. I understand that I am not required to have an Advanced Directives in order to receive medical treatment at this health care facility and 3, I understand that the term of any Advanced Directives that I have executed will be followed by the health care facility, physicians and my caregivers to the extent permitted by the law. The form continues with: Please Check one. of the following statements: I have executed an Advance Directive and will provide a copy to the facility. I understand that the staff and the

Event ID: JSQX11

Facility ID: 62932

If continuation sheet Page 79 of 213

08/07/2015 18:15

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CENT	ERS FOR MEDICARI	HAND HUMAN SERVICES			PRINTED: 08/07/201 FORM APPROVE
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		105884	a, WING	_	C
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/2015
<u> </u>	REHABILITATION AND			2811 CAMPUS HILL DR TAMPA, FL 33612	
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
F 224	Continued From pag	na 70			
	physicians at this for	clity will not be able to follow	F 22	₹4	
	the term on my Adus	anced Directives until I			
	provide a copy of it t	o the staff; or I have not			
	executed an Advance	ed Directive and do not wish			
	TO discuss Advanced	Directives further at this			
	time. The spaces to	check either statement were			
	Diank, The form was	Signed by the recident and			
	trie Admissions Repr	esentative Employee H and			
	nared				·
	Review of Resident #				
	revealed a Determina	ition of Incapacity document			1
	dated batering	signed by his attending			
	physician. It included	the following language: Ac			
•	attending physician fo	If the above stated recident			1
	resident #1), I have	evaluated and determined			1
	ne above stated resid	ent lacks the connects to			
S	rive informed consent	to make medical decisions			
a	and does not have the	reasonable medical			
Ċ	apacity to directly exe	ng mental and physical ercise rights.			
F	urther review of Resi	dent #1 's medical record			
16	evealed a document t	itled Activated Modical			1
υ	ecision Maker signed	by the resident 's father			1
di	in momer and witnes	Sed by two signatures on			
la.	The Determine	ent included the following ination of Incapacity form			1
ha	as been completed or				1
at	test that I am at least	os aldos			-
an	id am willing to become	ne involved in the above			f
912	ated resident is healt	h care decisions I have			
ma	aintained requiar cont	act and am familiar			1
uve	Leginerii 2 Schriibe	health religious and			1
mc	oral beliefs, so that I a	OR Make haville			1
Dro Dro	donalna decision	holding/withdrawing life			1
		at would be the decisions made, if capable, I am			ĺ
315	Acide in Monio Vave	mage, if capable, I am			1

willing to produce clear and convincing evidence

OEPAF CENTE	RTMENT OF HEALTH	AND HUMAN SERVICES				FOR	D: 08/07/201
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILC		E CONSTRUCTION	(X3) D/	O. 0938-039 ATE SURVEY OMPLETED
		105864	B. WING				C 6/26/2015
	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	1 00	3/26/2015
EXCEL	REHABILITATION AND	HEALTH CENTER			111 CAMPUS HILL DR AMPA, FL 33612		
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F 224	Continued From pag	ne 80	F 2	24			
	upon request. I unde become active and a which is one of the fi	erstand that my role has accept my responsibility, ollowing Medical Decision checked were Proxy and A	FZ	24			
	hospital on facility on did not include docum Medical Decision Ma Information on Advan " Advanced Directive: In the admission pape	It is medical record was discharged to the and readmitted to the this admission paperwork nentation that his Active ker, his father, was given ce Directives. There was no s Acknowledgement "form swork for the Resident is no the facility.					
i C C	nospital on His admiss nolude documentation Decision Maker, his fa In Advance Directives A decaded Directives A decaded Directives A decaded Directives A	was discharged to the and readmitted on alon paperwork did not n that his Active Medical other, was given information		٠			
# w (H ac En (N (0	1 dated : Pa dmitted to the emerge	E (Resistant) and					

Fectility ID: 82932

due to

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINT	ED: 08/07/201
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIP	LE CONSTRUCTION	OMB N	O 0938-039
		105884	e, wing			1	С
NAME OF	PROVIDER OR SUPPLIER			- 9	TREET ADDRESS, CITY, STATE, ZIP CODE		6/26/2015
EXCEL R	REHABILITATION AND	MENTY CENTER		2	811 CAMPUS HILL DR		
					AMPA, FL 33612		
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
					DEFICIENCY	-KINI E	Dit
F 224	Continued From pag	n 61					
	basing noted at at	je o i	F 2	24			
	I shoraton da	that were positive for occult					
	B.5 and a nistelet co.	ta revealed hemoglobin of unt of 335 indicating the					
	patient was	with occult					
	() loss. The	patient did not show any					
5	Signs or active	at the time					
	Recommendations in	cluded continue tube					
1	eedings as tolerated;	monitor the hemoglobin					
	1 was discharged from	as needed basis. Resident					
tr	ansferred to the abili	om the hospital and led nursing facility on					
_	The skyl	ed nursing facility on					
_							- 1
R	eview of Resident #1	's physician orders dated					1
	revealed a	Code Status of Full Code.					1
Þ	andone of Dealers at						
re	cord including the ele	's complete medical osed record revealed no					1
	- I wooding the oil) form was present.					1
	١.	ram was present.					1
							1
A I	review of the Nursing	Admission Evaluation					- 1
	ol dated a	t 3:00 PM revealed: patient					i
911	ived via stretcher fro	m hospital with and					- 1
air	ectives upon admice	The resident has advance lon? NO. Are advance					- 1
dire	ectives in the chart?	NO. Activities of Dally					- 1
							- 1
mo	bility; transfers; dres	sing and personal					- 1
riyg	liene. Alert to person	and non-warhal akin					1
Ditte	se, but can make fac	ient not verbal with this					- 1
rea	ular and audible, puls	es for pain. rate					1
	breath sounds	close					1
ın pi	ace. Has referrals fo	or Physical					- 1
Occ	upational a	nd Speech					- 1
Sign	led by Employee C. ;	a Licensed Practical					ı
Nurs	se (LPN)						1

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#055 P.034/051

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AND AN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 105884 B. WING NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION DOCEN (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG MPLETION DEFICIENCY F 224 Continued From page 82 F 224 A review of Resident #1 's medical record, Social Service Admission Evaluation Tool document dated at 5:32 AM (Thursday) Included the following intormation: the resident was had resided with his father in the past. was a nigh school graduate and had been in the Marines for 10 years. It also included the questions with corresponding answers written in capital letters. Does the resident have advanced directives? INCAPACITY & HC (health care) PROXY ON CHART; Does the resident have a legal representative? YES, (the resident 's father 's name and phone number); What is the resident's code status? FULL CODE. It was Electronically signed by Employee G. A review of the Admission Minimum Data Set (MDS) assessment dated revealed under Section C (Patterns): Staff Assessment for Mental Status: Short term memory: memory problem. Long term memory: memory problem. skills for Daily Decision Making: severely Section D (Mood): Staff Assessment: feeling or appearing down, depressed, hopeless. Trouble falling or staying asleep or sleeping too much; Feeling tired or having little energy. Trouble concentrating. Under Section G (Functional Status): of one person assistance required for bed mobility and dressing. total dependence required for eating and personal hygiene, Under Section H (Bowel): Always of bowel and Under Section I (Active Diagnoses); failure . Under Section K (Swallowing and : o.atus): Height 66 "; weight 111 pounds; loss of 5% or more in the last month or loss of 10% or more in last 6 months-yes: Feeding tube. Under Section M (Skin Conditions):

Facility ID: 62932

(XS) MPLETION DATE

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#056 P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/07/2015 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION ALLABOR (X3) DATE SURVEY A BUILDING COMPLETED C 105884 B. WING NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES

TAMPA. FL 33612 10

PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

F 224 Continued From page 83

TAG

A risk of developing i. Under Section Q (resident 's Overall Expectation): Expects to remain in this facility; by family

EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

at 1:15 PM an interview was conducted with Employee G a Social Services Assistant regarding Resident #1 's Social Service Admission Evaluation Tool dated timed 5:32 AM, approximately 13 minutes prior to the resident's . When asked, Employee G stated he probably filled in the information based on prior admissions. He stated he was going to speak with the resident 's family and he confirmed that the resident had a health care proxy and a Determination of incapacity. He confirmed that the resident was a Full Code on previous admissions and remained a Full Code because there was not a signed medical record. He stated that his plan was to call the family and inform them of their right to formulate an advance directive for the resident. He further stated that the facility procedure in regards to advance directives required the Admissions Department to speak to residents on admission, advance directives are then addressed in the Nursing Admission Assessment and the Social Services Department reviews the information with the resident and/or the family.

at 1:20 PM an interview was conducted with the Social Services Director (SSD) regarding Resident #1. Per the SSD she spoke to the resident 's father on after he was readmitted on She confirmed that his parents were making the decisions regarding his care and were designated as his Activated Medical Decision Makers at that time. She stated that the father was given information in regards to formulating an advance directive

F 224

18:19

From:7275521162

#065 P. DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED 105884 8. WING NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS. CITY. STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION TAG DEFICIENCY F 224 Continued From page 84 F 224 SSD states. "If he wanted him to be a would have mailed him the paperwork. " She WO also stated that she had not spoken to the fother when the resident was admitted on She stated that the resident was designation and Full Code since his original admission in 2014 and had never had a : of paper in his medical record 3. A review of the facility policy: " Advance Directives " (Revised 2008), revealed a policy statement: "Advance directives will be respected in accordance with state law and facility policy. * Policy Interpretation and Implementation, section "1. When a resident is admitted to our facility, the Social Services Director (SSD) or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical pr surgical treatment, and the right to formulate advance directives. " "3. When a resident is admitted to our facility. SSD or designes will inquire of the resident, and/or his/her family members, about the existence of any written advance directives. " Policy Interpretation and implementation, section "5: In accordance with current OBRA definitions and guidelines governing advance directives, our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to: b. Do Not Resuschale-Indicates that, in case of resident, legal guardian, health care proxy, or representative (sponsor) has directed that no

1 () or other

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DEPARTMENT OF HEALTH	AND HUMAN CED ACCO			500 mm
CENTERS FOR MEDICARE	& MEDICAID SERVICES			PRINTED: 08/07/201 FORM APPROVE
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-039
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER		IPLE CONSTRUCTION	(X3) DATE SURVEY
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NAME OF PROVIDER OR SUPPLIER	103684	5. WING_		06/26/2015
			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/20/2015
EXCEL REHABILITATION AND	HEALTH CENTER		2811 CAMPUS HILL DR	
			TAMPA, FL 33612	
	PEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL.	1D	PROVIDER'S PLAN OF CORRECTIO	
TAG REGULATORY OR LS	C IDENTIFYING INFORMATION	PREFIX		
		IAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE
_			DEFICIENCY)	
F 224 Continued From pag	e 85			
. •		F 224		
A review of the facilit	y policy: " Emernency			
Procedure:	Transfer Email			
() " (Revised	2011), documented the			
policy statement: " P	ersonnel have completed			
maming on the initiate	on of			
- ()/	Basic Life Support (BLS) in			1
vicums of sudden			•	1
Policy and Interpretat	ion and implementation.			1
1. is de	fined as inadequate			1
resulting	in insufficient flow			1
anoughout the body (pulselessness). 2. Sudden			l l
In adulto 3 Version	s a leading cause of			
in adults, 3. Victims of have gasping				1
	or may even appear to			1
recognizing the	raining in BLS includes			1
The likelihood of recov	presentations of SCA, 4, ering from SCA due to an			i
acute event (such as) differs			
substantially from the l	kellhood of recursion			1
irom tha	t the and requires			i
multi-system failure and	d advance irreversible or			1
universiting cause, the c	hances of surviving SCA			1
may be increased if	is initiated immediate.			i
in chart same. 6. Any u	nnecessary interruptions			i
in chest compressions	including longer than			1
necessary pauses for re decreases effective	scue breathing)			}
reversible situations, ea	eness. 7. In potentially			1
with a defibrillator plus	iv delivery of a			1
collapse can further incr	within 3-5 minutes of ease chances of survival.			1
				i
maintain life until the em	Attonomy madical			1
response team arrives to	deliver Advance Life			1
				J
				1
				İ
BLS st	nall Initiate unless			1

Facility ID: 62932

/ ... / .. 18:20

From:7275521162

#055 P. DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEPICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING __ COMPLETED C. 105984 R WIND NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, 2IP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL OR TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 10 PROVIDER'S PLAN OF CORRECTION PREFIX TAG MEACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 224 Continued From page 86 F 224 a. it is known that a :1 order that specifically prohibits and /or external exists for that individual: Preparation for "1. Obtain and for maintain American Red Cross or American Association certification in Basic Life Support (BLS/ - () for key clinical staff members who will direct resuscitative efforts. including non-licensed personnel, 2. Provide periodic Mock Codes (simulations of an actual) for training purposes. 3. Select and identify a team for each shift in the case of an actual . To the extent possible. designate a team leader on each shift who is responsible for coordinating the rescue effort and directing other team members during the rescue effort. . 4. The team in this facility shall include at least one registered nurse, one LPN/LVN and two CNAs, all of whom have received training and certification in Maintain equipment and supplies necessary for /BLS in the facility at all times, 6. Provide intermation on /BLS policies and advance directives to each resident/ representative upon admission. 1 Emergency Procedure -.... " 1. the facility 's procedure for administrating shall incorporate the steps covered in the 2010 American Association Guldelines for and Emergency Care or facility BLS training material, 2. The basic life support (BLS) sequence of events is referred to as C-A-B " (chest compressions, airway, and breathing). This has been revised from the previous sequence of "A-B-C" (alreay,

breathing, chest compressions), 3. Begin

Facility ID: 52932

-/-/ - 18:21 #055 P.039/051

AND CLA	ERS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	Land		FORM APPROV OMB NO. 0938-03
ANDPLA	N OF CORRECTION	DENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
NAME C	F PROVIDER OR SUPPLIER	185884	B. WING		C
				STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/2015
EXCEL	REHABILITATION AND			2811 CAMPUS HILL DR TAMPA, FL 33612	
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL		PROVIDER'S BLANCE GODING	
TAG	REGULATORY OR LE	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	
F 224	Continued From pag	ge 87	F 22		
	normally (ignoring or	coasional gages) with a st	F 22	24	
	initial assessment h	s pulse. 4. Following the			
	compressions rather	than annals: U			
	trained or not, should				
	compressions to victi	ims of			
	Delivering high-quality	V chest component			
		of to a depth of at least 2			
	compressions per mir	nute B Allen full about			
		pression. C. Minimize compressions. 7. Trained			
		compressions. 7. Trained provide , with a			
	compression -	ratio of 30:2. "			
	A review of the facility	policy: "Admission			
	Aanual (Revised	Clis Policy and Procedure			
	if this procedure is to a				1
		i, emotional, , and upon admission for the			1
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	struments, including the ADS). "Steps in the F				1
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ad	Vance directives and	on his/her right to have			1
68					1
6-1					,
	ident 's medical recor				1

.../___i 16:54

08/07/2015 18:22

#055 P. /_ DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING __ COMPLETED 105884 С B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX ID PREEIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION YAG DEFICIENCY F 224 Continued From page 88 F 224 conducted with the NHA, in regards to the facility response to the incident of Resident #1 not when necessary she stated, "We started an investigation and a Quality Assurance Performance Plan (QAPI) immediately. We sent the ADON home for the day on suspension. We reviewed the policy and procedures for advance directives. , Code Blue Roles and Responsibilities, and the Emergency Procedure . We interviewed the staff regarding their ability to verbalize the process. We normally complete an audit of the advance directives and orders monthly. The SSD initiated an immediate audit for Advance Directives and for the entire resident population and it was completed by 2015. We were monitoring / reviewing the charts of residents who expired. We started in-service training regarding advance directives and and called a Code Blue Drill. Multiple interviews of the staff were initiated to ensure the direct staff knew about advance directives and when to call a code Training was conducted in for the entire facility. The DON did immediate in-servicing with the ADON and we completed a Federal report. We have been conducting weekly QA meetings regarding the event. These meetings will continue weekly through and then occur monthly. When asked when staff training had been conducted prior to the last couple of months, she stated, "we do it routinely and new hires get it at orientation." When asked how the facility audits the employee records for current she stated "the Human Resource (HR) manager does an audit, which includes reviewing cards. When asked if the event had been presented to the QA committee with an action plan she stated. "Yes"

On

00/07/2016 16:22

#955 P.041/051

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING C 105884 R. WING 06/26/2015

F 224

NAME OF PROVIDER OR SUPPLIES EXCEL REHABILITATION AND HEALTH CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR

TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREELY TAG TAC

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DEFICIENCY

F 224 Continued From page 89

contained the Quality Assurance Performance improvement Plan for review. The tool was dated and signed by the Quality Assurance team including the Medical Director on . A review of the information provided revealed policy revisions dated for *

Directives " which includes " Code Blue Roles and Responsibilities " and "Emergency Procedure -Review of these revisions revealed the following relevant changes: "Code Blue Roles and Responsibilities " (no effective date): " In the

event that a resident is found in the person discovering the immediately notify a nurse of the situation. A teammate should page overhead that there is a Code Blue and the location of the code. All available teammates are responsible to respond to a Code Blue Page. The nurse is responsible to immediately assess the resident to determine if the resident is in resident's medical record will be obtained to

determine if the resident has a () document in their record. (may check YELLOW BINDERS at each nurses station for status) if the is noted then there will be no further interventions implemented as per the resident 's advance directives. If there is no in the medical record then is to be initiated on the resident. Nurses are responsible for the implementation of on the resident. The nurse assigned to the resident will act as the TEAM LEADER of the code situation. Certified Nursing Assistants who

are certifled may be directed to assist with at the direction of the nurse. signature sheets were provided

for the rollowing in-services, dated FORM CMS-2567(02-89) Previous Vorsions Obsolete

Event ID: JSQX11

Facility ID: 82932

If continuation sheet Page 90 of 213

#055 P. / 1

DEPAI	RTMENT OF HEA	ALTH AND HUMAN SERVICES				DOLLER	
CENT	ERS FOR MEDIC	ARE & MEDICAID SERVICES				FORM	D: 08/07/2015 MAPPROVED
1 STATEME	VY OF DESIGIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	_			OMB NO	0.0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	JLTIP	LE CONSTRUCTION	(X3) DA	TE SURVEY
1			A. BUIL	.DrNG		CO	MPLETED
1		105884		_			c
NAME OF	PROVIDER OR SUPPL		B. WIN	_			/26/2015
1				1 8	STREET ADDRESS, CITY, STATE, ZIP CODE		20/2015
EXCEL	REHABILITATION.	AND HEALTH CENTER		1 2	811 CAMPUS HILL DR		
040.00				17	AMPA, FL 33812		- 1
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECT	-	
TAG	REGULATORY C	OR LSC (DENTIFYING INFORMATION)	PREF	1X			COMPLETION
			100	•	CROSS-REFERENCED TO THE APPRO DEFICIENCY	PRIATE	DATE
	-				DE 10-E115-11		
F 224	Continued From	page 90		224			
	3/21, 5/9, 5/20,	, 6/7, , , , , and		:24			- 1
	6/2 In ad	idition mock "Code Blue " drills					1
	were gone on	. 5/27. All					i
	documents that v	Vera provided to the					1
							- 1
							i
	or on employees.	1 110 COMParison revealed that					1
		11% of licensed nurses and 97%					1
	or the unlicensed	staff had completed the training.					- 1
							- 1
	advanced directive	e facility staff regarding					1
,	wate conducted is	es, and Code Blue drills					i
	The following rele	order to verify staff knowledge. vant interviews were obtained:					
		vant interviews were obtained:					- 1
	On at 4	:24 PM, an interview was					ĺ
c	onducted with En	nolouse C a susse at a star of					- 1
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th	e book. I wo	someone at the desk check					1
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wo	ould stop "	sident had a order then I					- 1
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Or		2 PM an interview was					- 1
co	naucted with Emp	DOVAR D & RUSSA What I I					1
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Co	do Plus delles	and participated in mock					- 1
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	esponsive; I would	If I found someone					1
son	reona to go to	start , shout for					- 1
l wa	Uld stop	book, if they were a					- 1
	110	ould call the physician and					1

16:24 #055 P.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/07/2015

CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING 105884 B. WING NAME OF PROVIDER OR SUPPLIED 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR

TAMPA, FL 33612

DEFICIENCY

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

10 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DOSCIV TAG

F 224 Continued From page 91

knew if they were a

family. If they were a full code I would keep going until the paramedics come. "

On at 4:40 PM an interview was conducted with Employee E a nurse, she stated she usually worked as needed on the 3:00 PM -11:00 PM shift. She stated that during orientation they discussed advance directives and orders. She had training in the last couple of months on advance directives and did a mock Code Blue drill also, if a resident was found unresponsive she stated she would, " check the resident, yell for help, and send someone in net more help. I would start . There is a book; I would send someone to check. If I have started and find out the resident is a then I would stop. I would start before I

or not."

at 7:22 AM an interview was conducted with Employee F a nurse, he stated he usually worked the 11:00 PM -7:00 AM shift, He stated " We had a Mock Code Blue training recently. We recently had a class on advance directives and " The training included: making sure we have advance directives, if resident is speak with the family, check the chart for me yellow form, make sure a POA is in the chart also. He was asked what he would do if he found an unresponsive resident, he stated "first assess for breathing, call a code, call somebody by name to call 911. Check Vital signs, call for crash cart. Call another person to look at form, I would start compressions right away, and if found they were a Would stop compressions.

During the interview conducted on 5:15 PM with the DON she stated that what she F 224

FORM CMS-2567(02-99) Previous Versions Obsolete

Event (D: JSO Y11

Facility ID: 62932

If continuation sheet Page 92 of 213

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/. /.... 10:24

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING COMPLETED 105884 B. WING NAME OF PROVIDER OR SUPPLIES 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES Ю PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FYING INFORMATION TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETIO TAG DEFICIENCY F 224 Continued From page 92 F 224 would expect that if a resident was found unresponsive and had a Full Code status the nurse should start . She was asked if a nurse should start rt prior to finding out about order. She stated, "The nurse a resident 's should know if the resident is a or not before they start . If the nurse starts and finds out the resident is a , the nurse can aton That is what I was told during my class. asked if that was in the facility policy, she stated. " It is not in our policy, so I do not teach that in the in-service classes." The DON was informed that 3 out of 7 nurses interviewed so far stated they would start when they found an unresponsive resident and then stop found the resident was a . She was asked if the facility conducted training since the event. She stated "yes, we started in event and we have given in-services again recently. " This training covered Orders and advance directives. The training is also being done on orientation. She stated, "We did the training for the whole month of because we had to get everybody. And then we just did it again. In addition, a Quality Assessment Performance Improvement (QAPI) was started. the day of the event. The Quality Assurance (QA) committee was informed. We did training with the CNAs and nurses and also preformed mock code blues. " asked if training hed been performed in the past, stated, " Yes, the in-service is done yearly and during orientation. " In addition, the DON was also asked, how the facility audits the employee records for current , she stated, "when we have new employee starting Human Resources (HR) sees the card

and then the ADON checks the

that. All nurses are supposed to be

Facility (D: 82832

card after

#055 P. ./__!

DEPARTMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 08/07/2015 FORM APPROVED
CENTERS FOR MEDICARE STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	OMB NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER	105884	B. WING		C 06/26/2015
EXCEL REHABILITATION AND	FMENT OF DESIGNATION		STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR TAMPA, FL 33612	
PRÉFIX (EACH DEFICIENCY TAG REGULATORY OR LS	MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFI) TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR OEFICIENCY)	100 DE COLUMN
monitors, audits the reviews orders the event had been p Assurance (QA) com and plan of correction DON completed the lot the corporate nurs direction! got was to codes, and file a fede On at 2:00 conducted with the Ni the content of the trail, and DON stated, we vpolicies: policy (for, orders and b paper, etc.). Advance Blue policy (described wilk in on an unrespons	r current she stated " s monthly and HR does s tasted the SS department advance directives, and monthly. The DON stated reserved to the Quality mittee and an action plan was put into place. The "defear leport and reported s. The DON stated." The do education, and do mock ard report. " PM, an interview was 1-4A and the DON to review ining in-services. The NHA vent over the following which included what to Inex ook, where to find the Directive policy and Code a mock code blue, if staff siève resident what your	F 2:	24	

of 8 nurses on

nursing staff that day.

received a packet. The expectation was for nursing / CNA staff to receive training by the first QAPI meeting. By the first QAPI we were almost at 100%. The concern regarding interviews with 4

surveyor which revealed the nurses would start prior to knowing the resident 's code status was discussed. The DON stated, "That is not what they were trained to do. " The NHA and the DON stated they would begin retraining the

and

at 1:00 PM an interview was

Facility ID: 62932

by the

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06/26/2015

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#055 P. PRINTED: 08/07/2015

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING __

FORM APPROVED OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

DEFICIENCY

105884 B. WING NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL OR

EXCEL REMABILITATION AND HEALTH CENTER

SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAMPA, FL. 33612 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

(Xs) COMPLETION

F 224 Continued From page 94

Procedure for advance directives and last reviewed, the Corporate Nurse (CN) stated " the Policy and procedure for advance directives and was reviewed and updated on ", after the event with Resident #1. He further stated that the Emergency Procedure was also updated. which included the Code Blue Roles and Responsibilities

- 5. Record reviews and interviews revealed the following corrective action was taken:
- in-service signature sheets were reviewed for retraining of the nursing staff, regarding advance directives, code blue drills. The NHA verified that all nursing staff with the exception of one employee that was unavailable had received the in-service retraining. The NHA verified that this employee will not return to work until they have received the retraining. On interview it was confirmed after the re-training, the nurses were able to verbalize Policy and Procedures: Advance Directives, and Emergency Procedure: and Code Blue Interviews were conducted with 21 out of the 31 nursing staff members on . All staff members interviewed

were ramiliar with the policy and able to verbalize the correct procedure

at 3:40 PM an Interview was conducted with the NHA. She was asked how the facility was going to ensure that residents had Advance Directives which accurately reflected their wishes in their first 14 days of admission since Residents #2 and #4 's advance directives had not been addressed and they were both recently admitted. She stated she met with the

F 224

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FORM CMS-2567(02-69) Previous Versione Obsolete

Event (D: JSOX11

Facility ID: 62932

If continuation sheet Page 95 of 213

From:7276521162

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 105884 B. WING NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE

EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFO (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 10 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG PREFIX COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY

F 224 Continued From page 95

SS department and said that all residents admitted in the last 2 weeks or since would be reviewed regarding advance directives and the reviews would be documented in the progress notes. When asked how the facility was going to address blanks in the Advance Directive Acknowledgement form she stated the Regional Business office will do a complete audit of our admissions for completion: will audit immediately to ensure the paper work is being filled out correctly and completely.

the facility provided the following note written on facility letterhead and dated 5 signed by the NHA:

Social Service: In regards to assuring that residents are given the opportunity to discuss/choose an advance directive, 100% of all admissions from forward have been reviewed by the Director of Social Services and a progress note regarding same has been added to these records as an addendum to the initial assessment done at the time of the admission. Admissions Contract: in regards to assuring that residents are given the opportunity to discuss/choose an advance directive, 100% of all admissions contracts from have been reviewed by the Admissions Coordinator to ensure completion of all forms including the advanced Directive Acknowledgement.

On at 9:50 AM an interview was conducted with the NHA and the Corporate Nurse (CN). They stated they had initiated an audit on all admissions since . The SS department revisited each resident and wrote a progress note for each medical record to provide documentation. The Admissions department

F 224

FORM CMS-2987(02-99) Previous Versions Obsolete

Event ID: ISD 914

Facility (D: 82032

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICE	s
CENTERS FOR MEDICARE & MEDICAID SERVICE	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AND PLAN OF CORRECTION

105884

FORM APPROVED OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY A. BUILDING __ COMPLETED

NAME OF PROVIDER OR SUPPLIER

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TAG

STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR

EXCEL REHABILITATION AND HEALTH CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES

TAMPA, FL 33612 in PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

06/26/2015

F 224 Continued From page 96

TAG F 224

went through all admission paperwork for residents admitted on forward to make sure paperwork is correct and to review the advance directives section for completion. All incomplete forms were addressed with the resident last night or this morning. The Admissions department has been re-educated by the NHA regarding completion of admission agreement forms, with attention to the resident rights portion and advance directives, including not leaving blanks and having correct dates. The NHA stated she would review advance directive paperwork on all new admissions. They also stated that the Admissions department will do an audit of the paperwork for all admissions for the next three months. They said that after three months they would begin a monthly random audit that would be discussed at the QA meetings. They further stated that at the time of admission, the nurse will verify advance directives and document on a progress note. All new admissions will be reviewed at the daily clinical meeting and advance directives will be a focal point at that time; this will occur on the weekends as well. Social services will continue to assist the resident with development of advance directives and will document on a progress note. They stated that each resident 's advance directives will be discussed at their 14-21 day and quarterly care plan meetings. The expectation is that if a resident wants anything changed between the 14 day care plan and quarterly care plan meetings they will approach the facility steff or if steff notices a change in condition that it will be re-addressed with resident.

Based on this information the Immediate Jeopardy was found to be removed on

DEPAR'	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 08/07/2015 FORM APPROVED DMB NO. 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
		105864	a. WING _		06/26/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
EXCEL F	REHABILITATION AND	HEALTH CENTER		2811 CAMPUS HILL DR TAMPA, FL 33612	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 224	Continued From pa	ge 97	F 22	4	
		scope and severity was			
	reduced to a D.	WORE OBOVEDED MEET	F 28		4 -
F 261 SS=J	PROFESSIONAL S	VICES PROVIDED MEET TANDARDS	F 20	I	
	The services provid must meet profession	led or arranged by the facility onel standards of quality.	1.	Resident #1 Expired at the facility Family and Physician wo notified.	
	by. Based on review of Act, the Assistant Di description (Reviser review and intended description (Reviser review and intended Director, a resident physician, it was del to ensure that service professional standar initiation of assignitude of the sampled residents as per the resident sampled residents as a having Full Code facility's Advance Living and Control of the Control of	male, aff to be unresponsive and less than 24 hours after stant Director of Nursing did not medical services were al record contained a "Full". The whell Policy and Procedure		A review was completed for adv. directives on this include review of current full code, physician orders. A review was a be completed by to assu that all residents received in writ their rights to formulate advance directives according to their wish or that of their respective responsible parties. A Review has also been completed for complete of the Admissions Agreements are will be completed by . Am identified areas of concern have been addressed. All current residents advance directives are being acknowledged per their request. All residents are receiving care according to Professional Standards of Care.	ed a and iso ire iting e e es s s tion d y y

Erom:7276521162

DEPARTMENT OF HEALTH AND HUMAN SERVICES

#055 P. / PRINTED: 08/07/2015 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MUITIPLE CONSTRUCTION COMPLETED A BUILDING ^ 105884 06/26/2015 STREET ADDRESS CITY STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER

EXCEL REMARK ITATION AND HEALTH CENTER

(X4) ID PREFIX CUMMARY STATEMENT OF DESIGNATIONS (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

2811 CAMPUS HILL DR

TAMPA FI 33812 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

F 281 Continued From page 98

directives and denied the resident the opportunity to receive emergency lifesaving services to prolong his life.

Failure of the facility to ensure nurses met professional standards and acted in accordance with the Nurse Practice Act as defined in the Florida Statues, Chapter 464, resulted in Immediate Jeopardy, which were removed on , and the severity and scope was reduced to D

Findings include:

- 1 The Florida Nurse Practice Act Chapter 464.003 defines the (20) "practice of professional nursing" as "the performance of those acts requiring substantial specialized knowledge. judgment, and nursing skill based upon applied principles of ', biological, physical. and social sciences which shall include, but not he limited to:
- (a) " The observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care; health teaching and counseling of the ill. injured, or infirm; and the promotion of wellness. maintenance of health, and prevention of illness of others
- (b) "The administrations of medications and treatments a prescribed or authorized by a duly licensed practitioner authorized by the laws of this state to prescribe such medications and treatments.
- (c) " The supervision and teaching of other personnel in the theory and performance of any of the acts described in this subsection. " A profession nurse is responsible and accountable for making decisions that are based

F 281

in

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TAG

3. The facility's policy and procedures for Advance Directives.

> and Do Not Orders have been

reviewed and revised as necessary by the QAPI Committee on Licensed Nursing staff has been reeducated related to Advance Directives.

. Code Blue Roles and Responsibilities on thru 6-25-15. Re-education will be provided again and will be completed by . The Social Services Department and Admissions Department has been re-educated on completion of the Admission Agreement and Documentation in the medical record regarding resident Advance Directives. Education was provided by the Staff Development Coordinator/DON/ Administrator

(X4) ID

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#055 B

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTER: 08/07/2015 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED 105224 8. WING 06/28/2015 NAME OF PROVINCE OR SURPLIED STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR

EXCEL REHABILITATION AND HEALTH CENTER

TAMPA, FL 33612

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

F 281 Continued From page 99 upon the individual 's educational preparation and experience in nursing.

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION!

2. Review of the "Assistant Director of Nursing"

iob description (Revision Date: included: Purpose of Your Job Position: "The primary purpose of your position is to assist the Director of Nursing Services (DON) in planning. organizing, developing, and directing the day-to-day function of the Nursing Service Department in accordance with current federal. state, and local standards, guidelines, and regulations that govern our Facility, and as may be directed by the Administrator, the Medical Director, and/or DON to ensure the highest degree of quality care is maintained at all times. **Duties and Responsibilities:** Administrative Functions: Assist the DON in planning, developing, organizing, implementing, evaluating, and directing the day-to-day functions of the nursing service department, in accordance with current rules, regulations, and guidelines that govern the Facility. Participate in developing. maintaining, and updating our written policies and procedures that govern the day-to-day functions of the nursing service department. Periodically review the department 's policies, procedure manuals, job descriptions, etc. Make recommendations for revisions of policies. procedures, etc. to the Director. Participate in the development, maintenance, and implementation of the Facility's quality assurance program for

the Director with recommendations that will be helpful in eliminating problem areas. Committee Functions: Serve on the Quality

the nursing service department. Monitor the

Facility's QI, QM and survey reports and provide

F 281

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and Nurse Consultant When a resident is admitted to the facility the Licensed Nursing staff will inquire with the resident/responsible party if they have current advance directives. If the resident has advance directives and the copies are available they will be placed in the medical record and implemented. If copies of the resident's advance directives are not available the nurse will request the resident/responsible party to provide copies to the facility at their earliest convenience. Resident wishing to implement advance directives will be referred to the Social Services department for further discussion. The nurse will document in the resident's medical record that this discussion has taken place. Admissions will be reviewed at the Daily Clinical Meeting to assure that the resident's advance directives have been addressed by the facility per their request and that any follow up has been completed. Current residents who do not have advance directives will have a rediscussion at their quarterly care reviews.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

.1.7 18:55

#056 P.002/051

CENT	ERS FOR MEDICARE	AND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/07/2015 FORM APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:			TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLEYED		
		105884	B. WING		С	
EXCEL	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR TAMPA, FL 33612	06/26/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D DC 00-17-1	
	Assurance and Asse directed. Assist the I and/or oral reports o programs and activit committee (s). Personnel Functions determining the staff service department. Nursing Care Function information relative to resident and to the nu	ssment Committee, as Director in preparing written If the nursing service	F 28	This area of care will be monitore by the DON/Social Services Director/Admissions Coordinator weekly times four weeks and the monthly times three months. This will also be over seen by the Administrator and the QAPI Committee.	n	

Control, etc.). Assist in developing advance directive in-service training programs for the staff and community. Care Plan and Assessment Functions: Participate

in the development of a written care plan (preliminary and comprehensive) for each resident that identifies the problems/needs of the

Prevention, Safety,

notes to ensure that they are informative and descriptive of the nursing care being provided, that they reflect the resident's response to the care, and that such care is provided in accordance with the resident 's wishes. Schedule daily rounds to observe residents and to determine if nursing needs are being met. Report problem areas to the Director, Assist in developing and implementing corrective action. Staff Development: Participate in developing, planning, conducting, and scheduling in-service training classes that provide instructions on " how to do the job, " and ensure a well-educated nursing service department. Develop, implement, and maintain an effective orientation program that orients the new employee to the department, its policies and procedures, and to his/her job position and duties. Assist in developing annual Facility in-service training programs (e.g., OSHA,

Facility ID: 62932

HIPAA.

18:56

#056 P.003/051

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 105884 B. WING NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) in PROVIDER'S PLAN OF CORRECTION TAG PREFIX EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 281 Continued From page 101 F 281 resident, indicates the care to be given, goals to be accomplished, and which professional serviced is responsible for each element of care. Encourage the resident and his/her family to participate in the development and review of the resident 's plan of care. Ensure that all personnel involved in providing care to the resident are aware of the resident 's care plan. Ensure that nursing personnel refer to the resident's care plan prior to administering daily care to the resident. Review nurses 'notes to determine if the care plan is being followed. Be sure that staff members are providing care that reflects the wishes of the resident. Resident Rights: Review complaints and grievance 's made by the resident and make a written or oral report to the DON, Report all allegations of resident and/or misappropriation of resident property. at approximately 5:00 PM an interview was conducted via telephone, with Employee A, the Certified Nursing Assistant (CNA), who found Resident #1 unresponsive on . She stated she no longer worked for the facility. Employee A stated she was making rounds before she went home and found Resident #1 not breathing. She called for the nurse to check on him. The ADON responded and checked on the resident. The ADON said, " He was gone. " Employee A stated that the ADON did not do)) on Resident #1 and that she did not recall anything else about the resident. at 1:00 PM an interview was conducted with the ADON, the nurse assigned to Resident #1 when he

was taking care of him for the first time on

. She stated that she

. W . 7 . 15 18:57 #055 P.

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES			p	RINTED	: 08/07/20
CENTE	NO FUR MEDICARE	& MEDICAID SERVICES				FORM	APPROVE
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SI/DOLIG		(X1) PROVIDER/SUPPLIER/CLIA IDENT/FIGATION NUMBER:	(X2) MU A. BUILI) MULTIPLE CONSTRUCTION BUILDING			0938-039 E SURVEY
		105884	8. WING	3		1	C
NAME OF	PROVIDER OR SUPPLIER			-		06/	26/2015
			i	ı	STREET ADDRESS, CITY, STATE, ZIP CODE		0.2010
EXCEL	REHABILITATION AND	HEALTH CENTER	28		2811 CAMPUS HILL DR		
				1	TAMPA, FL 33612		
(XA) ID PREFIX TAG		EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION;	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
					DEFICIENCY)		4
F 281	Continued From pag	e 102	F 2		4		
		a shift because another	F 2	ö	1		
	emnioves colled off	She stated the resident wash					
	't' worke' be seen on.	one stated the resident wash					
	verual, ne require	d total care and had been					
	readmitted from the f	ospital that day. When					
	asked to Lecall tue ev	ents that happened on					
	, the day F	Resident #1					
	ine AUUN stated, I w	es working the night shift, I					
	ned finished medicati	on pass and around 5:45					
	AM, the CNA was in t	he hallway and said, "I					
1	hink he is gone. I wer	nt in Resident #1 's					
	hecked him for pulse	and , he was					
٠	ery cool to touch. He	felt a little stiff in his upper					
•	extremities. His lower	extremities had sort of					
	. The resi	dent had white frothy stuff					ł
a	round his mouth. The	ere was nothing I could do					í
**	or him." When asked	if she looked at the chart					- 1
	ra order, she s	stated, I looked at his chart					- 1
a	iter i called the docto	r to tell him the resident					1
	ad and Ididn 't	see a . Honestly, when					- 1
1:	saw the resident after	the CNA called me he					- 1
w	as cool to touch, I do	n 't know if there was					- 1
a	nyming I could do for	him. At that point I made					1
th.	e decision to not cod	e him; because he was					- 1
	and stiff, I did not I	know how long he had					1
DE	en like that. The phy-	sician covering for the					1
at	tending physician wai	s called, and informed of					
	e resident 's , T	he ADON was asked if					
	e saw a order o	n the medical record, she					- 1
Sta	sted, "after looking a	it the chart, no. " When					i
as	ked if she had receive	ed training on how to					- 1
res	sporad when a resider	nt is found without vital					
sig	no site stated, we are	supposed to do chest					1
COI	mpressions and send	someone to check on					
\Aze							
VV F	ormine and att	ked if she knew how to					- 1
Jet	comme code status, s	she stated, if a resident is					
unr	copurisive, I am supp	posed to check the pulse					
and	ror someone els	e to check the chart for					- 1
	orders. I will a call	code blue and bring the					- 1

9 7 = 18:57 #066 P.005/051

TATEMENT OF DEFICIENCY NO PLAN OF CORRECTION	DICARE & MEDICAID SERVICE (X1) PROVIDERSUPPLIERICATION NUMBER (X2) IDENTIFICATION NUMBER (X3) PROVIDERSUPPLIERICATION NUMBER (X4) PROVIDERSUPPLIERICATION NUMBER (X4) PROVIDERSUPPLIERICATION NUMBER (X4) PROVIDERSUPPLIERICATION NUMBER (X4) PROVIDERSUPPLIERICATION NUMBER (X4) PROVIDERSUPPLIERICATION NUMBER (X4) PROVIDERSUPPLIERICATION NUMBER (X4) PROVIDERSUPPLIERICATION NUMBER (X4) PROVIDERSUPPLIERICATION NUMBER (X5) PROVIDERSUPPLIERICATION NUMBER (X6) PROVIDER	JA (X2) MULT	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
NAME OF COOK PART OF	105884	B. WING _		0	PLETED
NAME OF PROVIDER OR SUPPLIER EXCEL REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL OR TAMPA, FL 33612	06/	
	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL IY OR LSC IDENTIFYING INFORMATION)	(D	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD FOR AFFERENCED TO THE APPRIL DEFICIENCY)		COMPLETION DATE
stetion wire an an awa admissio chart. When a resident 's ad she states, 'I check the chair status.' urresponsive, checks the yell are or not in a srouation with a state of the she had had an stated yes, one Nursing (DON). Code Blue, and	In have a yellow book at the number of the seasons of the resident it may be necessary to look in sked how the number is nortified anneal detectives, including the steep with the number of the numbe	is a the of a control of a cont		;	
#1 revealed a N 5:45 AM: " this I Nursing Assistar puls amount of nothly extremities cool (attending physic from (covering plant)	nurse celled to Certifier (t CNA). Resident noted with in the cr. Noted larg saliva on face and chest. Uppe to touch. Call placed to ian) service, return call receiver tysician). Order received to	et d o ge or			

9/ 9 18:66 #056 P. 1/__1

DEPAR	RTMENT OF HEALTH	HAND HUMAN SERVICES				
CENTE	ERS FOR MEDICARI	E & MEDICAID SERVICES			PRINTED: 08/	07/20
		TWO SERVICES			FORM APP OMB NO. 093	ROVE
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUL	TIPLE CONSTRUCTION		
1		I I I I I I I I I I I I I I I I I I I	A. BUILD	NG	(X3) DATE SUR COMPLET	IVEY
İ		1	1		1	-
		105884	B. WING		C	
NAME UP	PROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/20	115
EXCEL	REHABILITATION AND			2811 CAMPUS HILL DR		
	AND THE PROPERTY OF	HEALIH CENTER	1			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		TAMPA, FL. 33612		
PREFIX			PREFIX	PROVIDER'S PLAN OF CORRECT	TION .	XS)
TAG	REGULATORY OR LE	C IDENTIFYING INFORMATION)	TAG			LETION
				CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE D	ATE
F 281	Continued From pag	ne 104	F 28			
	services with diagon	ses that included but not	F 26	1		
	limited to: sepsis,	ses mar incinded but bot				
		and injury Review of				
	ine Physician 's Ord	and injury. Review of er Sheet (POS) dated			i.	
	and signer	d by the physician on				
	revealed un	nder Special Needs; Code				
	Status: "Full" (hand	therition)				
	Tieres (Sa) (Rein	owniterij.				
	Review of Resident #	11 's physician orders dated				
	revealed a	Code Status of Full Code				
		Code Status of Pull Code.				
	Review of Resident #	1 *s complete medical				- 1
	ecords revealed no					ı
	orm was present.	:()				- 1
	The prosent					- 1
	Per the bosoital disch-	arge summary for Resident				- 1
	1 dated : P	atient was a				- 1
a	dmitted to the emerg	ency the hospital				- 1
. w		failure, HCAP				- 1
0	Healthcare-associate	d 3				
	dvance VF					- 1
E	nterococci) () and				- 1
- (-resistant)				- 1
ì		nis hospital stay, a				- {
èc	onsultation was perfor					- 1
ha	iving noted stools the	rmed on due to at were positive for occult				- 1
	Laboratory data	revealed hemoglobin of				- 1
8.3	5 and a platelet coun	t of 335 indicating the				
pa	itient was with	h occult				- 1
() loss. The par	tient did not show any				
Sig	ins or active	at the time				
Re	commendations incli	uded continue tube				
100	edings as tolerated: m	Conitor the hamodishin				- 1
anı	o transfuse on an as	needed basis Bosidani				- 1
#1	was discharged from	the hospital and				- 1
tra	nsferred to the skilled	nursing facility on				1
		• • •				- 1
						1
Are	eview of the Nursing	Admission Evaluation				-

From:7275521162

/ / _ 18:59 #056 P.007/081

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			TIPLE CONSTRUCTION		OATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILD	ING		OMPLETED
		105884	B. WING			C
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	6/26/2015
EXCEL	REHABILITATION AN	D HEALTH CENTER		2811 CAMPUS HILL DR TAMPA, FL 33812		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFID TAG	CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SMOULD BE CED TO THE APPROPRIATE EFICIENCY)	COMPLETS DAYE
F 281	Continued From pa		F 2	81		
	Tool dated arrived via stretche	at 3:00 PM revealed: patient r from hospital with and The resident has advance				
	directives in the cha	nission? NO. Are advance art? NO. Activities of Daily				
	Living: mobility; transfers; o hygiene, Alert to per	required for bed fressing; and personal rson and non-verbal, skin				
	pale, warm and dry, nurse, but can make	Patient not verbal with this at faces for pain.				
	. Breath so in place. Has referre					
	Occupational	and Speech c C, a Licensed Practical				
		t#1 's Social Service				
	at 5:32 Al	n Tool document dated If (Thursday) included the				
	following information had resided with	his father in the past, was a				
	high school graduate	and had been in the . It also included the				
	questions with corre	sponding answers written in the resident have advanced				
	directives? INCAPAC	OTY & HC (health care) Does the resident have a				
1	egal representative?	YES, (the resident 's father number); What is the				
r	s name and phone i esident 's code stati Electronically signed	us? FULL CODE. It was				
(MDS) assessment d					
P	nder Section C (assessment for Ment	Patterns): Staff al Status: Short term blem. Long term memory:				

08/07/2015 18:59 #056 P.006/051

DEPAR	RTMENT OF HEALTH	HAND HUMAN SERVICES				****	
CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES				PRINT	ED: 08/07/201
		MEDICAID SERVICES				OMPA	RM APPROVED 10. 0938-039
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MI	ATIPLE	CONSTRUCTION	OIVID I	0.0938-039
į		STATE OF THE PROPERTY	A. RUIL	DING_		(40)	DATE SURVEY OMPLETED
		1	1			"	
		105884	B. WING	š			С
NAME OF	PROVIDER OR SUPPLIER		-	078	EET ADDRESS, CITY, STATE, ZIP COD		
EXCEL	REHABILITATION AND			204	CAMPUS HILL DR	Æ	
	AND MOUNTAINS	HEALTH CENTER					
(X4) ID	RI MMADV STA	TELEGRAP OF DESIGNATION		IAR	MPA, FL 33612		
PREFIX	EACH DEFICIENCY MUST BE PRECEDED BY STATE		10		PROVIDER'S PLAN OF CORRE	CTION	(X5)
TAG	REGULATORY OR LE	C IDENTIFYING INFORMATION	PREFIX		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP		COMPLETION
					DEFICIENCY)	ROPRIATE	DATE
							
F 281	Continued From pag	se 106	F 2				
	Decision Making: se		F 2	81			
	Section D (Mond): 0	iverely Under itaff Assessment: feeling or					
	annearing doug, do	pressed, hopeless. Trouble					
	felling or steving act	eep or sleeping too much;					
	Feeling tired or house	ng little energy; Trouble					i
	concentration Hade	r Section G (Functional					
	Status):						1
		of one person for bed mobility and dressing:					
	total dependence rec	ior dec mobility and cressing;					1
	personal hygiene. Ur	fulled for eating and					1
	Bowei): Always						
	Under Section I (Activ	of bowel and					- 1
	and Use	ve Diagnoses): fallure					- 1
		nder Section K (Swallowing					
	and reductional Status	i): Height 66 "; weight 111					1
	ounds; loss of 5% of	r more in the last month or					ł
,	oss of 10% or more i	n last 6 months-yes;					- 1
- 7	eading tube. Under	Section M (Skin Conditions):					- 1
,	risk of developing	. Under					1
	ection & (Resident	s Overall Expectation);					1
-	expects to temain to I	this facility; by family.					1
	n :=11/1	C Obt (-t t					- 1
		5 PM an interview was byse G a Social Services					
۵	esistant renarding D	esident #1 's Social Services					i
Δ.	dmission Evaluation	Tool dated					į.
fi	med 5:32 ALL anners	Tool dated and kimately 13 minutes prior to					1
**	e resident 's	Amately 13 minutes prior to					- 1
		When asked, Employee G					1
	ated he probably fille	ed in the information based le stated he was going to			•		i
SI	eak with the residen	t stated he was going to					
Cr	offirmed that the reni	dent had a health care					i
nr	oxy and a Determina	ition of Incapacity. He					1
cc	offirmed that the resi	dent was a Full Code on					- 1
Dr.	evious admissions a	nd remained a Full Code					i
he	cause there was not	a signed in the					1
me	edical record. He ete	ted that his plan was to call					1
the	family and inform the	new mat rise plant Was to call					1
for	mulate an advance	directive for the resident.					1
He	further stated that the	ne facility procedure in					1
116	Siereo (lat il	ie racinty procedure in					

10.00

				19:00	#0-	_
DEPA	RTMENT OF HEALT	H AND HUMAN SERVICES				
	EDG FOR MEDICAR	E & MEDI ID SERVICES			PRINT	ED: 08/07/201 RM APPROVE
	NT OF DEFICIENCIES	(X1) PROVIDERISTIPPI TERVICIA	(X21 MI)	LTIPLE CONSTRUCTION	OMB N	10. 0938-039
1		DENTIFICATION NUMBER:	A. BUILD	DING	(X3) (DATE SHRVEY
1		1	i		۰	OMPLETED
NAME O	PROVIDER OR SUPPLIER	105884	B. WING			C
į.				STREET ADDRESS, CITY, STATE, ZIP CO.		
EXCEL	REHABILITATION AND	HEALTH CENTER	- 1	2611 CAMPUS HILL DR		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		TAMPA, FL 33612		
PREFIX			PREFIX	PROVIDER'S FLAN OF CORRI	ECTION	
,~~	HEGDINIONY OR E	SC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHORT CROSS-REFERENCED TO THE AP	OULD BE	COMPLETION DATE
				DEFICIENCY)	TOPRIALE	UATE
F 281	Continued From pag	te 107				
	regards to advance	directives required the	F 28	31		1
	Admissions Departm	tent to speak to conidonts				
	admission, advance	directives are than				1
	accressed in the Nu	rsing Admission Assessment				:]
	information with the	es Department reviews the resident and/or the family.				:
	sin the Honding	esident and/or the family,				
	On lat 1:2	0 PM an interview was				- 1
	conducted with the S	ocial Services Director				1
	(SSD) regarding Res	dent #1. Per the SSD, she				1
	spoke to the resident he was readmitted on					J
	that his parents were	. She confirmed				- 1
	regarding his care and	were designated as his				í
	Activated Medical Dec	dsion Makers at that time				!
	She stated that the far	ther was given information				1
	n regards to formulati SSD states, "If he wa	ng an advance directive.				ı
	vould have mailed him	inted him to be a we				
a	ilso stated that she ha	d not spoken to the father				1
٧	when the resident was	admitted on				1
5	he stated that the res	ident was designated as a				- 1
5	ull Code since his ori 014 and had never ha					- 1
n	nedical record.	nd a paper in his				1
						1
	n at 12:40	PM, a telephone interview				1
w	as conducted with Re	sident #1 's father. He				- 1
ai	ated his son was in the	hed to have surgery. He				- 1
61	ated the resident lived	by himself for a while				i
ar	to then he started livir	IO with his cirlfriand. Ha				
W	ent to the hospital and	they sent him to the				- 1
ex	rsing home. When as	sked if they were				1
ca	re for him anymore H	stated, he " could not not 's why he went to the				
110	SING HOME. He was	wearing diapers and				1
CO	uidh it dress himself :	3DVMCCs * Leouide / t				- 1
hai	ndle him anymore. " I	He went to the hospital				

08/ __15 19:01 #068 P. /

#068 P.

DEPAI	RTMENT OF HEALTH	HAND HUMAN SERVICES					
_CENT	ERS FOR MEDICARI	E & MEDICAID SERVICES				PRINTED	08/07/201
STATEME	NT OF DEPICIENCIES	WEDICAID SERVICES		_		OMB NO	.0938-039
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	λTI	IPLE CONSTRUCTION		E SURVEY
			A. BUIL	DIN	IG	COM	PLETED
		105884	1				0
NAME OF	PROVIDER OR SUPPLIER	105884	B. WING	3_			26/2015
				Г	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2015
EXCEL	REHABILITATION AND	HEALTH CENTER		ı	2811 CAMPUS HILL DR		
				1	TAMPA, FL 33612		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	iD.		PROVIDER'S PLAN OF CORREC		
TAG	REGULATORY OR US	MOST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
F 281	Continued From pag	ne 108					
		home; he "was in and out	F2	81			
	of the nursing home	.* Ithink he in the					
	hospital, no, the nurs	ind home I ent					
	sometimes. I couldn	't do anything with him. He					
	was having problems	breathing, they put him on					
	. The last time	e I saw him he was in the					
	hospital, and then so	meone called and said he					
	was						
	On at 5-nn						
		PM an interview was					
	(NHA) When saked	ursing Home Administrator if she could recall the events					- 1
	that happened on	, the day Resident					- 1
		stated the DON informed					- 1
i	her that the ADON ha	d found the resident					- 1
	unresponsive and did	not perform . The NHA					- 1
	stated in her opinion t	he ADON should have					- 1
1	ooked at the chart an	d Initiated :.					- 1
							1
	On at 5:15	PM an Interview was					i
	when asked if she was	rector of Nursing (DON), s familiar with Resident #1,					
,	he stated "voe " M	s familiar with Resident #1. Then asked about the day					- 1
Ĕ	Resident #1	, she stated, " When I					
		If the (ADON) stated that					- 1
F	esident #1 had pass	ed. I asked the (ADON) if					
5	he had performed	the (ADON) said no I					- 1
S	tated to the (ADON) t	hat she should have called					1
a	code and the (ADON), and stated she did not					- 1
a.	o it. I educated the (A	DON) right then and there					- 1
to	start a code on mett	he policy states, we have er what, on a Full Code					
re	sident. I interviewed	er what, on a Full Code (Employee A) who stated					- 1
sr	ie was making her ro	unds, and the resident					
d+	dn 't look right, she s	hook him, and he was not					
re.	sponding, so she got	the nurse " The DOM					
st	sted, "The chart reve	ealed the resident was a					
Fu	ill Code. " The DON:	stated. "I knew he was a					- 1
ful	code because he ha	id been here for so long."					

			08/07/2015 -0		ופטעוטיי
DEPARTMENT OF HEALTH	AND HIMAN OF BURNE				
SCHIERS FOR MEDICARE	& MEDICAID SERVICES			FOR	D: 08/07/2015 M APPROVED
STATEM OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SURBILIED/OLD	(V2148	LTIPLE CONSTRUCTION	OMB N	0. 0938-0391
- Second Country	IDENTIFICATION NUMBER	A. BUIL	ALTIPLE CONSTRUCTION	(X3) D4	TE SURVEY
1 1		A. BUILI	DING	CO	MPLETED
	105884	B. WING			c
NAME OF PROVIDER OR SUPPLIER		D. WING		- 1	•
			STREET ADDRESS, CITY, STATE, ZIP CODE.		
EXCEL REHABILITATION AND	HEALTH CENTER		2811 CAMPUS HILL DR		
		- 1	TAMPA, FL 33612		i
(X4) ID SUMMARY STATE PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES	ID	Secretary of the secretary		
TAG REGULATORY OR I SO	AUST BE PRECEDED BY FULL DENTIFYING INFORMATION	PREFE			(75)
	TO CHAIR MAN TO NOW TO NO	TAG	CHOOSING FENENCED TO THE APPR	OPRIATE	COMPLETION
			DEFICIENCY)		
F 281 Continued From page					
Continued From page	109	F 2	81		1
The DON stated "the	(ADON) decided on her				į
own not to do".	The DON, stated * the				ĺ
nurse pronounced hin	n '"				- 1
					- 1
On at 12:00	PM, an interview was				- 1
conducted with the Me	edical Director, When seken				1
if his expectation was	for a purse to perform				
on a Full Code resider	it he stated * chould				
be done. " He has bee	en the Medical Director for			- 1	- 1
almost 4 years. "If the	e resident was				1
unresponsive.they hav	e to do Code Blue is				i
for all non- reside	nts "				1
On at appr	oximately 10:00 AM, an				1
interview was conducted	ad with Resident #1 's				- 1
attending physician. Th	e physician eteted the				- 1
resident had multiple of	roblems including: multiple				- 1
issues.	released including. Indiaple				1
(), and	" He did not look well at all.				1
He was thin and looked	90. He was new to me se				1
a patient. He was back	and forth to the bosoilet				- 1
was not called the day t	ne the obvicion				l
covering was called. " I	found out the next day or				- 1
so, probably when the fi	uneral home called mo."				1
Normally if a patient dos	es not have a DNP on				
their chart, would t	ne initiated and 911 collect				- 1
My expectation is that the	16 nurse would start				- 1
if a was not on the	chart "				1
					- 1
On at 2:40 PM.	a telephone interview				- 1
was conducted with the	covering physician who				1
received the call regarding	ng Resideni #1 on				1
. She stated s	she was covering for the				i
attending physician on	but doesn't				1
remember the call as she	stated she covers 1000				- 1
patients. When asked if a	she was informed the				
resident was a Full Code	and he was not				1
, she stated.	" I apologize, but I don '				1
t remember. "					- 1

08/07/20*c ---- --- :.412/0E1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/GUA	(X2) 14(II	TIPLE CONSTRUCTION	OMB	RM APPRO VO. 0938-0
- To Said Con Oil	IDENTIFICATION NUMBER:	A BUILD	ING	(X3)	DATE SURVE
NAME OF PROVIDER OR SUPPLIE	105884	B. WING			C
			STREET ADDRESS, CITY, STATE, ZIP COD		
EXCEL REHABILITATION AN	ID HEALTH CENTER	- 1	2811 CAMPUS HILL DR		
			TAMPA, FL 33612		
	IATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLET DATE
F 281 Continued From pa	age 110	F 28	1		
4. On at	5:00 PM an interview was				
	NHA, in regards to the facility				
response to the inc	ident of Resident #1 not				
receiving whe	O Decessary she stated " WA				
Started an investiga	ation and a Quality Assurance				
the ADON home for	(QAPI) immediately. We sent the day on suspension. We				
raviewed the notice	and procedures for advance				
directives Co	de Blue Roles and				
Responsibilities, an	d the Emergency Procedure				
for . We intervi	ewed the staff regarding their				
ability to verbalize th	e process. We normally				
complete an audit of	f the advance directives and				
orders monthly	y. The SSD initiated an Advance Directives and				
for the entire resider	nt population and it was				
completed by	. 2015. We were				
monitoring / reviewing	the charts of residents who				
expired. We started	in-service training regarding				
advance directives a	nd and called a Code				
bille Urill. Multiple in	terviews of the staff were				
advance directives,	e direct staff knew about and when to call a code.				
Training was conduct	ted in for the entire				
facility. The DON did	Immediate in-servicing with				
the ADON and we co	mpleted a Federal report				
We have been condu	icting weekly OA meetings				
regarding the event.	These meetings will continue				
weekly through When asked when st	and then occur monthly ".				
conducted prior to the	an training had been a last couple of months, she				
stated, "we do it rout	Unely and new hires cat it at				
orientation, " When a	sked how the facility audits				
the employee records	for current she stated				
the Human Resource	e (HR) manager does an				
audit, which includes i	eviewing cards."				
the OA committee with	ant had been presented to an an action plan she stated.				
MS-2567(02-99) Previous Versions Obs					
	soleto Event /D: J5QX11				

--/-// .15 19:03 #056 P.013/051

	NT OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	1,000		OMB NO	08/07/20 1 APPROV
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDE	TIPLE CONSTRUCTION NG	(X3) DAT	E SURVEY
NessE or	PROVIDER OR SUPPLIE	105884	B. WING	_	- -	С
				STREET ADDRESS, CITY, STATE, ZIP COL	06/	26/2015
EXCEL	REHABILITATION AN	ID HEALTH CENTER	- 1	2811 CAMPUS HILL DR		
(X4) ID PREFIX	SUMMARY S	ATEMENT OF DEFICIENCIES		TAMPA, FL 33612		
TAG		TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)		COMPLETIC DATE
F 281	Continued From pa	30e 111				
	"Yes ".	-3	F 28	!		
	On the !	NHA provided a " QA Book ", it				
	contained the Chal	fy Δeeμranon Domes				
	dated an	for review. The tool was				
		d signed by the Quality cluding the Medical Director on				
	A revie	w of the information provided				
	revealed policy revi	sions dated for "				
		enneuha" "				
	Directives " which is	ndudes "Code Rive Polos				
	and Responsibilities Procedure -	and "Emergency				
		sions revealed the following				
- 1	elevant changes: "	Code Rive Poles and				
	Responsibilities " (n	o effective date): " In the				
е	went that a resident	is found in				
	the person dis	covering the should				
Ir	nmediately notify a	nurse of the situation. A				
Č	rammate snould pa	ge overhead that there is a scation of the code. All				
a	vailable teamnates	are responsible to respond				
IÇ.	a Code Blue Page	The nurse is reconnable to				
16.2	ineciately assess [he resident to determine if				
th	e resident is in	The				
re	sident 's medical re	ecord will be obtained to				
ge '	termine if the resid	ent has a () document				
ın ət	their record, (may or each nurses station	heck YELLOW BINDERS				
is	noted then there wil	for status) if the I be no further interventions				
(m	piemented as per th	in resident ' e advance				
OIF	ectives, if there is n	 In the medical 				
	ord then is to	be initiated on the resident.				
INI	on the resident 1	e for the implementation of				- 1
res	ident will act as the	The nurse assigned to the TEAM LEADER of the				- 1
coc	le situation. Certifie	d Nursing Assistante who				- 1
						1
are	certified may at the direction of	De directed to penint with				- 1

-3/-./ ... 19:04 #056 P

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 08/07/2015 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED 105884 c B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 06/26/2015 EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL 10 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION COMPLETION DATE TAG DEFICIENCY F 281 Continued From page 112 F 281 signature sheets were provided for the following in-services, dated . 5/29, 6/7, 1 and In addition mock "Code Blue " drills were done on J. All documents that were provided to the survey team were reviewed. A comparison was made between the in-service signature sheets and the master list of all employees. The comparison revealed that as of 91% of licensed nurses and 97% of the unlicensed staff had completed the training. Interviews with the facility staff regarding advanced directives. and Code Blue drills were conducted in order to verify staff knowledge. The following relevant Interviews were obtained: at 4:24 PM, an interview was conducted with Employee C a nurse; she stated she worked full time on the 7:00 AM -3:00 PM shift. She stated she had been part of a mock Code Blue drill a couple of months ago and that " we just had an in-service on where to find the forms, in the yellow book." When asked how she would respond if a CNA said a resident was unresponsive she stated she " would check the resident, have someone at the desk check book. I would initiate until t determined if the resident had a order then I would stop at 4:32 PM an interview was conducted with Employee D a nurse, who stated she worked full time on the 7:00 AM -3:00 PM shift. She stated she had training on advanced directives and participated in mock Code Blue drills a few months ago and again in . She also stated " If I found someone

unresponsive: I would start

. shout for

09/. /... 19:04 #056 P. /...!

STATEME	ERS FOR MEDICARE	AND HUMAN SERVICES			FOR	D: 06/07/2015 MAPPROVED O: 0938-0391
AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	LTIPLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
NAME O	F PROVIDER OR SUPPLIER	105884	B. WING		1	С
				STREET ADDRESS, CITY, STATE, ZIP CODE	1 06	5/26/2015
EXCEL	REHABILITATION AND	HEALTH CENTER		2811 CAMPUS HILL DR		
(X4) ID	SUMMARY STAT	FEMENT OF DEFICIENCIES		TAMPA, FL 33812		
PREFIX		MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 281	Continued From pag	ne 113				
		would call the physician and	F 2	81		
	ramily, if they were a	full code I would keep going				1
	until the paramedics	come, "				
	On at 4:40	PM an interview was				
	conducted with Empl	OVER E a nurse she etated				
	sne usually worked a	S Deeded on the 3:00 DM				
	-11:00 PM shift. She	stated that during ssed advance directives and				
	. orders. She had	training in the last counts of				
	months on advance d	frectives and did a mock			-	
	Code Blue drill also, fi	a resident was found				i
	resident, vell for holn	ted she would, " check the and send someone to get]
	more help. I would sta	rt There is a				- 1
	book; I would send so	meone to check. If I have		4		i
	started and find of them I would stop. I wo	out the resident is a				
	knew if they were a	or not. "				
	at 7:22 AM	1 an interview was				
	conducted with Employ	yee F a nurse, he stated he				1
	stated "We had a Mon	00 PM -7:00 AM shift. He				
r	ecently. We recently h	and a class on advance				1
•	irectives and DNR, "	The training included:				1
	naking sure we have a	dvance directives, if				ľ
ti	ne chart for the vellow	beak with the family, check form, make sure a				
F	OA is in the chart also	He was seked what he				- 1
W.	rould do if he found an	Unresponsive revident he				- 1
G	all somebody by name	breathing, call a code. to call 911. Check Vital				- 1
SI	gns, call for crash cart	. Call another person to				
10	okat form Iwou	lid start compressions				
rig st	tht away, and if found op compressions."	they were a would				1
	,					1
Dt	uring the interview con	ducted on at				

/--/ - 19:05 #058 P. /.-!

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES	& MEDICAID SERVICES					FORM	08/07/201: APPROVE
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CON DING	ISTRUCTION	0	(X3) DATE	0938-039 SURVEY LETED
NAME OF PROVIDER OR SUPPLIER	105884	B. WING	à				
EXCEL REHABILITATION AND	HEALTH CENTER		2811 CA	ADDRESS, CITY, STATE. MPUS HILL DR , FL 33612	ZIP GODE	06/2	6/2015
	EMENT OF DEFICIENCIES MUST BE PRECEDED BY PULL CIDENTIFYING INFORMATION)	PREFI TAG	x	PROVIDER'S PLAN OF (EACH CORRECTIVE AC ROSS-REFERENCED TO DEFICIENCE	TION SHOULD E	SE ATE	(X5) COMPLETION DATE
would expect that if a unresponsive and ha nurse should start nurse should start a resident is or should know if the res they start if the out the resident is a That is what I was told When asked if that we stated, "It is not in ou that in the in-service co informed that 3 out of stated they would start unresponsive resident found the resident was the facility conducted to She stated "yes, we event and we have give recently." This trainin advance directives. The done on orientalion. Si training for the whole me we had to get everybood again. In addition, a Qi performance improver the day of the event. The committee was informer CNAs and nurses and a blues." When asked if performed in the past, si in-service is done yearly in addition, the DON was facility audits the emidout the should shad with the middition, the DON was facility audits the emidout with the middition, the DON was facility audits the emidout should shad with the middition, the DON was facility audits the emidout should shad and should shad should shad shad should shad should shad should shad should shad should shad should shad should shad should shad should shad s	N she stated that what she resident was found at a Full Code status the section was found at a Full Code status the She was asked if a prior to finding out about ser. She stated. "The nurse ident is a nor not before states and fines not seem to state the section of the se	F2	81	Grant LENN		The state of the s	

08/ 3 19:05 #056 P. 7 _1

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDERS UPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	OMB N	M APPROV O. 0938-0: ATE SURVEY
	105264	A. BUILD	NG	(3) 60	MPLETED
AME OF PROVIDER OR SUPPLIE	R	8. WING		1 00	
XCEL REHABILITATION A			STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR		3/26/2015
		- 1	TAMPA, FL 33612		
REFIX (EACH DESICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S OF AN OF AGE		COMPLETIC DATE
F 281 Continued From p	448				
" When solved it is	age 115	F 28	1		
employee records	ne facility had audited the				
Yes, the ADON au	tits monthly and UD de				
it on hire. " The Do	N stated the SS deaders				
monitors, audits the	advance directives and				
the event had been	s monthly. The DON stated presented to the Quality				
Assurance (QA) co	mmittee and an nation -t				
DON COmpleted the	Federal report and reported it				
io ine corporate nui	SR The DON crated "The				
codes, and file a fed	o do education, and do mock				
	ici ai report.				
On at 2 P	M, an interview was				
conducted with the r	HA and the DON to review				
and DON stated was	Ining in-services. The NHA went over the following				
policies: policy	(which included what to look				
tor, orders and	book where to find the				
paper, etc.), Advance	Directive policy and Course				
DIVE DUILEY (DASCRINA	fig mock code blue if a				
waix in on an unresp	Official regident what were				
	mergency procedure policy. ntation and every nurse				
	first QAPI we were almost regarding interviews with 4				
surveyor which reveal	ed the nurses would are				
what they were trainer	ON stated, "That is not to do." The NHA and the				- 1
	begin retraining the				- 1
nursing staff that day.					
On strong	M an interview was				- 1
conducted with the NH					

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DEPARTMENT OF HEALTH AND HUMAN CENTERS FOR MEDICARE & MEDICAID	SERVICES		PRINTED: 08/07/2015 FORM APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDERS AND PLAN OF CORRECTION IDENTIFICATION	SUPPLIER/CLIA (X2) N	ULTIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
DENIFICATION .	A. BUI	LDING	COMPLETED
	5884 B. WIN	ıG	0
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, ST.	06/26/2015
EXCEL REHABILITATION AND HEALTH CENT	TER .	2811 CAMPUS HILL DR	THE 24 CODE
		TAMPA, FL 33612	
(X4) ID SUMMARY STATEMENT OF DESIGN PREFIX (EACH DEFICIENCY MUST BE PRECED TAG REGULATORY OR LSC IDENTIFYING IN	FD BY FULL DOE	FIX (EACH CORRECTIVE CROSS-REFERENCE)	N OF CORRECTION (XS) E ACTION SHOULD BE COMPLETION OTO THE APPROPRIATE DATE DETCY)
F 281 Continued From page 116	_		
(CN). When asked when the Policy	F	281	
Procedure for advance directives a	nd :were		
last reviewed, the Corporate Nurse	(CN) stated 4		
the Policy and procedure for advan-			ļ
and was review updated on ", after the e			J
Resident #1 He further stated that t	the		1
Emergency Procedure was als	so undated		:
which included the Code Blue Roles Responsibilities.	s and		
Record reviews and interviews re- following corrective action was taken	vealed the		
On in-service signature si reviewed for retraining of the nursing	heets were		
regarding advance directives.	: and		1
code blue drills. The NHA verified the	at all nursing		i
staff with the exception of one emplo unavailable had received the in-servi	ice retroining		ŀ
The NHA verified that this employee	will not		1
return to work until they have receive	ed the		1
retraining. On interview it was confirm	ned after the		1
re-training, the nurses were able to vi Policy and Procedures: Advance Dire	erbalize the		1
and Emergency Procedure: : and	Code Blue		
Interviews were conducted with 21 or	ul of the 31		i
nursing staff members on	الارساني ا		İ
and All staff members inte were familiar with the policy and able	io vachaliza		1
the correct procedure.	to verbalize		
On at 3:40 PM an intervie	nt/ mge		
conducted with the NHA. She was asi	ked how the		-
facility was going to ensure that reside	ents had		i
facility was going to ensure that reside Advance Directives which accurately a	ents had reflected		
facility was going to ensure that reside	ents had reflected Imission		

. 4 7 . 3 19:07 #056 P. 7 . 1

CENT	ERS FOR MEDICARE	AND HUMAN SERVICES				FORM	08/07/2018 APPROVED
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MU A. BUILI		.E CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY MPLETED
		105884	B. WING	<u>.</u>		1	С
1	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	06	28/2015
EXCEL	REHABILITATION AND	HEALTH CENTER		24	B11 CAMPUS HILL DR		
(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES	OI CI		AMPA, FL 33612		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFI	×	PROVIDERS PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 281	Continued From pag	ie 117	F 2				
	recently admitted. S	he stated she met with the	r 2				
	SS department and a admitted in the last 2	said that all residents					
	would be reviewed re	garding advance directives					
	and the reviews wou	d be documented in the					
	progress notes. Whe	n asked how the facility was hks in the Advance Directive				1	
	Acknowledgement to	rm she stated the Regional					I
	Business office will di	a complete audit of our					1
	to ensure the paper v	letion; will audit immediately					ı
	correctly and complet	ely.					
	On the fe	cility provided the following					- 1
	note written on facility	letterhead and dated					1
	signed by						1
	Social Service: In regi residents are given th	e opportunity to					- 1
	discuss/choose an ad	vance directive, 100% of all					- 1
	admissions from reviewed by the Direct	forward have been for of Social Services and a					
	progress note regardir	o same has been added to					1
	these records as an a	dendum to the initial ne time of the admission.					
,	Admissions Contract:	ne time of the admission. In regards to assuring that					
r	esidents are given the	apportunity to					
2	discuss/choose an adv admissions contracts f	ance directive, 100% of all					1
h	lave been reviewed by	the Admissions					1
i c	Coordinator to ensure acluding the advanced	completion of all forms					
Ä	cknowledgement.	Duactiva					- 1
C		AM an interview was					1
C	onducted with the NH	A and the Corporate Nurse					
(0	DN). They stated they I admissions since	had initiated an audit on					
		. The SS ich resident and wrote a					
þr	ogress note for each	medical record to provide					

08/_ 7 ... 19:08 #065 P.020/051

CENT	RS FOR MEDICARE	AND HUMAN SERVICES				FO	ED: 08/07/201 RM APPROVE IQ: 0938-039
AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIF	LE CONSTRUCTION		DATE SURVEY
1		IDENTIFICATION NUMBER:	A. BUILD	OMIC			COMPLETED
		105884	B. WING				С
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL	REHABILITATION AND	HEALTH CENTER	- 1		2811 CAMPUS HILL DR		
			- 1	1	TAMPA, FL 33612		
PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFIX TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	0.00	COMPLETION DATE
F 281	Continued From pag	ne 118	F 21	04			
		Admissions department	F 20	01			
	went through all adn	nission paperwork for					
	residents admitted o	n forward to					
	make sure paperwor	rk is correct and to review the					
	advance directives s	ection for completion. All					
	resident last night or	ere addressed with the					
	Admissions denarm	ent has been re-educated by					
	the NHA regarding of	ompletion of admission					
	agreement forms, wil	th attention to the resident					
		vance directives, including					
	not leaving blanks an	nd having correct dates. The					
		d review advance directive					1
		admissions, They also sions department will do an					ĺ
	audit of the nanerwor	k for all admissions for the					1
	next three months. Ti	hey said that after three					1
	months they would be	gain a monthly rendom audit					- 1
	that would be discuss	sed at the QA meetings.					ı
	They further stated th	at at the time of admission,					- 1
	document on a progre	dvance directives and					- 1
	admissions will be rev	riewed at the daily clinical					- 1
	meeting and advance	directives will be a focal					i
	point at that time; this	will occur on the weekends					1
8	s well. Social service	s will continue to assist the					1
ī	esident with develops	ment of advance directives					l
	trated that each regid	a progress note. They ent's advance directives					1
v	vill be discussed at th	eir 14-21 day and quarterly					
	are plan meetings. Ti	he expectation is that if a					- 1
P	esident wants anythin	g changed between the 14					1
d	ay care plan and qua	rterly care plan meetings					
tř	ney will approach the	facility staff or if staff					i
n	otices a change in co	ndition that it will be					- 1
re	e-addressed with resident	oent,					
B	ased on this informat sopardy was found to	ion the Immediate					

19:00 (P. W.L.)

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES			PR	INTED:	08/07/2015
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES				FORM	APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	X3) DAT	0938-0391 E SURVEY PLETED
		105884	9. WING	G	1		5
NAME O	PROVIDER OR SUPPLIER			T	STREET ADDRESS, CITY, STATE, ZIP CODE	06/2	26/2015
EXCEL	REHABILITATION AND	HEALTH CENTER		1	2811 CAMPUS HILL DR TAMPA, FL 33612		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRU DEFICIENCY)	E	COMPLETION DATE
F 281	Continued From pag	je 119	Fa	281			
	reduced to a D.	scope and severity was	, _				ĺ
F 282 SS≃J	483.20(k)(3)(ii) SER' PERSONS/PER CAI	VICES BY QUALIFIED RE PLAN	F 2	282			- 1
	must be provided by	d or arranged by the facility qualified persons in h resident's written plan of		1. 2.	Resident #1 Expired at the facility on 3-12 The family and physician were notified of resident's passing. A review was completed for advance direc on this included a review of curr	the	
	by: Based on review of f. procedures, resident, interviews with facility resident's father, and was determined that tell implement advance d accordance with the w physician's orders fo sampled, of 81 total re having Full Code order	record review, and staff. Medical Director, a difference of the attending physician, it he facility failed to irectives of () in fritten plan of care and r one (#1) of 7 residents			code, and hybician orders. A review. Of cur- code, and hybician orders. A review. completed by to assure that all resident with advance directives also have Comprehensive Care Plans addressing the resident's advance directive wishes. A revie be completed by to assure that all residents have received in writing their righ formulate advance directives according to to wishes or that of their respective responsibl parties. Any Identified areas of concern have been addressed.	rw will Il t to helr	
s s fi	was discovered by the pulse or le admission. The facility Emergency Medical Se wishes. The clinical r thysician order for full	ervices as per the resident 'ecord contained a . The facility licy and Procedure for "Revised 2008) and "					

Facility ID: 62932

From:727\$521162

/-/ _ 19:09 #056 P. //_d

DEPARTMENT OF HEALTH	& MEDICAID SERVICES			RINTED: 08/07/2019 FORM APPROVED MB NO. 0938-0391
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL		COMPLETED
	105884	B. WING		C
NAME OF PROVIDER OR SUPPLIER		10. 11.10		06/26/2015
EXCEL REHABILITATION AND			STREET ADDRESS, CITY, STATE, 2IP CODE 2811 CAMPUS HILL DR TAMPA, FL 33612	
	TEMENT OF DEPICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFI TAG	PROVIDER'S PLAN OF CORRECTION	
radiity falled to hono directives and denies to receive emergenc prolong his life. The staff did not ensi directives, which wen were carried out in as plan of care. Additionally, interview nurses (Employees C and reveaperforming with care and physicien or was found without put for the facilimplemented advance resulted in immer emoved on scope was reduced to Findings Include: 1. Review of Resident recently readmitted or recently readmitted to the on (Wednese with diagnoses that include with diagnoses that include on (Wednese with diagnoses that include with diagnoses with diagnoses that include with diagnoses w	"(Revised April 2011). The Resident #ir s advance if the resident it exportunity if leasing services to the resident is advance in effect for Full Code. coordance with the resident is with 4 of 8 licensed 0. E. & F) on led they would begin ut first verifying the plan of ters in the event a resident se or an of care for Resident #1 ity staff correctly directlyes and initiated distale Jeopardy, which were and the seventy and D. #It's closed medical praphic / face sheet, y admitted to the facility on and most the facility from the hospital any for skilled services and stalled services and by for skilled services and stalled services and signed **Resident facility from the hospital and for the Physician' early for skilled services and signed **Resident facility from the hospital and signed **Resident facility from the facility of and signed **Resident facility from the hospital and signed ***Resident facility from the facility from the ***Resident facility from the ****Resident facility from the ****Resident facility from the *****Resident facility from the *****Resident facility from the ************************************			This aff factors are all and a service an

4 / 3 19:10 #056 P. //

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTED: 0	8/07/2015
STATEME	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) ML A. BUR,		CONSTRUCTION	(X3) DATE S	938-0391 URVEY
		105884	B. WING	ì		C	
	PROVIDER OR SUPPLIER REHABILITATION AND	HEALTH CENTER		281	REET ADDRESS, CITY, STATE, ZIP CODE 11 CAMPUS HILL DR MPA, FL 33612	06/26/	2015
(X4) ID PREFIX TAG		EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREF TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(KS) MPLETION DATE
F 282	Continued From pag	e 121	F 2	82			
	Review of Resident a 2/19/2015 revealed a	#1 's physician orders dated Code Status of Full Code.				i	
	Review of Resident # record including the of Not : (f1 's complete medical closed record revealed no Do .) form was present.					
1	Tool dated viva stretcher from hos directives upon admis directives in the chart Living: mobility, transfers; dre hygiene. Alert to personale, warm and dry. Puurse, but can make feular and audible, pur Breath sound place. Has referrals occupational signed by Employee C Jurse (LPN).	The resident has advance sion? NO. Are advance sion? NO. Are advance? NO. Activities of Daily required for bed responsible of the sion of					
ff N o th pi ca in (N Di	om the Nursing Servil lanual (Revised f this procedure is to g the resident 's physical symposes of managing in urposes of managing it ire plan and completing struments, including the IDS). "Steps in the Fasidermine if the residen	w Up: Role of the Nurse " sees Policy and Procedure 2012). The purpose pather Information about , emotional, , and upon admission for the the resident, initiating the up required assessment the minimum date set					

7-7 - 19:11 #056 P. 7 1

CENT	RS FOR MEDICARE	AND HUMAN SERVICES				FQ	ED: 08/07/2019 RM APPROVED
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE		CONSTRUCTION	(X3)	NO. 0938-0391 DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIER	105884	B. WING		CTY	\perp	C 06/26/2015
	REHABILITATION AND			2811	EET ADDRESS. CITY, STATE, ZIP CODE I CAMPUS HILL DR IPA, FL 33612		
(X4) ID PREFIX TAG		EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SMOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
	resident with informal advance directives a establishing them. " following information resident's medical ri	record. If not, provide the tion on his/her right to have nd initiate the process of Documentation: "the should be recorded in the	F 2	82			
6 () () () () () () () () () (## dated F Adapted F A	failure, HCAP d , Resistant) NE (Resistant) Na (Resis					
Ag Di lar or	rectives Acknowledge iguage: I understand	age 31 of 39 Advanced ment with the following that I do not have to sign and Directive in order to					

--/_ / _ 19:11 #056 P.025/051

		E & MEDICAID SERVICES			FORM APPRO OMB NO. 0938-
VD PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVE COMPLETED
		105884	B. WING		C
IAME OF	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIF	06/26/201
XCEL	REHABILITATION AND	HEAT YE OF LOS	- 1	2811 CAMPUS HILL DR	, CODE
	The second secon	HEALTH CENTER	1	TAMPA, FL 33612	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.		
TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COMPLET
F 282	Continued From page	no 100			
	understand that I -	ge 123	F 28	82	
	Directive at any time	by implement an Advanced during my stay in the facility.			
	It is also my underes	anding that I may ask at any			
	time to review Advar	nced Directive information or			
	my Advanced Direct	ive (s) and ask questions (
	may have concerning	g them. I may revoke sev			
	Advanced Directive i	s) at any time that I have			
	made. I understand t	he facility 's staff connot			4
	give legal advice, but	can answer questions			
	concerning Advanced	Directives, I have the			
	hose provided to the	s(s) and my copies have			
	drawn through the ble	alth Care Center. A line was ank spaces in front of all the			
	choices which were:	Living Will or Direction to			
,	Withhold Life Sustain	ing Procedures			
	i i	/Yellow HRS Form.			
ì	Health Care Surrogat	e Health Care Provid			
- I	Durable Power of Atto	rney, Financial Power of			
,	attorney, Medical Pov	ver of Attorney Guardian			
- 1	Inancial of Medical.	Anatomical Gift Other			
	'hysician Statement d	f Incapacity Funeral Home			
	election. The form w	as initialed by the Denident			
a	ind witnessed by Emp	oloyee H on			
R	Review of the Resider	ele alles			
ρ	aperwork revealed a	it's Admissions			
A	dvanced Directives A	cknowledgement (an acce			
B)	umber) with the Resid	lents initials basido the			
St	sctions 1. I have beer	diven written material			
at	oout my right to acces	of or refuse medical and			
SU	irgical treatments and	my right to form			
A	uvanced Directives, 2	I understand that I am			
110	der to recolve made an	Advanced Directives in			
CR	re facility and 3 1 up	if treatment at this health derstand that the term of			
an	v Advanced Directive	s that I have executed will			
be	followed by the healt	th care facility, physicians			
211	u my caregivers to th	e extent permitted by the with: Please Check one			

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				P	RINTED: (8/07/2019
CTATELON	T OF DEFICIENCIES		-			0	FORM A MB NO. 0	PROVE
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	ILTIPLE (CONSTRUCTION		(X3) DATE S	URVEY
		105884	B. WING	3			С	
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EXCEL 6	REHABILITATION AND	118 4181			EET ADDRESS, CITY, STATE, S CAMPUS HILL DR	MP CODE		
	TENNESTATION AND	HEALIH CENTER			IPA, FL 33612			
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F 282	Continued From pag	a 124						
	of the following state	ments: I have executed an	F 2	82				
	Advance Directive ar	nd will provide a copy to the						- 1
	raciuty, i understand	that the staff and the						- 1
	physicians at this fac	ility will not be able to follow						- 1
	mis retur ou my vovsi	nced Directives until t						- 1
	provide a copy of it to	the staff; or I have not						- 1
	executed an Advance	d Directive and do not wish						i
	ime. The snaces to a	Directives further at this heck either statement were						- 1
i	plank. The form was	signed by the Resident and						- 1
1	ne Admissions Repre	sentative Employee H and						1
	lated .	21,007,210						
a la la la la la la la la la la la la la	avealed a document in cecksion Maker signed The docum The docum mguage. The Peterm as been completed or test that I am at least do arm willing to become altal Resident 's nea anhained regular com Resident's activities (sions, including with plonging decisions the fing to produce clear infigit or produce clear infigit or produce clear on request. I underst come active and accome this so me of the folion chis so me of the folion chis so me of the folion the contract of the come active and accome come br>active and accome come	me involved in the above ith care decisions. I have tact and am familiar with as, health, religious and can make health care hholding/withdrawing life at would be the decisions e made, if capable I am and convincing evidence and that my role have						
Rev	riew of Resident #1 '	s medical record						
reve	ealed a Determination	of Incapacity document						- 1
gate	and sign	ned by his attending						- 1
-M6-2867(02-	88) Previous Versions Obsole	te Event ID: JSQX11	Faci	My IO: 62	937 (Foot)	Dustion sheet	S	

From:7275521162

7. 7 19:13 #056 P. V. ...

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	& MEDICAID SERVICES			PRINTED: 08/07/201 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	105884	B. WING		С
NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	06/26/2015
EXCEL REHABILITATION AND		28	11 CAMPUS HILL DR MPA, FL 33612	
PREFIX (EACH DEFICIENCY	TEMENT OF DEPICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	
attending physician i (Resident #1), I have the above stated res give informed consex and does not have it probability of recover capacity to directly ex A review of the facility Directives "(Revised policy statement." A respected in accorda facility policy." Policy implementation, secti admitted to our facility Director (SSD) or des information to the resis right to make decision including the right to a surgical treatment, an advance directives." admitted to our facility, inquire of the resident, members, about the ex advance directives." implementation, sectio current OBRA definition governing advance direc- defined advanced direc- regarding treatment op not limited to: b, that, in case of resident, logal guardian representative (sponsor	the following language: Ao or the above stated Resident evaluated and determined dent lacks the stated Resident evaluated and determined dent lacks the state of	F 262		
life-saving methods are	to be used."			1
CMS-2987(02-99) Previous Versions Obsol	ein Eveni ID: JSQX11	Facility ID:	62932 If continuation	Sheet Pose 126 -/ Oct

From:7276521162

DEPARTMENT OF HEALTH	AND HUMAN SERVICES			PR	INTED: 08/07/201
CENTERS FOR MEDICARE	& MEDICAID SERVICES				FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING		MB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	105884	B. WING			С
NAME OF PROVIDER OR SUPPLIER		10.00			06/26/2015
EXCEL REHABILITATION AND			STREET ADDRESS, CF 2811 CAMPUS HILL I TAMPA, FL 33612	PR	
	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER X (FACH CORP.	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION
reveeled the Reside hospital on feolity on did not include docur Medical Decision Ma information on Advanced Directive in the admission paper in the admission paper in the admission paper in the admission paper in the admission paper in the admission paper in the admission paper in the admission paper in advance Directives the admission paper in advance Directives advanced Directives and Directives and Di	#1 's medical record was discharged to the and readmitted to the His admission paperwork. His admission paperwork his admission paperwork mentalion that his Active ker, his father, was given ceo Directives. There was no so Acknowledgement 'I form awork for the Resident's in the facility. 1 's medical record' was discharged to the and readmitted on the admission of the sound of t	F2	62		
A review of the Admission CMS-2567(02-99) Previous Versions Observed		E	Hy ID: 62832		
			my n≥. 62932	If continuation at a con-	

J 19:14 #056 P.029/051

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	ARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVE
	TOTAL TOTAL POMORY:	A. BUILDING		COMPLETED
NAME OF PROVIDER OR SUPPL	105884	8. WING		C
		s	TREET ADDRESS, CITY, STATE, ZIP CODE	08/26/201
EXCEL REHABILITATION.	AND HEALTH CENTER		B11 CAMPUS HILL OR	
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIES		AMPA, FL 33612	
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F 282 Continued From				
(MDS) assessm	and district	F 282		
under Section C				
Assessment for	(Patterns): Staff Mental Status: Short term			: .
memory:	problem. Long term memory:			
memory problem	skills for Daily			
Decision Making:	Severely Linder			
Section D (Mood)): Staff Assessment: feeling or			
appearing down.	Cepressed hopeless Trouble			
Fooling of Staying	asleep or sleeping too much;			
concentration 11	aving little energy; Trouble nder Section G (Functional			
Status):	of one person			
	ad for bed mobility and dressing.			1
total dependence	required for eating and			1
personal hygiene.	Under Section H (and			į.
Bowel): Always	of bowel and			1
Under Section I (A	ctive Diagnoses): failure			
and	Under Section K (Swallowing			
and Nutritional Sta	tus): Height 66 "; weight 111			
loss of 10% or ma	or more in the last month or re in last 6 months-yes;			,
Feeding tube 1 ind	er Section M (Skin Conditions):			ì
A risk of developing	G . Under			
Section Q (Resider	nt 's Overall Expectation):			
Expects to remain	in this facility; by family.			;
Per the Nurse 's N	otes dated at 5:45			•
AM: "this nurse ca	fled to Certified			
Dulse	CNA). Resident noted with no			
amount of frothy ea	or Noted large liva on face and chest. Upper			
extremities cool to t	ouch Call placed in			
(attending physician	Service return call received			
from (covering phys	iclan). Order received to			
release body. Call to	(Mother) name of			
tuneral home receiv	ed. Family declined to come			
to facility. " Signed I Nursing (ADON).	by the Assistant Director of			
HURSHING (ALDON),				
MS-2567(02-99) Previous Versions C	New York Co.			
Termine Yersions L	Obsolete Event ID: JSQX11	Facility ID:	62932 Micontinue	

#056 P.

From:7275521162

PRINTED: 08/07/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DESIGNACIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMBI STED A. BUILDING 105884 B. WING 06/26/2015 NAME OF PROVIDER OR SUPPLIES STREET ADDRESS, CITY STATE ZIP CODE 2811 CAMPUS HILL DR **EXCEL REHABILITATION AND HEALTH CENTER** TAMPA, FL 33612 SUMMARY STATEMENT OF DESICIENCIES ALC: N ID PROVIDER'S PLAN OF CORRECTION IEACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LISC (DENTIFYING MEDINALION) PREFIX PREFIX EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 282 Continued From page 128 F 282 On at 12:40 PM, a telephone interview was conducted with Resident #1 's father. He stated his son was in the Marines: he not an aneurysm in there and had to have surgery. He stated the Resident lived by himself for a while. and then he started living with his girlfriend and got on " crack " . He went to the hospital and they sent him to the nursing home. When asked if they not care for him anymore, that 's why he went to the nursing home. " He was wearing diapers and couldn't dress himself anymore, "I couldn't handle him anymore. " He went to the hospital and then the nursing home; he "was in and out of the nursing home. " I think he in the hospital, no, the nursing home, I get sometimes. I couldn't do anything with him, after he got on that " crack." He was having problems breathing, they put him on last time I saw him he was in the hospital, and then someone called and said he was On at approximately 5:00 PM an interview was conducted via telephone, with Employee A, the Certified Nursing Assistant (CNA), who found Resident #1 unresponsive. She stated she no longer worked for the facility. Employee A stated she was making rounds before she went home and found Resident #1 not breathing. She called for the nurse to check on him. The ADON responded and checked on the resident. The ADON said. " He was gone. Employee A stated that the ADON did not do Resident #1 and that she did not recall anything else about the Resident.

Facility ID: 62937

at 1:00 PM an interview was conducted with the ADON, the nurse assigned to

			19:16	#056	P.0 /
DEPARTMENT OF HEALTH	AND HUMAN SERVICES			PRINTE	D: 08/07/201
CENTERS FOR MEDICARE	& MEDICAID SERVICES			FOR	MAPPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	OMB NO	D. 0938-039
	105884	B. WING			С
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	. 06	/26/2015
EXCEL REHABILITATION AND			2811 CAMPUS HILL DR TAMPA, FL 33612	DE	
	(EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDED'S BLAN OF SERV		COMPLETION DATE
amployee called off, "I verbal, he required readmitted from the I asked to recall the ev sked to recall the ev sked to recall the ev sked to recall the ev had finished medical AM, the CNA was in it think he Spone. I we checked him for pulse very cool to touch. He extremities. His lower very cool to touch. The resi around his mouth. The for him." When asket for a order, she a after I called the doctor had land I didn't! I saw one resident after was cool to touch, I do anything I could do for the decision to not code ' and stiff,' I did not I open like that. The phy attending physician was the resident's	a. She stated that she m for the first time on a shift because another m for the first time on a shift because another she stated the resident wasn total care and had been sospilal that day. When ents that happened had been sospilal that day when ents that happened had said "I she working the night shift in Sexification 4" is as working the night shift in Revial dad," I he was and fatt a little stiff in his upper extremities had sort of dent had white frothy stuff at shift in shift in the resident at the chart taked. I looked at the chart taked, I looked at his chart said. I chart was nothing it could do the chart taked. I looked at his chart said, I looked at his chart said. I looked a his chart said. I looked a his chart said. I looked a his chart said. I looked a his chart said. I looked a his chart said. I looked he him the resident in the resident him the resident him the resident who work only he had chart said. I would be said the chart said. I would be said the chart said in the said of the	F 28			

determine code status, she stated, if a resident is

#056 P.032/051 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION MB NO. 0938-0391 (X1) PROVIDERVELIPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION XX) DATE SURVEY COMPLETED A. BUILDING C 105884 e. wing NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA. FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) ID. PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAC DEFICIENCY F 282 Continued From page 130 F 282 and call for someone else to check the chart for orders. I will a call code blue and bring the crash cart. We have a yellow book at the nurses station with all the forms. If the resident is a new admission it may be necessary to look in the chart. When asked how the nurse is notified of a resident 's advance directives, including she states, " It is the nurse 's responsibility to check the chart on every resident, so they know status." If someone finds someone unresponsive, they have to wait until someone checks the vellow book or the chart to see if they are or not. When asked what she would do in a situation wherein a resident is found but there is no Advance directive sne stated, "I would do a Code." When asked if she had had any training since the event, she stated yes, one-on-one with the Director of Nursing (DON) on advance directives Code Blue, and mack drills. The DON reviewed with me when we are supposed to do a code. A review of the facility policy: "Emergency Procedure: (Revised). " (2011), documented the policy statement: "Personnel have completed training on the initiation of)/Basic Life Support (BLS) in victims of sudden Policy and interpretation and implementation: is defined as inadequate resulting in insufficient throughout the body (pulselessness). 2. Sudden (SCA) is a leading cause of

have gasping

in adults, 3. Victims of

Facility ID: 82932

many initially

or may even appear to

presentations of SCA. 4.

Training in BLS includes

The likelihood of recovering from SCA due to an

08/_ / _ 19:17 #056 P. ./...

CENTERS FOR I	MEDICARI	HAND HUMAN SERVICES E & MEDICAID SERVICES				FOR	ED: 08/07/201 RM APPROVE IO: 0938-039
AND PLAN OF CORRECT	FION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILL		CONSTRUCTION	(X3) D	O. 0938-039 ATE SURVEY OMPLETED
		105884	B. WING	_			С
NAME OF PROVIDER O				STR	EET ADDRESS, CITY, STATE, ZIP CO	200	:
EXCEL REHABILIT	ATION AND	HEALTH CENTER	- 1	281	CAMPUS HILL DR	JUE	
			- 1		IPA, FL 33612		
		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REPERENCED TO THE A DEFICIENCY)		COMPLETION DATE
F 282 Continued	from par	ge 131					
acute eve	nt (such a	S \differe	F 2	52			
substantia	illy from th	e likelihood of recovering					
rom		hat the end result of					
mulu-syste	m tallure :	and advance irreversible or					
ungeriving	Cause the	5. Depending on the e chances of surviving SCA					
may be inc	reased if	is initiated immediately					
upon colla	ose. 6. An	VIIInnacoggan intomustana					
in chest co	mpression	19 (including logger than					- 1
decreases	pauses to	r rescue breathing)					- 1
reversible	enecireum:	tiveness. 7. In potentially early delivery of a					
with a defib	riliator niu	s within 2.5 minutes of					
coffapse ca	n further in	Crease changes of supplied					- 1
o. The goal	or earry or	PILYADY Of its to the ta					- 1
maintain life	until the	emergency medical					ł
Support (am arrives	s to deliver Advance Life Individual (resident, visitor,					- 1
or staff men	nber) is for	and unresponsive and not					1
breathing no	rmally, a i	icensed staff member who					- 1
is certified in	· /BLS	shall initiate unless					- 1
a. It is know	that a						
order that sp external	ecifically p	prohibits and for					- 1
external	е	xists for that individual; "					1
Preparation :	for						1
1. Obtain and	d /or maint	ain American Red Cross					1
or American Basic Life Su	Asso	ociation certification in					
Coalc Life 30		r key clinical staff					- 1
members wh	o will direc	requireitative effects					- 1
including non	-licensed r	personnel 2 Descripe					
periodic Maci	Codes (s	mulations of an actual					- 1
.) 101 (13)	ning purpo	oses, 3, Select and					1
an actual	ream ror	each shift in the case of					- 1
	em leader	To the extent possible, on each shift who is					
responsible to	r coordina	ting the rescue offers and					- 1
directing other	team mer	mbers during the rescue					- 1

PAGE .../....

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FC	TED: 08/0 DRM APPR NO. 0938	OVE
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a a a a a a a a a a a a a a a a a a a	Include at least one I-PNILVN and two CI received training and Ministra equipment (JRL) in the facility of the I-RNILVN and Ministra equipment (JRL) in the facility of the I-RNILVN and Ministrating and Ministrating a covered in the 2010 A Suddelines for und Emergency I-RNILVN and I-RNILVN and I	team in his facility shall eggistered nurse, one VAs, all of whom have certification in I/BLS. 5, and supplies necessary for ty at all times. 5. Provide 3L5 policies and advance ident representative upon effective types of the series of the	F2	82				

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inferview was attending phresident had (). and He was thin a a patient. He was not called covering was so, probably was not conducted with finite separation of a conducted with finite separation on a Full Code be done. "He almost 4 years unresponsive to was under the properties of the separation of	s conduity sician. multiple issue: and look was bacd of the da called. when the battent discount is that not on the Me on was the siden has been at 12:00 miles and the siden has	tied with Resident at 1's The physician stated the problems including: multible 8. "He did not look well at all. ed 90. He was new to me as it and forth to the hespital." If you he it he physician at all. ed 90. He was new to me as it and forth to the hespital. "I found out the next day or funeral home called me." uses not have a 91 to entitled and it called, the rurse would start ne chart." PM, an interview was dical Director When seked for a nurse to perform 1, he stated, " should in the Medical Director for resident was	F 24	32	: :	
was conducted was conducted received the cap shall be summing physic remember the capatients. When resident was a Fresident wa	with the it regard e stated cian on all as shasked if full Code e stated it 1:15 P Employe ing Resi	f. a telephone interview covering physician who ing Resident it on she was covering for the , but doesn't estates she covers 1000 she was informed the sand he was not "I spologize, but I don' "I spologize, but I don' "I spologize, but I don' do a Social Services dent if i's Social Service of dated				

Facility ID: 62932

06/07/2015 19:19

#056 P.036/061 PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 06/26/2015 (XS)

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (XZ) MULTIPLE CONSTRUCTION A. BUILDING 105994 A WINE NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA. FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) ID TAG PREFIX EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282 Continued From page 134 F 282 timed 5:32 AM, approximately 13 minutes prior to the Resident's . When asked, Employee G stated he probably filled in the information based on prior admissions. He stated he was going to speak with the resident's family and he confirmed that the resident had a health care proxy and a Determination of Incapacity. He

confirmed that the resident was a Full Code on previous admissions and remained a Full Code because there was not a signed medical record. He stated that his plan was to call the family and inform them of their right to formulate an advance directive for the resident. He further stated that the facility procedure in regards to advance directives required the Admissions Department to speak to residents on admission, advance directives are then addressed in the Nursing Admission Assessment and the Social Services Department reviews the information with the resident and/or the family.

at 1:20 PM an interview was conducted with the Social Services Director (SSD) regarding Resident #1, Per the SSD, she spoke to the Resident 's father on after he was readmitted on confirmed that his parents were making the decisions regarding his care and were designated as his Activated Medical Decision Makers at that time. She stated that the father was given information in regards to formulating an advance directive. SSD states, "If he wanted him to be a we would have mailed him the paperwork." She also stated that she had not spoken to the father when the resident was admitted on She stated that the Resident was

designated as a Full Code since his original admission in of 2014 and had never had a paper in his medical record.

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DEPARTMENT OF HEALTH	AND HUMAN SERVICES				D: 08/07/201
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F 282 Continued From pa	ge 135	F 2	32		
conducted with the I (NHA). When asket that happened on #1 she her that the ADON in unresponsive and did stated in her opinion looked at the chart a looked at the chart a looked at the chart a looked at the chart a looked at the chart a looked with the L familiar with Resident When saked about it is, she stated, "\ AM the ADON stated passed. The DON as performed the looked at the ADON state educated the ADON in the same and the ADON, state educated the ADON in the same as making her resident. Interviewe she was making her resident. Interviewe the responding, so she ge stated she reviewed it. The DON stated, "because he had been DON stated the ADON to do" The DOI pronounced his control of the DON to the look in the DON to the look in the DON to do" The DOI pronounced his control that the ADON to do" The DOI pronounced his control that the ADON to do" The DOI pronounced his control that the ADON to do" The DOI pronounced his control that the ADON to do" The DOI pronounced his control that the ADON to do" The DOI pronounced his control that the ADON to do" The DOI pronounced his control that the ADON to do" The DOI pronounced his control that the ADON tha	the ADON should have not initiated in initiated in initiated should have not offer and the should have a should have a should have a should have a should have a should have a should have called a code "should have called a code" should have called a code "should have called a code de mployee A who stated ounds, and the resident shook him, and he was not to the nurse. The DON he medical record and "a resident was Full Code. I knew he was a full code here for so long." The 1. "decided on her own not N, slated "the nurse."				

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Performance Plan Intestige Performance Plan Ithe ADON home to reviewed the policy directives, CC Responsibilities, and for "We Intervited Plan	in necessary she stated, "We into near Oscillary Assurance (QAP) immediately. We sent into and a Quality Assurance (QAP) immediately. We sent into day on suspension. We and procedures for advance the Emergency Procedure and the Emergency Procedure were the staff regarding their expension of the Staff regarding their expension of the Staff regarding their expension of the Staff intelligence and the staff regarding their expension of the Staff were the staff were their expension of the Staff were did and called a Code terviews of the staff were direct staff frew about and when to call a code, ed in March for the entire immediate in-servicing with impleted a Faderal report. Lining weekly CA meetings here meetings will continue in the court of the staff were intelligence to the staff were intelligen	F 28		

Facility ID: 62932

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		signed by the Quality uding the Medical Director on				i
	A review	of the information provided				
	revealed policy revisi	ons dated for "				- 1
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	Directives " which in	Cludes " Code Blue Balas				
	and weahousibilities.	"Emergency				- 1
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	review of these revis	ions revealed the following				- 1
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	event that a resident i	effective date): " In the				1
	the person disc	s round in				1
	mmediately notify a n	overing the should urse of the situation. A				- 1
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	mirecialety assess the	e resident to determine If				1
Ų.	ne resident is in	The				- 1
re	esident 's medical rec	ord will be obtained to				- 1
Q1	etermine if the resider	nt has a () document				- 1
at	each nurses station	eck YELLOW BINDERS				1
ls	noted then there will	for status) if the be no further interventions				- 1
41	ibiging is bet the	resident's advance				- 1
GH	rectives, if there is no	in the medical				1
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	on the resident. Th	P DUFER perianed to the				1
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are	de situation, Certified	Nursing Assistants who				- 1
ait	at the direction of the	e directed to agains with				1
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On		sheets were provided				
for	the following in-service	es. dated				1
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			F 2	82		
wer	e done on	n mock " Code Blue " drills				
doc	uments that were	, 5/28, All provided to the survey team				
o, u	omployees. The	COMBATISON revealed that				
or en	e unlicensed staf	f had completed the training.				
		ility staff regarding				
acva	TCBD HIPPOINGS	and Cade Of the				
were	conducted in ord	Ar to varify etall lambers				
The i	ollowing relevant	interviews were obtained:				- 1
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	icted with Employ	PM, an interview was yee C a nurse; she stated				- 1
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i would s		ook. If they were a				
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08/07/2015 19:23 #036 P.041/051 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 105884 c A WING NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPSRENCED TO THE APPROPRIATE in TAG TAG DEFICIENCY F 282 Continued From page 139 282 until the paramedics come, " at 4:40 PM an interview was conducted with Employee E a nurse, she stated she usually worked as needed on the 3:00 PM -11:00 PM shift. She stated that during orientation they discussed advance directives and orders. She had training in the last couple of munchs on advance directives and did a mock Code Blue drill also. If a resident was found unresponsive she stated she would. " check the resident, yell for help, and send someone to get more help. I would start . There is a book: I would send someone to check. If I have started and find out the resident is a then I would stop. I would start before i knew if they were a or not. " at 7:22 AM an interview was conducted with Employee F a nurse, he stated he usually worked the 11:00 PM -7:00 AM shift. He stated "We had a Mock Code Blue training recently. We recently had a class on advance directives and " The training included: making sure we have advance directives, if resident is , speak with the family, check the chart for the vellow form, make sure a POA is in the chart also. He was asked what he would do if he found an unresponsive resident, he stated " first assess for breathing, call a code, call somebody by name to call 911. Check Vital signs, call for crash cart. Call another person to look at form. I would start compressions right away, and if found they were a stop compressions.

During the interview conducted on 5:15 PM with the DON she stated that what she

Facilly ID: 62932

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 08/07/2015 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER: OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 105884 c NAME OF PROVIDER OR SUPPLIES 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ō PROVIDER'S PLAN OF CORRECTION JEACH CORRECTIVE ACTION SHOULD BE TAG PREFIX MPLETION DATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 282 Continued From page 140 F 282 unresponsive and had a Full Code status the nurse should start . She was asked if a nurse should start prior to finding out about a resident 's order. She stated, "The nurse should know if the resident is a or not before they start . If the nurse starts and finds out the resident is a , the nuree can stop. That is what I was told during my class * When asked if that was in the facility policy, she stated, "It is not in our policy, so I do not teach that in the in-service classes." The DON was informed that 3 out of 7 nurses interviewed so far stated they would start when they found an unresponsive resident and then stop found the resident was a . She was asked if the facility conducted training since the event. She stated "yes, we started in event and we have given in-services again recently. " This training covered Orders and advance directives. The training is also being done on prientation. She stated. "We did the training for the whole month of . because we had to get everybody. And then we just did it again. In addition, a Quality Assessment Performance Improvement (QAPI) was started the day of the event. The Quality Assurance (QA) committee was informed. We did training with the CNAs and nurses and also preformed mock code blues," When asked if training had been performed in the past, stated, "Yes, the in-service is done yearly and during orientation, " In addition, the DON was also asked, how the facility audits the employee records for current ... she stated, " when we have new employee starting Human Resources (HR) sees the card and then the ADON checks the after that. All nurses are supposed to be certified When asked if the facility had audited the

employee records for current

, she stated "

Event ID: JSQX11

walk in on an unresponsive resident what you would do), and the Emergency procedure policy. It was a verbal presentation and every nurse received a packet. The expectation was for nursing / CNA staff to receive training by the first QAPI meeting. By the first QAPI we were almost at 100%. The concern regarding interviews with 4 of 8 nurses on and surveyor which revealed the nurses would start prior to knowing the resident 's code status was discussed. The DON stated, "That is not what they were trained to do. " The NHA and the

at 1:00 PM an interview was conducted with the NHA and the Corporate Nurse (CN). When asked when the Policy and Procedure for advance directives and ware

DON stated they would begin retraining the

Facility ID: 62932

nursing staff that day.

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	INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(Vanada		FORM APP OMB NO. 093
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F 282	Continued From pa	30e 142			
	last reviewed, the i	Opposito Numa (OLD	F 26	32	
	the Folicy and proc	pedure for advance directives			
	40.10	was reviewed and			
	Updated on	after the avent whi			
	Resident #1. He fur Emergency Proced	ther stated that the			
	which included the	ure was also updated, Code Blue Roles and			
	Responsibilities.	odds blue Roles and			
	3. Record reviews a	nd interviews revealed the			
	following corrective	action was taken:			
	On in-ser	vice signature sheets were			
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	streaming, the nurse	S WALE able to unrhalled the			
a	nd Emergency Proce	s: Advance Directives,			
in.	iterviews were condi	icted with 21 out of the 24			
	around event misturbet	s on			
	nd All sta	ff members interviewed			
th	e correct proce	policy and able to verbalize			
Or					
		PM an interview was			
		IA. She was asked how the sure that residents had			
~~	varius Directives wh	ICD accurately reflects it			
		d and they were both stated she met with the			

Fecility ID: 62932

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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a h C	idmissions contracts i save been reviewed by	the Admissions			÷
al de pr	onducted with the NH. CN). They stated they i admissions since apartment revisited ea ogress note for each	AM an interview was A and the Corporate Nurse had initiated an audit on The SS ch resident and wrote a medical record to provide imissions department ign pagesprox			

Facility ID: 82932

1-11-19:26 #056 P.046/051

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED C 105884 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR **EXCEL REHABILITATION AND HEALTH CENTER** TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PREFIX EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 282 Continued From page 144 F 282 residents admitted on forward to make sure paperwork is correct and to review the advance directives section for completion, All incomplete forms were addressed with the resident last night or this morning. The Admissions department has been re-educated by the NHA regarding completion of admission agreement forms, with attention to the resident rights portion and advance directives, including not leaving blanks and having correct dates. The NHA stated she would review advance directive paperwork on all new admissions. They also stated that the Admissions department will do an audit of the paperwork for all admissions for the next three months. They said that after three months they would begin a monthly random audit that would be discussed at the QA meetings. They further stated that at the time of admission. the nurse will verify advance directives and document on a progress note. All new admissions will be reviewed at the daily clinical meeting and advance directives will be a focal point at that time; this will occur on the weekends as well. Social services will continue to assist the resident with development of advance directives and will document on a progress note. They stated that each resident 's advance directives will be discussed at their 14-21 day and quarterly care plan meetings. The expectation is that if a resident wants anything changed between the 14 day care plan and quarterly care plan meetings they will approach the facility staff or if staff notices a change in condition that it will be re-addressed with resident Based on this information the diate Jeopardy was found to be removed on and the

severity and scope was reduced to a D.

PRINTED: 08/07/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION A. BUILDING __ 105884 a wind 08/26/2015 STREET ADDRESS CITY, STATE 219 CODE NAME OF PROVIDER OR SUPPLIEF 2811 CAMPUS HILL DR EYES DEHARIS ITATION AND HEALTH CENTER TAMPA, FL 33612 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES iD (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY E 400 483 75 EEEECTIVE F 490 SS-1 ADMINISTRATION/RESIDENT WELL-BEING 1. Resident #1 Expired at the facility on A facility must be administered in a manner that enables it to use its resources affectively and The family and physician were notified of the efficiently to attain or maintain the highest resident's passing. practicable physical, mental, and psychosocial 2. A full facility review was completed for advance well-being of each resident. directives on ..., this included a review of a current full code. and physician orders. Also This REQUIREMENT is not met as evidenced a review was completed on , to assure that all residents have received in writing their Based on clinical record review, policy and right to formulate advance directives according procedure review for "Advance Directives ". to their wishes or that of their respective Emergency Procedures-()", "Code Blue Roles and responsible parties. Any identified areas of Responsibilities " and " Neglect and concern have been addressed. Policies and ", Nursing Home Administrator lob Procedures for /Neglect and description, and interviews with staff, family and Advance Directives, Implementation of physicians, it was determined the administration and Do Not Orders are of the facility failed to use its resource currently implemented and resident wishes for management to ensure that the resident's rights to receive emergency services () and advance directives are being honored by the facility staff. exercise advance directives was protected for one (#1) of 7 sampled residents of 81 residents identified as having Full Code status, according to the Advance Directive Audit Tool, provided by the facility and dated On Resident #1. a was discovered unresponsive, less than 24 hours after admission. The facility failed to ensure that in the event the resident was without a pulse or . that would be initiated or Emergency Medical Services be contacted to honor his wishes. The clinical record contained a

physician order for full

s administration did not ensure the direct functions and continued operations of the facility, including the right to be free from neglect, were in accordance with current regulations governing

Pacifity ID: 62932

. The facility '

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PRINTED: 08/07/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED PENTIFICATION NI IMPE A. BUILDING 105884 # WING 06/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIP CODE 2811 CAMPUS HILL DR SYCEL DEHABILITATION AND HEALTH CENTER TAMPA, FL. 33612 PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DESICIENCY F 490 Continued From page 146 F 490 Long Term Care facilities related to implementing The following policies and procedures were policies and procedures for reviewed and revised as necessary, Advance directives Directives. The administration 's failure to ensure that the Not Resuscitate Order, and Quality resident 's expressed wishes related to advance Assurrance/Performance Improvement, at a directives and the right to receive OAPI Meeting on overseen by the protected, led to the findings of Immediate Administrator and Medical Director, Education Jeopardy which were removed 5 and has been provided to the QAPI Committee the severity and scope was reduced to a D. Including the Administrator and Medical Director Findings Include: on the QAPI Process by the Nurse Consultant by 1. Review of the "Administrator" job utilizing the CMS QAPI at a Glance description (Revision Date:) included: " educational material. The QAPI Committee will The primary purpose of your position is to direct the day-to-day functions of the Facility In uelliza this for continued accordance with current federal, state and local identification, analysis and planning for standards guidelines and regulations that govern identified apportunities for improvement in the nursing facilities to assure that the highest degree facility. Identified poportunities for of quality care can be provided to our residents at improvement will be brought to the QAPI all times. As Administrator you are delegated the Committee for review and implementation of administrative authority, responsibility, and the OAPI process. Facility operations will be accountability necessary for carrying out your assigned duties. 1 overseen by the Administrator/Medical Director Duties and Responsibilities on an ongoing basis. Administrative Functions: " Review the Facility's 4. Facility operations will be monitored by the policies and procedures at least annually and Administrator and the Medical Director on a make changes as necessary to assure continued compliance with current regulations. Interpret the monthly basis and identified areas of concern Facility's policies and procedures to employees. will be addressed by them through the QAPI residents, family members, visitors, government process. agencies, etc., as necessary. Ensure that all employees, residents, visitors, and the general

and procedures.

public follow the Facility's established policies

Committee Functions: "Assist the Quality Assurance and Assessment Committee In developing and implementing appropriate plans of action to correct identified quality deficiencies

Feelilly ID: 62012

residents, "
FORM CMS-2567(02-98) Provious Versions Obsolete

Event ID: JSQX11

To an environment within the facility writen promotes resident well-being, safety and prohibits neglect, involuntary and the misappropriation of property for all

Facility IO: 62932

If continuation sheet Page 148 of 213

/ / 19:29 #056 P. /

TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XX) MULTIPLE CONSTRUCTION A BUILDING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
			1	NAC	"	C
		105884	B. WING		01	6/26/2015
NAME OF	PROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL	REHABILITATION AND	HEALTH CENTER		2811 CAMPUS HILL DR TAMPA, FL 33812		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	38 0.	COMPLETION DATE
F 490	Continued From pa	ge 148	F 4	90		
	I. " Furthermore, es	ech resident has the right to		••		
	be free from	corporal punishment, and				
	involuntary	. Residents must not be				-
	subjected to	by anyone, including but not				1
	limited to: facility sta	ff, other residents				
	consultants or volun	teers, staff of other agencies				
	serving the resident,	family members or legal				
	guardians, friends of	other individuals. " II. "				1
	Each resident has th	e right to be free from				
	mistreatment, negle	ct and misappropriation of				
	property. This includ	es the facility 's identification				
	of residents whose p	ersonal histories render				
	them at risk for abus	ing other residents, and				
	development of inter	vention strategies to prevent				
	occurrences, monitor	ring for changes that would				
	trigger beha	vior and reassessment of the				
	Interventions on a reg	gular basis."				- 1
	Dennilions: /, "Negi	ect: means fallure to provide				i
- 1	yours and services r	ecessary to avoid physical				
- 2	488.301) "	n, or mental illness. (42 CFR				- 1
	Procedures:					
		e facility screens potential				i
	employees for a histo					
'n	nistreating residents	ry of , neglect or as defined by the applicable				- 1
r)	equirements a 483 1:	3 © (1) (ii) (A) (B).This				- 1
ir	cludes attempting to	obtain information from				- 1
	revious employers a	nd /or current employers				- 1
à	nd checking with the	appropriate licensing				- 1
b	oards and registries.	Screening is done on all				- 1
9	mployees prior to hire	3. "				- 1
2.	. Training:" a. Each t	eam member is scheduled				- 1
10	attend a general original	entation session b Fach				j
te	am member is offere	d and asked to attend a				- 1
18	cility in-service where	the information is				1
re	viewed as needed th	roughout the year, c. each				i
te:	am member is notifie	d that a mandatory "				- 1
	Prevention " in-	service is scheduled on an				- 1

annual basis. This in-service includes: 1.

08/ / 19:30 #056 P. /

PRINTED: 08/07/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (XJ) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ 105R84 R WING 06/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE 7/D CODE 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION ancel. (EACH CORRECTIVE ACTION SHOULD BE MPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE TAR DEFICIENCY F 490 Continued From page 149 F 490 Appropriate interventions to deal with aggressive and / or catastrophic reactions: 4. What constitutes neclect and misappropriation of resident property. 3. Prevention: Every effort is made on behalf of the resident to prevent . This includes an analysis of: a. Features of the physical environment that may make and/or neglect more likely to occur, such as secluded areas of the facility; b. the deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that staff assigned have knowledge of the individual residents' care needs. C. the supervision of staff to identify inappropriate behaviors, such as ...ignoring residents while giving care,and d. the assessment, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as resident with communication . those that require heavy nursing care and/or the totally dependent on staff. Each team member reads and signs the " Resident Rights " upon employment. A copy of the resident rights is given to each team member within his/her probationary period of employment. This information is reviewed on an annual basis by the Social Services staff in an all-staff in-service Identification: Each team member is encouraged to attend a mandatory " Prevention ' in-service on an annual basis. This in-service includes methods to identify events, such as suspicious of residents, occurrences. patterns, and trends that may constitute and to determine the direction of het

Investigation: the Social Services Manager is the facility appointed designee who is the staff

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X2) MULTIPLE CONSTRUCTION A. BUILDING

OMB NO. 0938-0391 THE PART CHIEVEY COMPLETED c 06/26/2015

PRINTED: 08/07/2015

FORM APPROVED

NAME OF PROVIDER OR SUPPLIED

EXCEL REHABILITATION AND HEALTH CENTER

STREET ADDRESS CITY STATE ZIP CODE 2811 CAMPUS HILL DR TAMPA, FL 33612

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

105884

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

COMPLETION

F 490 Continued From page 150

member responsible for the initial reporting investigation of alleged violations and reporting results to proper authorities. The facility policy for any alienation of is for it to be brought immediately to the attention of the immediate supervisor. The supervisor is to notify the Social Services Manager, who is the facility appointed designee, the DON, and the Administrator ... the facility will also notify the appropriate agencies, based on the nature of the allegation in accordance with State and Federal Statute. Protection: the facility will make every effort to protect any individual form allegation of is against a team member. the team member will be immediately removed from duty during the investigation, and until it is complete

Reporting/Response: the facility will report all alleged violations to 1-800-96-.... and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective action depending on the results of the investigation; report to the state, or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for services; and analyze the occurrences to determine what changes are needed if any, to policies and procedures to prevent further occurrences. Federal neglect, and quidelines will also be followed by the reporting designee.

A review of the facility policy: " Advance Directives " (Revised 2008), revealed a policy statement: "Advance directives will be respected in accordance with state law and facility policy. " Policy Interpretation and Implementation, section "1, When a resident is F 490

D WING

FORM CMS-2567(02-99) Previous Versions Obsolete

Event iD: JSQX11

Facility ID: 62932

If continuation sheet Page 151 of 213

DEDARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/07/2015

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105884	B. WING		C 06/26/2015
	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1811 CAMPUS HILL DR FAMPA, FL 33612	1 00/20/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOI CROSS-RÉFÉRENCED TO THE APPR DEFICIENCY)	LED BE COMPLETION
F 490 Continued From page 151 admitted to our facility, the Social Services Director (SSD) or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives." "3. When a resident is admitted to our facility, SSD or designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives." "Deloy Interpretation and implementation, section "5: In accordance with current OBRA definitions and guidelines governing advanced directives, our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to: b. that, in case of or failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no () or other iffe-saving methods are to be used."		F 490		·	
1	Procedure: () ". (Revised policy statement: "training on the Initial Victims of Sudden Policy and Interpreta for the Initial Policy and Interpreta for the Initial Policy (SCA) n adults. 3. Victims have gasping	2011), documented the Personnel have completed tion of yBasic Life Support (BLS) in allon and Implementation: Jeffined as inadequate joi insufficient flow (puiselessness), 2, Sudden is a leading cause of			

-3/-3/_ - 12:03 #062 P.

riom:/275521162

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 08/07/2015 FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	ULTIPLE CONSTRUCTION DING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		105684	B. WING	3	C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2611 CAMPUS HILL DR TAMPA, FL 33612	06/26/2015 DE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEPICIENCIES MUST BE PRECEDED BY FULL C (DENTIFYING INFORMATION)	PREF TAG		HOURD BE COMPLETION
i i i i i i i i i i i i i i i i i i i	acute event (such a substantially from the from multi-system failure multi-system failure multi-system failure in conditions. I conditions. I conditions in conditions in conditions in conditions in conditions in conditions in conditions in conditions in conditions in conditions in conditions in conditions in conditions in conditions condit	presentations of SCA_40 overing from SCA due to an serior sold of the serior sold of the serior seri		490	
	actual	. To the extent possible, r on each shift who is			

#062 P.

. 31 1 12:04

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING ... COMPLETED c 105584 B. WING NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DR TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 10 PROVIDER'S PLAN OF CORRECTION PREED BREEN (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG COMPLETION TAG DATE DEFICIENCY F 490 Continued From page 153 F 490 responsible for coordinating the rescue effort and directing other team members during the rescue effort, 4. The team in this facility shall include at least one registered nurse, one LPN/LVN and two CNAs, all of whom have received training and certification in Maintain equipment and supplies necessary for /BLS in the facility at all times. 6, Provide information on /BLS policies and advance directives to each resident/ representative upon admission. " Emergency Procedure -" 1, the facility 's procedure for administration shall incorporate the steps covered in the 2010 American Association Guidelines for and Emergency Care or facility BLS training material. 2. The basic life support (BLS) sequence of events is referred to as C-A-B " (chest compressions, airway, and breathing). This has been revised from the previous sequence of "A-8-C" (airway, breathing, chest compressions). 3. Begin the adult victim is unresponsive and not breathing normally (ignoring occasional gasps) without assessing the victim 's pulse, 4. Following the initial assessment, begin with chest compressions rather than opening the airway and delivering rescue breathing, 5, All rescuers trained or not, should provide chest compressions to victims of Delivering high-quality chest compressions is essential: a. push hard to a depth of at least 2 inches (5 cm) at a rate of at least 100 compressions per minute. B. Allow full chest

recoil after each compression. C. Minimize interruptions in chest compressions. 7. Trained rescuers should also provide

ratio of 30:2. *

			12:05	#062 F	· / .
DEPARTMENT OF HEALTH AND HUM CENTERS FOR MEDICARE & MEDIC	MAN SERVICES			PRINTE	D: 08/07/201
STATEMENT OF DEFICIENCIES (X1) PROVI	DERVSUPPLIER/CLIA	(XS) WITE	TIPLE CONSTRUCTION	OMB NO	0.0938-039
AND PLAN OF CORRECTION IDENTI	FICATION NUMBER:	A. BUILDI		(X3) DA	TE SURVEY MPLETED
	105884	B. WING			C
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 06	/26/2015
EXCEL REHABILITATION AND HEALTH (2811 CAMPUS HILL DR TAMPA, FL 33612		
(XA) ID SUMMARY STATEMENT OF C PREFIX (GACH DEFICIENCY MUST BE PR TAG REGULATORY OR LSC IDENTIFYII	FCERED BY Et 2:	PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERÊNCED TO THE APPR DEFICIENCY)	11000	COMPLETION DATE
F 490 Continued From page 154		F 49	00		
A review of the facility policy: Assessment and Follow Up: R, from the Nursing Services Poli Manual (Revised 22 of this procedure is to gather in the resident's physical emotic psychosocial condition upon as purposes of managing the resi- care plan and completing requi- instruments, including the mini- (MDS). * Steps in the Procedu Determine if the resident has or directives. If so Initiate the po- directives. If so Initiate the copy for the medical record. In In resident with information on his advance directives and initiate it establishing tham. *Document following information should be a resident * needleal record* 3. Al assessment data obtained durin assessment data obtained durin	ole of the Nurse "yand Procedure yand Procedure yand Procedure In In In In In In In In In In In In In				
all she stated the L. Nursing (DON) informed her that Director of Nursing (ADON) had it resident unresponsive and did non The NHA stated in her opinion the have looked at the chart and initial On 15-15 PM an linter conducted with the Director of Nu when asked if she was famillar with she stated, "yes." When asked	e Administrator recall the events e day Resident irredor of the Assistant found the I perform ADON should tited view was rsing (DON).				

Facility ID: 62832

Fram:7275521162

08/10/2015 12:06 #062 P.007/032

DEDARTMENT OF				4062 F.007/032
DEPARTMENT OF HEALTH CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES	& MEDICAID SERVICES			PRINTED: 08/07/2015 FORM APPROVED
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	TIPLE CONSTRUCTION	OMB NO. 0938-0391
		A. BUILD	NHG	COMPLETED
NAME OF PROVIDER OR SUPPLIER	105884	B. WING		C
			STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/2015
EXCEL REMABILITATION AND	HEALTH CENTER	- 1	2811 CAMPUS HILL DR	
(X4) ID SUMMARY STAT	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL		TAMPA, FL 33812	
TAG REGULATORY OR LS	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO- DEFICIENCY)	
F 490 Continued From pag	ne 155			
Resident #1 had pas	sed. I asked the (ADON) if	F 49	90	1
				1
	that she, should have called in), and stated she did not			İ
to start a code on ma	ne policy states, we have			1
didn't look tight she	ounds, and the resident			1
				1
	I stated, "I knew he was a stated, "I knew he was a lad been here for so long,"			- 1
··· Activating (US	IADON) decided on her			ĺ
own not to do				1
	,			1
interview was conducte	ximately 5:00 PM an			1
				1
				1
making rounds before s	ha stated she was			1
				1
and checked on the resi He was gone. " Employ	dent. The ADON said, "			1
WOOM aid bot do				1
a,ing else about the n	nd that she did not recall			1
				1
COnducted with the ADON	an interview was			1
				1.
she took a sea	the first time on			1
	fl because another			
t verbal, he required total	care and had been			

#062 P.DO8/032 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DISFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NI MAREN (X3) DATE SURVEY A BUILDING COMPLETED 1058R4 B. WING NAME OF PROVIDER OR SUPPLIES 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTER 2811 CAMPUS HILL DO TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D OBCEN PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE TAG DEFICIENCY F 490 Continued From page 156 F 490 readmitted from the hospital that day. When asked to recall the events that happened on , the day Resident #1 bie Apon stated, I was working the night shift, I had finished medication pass and around 5:45 AM, the CNA was in the hallway and said, " I think he is gone. I went in Resident #1 's checked him for pulse and very cool to touch. He felt a little stiff in his upper extremities. His lower extremities had sort of . The resident had white frothy stuff erourie his mouth. There was nothing I could do for him. " When asked if she looked at the chart order, she stated. I looked at his chart after I called the doctor to lell him the resident and I didn 't see a . Honestiv when I saw me resident after the CNA called me he was cool to touch, I don't know if there was anything I could do for him. At that point I made the decision to not code him; because he was and stiff; I did not know how long he had ueen like that. The physician covering for the attending physician was called, and informed of the resident's The ADON was asked if she saw a order on the medical record, she stated, "after looking at the chart, no. " When asked if she had received training on how to respond when a resident is found without vital signs she stated, we are supposed to do chest compressions and send someone to check on status When the ADON was asked if she knew how to determine code status, she stated, if a resident is unresponsive, I am supposed to check the pulse

and call for someone else to check the chart for orders. I will a call code blue and bring the Gast. We have a yellow book at the nurses

new admission it may be necessary to look in the

forms, if the resident is a

08/10/2015 12:07 #062 P. V....

CENTE	RS FOR MEDICARE OF DEFICIENCIES	AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 08/07/2015
AND PLAN (OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ILTIPLE CONSTRUCTION DING	(X3) D.	O. 0938-0391 ATE SURVEY DMPLETED
		105884	B. WING		1	С
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL R	EHABILITATION AND	HEALTH CENTER		2811 CAMPUS HILL DR		
			i	TAMPA, FL 33612		- 1
PREFIX TAG		EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE ADDR		COMPLETION DATE
u c c a a in c c a a in in c c a a in in in in in in in in in in in in in	Continued From peg- chart. When asked sesident 's advance sesident 's advance sesident 's advance sesident 's lis in heck the chart on existure. It is the heck the chart on existure. It is sesident in sesident in sesident in sesident in sesident in sesident in sesident in sesident	a 157 now the nurse is notifier of a directives, including nurse is responsibility to ery resident, so they know each effect of the sound of the so	F 4:	DEFICIENCY)	OPRIATE	DATE

Occupational

Nurse (LPN)

dated

Facility ID: 62932

pale, warm and dry. Patient not verb -- h this nurse, but can make faces for pain. regular and audible, pulse rate emining . Breath sounds clear ---- Has referrals for Physical

A review of Resident #1 's medical record, Social Service Admission Evaluation Tool document

at 5:32 AM included th following information; the resident was had resided with his father in the past, was a h school graduate and had been in the

and Speech Signed by Employee C, a Licensed Practical

DOINTED: 09/07/2015

From:7275521162

"/ .J/__ .= 12:08 #062 P. /

ATSMENT	OF DEPICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MUI		ONSTRUCTION	(X3) DAT	E SURVEY MPLETED
ND PLAN C	F CORRECTION	105884	B. WING				C /26/2015
MAME OF	PROVIDER OR SUPPLIER	1,000			ET ADDRESS, CITY, STATE, ZIP COL	Æ	
	REHABILITATION AND	HEALTH CENTER			CAMPUS HILL DR PA, FL 33612		
EXCEL		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORR	ECTION	(XS) COMPLETION
(X4) ID PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	ix ·	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	DATE
F 490	Continued From pa	age 159		490			
	questions with corr	esponding answers written in					
	capital letters, Doe	s the resident have advanced ACITY & HC (health care)					
	DROYY ON CHAR	T. Does the resident have a					
	legal representative	e? YES, (the resident's fathe e number); What is the	er .				1
	resident 's code st	atus? FULL CODE. It was					
	Electronically signs	ed by Employee G.					
	(MDS) assessment or under Section C (Assessment for Mamory, memory memory problem. Decision Making: Section I (Modi) appaaring down, of alling or staying as peaing in a concentrating. Un Slatus) assistance requires total dependence personal hygiene. Bowell's Always Linder Section I (Mand) and Martinonal Sisteman (Martinonal Sisteman) and Mar	Patterns): Staff shall Status: Short term problem. Long term memory: skills for Daily severely skills for Daily severely skills for Daily severely skills for Daily severely skills for Daily severely skills for Daily severely skills for Daily severely skills for Daily severely skills for Daily severely skills for Daily severely sep or person of one person of one person of one person of one person of one person of bowel and collision of the bowel shall under Section K (Swallowing tus): Height 65 ", weight 111 or rin last 6 months-yes; ter Section M (Skin Condition	d e j				

From:7275521162

. / I/... 5 12:09 #052 P. . /

PRINTED: 08/07/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED A BUILDING __ 06/26/2015 105884 R WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33612 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX TAG DEFICIENCY) E 490 F 490 Continued From page 160 . Noted large , pulse or amount of frothy saliva on face and chest. Upper extremities cool to touch. Call placed to (attending physician) service, return call received from (covering physician). Order received to release body. Call to family, (Mother), name of funeral home received. Family declined to come to facility." Signed by the Assistant Director of Nursing (ADON). Review of Resident #1 's complete medical record including the closed record revealed no () form was present. at 12:00 PM. an interview was On . _. conducted with the Medical Director. When asked if his expectation was for a nurse to perform on a Full Code resident, he stated, " be done. " He has been the Medical Director for almost 4 years. " If the resident was unresponsive they have to do . Code Blue is residents." for all non-15 at approximately 10:00 AM, an interview was conducted with Resident #1 's attending physician. The physician stated the resident had multiple problems including: multiple issues, (_), and ... " He did not look well at all He was thin and looked 90. He was new to me as a patient. He was back and forth to the hospital. I was not called the day he the physician covering was called. "I found out the next day or so, probably when the funeral home called me. Normally if a patient does not have a would be initiated and 911 called. their chart.

My expectation is that the nurse would start if a was not on the chart. "

W 1/__ 12:10 #062 P. ...

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FOF	ED: 08/07/2015 RM APPROVED IO: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MUL A. BUILC		ONSTRUCTION	(×3) E	COMPLETED
		105884	e, WING				
NAME OF	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL F	EHABILITATION AND	HEALTH CENTER			CAMPUS HILL DR PA, FL 33612		
(X4) ID PREFIX TAG	JE ACH DEBICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREP TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LDØE	(X6) COMPLETION DATE
F 490	was conducted with received the call re 04/12/2015. She si attending physician ramember the call repatients. When the call repatients, when the call repatients when the call repatients when the call repatients when the call repatients when the call repatients when the call repatients when the call repatients are called repatients and the call repatients are called repatients and the called repatients are called repatients and the called repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients and repatients are called repatients and repatients are called repatients and repatients and repatients are called repatients and repatients and repatients and repatients and repatients are called repatients and repatients and repatients are called repatients and repatients and repatients are called repatients and repatients and repatients are called repatients and repatients and repatients are called repatients and repatients and repatients are called repatients and repatients and repatients are called repatients and repatients and repatients are called repatients and repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients and repatients are called repatients and repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients are called repatients and repatients	j.PM, a telephone interview the covering physician who parding Resident #1 on but doesn't as the save sovering for the on but doesn't as the was covering for the on but doesn't as the state dark eva covering for the on but doesn't as the state of the covers 1000 ad if she was informed the Code and he was not atted, "I apologize, but I don't lead to the code and he was not atted, "I apologize, but I don't lead to the code and the was not atted, and the code and the same the following and that I do not have to sign and that I do not have to sign and that I do not have to sign wance O izective in order to I Healthcare Center. I ay implement an Advanced e during my stay in the facility. Landing that I may sak at any inced Directive information or titre (s) and as the state of the code in	F	190			
	Durable Power of A Attorney, Medical P Financial or Medica	/Yellow HRS Form, ate, Health Care Proxy, ttorney, Financial Power of ower of Attorney, Guardian I, Anatomical Gift, Other; at of Incapacity, Funeral Home					

Selection. The form was initialed by the resident

______12:11

From:7275521162

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

, #062 F

> PRINTED: 08/07/2015 FORM APPROVED

> > 06/26/2015

DMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C

A WING STREET ADDRESS, CITY, STATE, ZIP CODE

2811 CAMPUS HILL DR

EXCEL REHABILITATION AND HEALTH CENTER

SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D CEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

105884

TAMPA, FL 33612 PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

F 490 Continued From page 162 and witnessed by Employee H on 3/10/2014.

> Admissions Review of the resident 5 paperwork revealed a second form titled Advanced Directives Acknowledgement (no page number) with the residents Initials beside the sections 1. I have been given written material about my right to accept or refuse medical and surgical treatments and my right to form Advanced Directives, 2, I understand that I am not required to have an Advanced Directives in order to receive medical treatment at this health care facility and 3. I understand that the term of any Advanced Directives that I have executed will be followed by the health care facility, physicians and my caregivers to the extent permitted by the law. The form continues with: Please Check one of the following statements: I have executed an Advance Directive and will provide a copy to the facility. I understand that the staff and the physicians at this facility will not be able to follow the term on my Advanced Directives until I provide a copy of it to the staff; or I have not executed an Advanced Directive and do not wish to discuss Advanced Directives further at this time. The spaces to check either statement were blank. The form was signed by the resident and the Admissions Representative Employee H and dated 3/10/2014.

Review of Resident #1 's medical record revealed the resident was discharged to the and readmitted to the hospital on . His admission paperwork facility on did not include documentation that his Active Medical Decision Maker, his father, was given information on Advance Directives. There was no " Advanced Directives Acknowledgement " form in the admission paperwork for the resident's

TAG F 490

(X2) MULTIPLE CONSTRUCTION

A BUILDING

1D

PREFIX

Facility ID: 62932

If continuation sheet Page 163 of 213

From:7275521162

__/ .../____ 12:11 #062 P. ,

DRINTED: 08/07/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (V2) MI ILTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED A. BUILDING AND PLAN OF CORRECTION C 06/26/2015 B. WING 105884 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33612 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES in COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DOCEN PREFIX TAG DEFICIENCY F 4QD F 490 Continued From page 163 readmission to the facility. Review of Resident #1 's physician orders dated revealed a Code Status of Full Code. Review of Resident #1 's medical record revealed the resident was discharged to the and readmitted on hospital on His admission paperwork did not include documentation that his Active Medical Decision Maker, his father, was given information on Advance Directives. There was no Advanced Directives Acknowledgement " form in the admission paperwork for the resident 's readmission to the facility. Further review of Resident #1 's medical record revealed a document titled Activated Medical Decision Maker signed by the resident's father and mother and witnessed by two signatures on The document included the following language: The Determination of Incapacity form , I do hereby has been completed on attest that I am at least and am willing to become involved in the above stated resident's health care decisions. I have maintained regular contact and em familiar with the resident 's activities, health, religious and moral beliefs, so that I can make health care decisions, including withholding/withdrawing life prolonging decisions that would be the decisions the Resident would have made, if capable. I am willing to produce clear and convincing evidence

upon request, I understand that my role has become active and accept my responsibility, which is one of the following Medical Decision

#062 P. / 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED A RUILDING AND PLAN OF CORRECTION С B. WING 105884

STREET ADDRESS CITY, STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR

FXCEL REHABILITATION AND HEALTH CENTER

TAMPA, FL 33612 PROVIDER'S PLAN OF CORRECTION 10

COMPLETION SUMMARY STATEMENT OF DEFICIENCIES EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REFIX TAG DEFICIENCY)

F 490 Continued From page 164

Maker designations; checked were Proxy and A parent of the resident.

Review of Resident #1 's medical record revealed a Determination of Incapacity document and signed by his attending physician, it included the following language: As attending physician for the above stated resident (Resident #1), I have evaluated and determined the above stated resident lacks the capacity to give informed consent to make medical decisions and does not have the reasonable medical probability of recovering mental and physical capacity to directly exercise rights.

at 12:40 PM, a telephone interview was conducted with Resident #1 's father. He stated his son was in the Marines; he got an aneurysm in there and had to havesurgery. He stated the resident lived by himself for a while, and then he started living with his girlfriend. He went to the hospital and they sent him to the nursing home. When asked if they were expecting his ____, he stated, he " could not care for him anymore, that 's why he went to the nursing home. " He was wearing diapers and couldn't dress himself anymore. "I couldn't handle him anymore." He went to the hospital and then the nursing home; he " was in and out of the nursing home. " I think he in the hospital, no, the nursing home, I get sometimes. I couldn't do anything with him." He was having problems breathing, they put him on . The last time I saw him he was in the

hospital, and then someone called and said he was

On at 1:15 PM an interview was conducted with Employee G a Social Services F 490

Facility ID: 62932

If continuation sheet Page 185 of 213

Prom:7276521162

(X4) IO PREFIX

TAG

PRINTED: 08/07/2015 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MILTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 06/26/2015 E WHING 105884 STORET ADDRESS CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR TAMPA FL 33812

FXCEL REHABILITATION AND HEALTH CENTER

PROVIDER'S PLAN OF CORRECTION INA WALETION FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

F 490 Continued From page 165

Assistant regarding Resident #1 's Social Service Admission Evaluation Tool dated timed 5:32 AM, approximately 13 minutes prior to . When asked, Employee G the resident 's stated he probably filled in the information based on prior admissions. He stated he was going to speak with the resident 's family and he confirmed that the resident had a health care proxy and a Determination of Incapacity. He confirmed that the resident was a Full Code on previous admissions and remained a Full Code in the because there was not a signed medical record. He stated that his plan was to call the family and inform them of their right to formulate an advance directive for the resident. He further stated that the facility procedure in regards to advance directives required the Admissions Department to speak to residents on admission, advance directives are then addressed in the Nursing Admission Assessment and the Social Services Department reviews the information with the resident and/or the family.

SLIMMARY STATEMENT OF DEFICIENCIES

REGULATORY OR LISC IDENTIFYING INFORMATION)

FACH DEFICIENCY MUST BE PRECEDED BY FU

at 1:20 PM an interview was conducted with the Social Services Director (SSD) regarding Resident #1. Per the SSD, she spoke to the resident 's father on he was readmitted on She confirmed that his parents were making the decisions regarding his care and were designated as his Activated Medical Decision Makers at that time. She stated that the father was given information in regards to formulating an advance directive. SSD states. " If he wanted him to be a would have mailed him the paperwork. " She also stated that she had not spoken to the father when the resident was admitted on She stated that the resident was designated as a of Full Code since his original admission in

TAG F 490

(D

FORM CMS-2567(02-99) Previous Versions Obsciete

Event (0: JSOX1:

Facility ID: 62932

if continuation sheet Page 166 of 213

#052 P 018/032

PRINTED: 08/07/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING ___ С a wing 105884 06/26/2015 STREET ANDRESS CITY STATE ZIE CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA FL 33612 PROVIDER'S PLAN OF CORRECTION CANTO SUMMARY STATEMENT OF DEFICIENCIES 10 (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DOCEIV COMPLETION CROSS-REPERENCED TO THE APPROPRIATE TAG DEFICIENCY F 490 Continued From page 166 F 490 2014 and had never had a paper in his medical record 4. Review of the medical record for Resident #2 revealed she was a admitted originally (Friday) discharged on against medical advice and was re-admitted on (Thursday) from the hospital. diagnoses included) and lung Review of the Resident 's Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (3 score of 13 indicating the resident was Review of Resident #2 's Admission Agreement (Friday) revealed an Advanced Directives Acknowledgement form. All blanks on the form for initials to signify that the resident had received the information and designated a choice of Full Code or were not filled in. The form was signed by the resident on (Tuesday) Review of Resident #2 's medical record revealed an Admission Evaluation Tool dated : admitted for (remission): History of lung ; arrived via stretcher from hospital; weight 94 pounds; height: 5 ' 6 "; alert; assist with bed mobility transfers. walking, dressing, toileting, personal hygiene and bathing, assistive device with a walker. The sections Living will, Organ Donor and Advance Directives Explained were all blank.

Review of Resident #2 's medical record (for her first admission) revealed a Social Services

W. .../_ . 12:14 #062 P. / 13

DEPARTMENT OF HEAL'	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			PRINTED: 08/07/2015 FORM APPROVED DMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A, BUILDING	E CONSTRUCTION	(X3) DATE SURVEY MPLETED
	105884	B. WING		C 3/26/2015
NAME OF PROVIDER OR SUPPLIE EXCEL REHABILITATION A	ER	ST 28	TREET ADDRESS, CITY, STATE, ZIP CODE 811 CAMPUS HILL DR	
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	AMPA, FL 33612 PROVIDERS PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
at 4:09 Ph many years; no a resident makes h code. mood; to 4 weeks, signe Review of Reside second admissio Evaluation Tool d arrived via stretch arrived via stretch iung advva advance directive communicated to mobility dressing, toileting upper ar Review of Reside revealed a Social Tool dated female; no advance to home with son Review of the res revealed a '_ under Code Statt Netther Full Code line provided to d Review of Reside revealed a '_ and the reside revealed a '_ and the reside revealed a ' and reside revealed a ' and reside revealed a ' and reside revealed a ' Review of Reside revealed a ' Review of Reside	usion Tool assessment dated with ived with granddaughter for advanced directives at this time; her own decisions at this time; full anticipated length of stay for 2 ed by the SSD. ent #2's medical record (for her nt) revealed an Admission dated (Thursday); her from hospital due to status post, smoker, ance directives - no; is the snoted in the chart and o staff no; independent in bed for transfers, g, personal hygiene; on ms; alert and oriented x 3. ent #2's medical record I san for the shart and oriented x 3. ent #2's medical record I san for the shart and oriented x 3. ent #2's medical record I san for the shart income of the shart and oriented x 3. ent #2's an edical record I san for the shart income of the s	F 490		

Medical Advice (AMA) resident 's son was in the facility and took resident home. Resident able to make her decisions independently and had no

From:7275621162

PRINTED: 08/07/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION A. BUILDING 105884 A WING 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR EXCEL REMARKLITATION AND HEALTH CENTER TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S BLANCE CORRECTION COMPLETION (X4) ID PREEIX 10 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PREFIX TAG DEFICIENCY F 490 Continued From page 168 F 490 .. signed by the SSD. Review of Resident #2 's medical record revealed a nursing progress note dated at 6:58 PM: resident admitted from hospital with admitting diagnosis of Data . status post i. lung collection stated findings as follow: old and new noted on the upper extremitles and lower extremities lung sounds clear to auscultation: bowel sounds heard all 4 quads; abdomen non-distended oriented to signed by the Unit manager. (one week after admission) at 7:45 AM an interview was conducted with Resident # 2. She was observed siting in a wheelchair at the bedside. When the resident was asked about her if needed, she stated she did not . After conversing about other subjects the resident was asked again about advance directives, she stated. "They have not asked me about that," When asked if she wented she stated. "don't want that, " "Don't want my family to suffer through that." at 1:49 PM an interview was conducted with the SSD. She stated in regards to Resident #2, " like I showed you yesterday, I spoke with her (Resident #2) about advance directives and she doesn't have any She does have a son. She doesn't want her son to make decisions for her. SSD was informed the advance directives acknowledgement form in Resident #2" s admission agreement packet was blank. She

stated, "Well I wouldn't know that,

On at 1:00 PM an Interview was conducted with the NHA, the DON, and the

08/ 13/_1.5 12:16 #062 P. W

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/07/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	CON	E SURVEY IPLETED C
		105884	e. WING			06/	26/2015
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
	REHABILITATION AND	HEALTH CENTER			CAMPUS HILL DR IPA, FL 33612		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEPICIENCY)	ALD BE	COMPLETION DATE
F 490	Continued From pa	age 169	F	490			
	Corporate Nurse (C	CN), The NHA stated that SS					
	should be documen	nting discussions regarding					
	advance directives	in a progress note. On review ogress notes it was revealed					
	that for Resident #2	2 there was no documentation					
	from SS in the prog	gress notes, and The NHA					
	verified this.						
	revealed Social Ser at 2:39 Resident #2 's later following notation. Social Services Ass with the resident ab	t #2's medical record rvice Progress Note dated PM; which was a week after ist re-admission found the Social Service Director and sistant together went to speak bout advanced directives.					
	directives at home.	Do Not () d. Resident was agreeable at order. Will follow up with					
		edical record revealed					
		rom the hospital with					
	diagnoses that inclu hematoma, chronic kidney	uded and					
	, since a	t #4 's medical record, on admission ()					
	revealed there was	no form in the record.					
	dated r Directives Acknowle	#4's Admission Agreement revealed an Advanced edgement form signed by the					
	resident 's daughte	er. All the blank lines on the					

form for initials to signify that the daughter had

PRINTED: 08/07/2015

/ 37 . 3 . 12:16

Fram:7275521162

		& MEDICAID SERVICES			MB NO. 0938-0391
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 06/26/2015
	PROVIDER OR SUPPLIER REHABILITATION AND	HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR TAMPA, FL 33612	
(X4) ID PREFIX TAG	FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		D BE COMPLETION
F 490	of Full Code or Review of the resid- revealed an undate page 1 of 2: under to blank line. Neither froit to the line p Status. Review of Resident Tool dated of) revea from hospital; diagn hematoma , and chronic directives - no; resia	ation and designating a choice were not filled in. The filled in the condition of the cond	F	490	

assist of 1 with transfers and ambulation: mechanically altered diet; alert to person, place and situation; patient long term memory not good per family, diagnosis of for several rate regular, continent of bowel; no pain; limited assist for ambulation; 1/4 side ralls for bed mobility, signed by Employee C. an LPN Review of the resident 's Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 6;

speaks Spanish requiring a translator; requires limited assistance for bed mobility, transfers. dressing, tolleting and personal hygiene; skin is pale, warm and dry has poor balance and needs

indicating severe Review of the Social Service Admission

Evaluation Tool dated (Monday) revealed: male born in Puerto Rico, lived in

#062 P. . . . /

From:7276521162

. / 1/... . 12/17

DEPARTMENT C	F HEALTH AND	HUMAN SERVICES	
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PRINTED: 08/07/2015

DEPARTMENT OF HEALTI CENTERS FOR MEDICAR				FORM APPROVE MB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A, BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	8. WING		
NAME OF PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE	
EXCEL REHABILITATION AN	D HEALTH CENTER		2011 CAMPUS HILL DR TAMPA, FL. 33612	
PRETTY (FACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEPICIENCY)	DE COMPLETION

F 490 Continued From page 171

F 490

when came to live with Puerto Rico until other daughter; no advanced directives on file at this time; Full Code; family visits dally; planning for Long Term Care.

A review of the nursing progress notes revealed the following relevant entries. PM: patient admitted via wheelchair from hospital: patient transported by family; Alert and oriented x 2: Speaks Spanish only: Daughters at bedside.

Further review of Resident #4 's medical record revealed the resident went back to the hospital for and spent one night a follow up visit on there. The record included a document of a verbal report given to the facility nurse from the hospital nurse titled "Nurse to Nurse". It included the following documentation. (Saturday, 8 days after admission) "the resident" s name ". /Do Not Intubate (DNI), Diagnoses, fatigue, low hemoglobin. , chronic kidney

clinic, 2 units of alert, oriented.

Review of the Nurse 's notes revealed - AM (Saturday, 8 days after admission), resident admitted from the hospital with a diagnosis of fatigue secondary to low hemoglobin, and administered, resident was transferred with his family via ambulation/wheelchair, Limited English. /DNIs status noted. Skin has some abnormal findings right temple noted: nurse from hospital stated that a consult with was ordered for bone . Further review of the nurse

's notes revealed at 2:30 PM: attending physician was called by the supervisor.

Facility ID: 82932

If continuation sheet Page 172 of 213

PRINTED: 08/07/2015 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIP IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES COMPLETED A. BUILDING ... С S MING 155884 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33612 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU 10 COMPLETION (X4) ID EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC (DENTIFYING INFORMATION) TAG DEFICIENCY F 490 F 490 Continued From page 172 Supervisor updated physician on re-admit. No new orders; it is okay to resume previous orders. at 12:20 PM (Thursday, 13 days after admission and 5 days after returning from overnight stay at hospital) an interview was conducted with Resident #4 's daughter. When asked if the facility had spoken with her regarding her father's advance directives, she stated, no. no one had spoken with her on admission. . She stated she took or on her father to the hospital on and the staff at the hospital spoke with her about advance

physician stated we may need to think about JDNI. We (the family) discussed the weekend after his visit to the hospital. We order is what we wanted: we decided that a want him to be comfortable. I would like to respect his wishes.

directives due to his condition. The hospital

at 1:00 PM an interview was conducted with the NHA, the DON, and the Corporate Nurse (CN). The NHA, the DON and the Corporate Nurse (CN) were shown Resident #4 's admission agreement packet, including the Advanced Directives Acknowledgement form. with blank lines. The NHA verified that the admissions representative was responsible for making sure the admission agreement packet was complete without any blanks. The NHA verified that the admissions representative was supposed to review the advance directive acknowledgement with the resident and or family member regarding the resident 's wishes and to protect their resident rights. When asked if a resident was admitted on Friday night, Saturday or Sunday if the nursing staff were supposed to discuss advance directives with the resident and

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From:7275521162

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE		,	FORM APPROVE
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	105884	8. WING	06/26/2015
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
EXCEL REHABILITATION AND	HEALTH CENTER	2811 CAMPUS HILL DR TAMPA, FL 33612	

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DOESIN

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F 490 Continued From page 173

or family, the NHA stated, "Yes," Also informed the facility staff that per interview with Resident #4 's daughter, she stated, no one has spoken with her regarding advance directives, and that her brother in Puerto Rico is the medical Power of Attorney (POA). The NHA, DON and Corporate Nurse (CN) confirmed that the included in the progress notes and nurse to nurse note. The NHA stated that they should have the medical POA information in the record if there is one. The Corporate Nurse stated. "We have 5 days to discuss advance directives during the assessment period. " The NHA stated that SS should be documenting discussions regarding advance directives in a progress note. On review of the electronic progress notes it was revealed that for Resident #4 there was no documentation from SS in the progress notes, the NHA verified this

at 1:49 PM an interview was On conducted with the SSD, SSD was informed the advance directives acknowledgement form in Resident #4 's admission agreement packet was blank. She stated. " Well I wouldn't know that."

at approximately 3:30 PM an interview was conducted with Employee G. He stated that the SS department spoke with the Daughter of Resident #4 and she wants to be health care proxy and have a her father. Employee G stated they are getting the paperwork together, and waiting on the incapacity certification from the physician.

Review of Resident #4 's medical record revealed a Social Services (SS) progress note at 2:46 PM (13 days after dated admission to the facility and 5 days after return TAG F 490

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:J50X11

Facility IO: 62932

If continuation sheet Page 174 of 213

#062 P. 7/ .../ . 12:19

PROVIDER'S PLAN OF CORRECTION

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DEPARTMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-039
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLER/CLIA IDENTIFICATION NAMER:		A. BUILD		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER EXCEL REHABILITATION AND	105884 HEALTH CENTER	18. Wind	STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR TAMPA, FL 33612	

F 490 Continued From page 174

TAG F 490

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from hospital overnight stay); this Social Service Director and the Social Services Assistant went to speak with the resident 's daughter about advanced directives. Resident's daughter stated she does not have any advanced directives at home. Also she reports that none of her siblings have Power of Attorney or any advanced directives either. Do Not 11 order was explained to the daughter. Resident #4 s daughter stated that she discussed the entire family and family was agreeable to sign order for her father. SSD explained process such as signing incapacity form, of signing Health Care Proxy form and after that, Will follow up with

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION)

6 On at 5:00 PM an interview was conducted with the NHA. In regards to the facility response to the incident of Resident #1 not receiving ... when necessary she stated, "We started an investigation and a Quality Assurance Performance Plan (QAPI) immediately. We sent the ADON home for the day on suspension. We reviewed the policy and procedures for advance), Code Blue directives Roles and Responsibilities, and the Emergency Procedure for . We interviewed the staff regarding their ability to verbalize the process. We normally complete an audit of the advance directives and orders monthly. The SSD initiated an Immediate audit for Advance for the entire resident Directives and population and it was completed by 2015. We were monitoring / reviewing the charts of residents who expired. We started in-service

training regarding advance directives and

and called a Code Blue Drill. Multiple interviews

If continuation sheet Page 175 of 213

From:7275521162

PRINTED: 08/07/2015 FORM APPROVED

#062 P.

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA 1921 MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING ... 105884 B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR

EXCEL REHABILITATION AND HEALTH CENTER

TAMPA, FL 33812 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATIONS DOCETY TAG TAG DECICIONOVI

F 490 Continued From page 175

of the staff were initiated to ensure the direct staff knew about advance directives. and when to call a code. Training was conducted in the entire facility. The DON did immediate In-servicing with the ADON and we completed a Federal report. We have been conducting weekly Quality Assurance (QA) meetings regarding the event. These meetings will continue weekly through and then occur monthly ". When asked when staff training had been conducted prior to the last couple of months, she stated, " we do it routinely and new hires get it at orientation." When asked how the facility audits the employee records for current she stated. "the Human Resource (HR) manager does an audit, which includes reviewing When asked if the event had been presented to the QA committee with an action plan she stated. " Yes " .

 \cap the NHA provided a " QA Book ", it contained the Quality Assurance Performance Improvement Plan for review. The tool was and signed by the Quality hetch Assurance team including the Medical Director on . A review of the information provided revealed policy revisions dated

and Responsibilities " and " Emergency Resuscitation. " Procedure -Review of these revisions revealed the following relevant changes: * Code Blue Roles and

Responsibilities " (no effective date): " In the event that a resident is found in the person discovering the immediately notify a nurse of the situation. A teammate should page overhead that there is a F 490

FORM CMS-2567(02-99) Previous Versions Obsolate

Event ID: J50X11

Facility ID: 62932

If continuation sheet Page 176 of 213

Fram:7275521162

7 5/.... 12:20 #062 P.028/032

		HAND HUMAN SERVICES					INTED: 08/07/2015 FORM APPROVED IB NO. 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION		(X3) DATE SURVEY COMPLETED C
		105884	s. WING				
NAME OF	PROVIDER OR SUPPLIER		-		REET ADDRESS. CITY, STATE, 2IP CO	300	
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F 490	Continued From pa	age 176	F.	490			
	available teammate to a Code Blue Pag immediately assess the resident is in	location of the code. All es are responsible to respond ge. The nurse is responsible to s the resident to determine if . The					
	determine if the res in their record. (may at each nurses state	y check YELLOW BINDERS tion for status) if the					
	Is noted then there implemented as per directives, if there is record then Is Nurses are respons on the resident will be a st tode situation. Cert are certified m	will be no further interventions or the resident 's advance					
	for the following in-s ,5/9. In additi were done on documents that wer were reviewed. A co the in-service signal of all employees. The as of 91%	nature sheets were provided services, dated , 6/7, and 16/10 mock "Code Blue " drills re provided to the survey team omparison was made between ture sheets and the master list be comparison revealed that % of licensed nurses and 97% fall had completed the training.					
	advanced directives were conducted in o The following releva	facility staff regarding s, : and Code Blue drilfs order to verify staff knowledge. ant interviews were obtained: 24 PM, an interview was					

conducted with Employee C a nurse; she stated she worked full time on the 7:00 AM -3:00 PM

08/10/2015 12:21 #062 P. /

DEPART	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM MB NO.	08/07/2015 APPROVED .0938-0391 E SURVEY
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		COM	PLETED C
		105884	B. WING			L	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STAT 2811 CAMPUS HILL DR	E, ZIP CODE		
EXCEL R	REHABILITATION AND	HEALTH CENTER		TAMPA, FL 33612			
(X4) ID PREFIX TAG	AC NOW OFFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TO THE APPROP	BE	COMPLETION DATE
F 490	Continued From pa	age 177	F	190			
750	shift. She stated shift code Blue drill a code just had an in-street forms, in the jown she would rest was unresponsive the resident, have site. book, I will determined if the rewould stop. On at 4:	he had been part of a mock pupile of months ago and that ! ervice on where to find the yellow book. "When asked pond if a CNA said a resident she stated she "would check someone at the desk check build initiate until ! sident had a order then ! 32 PM an interview was ployee D a nurse, who stated					
	shift. She stated sh advanced directive: Code Blue drills a fi She also stat unresponsive; I would someone to go to	s and participated in mock few months ago and again in ted "If I found someone uld start shout for book. If they were a) would call the physician and a full code! would keep going					
	conducted with Em she usually worked -11:00 PM shift. Sh orientation they disc orders. She hi	40 PM an interview was ployee E a nurse, she stated is a needed on the 3:00 PM he stated that during cussed advance directives and ad training in the last couple of e directives and did a mock	!				

Code Blue drill also. If a resident was found unresponsive she stated she would, " check the resident, yell for help, and send someone to get more help. I would start . There is a book; I would send someone to check. If I have started and find out the resident is a then,I would stop. I would start before I knew if they were a or not."

From:7275521162

08/10/2015 12:22 #062 P. 1/

-151111					DOINTED	: 08/07/2015
DEPART	IMENT OF HEALTH	AND HUMAN SERVICES			FORM	APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES				0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDR	FIPLE CONSTRUCTION		TE SURVEY MPLETED
		105RR4	B. WING		96	C /26/2015
		10000	1	STREET ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER		- 1	2811 CAMPUS HILL DR		
EXCEL R	REHABILITATION AND	HEALTH CENTER		TAMPA, FL 33812		
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F 490	Continued From pa	age 178	F 4	90		:
		AM an interview was				
	conducted with tem	ployee F a nurse, he stated he 11:00 PM -7:00 AM shift. He				
	stated "We had a	Mock Code Blue training				1
	recently. We recent	itly had a class on advance				
	directives and	." The training included:				1
	making sure we har	ive advance directives, if				1
		, speak with the family, check flow form, make sure a				
	the chart for the yel	also. He was asked what he				
		d an unresponsive resident, he				
	stated " first assess	is for breathing, call a code,				
	call somebody by n	name to call 911. Check Vital				
	signs, call for crash	n cart. Call another person to I would start compressions				
	right away, and if fo					
	stop compressions.	ond they more o				
	During the interview	w conducted on at				
	5:15 PM with the D	ON she stated that what she				
		f a resident was found				
		had a Full Code status the				
	nurse should start	. She was asked if a				
	nurse should start	prior to finding out about				
	a resident's should know if the r	order. She stated, "The nurse resident is a or not before				
		he nurse starts and finds				
	out the resident is a	a , the nurse can stop.				
	That is what I was to	told during my class."				
	When asked if that	was in the facility policy, she				
	stated, " it is not in	our policy, so I do not teach e classes. " The DON was				
		of 7 nurses interviewed so far				
	stated they would st					
	unresponsive reside					

found the resident was a ... She was asked if the facility conducted training since the event. She stated "yes, we started in ..., after the

#062 P. 1/ 11 12:22

			PRINTED:	08/07/2015

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				FORM	08/07/201 APPROVE 0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILL		CON	E SURVEY IPLETED
	105884	B. WING		06/	26/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL REHABILITATION AND	HEALTH CENTER	2811 CAMPUS HILL DR TAMPA, FL 33612			

event and we have given in-services again

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION in (X4) IC PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY

F 490 Continued From page 179

recently." This training covered orders and advance directives. The training is also being done on orientation. She stated, "We did the , because training for the whole month of we had to get everybody. And then we just did it again. In addition, a Quality Assessment Performance improvement (QAPI) was started. the day of the event. The Quality Assurance (QA) committee was informed. We did training with the CNAs and nurses and also preformed mock code blues." When asked if training had been performed in the past, stated, "Yes, the in-service is done yearly and during orientation." In addition, the DON was also asked, how the facility audits the employee records for current she stated, "when we have new employee starting Human Resources (HR) sees the card and then the ADON checks the that. All nurses are supposed to be certified. " When asked if the facility had audited the employee records for current , she stated ' monthly and HR does Yes, the ADON audits it on hire. " The DON stated the SS department monitors, audits the advance directives, and reviews DNR orders monthly. The DON stated the event had been presented to the Quality Assurance (QA) committee and an action plan and plan of correction was put into place. The DON completed the Federal report and reported it to the corporate nurse. The DON stated, "The direction I got was to do education, and do mock codes, and file a federal report.

at 2 PM, an interview was conducted with the NHA and the DON to review the content of the training In-services. The NHA and DON stated, we went over the following policies: : policy (which included what to look F 490

1.1 12:23 #062 P

Exam: 7976521162

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			FORM APPROVED OMB NO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE CONSTRUCTION A, BUILDING	(X3) DATE SURVEY COMPLETED C
	105884	B. WING	06/26/2015
NAME OF BROWNER OF SURPLIES		STREET ADDRESS, CITY, STATE, ZIP CODE	

E OF PROVIDER OR SUPPLIER

EXCEL REHABILITATION AND HEALTH CENTER

2811 CAMPUS HILL DR

TAMPA, FL 33612 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES)D CVAL IN (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX TAG DEFICIENCY

F 490 Continued From page 180

orders and book, where to find the paper, etc.), Advance Directive policy and Code Blue policy (described a mock code blue, if staff walk in on an unresponsive resident what you would do), and the Emergency procedure policy. It was a verbal presentation and every nurse received a packet. The expectation was for nursing / CNA staff to receive training by the first QAPI meeting. By the first QAPI we were almost at 100%. The concern regarding interviews with 4 of 8 nurses on and prior to knowing the resident 's code status

surveyor which revealed the nurses would start was discussed. The DON stated. "That is not what they were trained to do. " The NHA and the DON stated they would begin retraining the nursing staff that day.

On ____ et 1:00 PM an interview was conducted with the NHA and the Corporate Nurse (CN). When asked when the Policy and Procedure for advance directives and last reviewed, the Corporate Nurse (CN) stated " the Policy and procedure for advance directives was reviewed and and updated on . Resident #1. He further stated that the Emergency Procedure was also updated. which included the Code Blue Roles and Responsibilities

- 7. Record reviews and interviews revealed the following corrective action was taken:
- · in-service signature sheets were reviewed for retraining of the nursing staff, regarding advance directives,

F 490

FORM CMS-2557(02-89) Provious Versions Obsolete

Event ID: J50X11

Fectility ID: 62932

if continuation sheet Page 181 of 213

From:7275521162

/ / 19:93	#058 P. /
	PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-0391
(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIES

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X4) ID

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EXCEL REHABILITATION AND HEALTH CENTER

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

105884

STREET ADDRESS, CITY, STATE, ZIP GOOE 2811 CAMPUS HILL DR

TAMPA. FL 33612 PROVIDER'S PLAN OF CORRECTION in EACH CORPECTIVE ACTION SHOULD BE DESED CROSS-REFERENCED TO THE APPROPRIATE TAG DEELCHENCY

F 490 Continued From page 181

code blue drills. The NHA verified that all nursing staff with the exception of one employee that was unavailable had received the in-service retraining. The NHA verified that this employee will not return to work until they have received the retraining. On interview it was confirmed after the re-training, the nurses were able to verbalize the Policy and Procedures: Advance Directives. and Code blue. and Emergency Procedure: Interviews were conducted with 21 out of the 31 nursing staff members on . All staff members interviewed and

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

were femiliar with the policy and able to verbalize procedure. the correct

at 3:40 PM an interview was conducted with the NHA. She was asked how the facility was going to ensure that residents had Advance Directives which accurately reflected their wishes in their first 14 days of admission since Residents #2 and #4 's advance directives had not been addressed and they were both recently admitted. She stated she met with the SS department and said that all residents admitted in the last 2 weeks or since would be reviewed regarding advance directives and the reviews would be documented in the progress notes. When asked how the facility was going to address blanks in the Advance Directive Acknowledgement form she stated the Regional Business office will do a complete audit of our admissions for completion; will audit immediately to ensure the paper work is being filled out correctly and completely.

the facility provided the following note written on facility letterhead and dated signed by the NHA: Social Service: In regards to assuring that

F 490

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/ / ... 19:34 #056 P.

PRINTED: 08/07/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED STATEMENT OF DEFICIENCIES A BUILDING AND PLAN OF CORRECTION 06/26/2015 a wing 105884 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA FL 33612 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (X4) ID TAG DEFICIENCY TAG F 490 F 490 Continued From page 182 residents are given the opportunity to discuss/choose an advance directive, 100% of all forward have been admissions from reviewed by the Director of Social Services and a progress note regarding same has been edded to these records as an addendum to the initial assessment done at the time of the admission Admissions Contract: In regards to assuring that residents are given the opportunity to discuss/choose an advance directive, 100% of all admissions contracts from have been reviewed by the Admissions Coordinator to ensure completion of all forms including the advanced Directive Acknowledgement. at 9:50 AM an Interview was conducted with the NHA and the Corporale Nurse (CN). They stated they had initiated an audit on The SS all admissions since department revisited each resident and wrote a progress note for each medical record to provide documentation. The Admissions department went through all admission paperwork for residents admitted on forward to make sure paperwork is correct and to review the advance directives section for completion. All incomplete forms were addressed with the resident last night or this morning. The Admissions department has been re-educated by the NHA regarding completion of admission agreement forms, with attention to the resident rights portion and advance directives, including not leaving blanks and having correct dates. The NHA stated she would review advance directive paperwork on all new admissions. They also

stated that the Admissions department will do an audit of the paperwork for all admissions for the next three months. They said that after three

DEPARTMENT OF HEALTH AND HUMAN SERV CENTERS FOR MEDICARE & MEDICAID SERVI STATISHENT OF DEPICIENCES AND PLAN OF CORRECTION 105884		(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A, BURLOIN B, WING		FORM OMB NO (X3) DAT CON	08/07/2015 APPROVED . 0938-0391 TE SURVEY MPLETED C
		105884	18. (1.10	STREET ADDRESS, CITY, STATE, ZIP CO	SDE	
NAME OF PR	OVIDER OR SUPPLIER		- 1	2811 CAMPUS HILL DR TAMPA, FL 33612		
EXCEL RE	HABILITATION AND	HEALTH CENTER		THE PROPERTY OF AN OF COR	RECTION	(XS) COMPLETION
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	TEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG			DATE
.,,,,						•
	that would be dischedular they further stated the nurse will verific document on a production will be meeting and adversions will be meeting and adversion as well. Social seresident with deve and will document stated that each rewill be discussed or care plan meeting resident wants anday care plan and	begin a monthly random acus used at the CA meetings, that at the time of admission, yadvance directives and orgress note. All new reviewed at the daily clinical nee directives will be a focal this will occur on the weekerd topment of advance directives on a progress note. They saldem' is advance directives at their 14-21 day and quarterly s. The expectation is that if a tything obtained in the facility staff or if staff in condition that it will be	3 ;			
F 520 SS≃J	lean and was foll	MBERS/MEE	F	520		
	assurance comm	intain a quality assessment ar ittee consisting of the director a physician designated by the set 3 other members of the				

#058 P. 7 1 . ./ . / . 19:35

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			0	FORM MB NO	APPROVED 0938-0391
THRILITATO	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILC		CONSTRUCTION	CON	E SURVEY IPLETED
		105884	B. WING			06/	26/2015
(X4) ID PREFIX		HEALTH CENTER	ID PREF	28 T/	REET ADDRESS, CITY, STATE, ZIP CODE 111 CAMPUS HILL DR AMPA, FL. 33812 PROVIDERS PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERRINGED TO THE APPROF	O BE	(X3) COMPLETION DATE
TAG	REGULATORY OR L Continued From pa The quality assess committee meets as the second of	ge 184 ment and assurance these translations are seen as a second to the seen and assurance these quartery to identify to which quality essessment vities are necessary, and ments appropriate plans of mittled quality deficiencies retary may not require cords of such committee uch disclosure is related to the committee with the section. See by the committee to identify deficiencies will not be used as s. It is not met as evidenced vs with facility staff, the the Medical Director, facility deficiency of the section of the section of the section of the section of the section of the section of the section of the section of The facility tes a visite mit of the section of the resord retrieved and the section to correctly identify ing honoring the resident's of The facility te a system to action to correctly identify ing honoring the resident's of The facility te a visite mit onlightered.	F	520	Resident #1 expired at the facility on The family and physician wer notified of the resident's passing. A full facility review was completed fo advance directives on this inc	r cluded and ir right right tive tass of its and	:
	deficiencles follows						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/07/2015 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF THE MAN	A MEDICAID SERVICES		Ur	VIB NO. 0930-038			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	ENTERS FOR MEDICARE & MEDICAID SERVICES STEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				
	105884	e, wing					
NAME OF PROVIDER OR SUPPLIER EXCEL REHABILITATION AND	HEALTH CENTER	281	EET ADDRESS, CITY, STATE, ZIP CODE 1 CAMPUS HILL DR MPA, FL. 33812				
LOCAL DESIGIENCE	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFY! INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION			
F 520 Continued From pa	age 185	F 520					

survey of ... the facility failed to provide necessary care and services in accordance with acceptable standards of practice, failed to ensure care planning interventions/approaches were implemented as well as the facility administration failed to administer effectively and failed to utilize resources to assure residents were kept safe and received outsility of care.

. the facility old During the survey on not Initiate ____ on Resident #1, who was 66 years old and had not expressed wishes to have withheld, nor had his Health Care Proxy expressed wishes for ____ to be withheld if he was found unresponsive. On the resident was found unresponsive and absent of pulse and _____ less than 24 hours after admission. The facility did not initiate as per the resident 's wishes and his Health Care Proxy 's wishes. The facility falled to honor the resident without the 's Advanced Directive and he by receiving the papartunity to be services of

The facility failed to follow through on measures to ensure sustained compliance with standards of practice (F281); care plain implementation (F282) and the substance of Administration to manage resources effectively (F480). The lack of a sustained Quality Assurance Plain (F520) placed facility residents at continued risk and resulted in a determination of immediate Jeopardy on

at a severity and scope of J. The immediate Jeopardy was removed on and the scope and severity was reduced to D.

Findings include:

- The following policies and procedures were reviewed and revised as necessary, Advance Directives, Resuscitation, Do Not Order,
 - /Neglect/
 Quality/Assurance/Performance Improvement, ast a QAPI Meeting on overseen by the Administrator and Medical Director. Education has been provided to the QAPI Committee including the Administrator and Medical Director on the QAPI Process by the Nurse Consultant on utilities the CMS QAPI at a Glance
 - educational material. The QAPI Committee will utilize this for continued identification, analysis and planning for identified opportunities for improvement in the facility. Identified opportunities for improvement will be brought to the QAPI Committee for review and implementation of the QAPI process. QAPI meetings are currently being held bit monthly times 2 months, then monthly. Facility operations will be overseen by the Administrator/Medical Director on an ongoing basis.
- QAPI will be monitored by the Nurse Consultant monthly times three months and then quarterly. This will also be overseen by the Administrator and the Medical Director on an ongoing basis.

../_7/___ 19:36 #058 P. /

DEPARTMENT OF HEALTH	AND HUMAN SERVICES				OM	INTED: 08/0 FORM APPI 4B NO. 093	ROVED 8-0391
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC		INSTRUCTION		(X3) DATE SUR COMPLETE	MEY ED
	105884	B, WING				06/26/2	015
NAME OF PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE.	CIP CODE		
EXCEL REHABILITATION AND	LIE ALTH CENTER			CAMPUS HILL DR PA, FL 33612			
			FAM	PROVIDER'S PLAN OF	CORRECTION		(X3)
	(TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		H CORRECTIVE AC C REFERENCED TO DEFICIEN	TION SHOULD I	BE COM	PLETION DATE
F 520 Continued From pa	age 186	F	520				
1 The Plan of Con	rection, following the survey of						
, with a	completion date of 90, the facility administration						
falling to administer	r effectively and utilize						
resources to assure	e residents were safe and						
received quality of	care regarding education and QAPI, provided that: "						
Education has been	n provided to the QAPI						
committee including	a the Administrator on the						
utilizing CA	ne Nurse Consultant on MS QAPI at a Glance						
educational materia	als. The QAPI Committee will						
utilize this	for continued sis and planning for identified						
opportunities for im	provement in the facility. The						
Medical Director al:	so participated in this						
educational program	m and is current with the QAPI ified opportunities for						
improvement will be	e brought to the QAPI						
Committee for review	ew and implementation of the						
QAPI process. Mee	etings are currently being held nes eight weeks and then						
bi-monthly times ei	ght weeks and the monthly.						
Facility operations	will be overseen by the						
Administrator/ Med	ical Director on an ongoing atlons will be monitored by the						
administrator and the	he Medical Director on a						
monthly basis and	Identified areas of concern will						
be addressed by the	em through the QAPI Process. tion for F F282, following the						
survey of	, with a completion date of						
, for the	facility falling to ensure care ons / approaches were						
planning intervention	sure resident safety and quality						
of care revealed: "	nursing staff has been						
re-educated on 5-1	9, 20, 21, and 22, 2015 on sident's comprehensive care						
nians are belog folk	owed, "						i
Additionally, the Pla	an of Correction for F 282,						

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	: 08/07/2015 APPROVED : 0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES				(X3) DA	TE SURVEY
CENTEN	OF DEFICIENCIES				CONSTRUCTION	CO	MPLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		1	c I
			B. WING			06	/26/2015
		105884	B. WING	_	EET ADDRESS, CITY, STATE, ZIP CODE		
WHE OF	PROVIDER OR SUPPLIER						- 1
					CAMPUS HILL DR		i
EXCEL R	REHABILITATION AND	HEALTH CENTER		TAP	APA, FL 33612		
(X4) ID PREFIX TAG		ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	ix i	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
F 500	Continued From pa	ane 187	F	520			
r 520							
	following the surve						
	completion date of	nniement and monitor a known					
	deficient system re	vealed: "Education has been					
	provided to the QA	PI Committee Including on					
	utilizing Ci	us CAPI at a Glance					
	educational materi	als. The QAPI Committee will					
	utiliza lhie	for continued					
	identification, analy	sis and planning for identified					
1	opportunities for in	provement in the facility. The					
	Medical Director al	so participated in this m and is current with the QAPI					
	educational progra	m and is current with the carri					
	iden	e brought to the QAPI					
	Committee for sold	ew and implementation of the					
	Committee for revi	Pl Meetings are currently being					
	hold on a weekly h	asis times eight weeks and					
	then hi-monthly lim	res eight weeks and the					
	monthly OAPI will	be monitored by the Nurse					
	Consultant bi-mon	thiv for three months and then					
	augherly This pro-	nram will also be over seen by					
	the Administrator a	nd the Medical Director on an					
	ongoing basis."						
	J						
}	2. On at	5:00 PM, an interview was					
	conducted with the	NHA regarding the facility's					
		ent of Resident #1 not when found					
	receiving on	stated, "We started an					
	unresponsive. Sn	Quality Assurance					
	Derformance Dian	(QAPI) immediately. We sent					
	the ADON home for	or the day on suspension. We					
	reviewed the policy	and procedures for advance					
	directives C	ode Blue Roles and					
	Responsibilities at	nd the Emergency Procedure					
		lewed the staff regarding their					
	ability to verbalize	the process. We normally					
	complete an audit	of the advance directives and					

PRINTED: 08/07/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A BUILDING_ 06/26/2015 R. WING STREET ADDRESS, CITY, STATE, ZIP CODE 105884 NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33612 COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION) (X4) ID TAG DEFICIENCY PREFIX TAG F 520 F 520 Continued From page 188 _... orders monthly. The SSD initiated an immediate audit for Advance Directives and for the entire resident population and it was 2015. We were completed by monitoring / reviewing the charts of residents who expired. We started in-service training regarding and called a Code advance directives and Blue Drill. Multiple interviews of the staff were initiated to ensure the direct staff knew about and when to call a code. advance directives, for the entire Training was conducted in facility. The DON did immediate in-servicing with the ADON and we completed a Federal report. We have been conducting weekly QA meetings regarding the event. These meetings will continue and then occur monthly ". weekly through When asked when staff training had been conducted prior to the last couple of months, she stated, " we do it routinely and new hires get it at orientation." When asked how the facility audits she stated. the employee records for current "the Human Resource (HR) manager does an cards. audit, which includes reviewing When asked if the event had been presented to the QA committee with an action plan she stated. "Yes". the NHA provided a " QA Book. 3. On ... It contained the Quality Assurance Performance Improvement Plan for review. The and signed by the tool was dated Quality Assurance team including the Medical A review of the Director on information provided revealed policy revisions for ". "Advance Directives " which includes " Code Blue Roles and Responsibilities " and

Emergency Procedure -

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM MB NO.	APPROVED . 0938-0391
CENTER	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	CON	E SURVEY APLETED C
		105884	B. WING			06/	26/2015
	ROVIDER OR SUPPLIER	HEALTH CENTER		2811	EET ADDRESS, CITY, STATE, ZIP CODE CAMPUS HILL DR APA, FL 33612		
(X4) ID PREFIX TAG	SUMMARY STA	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	COMPLETION DATE
		100	F	520			
F 520	Continued From pa	" Code Blue Roles and					1
	Responsibilities " (no effective date): "In the					1
	event that a reside	nt is tound in					
	Immediately notify	a nurse of the situation, A					
	teammate should t	page overhead that there is a location of the code. All					
	a milable teammet	as are responsible to respond					
	to a Code Blue Par	ne. The nurse is responsible to					
	the recident is in	s the resident to determine if					
	resident 's medica	record will be obtained to					
	determine if the re-	sident has a () document by check YELLOW BINDERS					1
	at each nurses sta	fion for status) if the					
	in noted then there	will be no further interventions					ŧ
	directives if there	er the resident 's advance					
	record then is	to be initiated on the resident.					
	Nurses are respon	sible for the implementation of nt. The nurse assigned to the					
	resident will act as	the TEAM LEADER of the					
	code situation. Cer	tified Nursing Assistants who					
	are certified r at the direction	nay be directed to assist with on of the nurse.					
	On sig	nature sheets were provided					
	for the following In- 5/9, 5/20, 5/2 In add	services, dated 9, 6/7, 6/18, 6/19, and tion mock. "Code Blue." drills.					
	were done on	All ere provided to the survey team					
	were reviewed. A c	omparison was made between					
	of all employees. T	ature sheets and the master ilst he comparison revealed that					
	as of 91	% of licensed nurses and 97%					

training.

PRINTED: 08/07/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A BUILDING ... 06/26/2015 R WING 105884 STREET ADDRESS. CITY, STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33812 COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X4) ID TAG DEFICIENCY) TAG E 520 F 520 Continued From page 190 4. Interviews with the facility staff regarding and Code Blue drills advanced directives. were conducted in order to verify staff knowledge. The following relevant interviews were obtained: at 4:24 PM, an interview was conducted with Employee C a nurse; she stated she worked full time on the 7:00 AM -3:00 PM shift. She stated she had been part of a mock Code Blue drill a couple of months ago and that we just had an in-service on where to find the forms, in the yellow book, " When asked how she would respond if a CNA said a resident was unresponsive she stated she " would check the resident, have someone at the desk check : until i book, I would initiate the order then I determined if the resident had a would stop at 4:32 PM an interview was conducted with Employee D a nurse, who stated she worked full time on the 7:00 AM -3:00 PM shift. She stated she had training on advanced directives and participated in mock Code Blue drills a few months ago and again in She also stated " If I found someone shout for unresponsive; I would start book. If they were a someone to go to .. I would call the physician and I would stop family. If they were a full code I would keep going until the paramedics come. at 4:40 PM an interview was conducted with Employee E a nurse, she stated she usually worked as needed on the 3:00 PM -11:00 PM shift. She stated that during

orientation they discussed advance directives and orders. She had training in the last couple of months on advance directives and did a mock

././_) 19:40 #058 P. 7

-	THE MEAN TH	AND HUMAN SERVICES				FORM APPROVED MB NO. 0938-0391
DEPARI	MENT OF REALTH	& MEDICAID SERVICES				(X3) DATE SURVEY
	OF DERICHENCIES	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		COMPLETED
AND PLAN O	FCORRECTION	IDEA FICA ION INC.	, Built			C
			B. WING			06/26/2015
		105884	1	STREET ADDRESS, CI	TY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER			2811 CAMPUS HILL		1
	EHABILITATION AND	WEALTH CENTER		TAMPA, FL 33612		
EXCEL R				220/427	S PLAN OF CORRECTION	N (X5)
(X4) IO PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	X (EACH COR	RECTIVE ACTION SHOULD RENCED TO THE APPROPE DEFICIENCY)	
	Continued From pa	nna 191	F	520		1
r 520	Continued From pa	v = socidosi was found				
	Code Blue drill also	o. If a resident was found stated she would, " check the				1
	unresponsive sne	lp, and send someone to get				
	mess halo Lucuid	etart There is a				
	book I would send	someone to check, If I have				' 1
	started and fi	nd out the resident is a				
	then I would stop.	would start before				
	knew if they were	a _ or not. "				
	conducted with Err usually worked the stated "We had a recently. We receive the received with the received with the received the received with the received with the chart for the ye POA is in the chart would do if he four stated "first asset call somebody by signs, call for crast look at corm. right away, and if stop compressions	s. "	3			
	would expect that unresponsive and nurse should start nurse should start a resident 's should know if the they start if out the resident is That is what I was	DON she stated that what she if a resident was found had a Full Code status the . She was asked if a prior to finding out about order. She stated, "The nurs resident is a or not befor he nurse starts and finds a the nurse can stop.	•			
	cate 00) Previous Version		11	Facility ID: 62932	If continuation	sheet Page 192 of 213

. J-7/== = 19:40 #056 P.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCES AND FLAN OF CORRECTION 1050HTF ICATION NUMBER:		(X2) MULTIPI A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVI COMPLETED C 06/26/201		
		105684	B. 171110	TREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER			1811 CAMPUS HILL DR		
		HEALTH CENTER		TAMPA, FL 33612		
EXCEL				PROVIDER'S PLAN OF CORRECT	ON	COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
		100	F 520	` 1		
F 520	Continued From pa	age 192				1
		our policy, so I do not teach be classes." The DON was				
	informed that 3 Out					
	ethted they would t	start when they lound an				
	unresponsive resid	tent and then stop in tries				
	found the resident	ted training since the event.				
	the facility conduct She stated "yes,"	we started in after the				
	avent and we have	given in-services again				
	Thie by	olning covered orders and				
	done on orientatio	n. She stated, We on the				
	training for the wh	rybody. And then we just did it				
	CNAs and nurses	and also preformed mock code	,			
	blues." When as	ked if training had been past, stated, " Yes, the				
	in condend to done	vearly and during orientation.				
	te addition the DC	ON was also asked, now the				
	de altre en estada de de de	omployee records for CUTTEDI				
	hateta ada	" when we have new employee				
	etarting Human R	esources (MK) sees the call				
	and then the ADO	e supposed to be certified				
	4 When acked if t	the facility had audited the				
	amployee records	for current she stated				
	Was the ADOM of	monthly and HR does	\$			
	Was bles " The F	ON stated the SS department				
		he advance directives, and ers monthly, The DON stated				
ĺ	reviews orde	ers monthly. The DON stated on presented to the Quality				
	Acquestica (OA) o	committee and an action plan				
1	and plan of correc	tion was put into place. The				

o E BA DT	MENT OF HEALTH	AND HUMAN SERVICES			,	FORM A	08/07/2015 APPROVED 0938-0391
DEPART	C FOR MEDICARE					(X3) DATE	SURVEY
CENTER	OF DEFICIENCIES				LE CONSTRUCTION	COMP	LETED
NO PLAN O	F CORRECTION	DENTIFICATION NUMBER:	A, BUILD	DING		1 0	;
			B WING			06/2	6/2015
		105884	B. Water	-	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAKE OF S	PROVIDER OR SUPPLIER				2811 CAMPUS HILL DR		
		TU CENTER			TAMPA, FL 33612		
EXCEL R	EHABILITATION AND	HEALTH CENTER		_	OR OF THE PARTY BY AN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRES	AX.	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROX DEFICIENCY)		COMPLETION DATE
	codes, and file a fe On	to do education, and do mock destar lepont." PM, an interview was NHA and the ODN to review raining in-services. The NHA we went over the following ty (which included what to look do book, where to find the neo Directive policy and Cooce bed a mock code bitue, if staff sponsive resident what you Emergency procedure policy, sentation and every nurse the first QAPI we were aimost sent regarding interviews with 4 and by the first QAPI we were aimost sent regarding interviews with 4 and by the first QAPI we were aimost sent regarding interviews with 4 and by the called the nurses would start ingo the resident is code status to DON stated. "That is not insed to do." The NHA and the comporate Nurse when the Policy and ance directives and comporate Nurse (Chy) stated codure for advance directives and control control was recovered and where Corporate Nurse (Chy) stated codure for advance directives was reviewed and	ì	520			
	the Policy and pro and updated on Resident #1, He file Emergency Proce	was reviewed and ", after the event with urther stated that the					

		SERVICES					FORM	08/07/2015 APPROVED
DEPART	MENT OF HEALTH	AND HUMAN SERVICES				0		0938-0391 E SURVEY
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(X2) MUL	TIPLE CO	NSTRUCTION		(X3) DAT	PLETED
TATEMENT	OF DEFICIENCIES CORRECTION	DENTIFICATION NUMBER:	A. BUILD	NG		_	l	c
ND PLAN O	COMEDITOR						1	26/2015
		105884	B. WING		T ADDRESS, CITY, S	CATE ZIR CODE	1 00	10:10:10
	ROVIDER OR SUPPLIER		_			A E 21 0000		
		CENTER			AMPUS DR			
EXCEL R	EHABILITATION AND			IAMP	annument of	AN OF CORRECTIO	N	(X6)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECT CROSS-REFERENC			COMPLETION
			E	520				
F 520	Continued From pa	age 194		JEU				
	6. Review of Resid	ent #1 's closed medical						1
	record, to include a	demographic / face sheet, litially admitted to the facility on						
		to the facility from the hospital						
	War	inesday, for skilled services						•
	with diagnoses the	t included but not limited to:						
	() and hrain it	njury. Review of the Physician s						
	Order Sheet (POS) dated and signed						1
	husha physician fil	n revealed under						
	Special Needs; Co	de Status: "Fuil" (handwritten).						
	One she bookital di	scharge summary for Resident						
	#1 dated	: Patient was a						
	admitted to the en	nergency the hospital						
	with acute	failure, HCAP						
	(Healthcare-association)	VRE (Resistant						
	Enterococci) () and						
	/ -resista	nt j						
	() Du	ing his hospital stay, a						
	consultation was p	performed on due to is that were positive for occult						
	having noted stoo	data revealed hemoglobin of						
	8.5 and a plateiet	count of 335 indicating the						
	nationt was	with occult						
	() loss. Ti	ne patient did not show any						
	signs of active	at the time.						
	Recommendation	s included continue tube ted; monitor the hemoglobin						
	reedings as tolera	an as needed basis. Resident						
	#1 was discharge	d from the hospital and						
	transferred to the	skilled nursing facility on						

PRINTED: 08/07/2016

. J _ 77_ . . . 19:43 #056 P.016/038

OFFI OF	MENT OF HEALTH	AND HUMAN SERVICES				OMB N	M APPROVED O. 0838-0391
CENTER	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILL		ONSTRUCTION	(X3) C	ATE SURVEY OMPLETED
		105884	B. WING	-			6/26/2015
	ROVIDER OR SUPPLIER EHABILITATION AND	HEALTH CENTER		2811	ET ADDRESS, CITY, STATE, ZIP CODE CAMPUS HILL DR PA, FL 33612		(X5)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY PULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDERS PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEPIDIENCY)		COMPLETION DATE
F 520	directives in the ch Living: mobility, transfers; Myglene. Alert to pi pale, warm and dn rurse, but can mai reaular and audible Breath in place. Has refer Occupational Signed by Employ Nurse (LPN). A review of Reside Service Admission dated the following inforr had resi was a high school Marines for 10 yes questions with con capital elters. Doe directives? INCAP PROXY ON CHAF PROXY ON CHAF PROXY ON CHAF RESIDENT OF THE CONTROL OF THE CONTROL SIGNED STATE OF THE CONTROL RESIDENT OF	The resident has advance mission? NO. Are advance mission? NO. Activities of Daily required for bed dressing; and personal seno and non-verbal, skin , Patient not verbal with this ke faces for palh. rate and palh. rate and pale and Speech and Speech and Speech are C. a Licensed Practical with the seno send of the seno seno send of the seno seno seno seno seno seno seno sen		5520			
	Review of Resider	d a Code Status of Full Code.					

A review of the Admission Minimum Data Set

DEPARTMENT OF HEALTH	AND HUMAN SERVICES				FOR OMB N	D: 08/07/2015 M APPROVED O. 0938-0391
				ONSTRUCTION	(X3) D	ATE SURVEY
THE PERSON OF DEEPOIENCIES				ONS I ROCTION	C	OMPLETED
IND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			C
		R. WING			1 0	6/26/2015
	105884	D. WING		ET ADDRESS, CITY, STATE, ZIP C	ODE	
NAME OF PROVIDER OR SUPPLIER				CAMPUS HILL DR		
	CENTER			PA, FL 33612		1
EXCEL REHABILITATION AND	HEALTH CENTER		IAN	THE PERSON OF THE PERSON OF THE	RECTION	(XS)
	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 9C IDENTIFYING INFORMATION)	PREF TAC	ix i	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE
memory, memory immory, memory, memory, memory problem. Dacision Making: section 0 (Mood), appearing down, disting or staying at Feeling tired or have concentrating. Unit of the section o	Lidated 03' revaled Patterns' visualed Patterns' visualed Patterns' Staff and Status: Short term oroblem. Long term memory: skills for Dally severely Under Staff Assessment: feeling or epressed, hopeless. Trouble sleep or sleeping too much; ving little energy; Trouble der Section G (Functional of one person of for bed mobility and dressing required for setting and Under Section H (and citive Diagnoses): Inalitize Under Section K (Swallowing term is set of month ore in list of morth-yes; ler inset of month-yes; ler Section M (Skin Conditions) 9 Overall Expectation): in this facility, by family. Notes dated alled to Certified Patterns of the section of Certified Section M (Skin Conditions) of Certified Section M (Skin Conditions) 9 Overall Expectation): in this facility, by family.		520			

DO/ U// EU 15 18(44

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FOR OMB N	D: 06/07/2015 M APPROVED O: 0938-0391
CTATELIENT	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULT A. BUILDI		INSTRUCTION	(x3) C	ATE SURVEY OMPLETED
		105884	B. WING				6/26/2015
		100004	1	STREE	T ADDRESS, CITY, STATE, ZIP COD	E	
	ROVIDER OR SUPPLIER		1	2811	CAMPUS HILL DR		
EXCEL R	EHABILITATION AND	HEALTH CENTER	l l	TAM	PA, FL 33612		
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI CROSS-REFERÊNCED TO THE AP OEFICIENCY)	KOULD BE	COMPLETION DATE
	conducted with the the realdent when I was taking care of I verbal, he require readmitted from the asked to read the asked to read the ADON stated, and finished make the ADON stated, and finished make the ADON stated, and finished make the ADON stated, and finished make the ADON stated, and finished make the ADON stated, and finished make the ADON stated in the for a crude of the around his mouth. For him. When as for a crude, all and I did to have the ADON stated in the ADON stated in the ADON stated in the ADON stated in the ADON stated in the ADON stated in the resident is a stated in the physician the resident is she saw a crude and stated in the ADON stated. The ADON stated is the had the ADON stated. The ADON stated is the had the ADON stated. The ADON stated is the had the ADON stated.	00 PM an interview was ADON, the nurse assigned to the She stated that she him for the first time on k a shift because another 5. She stated that she him for the first time on k a shift because another 6. She stated the resident was additional to the she she she she she she she she she s	F6	120			
	signs she stated, w	e are supposed to do chest					

When the ADON was asked if she knew how to

	, 2, 555	CERVICES			FORM	: 08/07/2015 APPROVED : 0938-0391
DEPART	MENT OF HEALTH	AND HUMAN SERVICES				E SURVEY
CENTER	S FOR MEDICARE	& MEDICAID DETTINE	(X2) MULTI	IPLE CONSTRUCTION	CO	MPLETED
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDENTIFICATION NUMBER:	A. BUILDIN	KS		C .
		105884	g, WING	STREET ADDRESS, CITY, STATE, ZIP COL	DE .	
	ROVIDER OR SUPPLIER			2811 CAMPUS HILL DR	-	
		OENTER		TAMPA, FL 33612		
EXCEL R	EHABILITATION AND	HEALIH CERTER		PROPERTY OF AN OF CORP	ECTION	(X5)
		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG			COMPLETION
			F 5	20		
F 520	Continued From pa	age 198				
		atus, she stated, if a resident is a supposed to check the pulse				
	crash cart. We have	ve a vellow book at the nurses				
	new admission it n	nay be necessary to look in the d how the nurse is notified of a				
	Ideal ' c aduant	-a directives, including				
	-h- states " it is !	the nurse 's responsibility to				
	" atotus " If s	enmanna finds someurie				
	unresponsive, the	y have to wait until someone book or the chart to see if they				
		When asked what she would do				
	in a situation when	ein a resident la found				
	, hı	it there is no Advance directive				
	she stated, "I wo	uld do a Code. " When asked				
	if she had had any	training since the event, she				
	stated yes, one-or Nursing (DON) on	n-one with the Director of advance directives,				
	Cada Blue and m	ack drills. The DON reviewed				
	with me when we	are supposed to do a code.				
	On at a	oproximately 5:00 PM an				
	interview was con	ducted via telephone, with				
	Employee A, the (CNA, who found Resident #1				
	unresponsive. Sh	e stated she no longer worked nployee A stated she was				
	making rounds be	fore she went home and found				
	Dealdont #1 not h	reathing. She called for the				
	nume to check on	him The ADON responded				
	and checked on ti	he resident. The ADON said.				
	He was gone. * I	Employee A stated that the				

ADON did not do

(____) on Resident #1 and that she did not recall anything else about the resident.

at 1:15 PM an Interview was

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	08/07/2015 APPROVED 0.0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			ONSTRUCTION	(X3) DA	TE SURVEY
CTATCHENT	OF DEFICIENCIES				ONSTRUCTION	CO	MPLETED
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A BUILD	ANG		1	С
						1	-
		105884	B. WING		EET ADDRESS, CITY, STATE, ZIP CODE		
HAND OF S	ROVIDER OR SUPPLIER						
					CAMPUS HILL DR		
EXCEL R	EHABILITATION AND	HEALTH CENTER		TAN	APA, FL 33612		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY ROOM OF THEY IND INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)		COMPLETION DATE
F 520	Continued From pa	ige 199	F	520			
,	conducted with Em	plovee G a Social Services					
	Cardea Admission	Resident #1 's Social Evaluation Tool dated					
	and timed minutes prior to the	5:32 AM, approximately 13					
	acked Employee (a stated he probably filled in					
	the information bas	sed on prior admissions. He g to speak with the resident's					
	family and he confi	rmed that the resident had a					
	heelth care proxy a	and a Determination of					
	Incapacity. He cor	firmed that the resident was a ous admissions and remained					
	Full Code on previo	se there was not a signed					
	in the medical reco	nd He stated that his plan was					
	to call the family at	nd inform them of their right to					
	formulate an advar	nce directive for the resident. nat the facility procedure in					
	He further stated to	directives required the					
	Admissions Depart	ment to speak to residents on					
	admission, advance	e directives are then					
	addressed in the N	jursing Admission Assessment					
	and the Social Ser	vices Department reviews the					
	Information with the	e resident and/or the family.					
	Onat *	1:20 PM an interview was					
	conducted with the	Social Services Director					
	(SSD) regarding R spoke to the reside	esident #1. Per the SSD, she					
	he was readmitted						
	that his narents we	re making the decisions					
	regarding his care	and were designated as his					
	Activated Medical (Decision Makers at that time.					
	She stated that the	father was given information					
	in regards to formu	lating an advance directive.					
	SSD states, " If he	wanted him to be a , we					
	would have mailed	him the paperwork. " She had not spoken to the father					
	also stated that she when the resident						
	Wildli the leginerit	Lena manimum a.,					

She stated that the Resident was designated as a

19:48

PRINTED: 08/07/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING c 06/26/2015 a wind 105884 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33612 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION ıb. SUMMARY STATEMENT OF DEFICIENCIES PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION) TAG PREFIX DEFICIENCY F 620 F 520 Continued From page 200 i of Full Code since his original admission in paper in his 2014 and had never had a medical record at 12:40 PM, a telephone interview was conducted with Resident #1 's father. He stated his son was in the Marines; he got an aneurysm in there and had to have surgery. He stated the resident lived by himself for a while, and then he started living with his girifriend " . He went to the hospital and they sent him to the nursing home. When asked if they were expecting his _____, he stated, he " could not cere for him anymore, that 's why he went to the nursing home. " He was wearing dispers and couldn't dress himself anymore. "I couldn't handle him anymore." He went to the hospital and then the nursing home, he "was in and out lin the of the nursing home. " I think he hospital, no, the nursing home, I get sometimes. I couldn't do anything with him. " He was having problems breathing, they put him hospital, and then someone called and said he was at 5:15 PM an Interview was conducted with the Director of Nursing (DON). when asked if she was familier with Resident #1. she stated, "yes." When asked about the day , she stated. "When I came in about 5:30 AM the (ADON) stated that Resident #1 had passed. I asked the (ADON) If , the (ADON), said, no. I she had performed stated to the (ADON) that she, should have called

a code and the (ADON), and stated she did not do it. I educated the (ADON) right then and there regarding our policy. The policy states, we have to start a code no malter what, on a Full Code

#058 P. 19:47

> PRINTED: 08/07/2015 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING _ 06/28/2015 a. WING 105884 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIPE 2811 CAMPUS HILL DR

EXCEL REHABILITATION AND HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

TAMPA, FL 33612 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE FRACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY

F 520 Continued From page 201

(X4) ID PREFIX

TAG

resident. I interviewed (Employee A) who stated she was making her rounds, and the resident didn't look right, she shook him, and he was not responding, so she got the nurse." The DON stated, "The chart revealed the resident was a Full Code." The DON stated. "I knew he was a full code because he had been here for so long. The DON stated "the (ADON) decided on her

at 5:00 PM an interview was conducted with the Nursing Home Administrator (NHA). When asked if she could recall the events the day Resident that happened on she stated the DON informed her that the ADON had found the resident unresponsive and did not perform stated in her opinion the ADON should have looked at the chart and initiated

at 2:40 PM, a telephone interview was conducted with the covering physician who received the call regarding Resident #1 on

She stated she was covering for the but doesn't attending physician on remember the call as she stated she covers 1000 patients. When asked if she was informed the resident was a Full Code and he was not , she stated, "I apologize, but I don" t remember.

at approximately 10:00 AM. an interview was conducted with Resident #1 's attending physician. The physician stated the resident had multiple problems including: multiple

issues,
"He did not look well at), and all. He was thin and looked 90. He was new to

F 520

/ /_ 19:47 #058 P. /

							INTEO	08/07/2015
DEPART	MENT OF HEALTH	AND HUMAN SERVICES					FORM AB NO.	APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILD	TIPLE CONST	RUCTION		(X3) DATE COMP	SURVEY PLETED
		105884	B. WING				06/2	26/2015
	PROVIDER OR SUPPLIER	HEALTH CENTER		2811 CAM	DDRESS, CITY, STAT IPUS HILL DR FL 33612	E. ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES / MUST 8E PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		REFERENCED	ACTION SHOULD	RE.	COMPLETION DATE
E 520	Continued From pa	oe 202	F!	520				
P 520	me as a patient. He hospital. I was not physician covering	e was back and forth to the called the day he the was called. "I found out the bably when the funeral home lativ if a patient does not have						3
	a on their cha 911 called. My exp start if a	ectation is that the nurse would was not on the chart."						-
	conducted with the if his expectation won a Full Code resibe done. "He has almost 4 years."	2:00 PM, an interview was Medical Director. When asked as for a nurse to perform dent, he stated, " should; been the Medical Director for if the resident was have to do Code Blue is sidents, "						
	Directives Acknowl language: I unders or implement an Ai- be a resident at thi understand that I in Directive at any tim it is also my under time to review Adv. my Advanced Directive made. I understan- give legal advice, the concernion Advance Advanced concernion Advance.	lent's Admission di page 31 d 39 Advanced degement with the following thank that I do not have to six evened Directive in order to sheathcare Center. I way implement an Advanced be ouring my stay in the facility-tanding that I may ask at any anced Directive Information or titute (a) and ask questions I ng them. I may revoke any (s) at any time that I have the facility's staff cannot ut can enswer questions and Directives. I have the decirity's later cannot ut can enswer questions end Directives. I have the ms(s) and my coptles have						

been provided to Health Care Center. A line was drawn through the blank spaces in front of all the choices which were: Living Will or Direction to

#058 P

__/ 19:48

PRINTED: 08/07/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (Y2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A BUR DING ~ 06/26/2015 B. WING 105884 STREET ADDRESS. CITY. STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33612 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID DYAL IP PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY TAG F 520 F 520 Continued From page 203 Yellow HRS Form. Order/ Health Care Surrogate, Health Care Proxy. Durable Power of Attorney, Financial Power of Attorney, Medical Power of Attorney, Guardian Financial or Medical, Anatomical Gift, Other:, Physician Statement of Incapacity, Funeral Home Selection. The form was initialed by the resident and witnessed by Employee H on Admissions Review of the resident's paperwork revealed a second form titled Advanced Directives Acknowledgement (no page number) with the residents initials beside the sections 1. I have been given written material about my right to accept or refuse medical and surgical treatments and my right to form Advanced Directives, 2. I understand that I am not required to have an Advanced Directives in order to receive medical treatment at this health care facility and 3. I understand that the term of any Advanced Directives that I have executed will be followed by the health care facility, physicians and my caregivers to the extent permitted by the law. The form continues with: Please Check one

Review of Resident #1 's medical record revealed the resident was discharged to the

of the following statements: I have executed an Advance Directive and will provide a copy to the facility. I understand that the staff and the physicians at this facility will not be able to follow the term on my Advanced Directives until I provide a copy of it to the staff; or I have not executed an Advanced Directive and do not wish to discuss Advanced Directives further at this time. The spaces to check either statement were blank. The form was signed by the resident and the Admissions Representative Employee H and

dated

From:7275521162

PRINTED: 08/07/2015 FORM APPROVED

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					RM APPROVED NO. 0938-0391
		& MEDICAID SERVICES			E CONSTRUCTION	(X3)	DATE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD			15.00	COMPLETED
AND PLAN C	P CORRECTION	(DE)(III CA) (CITTODIA	A BUILU	mo.			С
		105884	B. WING				06/26/2015
NAME OF L	PROVIDER OR SUPPLIER		T		TREET ADDRESS, CITY, STATE, ZIP CODE		
			1		11 CAMPUS HILL DR		
EXCEL R	EHABILITATION AND	HEALTH CENTER		T/	AMPA, FL 33612		
(X4) ID PREFIX TAG	ISACH DESIGNENCY	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	BE GJUD	COMPLETION DATE
			F 5	20			
F 520	Continued From pa		F 0	20			1
	hospital on	and readmitted to the					i .
	facility on	. His admission paperwork umentation that his Active					
	Medical Decision M	laker, his father, was given					
	information on Adva	ance Directives. There was no					
	" Advanced Directive	es Acknowledgement " form					
	in the admission pa	perwork for the resident's					
	readmiss	sion to the facility.					
	Daviess of Recident	#1 's medical record					
	revealed the resider	nt was discharged to the					
	hospital on	and readmitted on					
		ission paperwork did not					
	include documentat	ion that his Active Medical					
	Decision Maker, his	father, was given information es. There was no "					
	Advanced Directive	s Acknowledgement " form in					
	the admission page	rwork for the resident's					
		ion to the facility.					
	Further review of Re	esident #1 ' s medical record					
		nt titled Activated Medical					
	Decision Maker sign	ned by the resident 's father					
		nessed by two signatures on					
		ument included the following					
	language: I ne Dete has been completed	rmination of incapacity form					
	attest that I am at le						
	and am willing to be	come involved in the above					
	stated resident 's he	ealth care decisions. I have					
		contact and am familiar with					
		itles, health, religious and it I can make health care					
		withholding/withdrawing life					
		that would be the decisions					
		ave made, if capable, I am					
	willing to produce cle	sar and convincing evidence					
		erstand that my role has					i
	become active and a	accept my responsibility,					

From:7275521162

7 /_ /_ 19:49 #058 P. /

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM OMB NO	D: 08/07/2015 MAPPROVED D: 0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILO		CONSTRUCTION	(×3) DA	TE SURVEY MPLETED
		105884	B. WING			00	6/26/2015
	PROVIDER OR SUPPLIER			STR	EET AODRESS, CITY, STATE, ZIP CODE		
	EHABILITATION AND	HEALTH CENTER			I CAMPUS HILL DR IPA, FL 33612		
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILO RE	COMPLETION DATE
F 520	Maker designations parent of the resider Review of Resident revealed a Determine dated an physician. It include attending physician (Resident #1). I have	following Medical Decision : checked were Proxy and A	F	520			
	give informed consi	ant to make medical decisions the reasonable medical ering mental and physical exercise rights.					
	and (Not dated), reveal (Not dated), reveal (Not dated), reveal or revention and profused from the control of t	environment within the facility ident well-being, safety and ject, involuntary into or property for all sach resident has the right to corporal punishment, and Residents must not be by anyone, including but not					

/ / 19:50 #058 P. /

PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-0391

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					RM APPROVED IO. 0938-0391
CENTER	RS FOR MEDICARE	8 MEDICAID SERVICES					ATE SURVEY
	OF DEFICIENCIES	(Y1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	1,000	OMPLETED
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER	A. BUILD	MNG		1	•
		-	1			1	С
		105884	B. WING				06/26/2015
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
			-		2811 CAMPUS HILL DR		
EXCEL R	EHABILITATION AND	HEALTH CENTER			TAMPA, FL 33612		
	CUBBIADY STA	TEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECT	ION	CO JETION
(X4) ID PREFIX	(EACH OSSICIENCY	/ MIRT RE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPR	OPRIATE	STAC
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	•	DEFICIENCY)		
F 520	Continued From pa		F	520)		
	them at risk for abu	sing other residents, and					
	development of inte	ervention strategies to prevent					
	occurrences, monit	oring for changes that would					
	trigger beh	avior and reassessment of the					
	interventions on a r	egular basis. "					
	Definitions: 7. "Ne	glect: means fallure to provide					
	goods and services	necessary to avoid physical					
	harm, mental anoul	sh, or mental illness. (42 CFR					
	488,301) "						
	Procedures:						
	1. Screening: " a. T	he facility screens potential					
	employees for a his						
	mistreating resident	ts as defined by the applicable					
	requirements a 483	.13 @ (1) (il) (A) (B).This					
	includes attempting	to obtain information from					
	previous employers	and for current employers					
	and checking with ti	he appropriate licensing					
	baards and registrie	s. Screening is done on all					-
	employees prior to I						
	2 Training " a Fac	h team member is scheduled					
	to attend a peneral	orientation session. b. Each					
	team member is off	ered and asked to attend a					
		ere the information is					
	reviewed as needed	throughout the year, c. each					
	team member is no	tified that a mandatory "					
	Prevention "	in-service is scheduled on an					
		n-service includes: 1.					
		ntions to deal with aggressive					
	and / or catastrophic	reactions; 4. What					
	constitutes	eglect and misappropriation					
	of resident property.						
		effort is made on behalf of					
	the resident to preve						I
	analysis of: a. Featu	res of the physical					
	environment that me	y make and/or neglect					
		such as secluded areas of					1
		ployment of staff on each					j
		nbers to meet the needs of					
	the residents, and a	ssure that staff assigned have					1

__/ _ /___ 19:51 #058 P.

DEPARTMENT OF HEALTH	AND HUMAN SERVICES	•	RINTED: 08/07/2015 FORM APPROVED MB NO. 0938-039
CENTERS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
		a wwa	06/26/2015

B. WING

105BB4 STREET ADDRESS. CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIES 2811 CAMPUS HILL DR

EXCEL REHABILITATION AND HEALTH CENTER TAMPA FL 33612 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LIC IDENTIFYING INFORMATION) TAR DEFICIENCY TAG

F 520 Continued From page 207

knowledge of the individual residents ' care needs, C. the supervision of staff to identify inappropriate behaviors, such as ...ignoring residents while giving care,and d. the assessment, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as resident with , those that require communication heavy nursing care and/or the totally dependent

on staff. Each team member reads and signs the " Resident Rights " upon employment. A copy of the resident rights is given to each team member within his/her probationary period of employment. This information is reviewed on an annual basis by the Social Services staff in an all-staff in-service.

Identification: Each team member is encouraged to attend a mandatory " ___ Prevention " in-service on an annual basis. This in-service includes methods to identify events, such as of residents, occurrences, sugnicious patterns, and trends that may constitute and to determine the direction of het investigation.

Investigation: the Social Services Manager is the facility appointed designee who is the staff member responsible for the initial reporting. investigation of alleged violations and reporting results to proper authorities. The facility policy for any allegation of is for it to be brought immediately to the attention of the immediate supervisor. The supervisor is to notify the Social Services Manager, who is the facility appointed designee, the DON, and the Administrator ...

...the facility will also notify the appropriate agencies, based on the nature of the allegation in accordance with State and Federal Statute. Protection: the facility will make every effort to

F 520

PRINTED: 08/07/2015

DEPARTMENT OF HEALTH	AND HUMAN SERVICES				FOF	M APPROVED O. 0938-0391
CENTERS FOR MEDICARI STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) D	OMPLETED
	105884	B. WING				6/26/2015
NAME OF PROVIDER OR SUPPLIER EXCEL REHABILITATION AN			2811	eet address, city, state, zip coo I campus Hill dr MPA, FL 33612	Œ	
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREF TAC	ıx	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE
allegation of the team member from duly during it complete. Reporting/Resport alleged violations alleged violations alleged violations substantiated inclusion and the substantiated inclusion and the substantiated inclusion and the substantiated inclusion and the substantiated inclusion and the substantial actions by a court employee is unfit occurrences to de needed if any, to prevent further occurrences to de needed if any, to prevent further on englect, and followed by the A review of the fat Directives " (Rev) policy statement: respected in accook facility policy." Primplementation, admitted to our fa control of the substantial and the substantial substan	ual formif the is against a team member, will be immediately removed he investigation, and until it is see the facility will report all		520			

#058 P. 1/ 08/-"/. 19:52

AND HUMAN SERVICES				FORM OMB NO	D: 08/07/2015 M APPROVED D: 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	TE SURVEY OMPLETED
105884	B. WING				
	٠				
HEALTH CENTER	!	1/			
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)		FIX	JEACH CORRECTIVE ACTION SHOU	JLD BE	COMPLETION DATE
age 209 directives, our facility has	F	520			
directives as preferences at options and include, but are					
dian, health care proxy, or ensor) has directed that no (:) or other					
lity policy: "Emergency 2011), documented the Personnel have completed siten of 'JBasic Life Support (BLS) in Lation and Implementation: " defined as inadequate ng in insufficient 'flow (pulsielssness). 2. Sudden (youtselssness). 2. Sudden (youtselssness). 2. Sudden (or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may even appear to Training in BLS includes or may					
District Children in the Country of	A MEDICALO SERVICES (XI) PROVIDENS UPPLETION 105894 HEALTH CENTER TEMENT OF DEPICIENCIES AUST RE PRECEDED BY FULL SCIENTIFY OF A PROPERT	A MEDICAID SERVICES (XI) PROVIDENSIEMPERENCIA (XI) PROVIDENSIEMPERENCIA (XI) MANUALER 105594 PHEALTH CENTER TREMENT OF DEPICIENCIES MAST RE PRECEDED OF PULL SCIDENTEYING INFORMATION PREFE TAX TO CONTINUE TO THE PROVIDENCIA GRAPH CONTINUE TO THE PROVIDENCIA TO TAILUTE, the diam, health care proxy, or nsor) has directed that no () or other are to be used. (I) or other to the preference to the providence to the	A MEDICAID SERVICES (XI) PROVIDERSUPPLERCIAL (XI) PROVIDERSUPPLERCIAL (XI) MALTIPLI A BULIDING 105894 PHEALTH CENTER THEMENT OF DEPOTIENCIES MAST RE PRECEDED BY PULL SCIDENTFYING INFORMATION GREEN PERSIX F 520 TRACE TRA	AND HUMAN SERVICES 8 MEDICAID SERVICES (X1) PROVIDERS PREJECTION 105894 PHEALTH CENTER TRUENT OF DEPCIENCIES (MAST RE PREDEDIO BY FULL) (ADDITION AND AND AND AND AND AND AND AND AND AN	AND HUMAN SERVICES A MEDICAL SERVICES A MEDICAL SERVICES A MEDICAL SERVICES A MEDICAL SERVICES (X1) MALTIPLE CONSTRUCTION A BULLDING 105884 PHEALTH CENTER TEMENT OF DEFICIENCIES (X2) MALTIPLE CONSTRUCTION A BULLDING STREET ADDRESS. CITY, SYATE, ZIP CODE 2811 CAMPUS HILL DR TAMPA, FL 33612 TEMENT OF DEFICIENCIES (MAST SER PRESENDED ST PLAN) CONSS-REFERENCED TO THE APPROPRIATE OF CHARLES AS PRESENCED ST PLAN OF CORRECTION FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION TAMPA, FL 33612 FAMPO, FL 33612 FAMPO, FL 33612 FAMPO, FL 33612 FAMPO, FL 33612 FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION TEACH CORRECTION FEACH CORRECTION TAMPO, FL 33612 FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION TAMPO, FL 33612 FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION TAMPO, FL 33612 FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION FEACH CORRECTION TAMPO, FL 33612 FEACH CORRECTION FEACH CARREST PLAN OF CORRECTION FEACH CORRECTION FEACH CARREST PLAN OF CORRECTION FEACH CARREST PLAN OF CORRECTION FEACH CARREST PLAN OF CORRECTION FEACH CARREST PLAN OF CORRECTION FEACH CARREST PLAN OF CORRECTION FEACH CARREST PLAN OF CORRECTION FEACH

necessary pauses for rescue breathing) decreases effectiveness. 7. in potentially

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DEPAR'	TMENT OF HEALTH	AND HUMAN SERVICES				FORM MB NO.	08/07/2015 APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION MUNBER:			(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ı	105884	B. WING			06/	28/2015
MANE OF	PROVIDER OR SUPPLIER		-		REET ADDRESS, CITY, STATE, ZIP CODE		
	REHABILITATION AND				1 CAMPUS HILL DR MPA, FL 33612		
(X4) ID PREFIX TAG	JEACH DESIGNEY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	COMPLETION DATE
F 520	Continued From pa		 F(520			
	reversible situations	s, early delivery of a					
	with a defibrillator p	plus within 3-5 minutes of or increase chances of survival.					
	8. The goal of early	delivery of is to try to					
	maintain life until th	ne emergency medical					
	response team arm	ives to deliver Advance Life f an individual (resident, visitor,					
	or staff member) is	found unresponsive and not					
	breathing normally,	, a licensed staff member who BLS shall initiate unless:	-				į.
	is certifled in /E a, it is known that a						
	order that specifical	ally prohibits and for					
	external	exists for that individual: "					
	Preparation for	. *					
	1. Obtain and /or ma	naintain American Red Cross					
		Association certification in (BLS/Cardiopulmonary					
	i () for key clinical staff					
	members who will d	direct resuscitative efforts,					
		sed personnel. 2. Provide					
) for training c	es (simulations of an actual ourposes. 3. Select and					
	Identify a team	n for each shift in the case of					
	an actual	. To the extent possible.					
		eader on each shift who is rdinating the rescue effort and					
	directing other team	n members during the rescue					
		team in this facility shall					
		registered nurse, one CNAs, all of whom have					
	received training and	d certification in /BLS. 5.					
	Maintain equipment	and supplies necessary for					
	/BLS in the laci	ility at all times. 6. Provide /BLS policies and advance					
	directives to each re	esident/ representative upon					
	admission. "						

Emergency Procedure -

#058 P. / __/__/___ 19:54

DOINTED: 08/07/2015

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED 0.0938-0391
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES UND PLAN OF CORRECTION		& MEDICALD SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		105884	B. WING			06	/26/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	REHABILITATION AND	HEALTH CENTER			2811 CAMPUS HILL DR TAMPA, FL 33612		
EXCEL		TEMENT OF DEFICIENCIES	IP.	┺-	ODOVIDED'S PLAN OF CORRECTION	N .	(X8) COMPLETION
(X4) ID PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	-IX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
F 520	Continued From pa	ige 211	F	520			
	administrating covered in the 2010	shall incorporate the steps					
	(BLS) sequence of CA-B " (chest ond breathing). This has previous sequence breathing, chest co the adult victim is unormally (ignoring assessing the victim initial assessment, compressions rathreathing delivering rescue be trained or not, shot compressions to viu befivering high-que essential: a, push inches (5 cm) at a compressions por tracoil after each co	ar than opening the airway and reathing. 5. All rescuers did provide chest clims of . 6. littly chest compressions is hard to a depth of at least 2 rate of at least 100 minute. B. Allow full chest mpression. C. Minimize st compressions. 7. Trained					
	compression - A review of the facil Assessment and From the Nursing Si Manual (Revised of this procedure is the resident 's phys psychosocial condit purposes of manag care plan and comp instruments, includi (MDS)." Stops in	ity policy: "Admission ollow Up: Role of the Nurse "ervices Policy and Procedure 2012). The purpose to gather information about sical, amotional, "and ion upon admission for the ing the resident, initiating the letting required assessment on the minimum data set					

#058 P.

PRINTED: 06/07/2015 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	
CENTERSTORMEDIS	(VOLINI II TIPLE CO.

OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

LE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING AND PLAN OF CORRECTION 06/26/2015 B. WING 105884 SYREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTER TAMPA, FL 33612 PROVIDER'S PLAN OF CORRECTION

SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)

F 520 Continued From page 212

directives. If so, initiate the process of obtaining a copy for the medical record. If not, provide the resident with information on his/her right to have advance directives and initiate the process of establishing them. " Documentation: " the following information should be recorded in the resident's medical record: 3. All relevant assessment data obtained during the procedure.

8. Record reviews and interviews revealed the following corrective action was taken:

in-service signature sheets were reviewed for retraining of the nursing staff. recarding advance directives. code blue drille. The NHA verified that all nursing staff with the exception of one employee that was unavailable had received the in-service retraining. The NHA verified that this employee will not return to work until they have received the retraining. On interview it was confirmed after the re-training, the nurses were able to verbalize the Policy and Procedures: Advance Directives, and Emergency Procedure: and Code Blue. interviews were conducted with 21 out of the 31 nursing staff members on . All staff members interviewed and were familier with the policy and able to verbalize the correct procedure.

The finding of Immediate Jeopardy was found to be removed on and the scope and severity was reduced to D.

F 620

		1-1-1-1-11-4			FORM APPROVED	
Agency for Health Care Adm STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		INISTRATION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SL VEY COMPLE. ED	
		62932	B. WING		C	
NAME OF F	ROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
EXCEL R	EHABILITATION AND	HEALTH CENTE TAMPA, F				
(X4) ID PREFIX TAG	(FACH DESIGIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
N 000	Excel Rehabilitation deficiencies found Class I was identifie	G FACILITY STIGATION was conducted on n and Health Care Center had at the time of the visit. ed at N0201 was informed of the Class I on	N 000	Preparation and submission of This plan of correction does not Constitute and admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correctio is prepared and submitted solely because of the requirement under State and Federal law. This plan of correction will serve as the Facility's allegation of substantial compliance.	n s	
N 201 SS=J	Appropriate Health The right to receive health care and princluding social set if available; planne therapeutic and rel with the resident c recognized practic community, and w agency. This Statute or Ru Based on facility a interviews with the administrative staf and review of the I determined that th care and support s sustaining wishes residents of 81 tot	a adequate and appropriate otective and support services, mental health services, rvices; mental health services, rvices; mental health services, and habilitative services consistent are plan, with established and e standards within the thrules as adopted by the le is not met as evidenced by: nd resident record review, facility's nursing and f, family, the Medical Director acility policies, it was e facility failed to ensure health services consistent with life for one (#1) of 7 sampled al residents, identified as status according to the Advance		Resident #1 Expired at the facility on The family and physician were notifier resident's passing. A full facility review was completed for directives on , , this included a current full code, and physician or a review was completed by , that all residents have received in writing to formulate advance directives to their wishes or that of their respect responsible parties. Any identified are concern have been addressed, Policie Procedures for Advance Directives, implementation of currently implemented and resident advance directives are being honored facility staff. PCA TIZZIE HUMANSTORTUC	of the r advance review of a rdder. Also assure ing their according ive as of s and	
HCA Form	2000 0004	IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	Administration to a	7/16/1T	
	777		6890	J5QX11	If continuation sheet 1 of 2	

STATE FORM

" RECEIVED] Jul. 16 2015

FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED. AND PLAN OF CORRECTION A. BUILDING: \mathbf{C} B WING 62932 STREET ADDRESS CITY STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTE TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL) (FACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEEICIENCY N 201 Continued From page 1 N 201 The facility's policy and procedures for Advance Directives. facility failed to initiate () on Resident #1, who was a was reviewed and revised by the QAPI Committee on . . . male. The clinical record contained a Licensed Nursing Staff has been re-educated physician order for Full On Resident #1 was discovered related to Advanced Directives unresponsive, without pulse or ____, ___. The . Code Blue Roles and facility failed to ensure that ____ or Emergency Responsibilities on Re-Medical Services were contacted to honor the education will be provided again and will be advance directives and wishes of the resident. completed by . This has been provided The facility failed to protect the rights of Resident by the ADON/Staff Development Coordinator. #1 by denying the resident the opportunity to When a resident is admitted to the facility the receive emergency lifesaving services to prolong Social Services Director/Designee with provide his life. the resident with written Findings include: .("Questions about Health Care Advanced Directives"). The resident/responsible 1. A review of the facility policy: " Neglect party will sign an acknowledgement form and _____ : Prevention and Prohibition confirming that they have received this (Not dated), revealed a Standard: "The information. A meeting was held with the prevention and prohibition of . neglect and Resident Council by . the Social Services Director will provide education regarding which promotes resident well-being, safety and Advance Directives, Resident Rights and prohibits ____, neglect, involuntary Responsibilities and and the misappropriation of property for all The facility policies for these areas of care were residents. ' I. "Furthermore, each resident has the right to reviewed. All new admissions and residents who , corporal punishment, and be free from . ': have obtained new orders for advance directives will be reviewed at the daily clinical meeting to by anyone, including but not subjected to ... assure that resident wishes for advance limited to: facility staff, other residents. directives are acknowledged and implemented. consultants or volunteers, staff of other agencies This will be monitored by the Social Services serving the resident, family members or legal Director/Designee weekly times four weeks and quardians, friends or other individuals. " II."

AHCA Form 3020-0001

Each resident has the right to be free from mistreatment, neglect and misappropriation of

of residents whose personal histories render

them at risk for abusing other residents, and development of intervention strategies to prevent

occurrences, monitoring for changes that would

property. This includes the facility's identification

compliance.

then monthly utilizing a Data Collection Tool.

and the QAPI Committee for ongoing

This will also be over seen by the Administrator

PRINTED: 07/10/2015 Agency for Health Care Administration (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CHA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND BLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C 62932 B WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR **EXCEL REHABILITATION AND HEALTH CENTE** TAMPA, FL 33612 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES in (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (FACH DEFICIENCY MUST BE PRECEDED BY FULL DDEELX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 201 N 201 Continued From page 2 behavior and reassessment of the interventions on a regular basis. Definitions: 7. " Neglect: means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (42 CFR 488 301) "

Procedures: 1. Screening: " a. The facility screens potential neglect or employees for a history of mistreating residents as defined by the applicable requirements a 483.13 @ (1) (ii) (A) (B).This includes attempting to obtain information from previous employers and /or current employers and checking with the appropriate licensing boards and registries. Screening is done on all

employees prior to hire. * 2. Training:" a. Each team member is scheduled to attend a general orientation session. b. Each team member is offered and asked to attend a facility in-service where the information is reviewed as needed throughout the year. c. each team member is notified that a mandatory " Prevention " in-service is scheduled on an annual basis. This in-service includes: 1.

Appropriate interventions to deal with aggressive

and / or catastrophic reactions; 4. What , neglect and misappropriation constitutes of resident property. " 3. Prevention: Every effort is made on behalf of . This includes an the resident to prevent analysis of: a. Features of the physical and/or neglect environment that may make more likely to occur, such as secluded areas of the facility; b. the deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that staff assigned have knowledge of the individual residents ' care needs, C, the supervision of staff to identify inappropriate behaviors, such as ...ignoring residents while giving care,and d. the

Agency for Health Care Administration (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND BLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B WING 62932

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTE TAMPA, FL 33612 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 201 NI 201 Continued From page 3 assessment, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as resident with , those that require communication heavy nursing care and/or the totally dependent on staff. Each team member reads and signs the " Resident Rights " upon employment. A copy of the resident rights is given to each team member within his/her probationary period of employment. This information is reviewed on an annual basis by the Social Services staff in an all-staff in-service. Identification: Each team member is encouraged Prevention * to attend a mandatory " in-service on an annual basis. This in-service includes methods to identify events, such as of residents, occurrences, suspicious patterns, and trends that may constitute and to determine the direction of the investigation. Investigation: the Social Services Manager is the facility appointed designee who is the staff member responsible for the initial reporting. investigation of alleged violations and reporting results to proper authorities. The facility policy for is for it to be brought any allegation of immediately to the attention of the immediate supervisor. The supervisor is to notify the Social Services Manager, who is the facility appointed designee, the DON, and the Administratorthe facility will also notify the appropriate agencies, based on the nature of the allegation in accordance with State and Federal Statute. Protection: the facility will make every effort to protect any individual form ____, If the is against a team member, allegation of the team member will be immediately removed from duty during the investigation, and until it is complete.

PRINTED: 07/10/2015 Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER-A. BUILDING: C 62932 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTE TAMPA, FL 33612 STREAM DV STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DOCETY CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 201 N 201 Continued From page 4 Reporting/Response: the facility will report all alleged violations to 1-800-96-, and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective action depending on the results of the investigation; report to the state, or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for services; and analyze the occurrences to determine what changes are needed if any, to policies and procedures to prevent further occurrences. Federal nealect, and quidelines will also be followed by the reporting designee. 2. Review of Resident #1 's closed medical record, to include demographic / face sheet, indicated he was initially admitted to the facility on . readmitted on and most recently readmitted to the facility from the hospital

(Wednesday) for skilled services with diagnoses that included but not limited to:

Review of the Physician '

revealed under

Certified

and signed

at 5:45

. Noted large

to facility. " Signed by the Assistant Director of ICA Form 3020-0001 ATE FORM

(), and

(handwritten).

s Order Sheet (POS) dated by the physician on

Per the Nurse's Notes dated AM: "this nurse called to

, pulse or

Special Needs; Code Status: "Full "

Nursing Assistant (CNA). Resident noted with no

amount of frothy saliva on face and chest. Upper extremities cool to touch. Call placed to (attending physician) service, return call received from (covering physician). Order received to release body. Call to family, (Mother), name of funeral home received. Family declined to come

A	for Health Care Adm	inintration				0: 07/10/2015 1 APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	COM	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREE	TADDRESS, CITY,	STATE, ZIP CODE		
EXCEL	REHABILITATION AND		CAMPUS HILL D A, FL 33612	PR		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
N 201	Nursing (ADON). On at 1:1 conducted with the the resident when I was taking care of I ; she tool employee called off 't verbal, he require readmitted from the asked to recall the resolution of the ADON stated, I had finished medica. AM, the CNA was in think he is gone. I we checked him for pul very cool to touch. Extremities. His low. The raround his mouth. The raround his mouth. I shall be a shafter I called the do had I and I didn. I saw the resident a was cool to touch, I say the resident a was cool to touch. I say the resident a was cool to touch. I can difficult of the decision to not call and stiff; I did not been like that. The pattending physician the resident's	00 PM an interview was ADON, the nurse assigned be I. She stated that she him for the first time on a shift because another She stated the resident wid total care and had been thospital that day. When events that happened on resident with the she was working the night shift, alton pass and around 6.45 the hellway and said, "I rent in Resident #1" sea and he was le felt a little stiff in his upper extremities had sort of esident had white frothy stufhere was nothing to could dived if she looked at the chae stated, I looked at the she stated, I looked at this chae tort to tell him the resident the resident was recommended.	l er f o tt			

ICA Form 3020-0001

status.

stated, " after looking at the chart, no. " When asked if she had received training on how to respond when a resident is found without vital signs she stated, we are supposed to do chest compressions and send someone to check on

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Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A RUILDING: C B WING

NAME OF PROVIDER OR SUPPLIER

62932

STREET ADDRESS CITY STATE ZIP CODE

2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTE TAMPA, FL 33612 (YA) IO SUMMARY STATEMENT OF DEFICIENCIES in PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 201 Continued From page 6 N 201 When the ADON was asked if she knew how to determine code status, she stated, if a resident is unresponsive. I am supposed to check the pulse and call for someone else to check the chart for orders. I will a call code blue and bring the crash cart. We have a vellow book at the nurses ' station with all the forms. If the resident is a new admission it may be necessary to look in the chart. When asked how the purse is notified of a resident's advance directives, including she states. " It is the nurse 's responsibility to check the chart on every resident, so they know status. " If someone finds someone unresponsive, they have to wait until someone checks the vellow book or the chart to see if they or not. When asked what she would do in a situation wherein a resident is found but there is no Advance directive she stated. "I would do a Code." When asked if she had had any training since the event, she stated ves. one-on-one with the Director of Nursing (DON) on advance directives Code Blue, and mock drills. The DON reviewed with me when we are supposed to do a code. On at approximately 5:00 PM an interview was conducted via telephone, with Employee A, the Certified Nursing Assistant (CNA), who found Resident #1 unresponsive. She stated she no longer worked for the facility. Employee A stated she was making rounds before she went home and found Resident #1 not breathing. She called for the nurse to check on him. The ADON responded and checked on the resident. The ADON said, "He was gone. ' Employee A stated that the ADON did not do 1) on Resident #1 and that she did not recall anything else about the resident.

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Г		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	SURVEY	
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	N 201	Continued From page	ge 7	N 201				
	Valuability	conducted with the (NHA). When asked that happened on #1 she her that the Assistar had found the reside perform . The N	00 PM an interview was Nursing Home Administrator if she could recall the events , the day Resident e stated the DON informed at Director of Nursing (ADON) ent unresponsive and did not NHA stated in her opinion the looked at the chart and					
		On at 5:1	5 PM an interview was					

conducted with the Director of Nursing (DON). when asked if she was familiar with Resident #1. she stated, "yes." When asked about the day , she stated, "When I came in about 5:30 AM the (ADON) stated that Resident #1 had passed. I asked the (ADON) if she had performed , the (ADON), said, no. I stated to the (ADON) that she, should have called a code and the (ADON), and stated she did not do it. I educated the (ADON) right then and there regarding our policy. The policy states, we have to start a code no matter what, on a Full Code resident. I interviewed (Employee A) who stated she was making her rounds, and the resident didn 't look right, she shook him, and he was not responding, so she got the nurse, " The DON stated. "The chart revealed the resident was a Full Code. " The DON stated, "I knew he was a full code because he had been here for so long. " The DON stated "the (ADON) decided on her own not to do ... ". The DON, stated " the

was conducted with Resident #1 's father. He stated his son was in the Marines; he got an aneurysm in there and had to have surgery. He

at 12:40 PM, a telephone interview

On

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A Form 3020-0001

their chart.

covering was called. " I found out the next day or so, probably when the funeral home called me. " Normally if a patient does not have a

would be initiated and 911 called.

PRINTED: 07/10/2015 Agency for Health Care Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED 62932 C R. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTE 2811 CAMPUS HILL DR TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY N 201 | Continued From page 9 N 201 My expectation is that the nurse would start ifa was not on the chart. " On at 2:40 PM. a telephone interview was conducted with the covering physician who received the call regarding Resident #1 on . She stated she was covering for the auenging physician on , but doesn't remember the call as she stated she covers 1000 patients. When asked if she was informed the resident was a Full Code and he was not , she stated, "I apologize, but I don' t remember " Review of the Resident #1 's Admission Agreement revealed; page 31 of 39 Advanced Directives Acknowledgement with the following language: I understand that I do not have to sign or implement an Advanced Directive in order to be a resident at this Healthcare Center, I understand that I may implement an Advanced Directive at any time during my stay in the facility. It is also my understanding that I may ask at any time to review Advanced Directive information or my Advanced Directive (s) and ask questions I may have concerning them. I may revoke any Advanced Directive (s) at any time that I have made. I understand the facility 's staff cannot give legal advice, but can answer questions concerning Advanced Directives. I have the following designations(s) and my copies have been provided to Health Care Center. A line was drawn through the blank spaces in front of all the choices which were: Living Will or Direction to Withhold Life Sustaining Procedures. Yellow HRS Form.

Financial or Medical, Anatomical Gift, Other: Form 3020-0001

Health Care Surrogate. Health Care Proxy, Durable Power of Attorney, Financial Power of Attorney, Medical Power of Attorney, Guardian

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A Form 3020-0001

the above stated resident lacks the capacity to give informed consent to make medical decisions

PRINTED: 07/10/2015 Agency for Health Care Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED C 62932 8 WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTE TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (XS) TAG REGULATORY OR LSC (DENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY N 201 Continued From page 11 N 201 and does not have the reasonable medical probability of recovering mental and physical capacity to directly exercise rights Further review of Resident #1 's medical record revealed a document titled Activated Medical Decision Maker signed by the resident's father and mother and witnessed by two signatures on . The document included the following language: The Determination of Incapacity form has been completed on . I do hereby attest that I am at least or older and am willing to become involved in the above stated resident's health care decisions. I have maintained regular contact and am familiar with the resident 's activities, health, religious and moral beliefs, so that I can make health care decisions, including withholding/withdrawing life prolonging decisions that would be the decisions the resident would have made, if capable. I am willing to produce clear and convincing evidence upon request. I understand that my role has become active and accept my responsibility. which is one of the following Medical Decision Maker designations: checked were Proxy and A parent of the resident Review of Resident #1 's medical record revealed the resident was discharged to the hospital on and readmitted to the facility on . His admission paperwork did not include documentation that his Active Medical Decision Maker, his father, was given information on Advance Directives. There was no " Advanced Directives Acknowledgement " form in the admission paperwork for the Resident's

Review of Resident #1 's medical record 4 Form 3020-0001

readmission to the facility.

PRINTED: 07/10/2015 Agency for Health Care Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER A. BUILDING: COMPLETED 62932 R WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTE TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY N 201 | Continued From page 12 N 201 revealed the resident was discharged to the hospital on and readmitted on . His admission paperwork did not include documentation that his Active Medical Decision Maker, his father, was given information on Advance Directives. There was no " Advanced Directives Acknowledgement " form in the admission paperwork for the resident's readmission to the facility. Per the hospital discharge summary for Resident #1 dated : Patient was a admitted to the emergency the hospital with acute failure, HCAP (Healthcare-associated advance , VRE (-Resistant Enterococci) () and -resistant). During his hospital stay, a consultation was performed on having noted stools that were positive for occult . Laboratory data revealed hemoglobin of 8.5 and a platelet count of 335 indicating the patient was with occult () loss. The patient did not show any signs of active at the time. Recommendations included continue tube feedings as tolerated; monitor the hemoglobin and transfuse on an as needed basis. Resident #1 was discharged from the hospital and transferred to the skilled nursing facility on Review of Resident #1 's physician orders dated revealed a Code Status of Full Code. Review of Resident #1 's complete medical record including the closed record revealed no

3 Form 3020-0001

) form was present.

PRINTED: 07/10/2015 Agency for Health Care Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING: COMPLETED C 62932 B WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTE 2811 CAMPUS HILL DR TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY N 201 Continued From page 13 N 201 A review of the Nursing Admission Evaluation Tool dated at 3:00 PM revealed; patient arrived via stretcher from hospital with The resident has advance directives upon admission? NO. Are advance directives in the chart? NO. Activities of Daily Livina: required for bed mobility; transfers; dressing; and personal hygiene. Alert to person and non-verbal, skin pale, warm and dry. Patient not verbal with this nurse, but can make faces for pain. regular and audible, pulse rate equal and . Breath sounds clear in place. Has referrals for Physical Occupational and Speech Signed by Employee C, a Licensed Practical Nurse (LPN) A review of Resident #1 's medical record, Social Service Admission Evaluation Tool document dated at 5:32 AM (Thursday) included the following information: the resident was , had resided with his father in the past. was a high school graduate and had been in the Marines for 10 years. It also included the questions with corresponding answers written in capital letters. Does the resident have advanced directives? INCAPACITY & HC (health care) PROXY ON CHART; Does the resident have a legal representative? YES, (the resident's father s name and phone number): What is the resident's code status? FULL CODE. It was Electronically signed by Employee G. A review of the Admission Minimum Data Set (MDS) assessment dated

memory: memory problem. Long term memory: Form 3020-0001

under Section C (

Assessment for Mental Status: Short term

revealed

Patterns): Staff

Agency for Health Care Administration PRINTED: 07/10/2015 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED 62932 B. WING NAME OF PROVIDER OR SUPPLIER 06/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTE 2811 CAMPUS HILL DR TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (XS) TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE DEFICIENCY) N 201 Continued From page 14 N 201 memory problem. skille for Daily Decision Making: severely Under Section D (Mood): Staff Assessment: feeling or appearing down, depressed, hopeless, Trouble falling or staving asleep or sleeping too much: Feeling tired or having little energy: Trouble concentrating. Under Section G (Functional Status): of one person assistance required for bed mobility and dressing: total dependence required for eating and personal hygiene. Under Section H (Bowel): Always of bowel and Under Section I (Active Diagnoses): failure and Under Section K (Swallowing and I satus): Height 66 "; weight 111 pounds; loss of 5% or more in the last month or loss of 10% or more in last 6 months-yes; Feeding tube. Under Section M (Skin Conditions): A risk of developing . Under Section Q (resident's Overall Expectation); Expects to remain in this facility; by family, at 1:15 PM an interview was conducted with Employee G a Social Services Assistant regarding Resident #1 's Social Service Admission Evaluation Tool dated timed 5:32 AM, approximately 13 minutes prior to the resident 's . When asked, Employee G stated he probably tilled in the information based on prior admissions. He stated he was going to speak with the resident 's family and he confirmed that the resident had a health care proxy and a Determination of Incapacity. He confirmed that the resident was a Full Code on previous admissions and remained a Full Code because there was not a signed medical record. He stated that his plan was to call the family and inform them of their right to formulate an advance directive for the resident.

He further stated that the facility procedure in \(\)

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	FL 33612 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
N 201	Continued From page 15	N 201	DericleNCT)	J
t t t r A S irr S w all	regards to advance directives required the Admissions Department to speak to residents on admission, advance directives are then addressed in the Nursing Admission Assessment and the Social Services Department reviews the information with the resident and/or the family. On at 1:20 PM an interview was conducted with the Social Services Director (SSD) regarding Resident #1. Per the SSD. she spoke to the resident 's father on after ne was readmitted on She confirmed hat his parents were making the decisions regarding his care and were designated as his activated Medical Decision Makers at that time, she stated that the father was given information regards formulating an advance directive. SSD states, "If he wanted him to be awe would have mailted him the paperwork." She loss stated that she had not spoken to the father hen the resident was admitted on he stated that the resident was designated as a ull Code since his original admission in of 114 and had never had apaper in his edical record.			
pol res fac Imp adr Dire info	A review of the facility policy: "Advance reactives" (Revised 2008), revealed a licy statement: "Advance directives will be specied in accordance with state law and littly policy." Policy Interpretation and plementation, section "1. When a resident is mitted to our facility, the Social Services ector (SSD) or designee will provide written smatten to the resident concerning medical care, uding the right to accept or refuse medical or			

PRINTED: 07/10/2015 Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING: COMPLETED C 62932 R WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTE 2811 CAMPUS HILL DR TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES FEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC (DENTIFYING INFORMATION) DOCCIA (EACH CORRECTIVE ACTION SHOULD BE (Y5) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 201 | Continued From page 16 N 201 advance directives. " "3. When a resident is admitted to our facility, SSD or designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives. " Policy Interpretation and implementation, section " 5: In accordance with current OBRA definitions and guidelines governing advance directives, our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to: h -Indicates that, in case of or failure, the resident, legal quardian, health care proxy, or representative (sponsor) has directed that no) or other life-saving methods are to be used. A review of the facility policy: "Emergency Procedure: .) " (Revised 2011), documented the policy statement: "Personnel have completed training on the initiation of)/Basic Life Support (BLS) in VICTIMS of sudden Policy and Interpretation and Implementation: " is defined as inadequate resulting in insufficient throughout the body (pulselessness). 2. Sudden (SCA) is a leading cause of in adults, 3. Victims of many initially have gasping or may even appear to be having a . Training in BLS includes recognizing the presentations of SCA, 4, The likelihood of recovering from SCA due to an

underlying cause, the chances of surviving SCA 4 Form 3020-0001 E FORM

from

acute event (such as

substantially from the likelihood of recovering

) differs

that the end result of multi-system failure and advance irreversible or conditions, 5. Depending on the

Agency for Health Care Administration FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED B. WING _____ С 62932

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(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)	(XS) COMPLET DATE
c E E E E E E E E E E E E E E E E E E E	Continued From page 17 may be increased if is initiated immediately upon collapse. 6. Any unnecessary interruptions in chest compressions (including longer than necessary pauses for rescue breathing) decreases effectiveness. 7. In potentially reversible situations, early delivery of a with a defibrillator plus within 3-5 minutes of collapse can further increase chances of survival. 8. The goal of early delivery of is to try to maintain life until the emergency medical response team arrives to deliver Advance Life Support (). 9. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in /BLS shall initiate unless: a it is known that a order that specifically prohibits and for external exists for that individual: "Preparation for 1. Obtain and for maintain American Red Cross or American Association certification in assic Life Support (BLS/) () for key clinical staff nembers who will direct resuscitative efforts, including non-licensed personnel, 2. Provide eriodic Mock Codes (simulations of an actual) for training purposes. 3. Select and tentify a team for each shift in the case of a nactual 10 to the extent possible, essignate a team leader on each shift who is sponsible for coordinating the rescue effort and receiting other team members during the rescue effort and receiting other team members during the rescue effort and receiting other team members during the rescue effort and receiting other team members during the rescue effort and receiting other team members during the rescue effort and receiting other team members during the rescue effort and receiting other team members during the rescue effort and receiting other team members during the rescue effort and receiting other team members during the rescue effort and receiting other team members during the rescue effort and receiting other team members during the rescue effort and receiting other team members during the rescue effort and receiting other team members dur	N 201		

Agency for Health Care Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED 62932 B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EXCEL REHABILITATION AND HEALTH CENTE

2811 CAMPUS HILL DR TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETE TAG -REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 201 | Continued From page 18 N 201 admission " Emergency Procedure -: " 1. the facility 's procedure for administrating shall incorporate the steps covered in the 2010 American Association Guidelines for and Emergency Care or facility BLS training material. 2. The basic life support (BLS) sequence of events is referred to as C-A-B " (chest compressions, airway, and breathing). This has been revised from the previous sequence of "A-B-C" (airway, breathing, chest compressions), 3, Begin the adult victim is unresponsive and not breathing normally (ignoring occasional gasps) without assessing the victim 's pulse. 4. Following the initial assessment, begin compressions rather than opening the airway and delivering rescue breathing, 5. All rescuers trained or not, should provide chest compressions to victims of Delivering high-quality chest compressions is essential: a. push hard to a depth of at least 2 inches (5 cm) at a rate of at least 100 compressions per minute. B. Allow full chest recoil after each compression. C. Minimize interruptions in chest compressions, 7, Trained rescuers should also provide compression ratio of 30:2. " A review of the facility policy: "Admission

Assessment and Follow Up: Role of the Nurse " from the Nursing Services Policy and Procedure Manual (Revised 2012). The purpose of this procedure is to gather information about the resident 's physical, emotional, psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan and completing required assessment instruments, including the minimum data set

PRINTED: 07/10/2015 Agency for Health Care Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING: COMPLETED 62932 C B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTE 2811 CAMPUS HILL DR TAMPA. FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREEIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL tn PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREEIX (EACH CORRECTIVE ACTION SHOULD BE (X5) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAC DATE DEFICIENCY N 201 Continued From page 19 N 201 (MDS), " Steps in the Procedure: " 10. Determine if the resident has existing advance directives. If so, initiate the process of obtaining a copy for the medical record. If not, provide the resident with information on his/her right to have advance directives and initiate the process of establishing them. " Documentation: " the following information should be recorded in the resident 's medical record: 3. All relevant assessment data obtained during the procedure. 4 On at 5:00 PM an interview was conducted with the NHA. In regards to the facility response to the incident of Resident #1 not when necessary she stated, "We started an investigation and a Quality Assurance Performance Plan (QAPI) immediately. We sent the ADON home for the day on suspension. We reviewed the policy and procedures for advance directives. . Code Blue Roles and Responsibilities, and the Emergency Procedure . We interviewed the staff regarding their ability to verbalize the process. We normally complete an audit of the advance directives and orders monthly. The SSD initiated an immediate audit for Advance Directives and for the entire resident population and it was completed by , 2015. We were monitoring / reviewing the charts of residents who expired. We started in-service training regarding advance directives and and called a Code Blue Drill. Multiple interviews of the staff were initiated to ensure the direct staff knew about advance directives. and when to call a code. Training was conducted in for the entire facility. The DON did immediate in-servicing with the ADON and we completed a Federal report. We have been conducting weekly QA meetings regarding the event. These meetings will continue Form 3020-0001

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implemented as per the resident 's advance 1 Form 3020-0001

PRINTED: 07/10/2015 Agency for Health Care Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED 62932 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTE 2811 CAMPUS HILL DR TAMPA, FL 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE over COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 201 Continued From page 21 N 201 directives. If there is no in the medical record then is to be initiated on the resident. Nurses are responsible for the implementation of on the resident. The nurse assigned to the resident will act as the TEAM LEADER of the code situation. Certified Nursing Assistants who certified may be directed to assist with are at the direction of the nurse. * On signature sheets were provided for the tollowing in-services, dated 1, . 5/9. , 6/7, and ... In addition mock "Code Blue " drills were done on documents that were provided to the survey team were reviewed. A comparison was made between the in-service signature sheets and the master list of all employees. The comparison revealed that 91% of licensed nurses and 97% of the unlicensed staff had completed the training Interviews with the facility staff regarding advanced directives. and Code Blue drills were conducted in order to verify staff knowledge. The following relevant interviews were obtained: at 4:24 PM, an interview was conducted with Employee C a nurse; she stated she worked full time on the 7:00 AM -3:00 PM shift. She stated she had been part of a mock Code Blue drill a couple of months ago and that " we just had an in-service on where to find the forms, in the yellow book. " When asked how she would respond if a CNA said a resident was unresponsive she stated she "would check the resident, have someone at the desk check book. I would initiate Ontil I determined if the resident had a

\Form 3020-0001

would stop

order then I

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would do if he found an unresponsive resident, he Form 3020-0001

resident is

the chart for the yellow

making sure we have advance directives, if

POA is in the chart also. He was asked what he

, speak with the family, check

form, make sure a

PRINTED: 07/10/2015 Agency for Health Care Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED 62032 B WING 06/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EXCEL REHABILITATION AND HEALTH CENTE 2811 CAMPUS HILL DR TAMPA FI 33612 O(4) ID SUMMARY STATEMENT OF DEFICIENCIES PREEIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREELY (EACH CORRECTIVE ACTION SHOULD BE (X5) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 201 | Continued From page 23 N 201 stated "first assess for breathing, call a code. call somebody by name to call 911. Check Vital signs, call for crash cart. Call another person to look at form. I would start compressions right away, and if found they were a stop compressions, " During the interview conducted on 5:15 PM with the DON she stated that what she would expect that if a resident was found unresponsive and had a Full Code status the nurse should start . She was asked if a nurse should start prior to finding out about a resident 's order. She stated. "The nurse should know if the resident is a or not before they start . If the nurse starts and finds out the resident is a , the nurse can stop. That is what I was told during my When asked if that was in the facility policy, she stated, " It is not in our policy, so I do not teach that in the in-service classes. " The DON was informed that 3 out of 7 nurses interviewed so far stated they would start when they found an unresponsive resident and then stop found the resident was a . She was asked if the facility conducted training since the event. She stated "yes, we started in event and we have given in-services again recently. " This training covered orders and advance directives. The training is also being done on orientation. She stated, "We did the training for the whole month of , because we had to get everybody. And then we just did it again. In addition, a Quality Assessment Performance Improvement (QAPI) was started,

4 Form 3020-0001

the day of the event. The Quality Assurance (QA) committee was informed. We did training with the CNAs and nurses and also preformed mock code blues." When asked if training had been performed in the past, stated, "Yes, the

Agency for Health Care Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER A. BUILDING: _ COMPLETED C 62932 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE ZIP CODE 2811 CAMPUS HILL DR EXCEL REHABILITATION AND HEALTH CENTE TAMPA, FL 33612 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY N 201 Continued From page 24 N 201 in-service is done yearly and during orientation, " In addition, the DON was also asked, how the facility audits the employee records for current , she stated, " when we have new employee starting Human Resources (HR) sees the card and then the ADON checks the card after that. All nurses are supposed to be certified " When asked if the facility had audited the employee records for current , she stated " Yes, the ADON audits monthly and HR does it on hire. " The DON stated the SS department monitors, audits the advance directives, and reviews orders monthly. The DON stated the event had been presented to the Quality Assurance (QA) committee and an action plan and plan of correction was put into place. The DON completed the Federal report and reported it to the corporate nurse. The DON stated, "The direction I got was to do education, and do mock codes, and file a federal report." On at 2:00 PM, an interview was conducted with the NHA and the DON to review the content of the training in-services. The NHA and DON stated, we went over the following policies: policy (which included what to look orders and book, where to find the for. paper, etc.), Advance Directive policy and Code Blue policy (described a mock code blue, if staff walk in on an unresponsive resident what you would do), and the Emergency procedure policy. It was a verbal presentation and every nurse received a packet. The expectation was for nursing / CNA staff to receive training by the first

was discussed. The DON stated. "That is not Form 3020-0001

of 8 nurses on

QAPI meeting. By the first QAPI we were almost at 100%. The concern regarding interviews with 4

surveyor which revealed the nurses would start prior to knowing the resident 's code status

and

· by the

FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED. C 62032 R WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2811 CAMPUS HILL DR **FXCEL REHABILITATION AND HEALTH CENTE** TAMPA, FI 33612 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X6) REGULATORY OR LSC IDENTIFYING INFORMATION) DOFFIX (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 201 Continued From page 25 N 201 what they were trained to do. " The NHA and the DON stated they would begin retraining the nursing staff that day. On at 1:00 PM an interview was conducted with the NHA and the Corporate Nurse (CN). When asked when the Policy and Procedure for advance directives and last reviewed, the Corporate Nurse (CN) stated " the Policy and procedure for advance directives and was reviewed and " after the event with undated on Resident #1. He further stated that the Emergency Procedure was also updated. which included the Code Blue Roles and Responsibilities 5 On in-service signature sheets were reviewed for retraining of the nursing staff, regarding advance directives. code blue drills. The NHA verified that all nursing staff with the exception of one employee that was unavailable had received the in-service retraining. The NHA verified that this employee will not return to work until they have received the retraining. On interview it was confirmed after the re-training, the nurses were able to verbalize the Policy and Procedures: Advance Directives, and Emergency Procedure: and Code Blue. Interviews were conducted with 21 out of the 31 nursing staff members on and . All staff members interviewed were familiar with the policy and able to verbalize the correct procedure. On at 3:40 PM an interview was

4 Form 3020-0001

conducted with the NHA. She was asked how the facility was going to ensure that residents had Advance Directives which accurately reflected their wishes in their first 14 days of admission

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department revisited each resident and wrote a 4 Form 3020-0001

On

all admissions since

at 9:50 AM an interview was conducted with the NHA and the Corporate Nurse (CN). They stated they had initiated an audit on

. The SS

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4 Form 3020-0001

CLASS I

they will approach the facility staff or if staff notices a change in condition that it will be re-addressed with resident.



. 2015

Administrator
Excel Rehabilitation And Health Center
2811 Campus Hill Dr
Tampa, FL 33612

RE: CCR #2015005834

Dear Administrator:

On , 2015- , 2015, a survey was conducted in your facility by representative(s) of this office. Your facility was found not in substantial compliance with the participation requirements. A partial extended survey was conducted , 2015.

The findings of the survey revealed Immediate Jeopardy at No201 – S/S: J – 400.022(1)(i), FS – Right To Adequate And Appropriate Health Care F0155 – S/S: J – 483.10(b)(4) – Right To Refuse; Formulate Advance Directives F0156 – S/S: J – 483.10(b)(5) - (10), 483.10(b)(1) – Notice Of Rights, Rules, Services, Charges F0224 – S/S: J – 483.13(c) – Prohibit Mistreatment/neglect/misappropriatn F0281 – S/S: J – 483.20(k)(3)(i) – Services By Qualified Persons/per Care Plan F0490 – S/S: J – 483.75 – Effective Administration/resident Well-Being, identified on 2015. Which was removed on 2015.

Your facility's noncompliance with F0224 – S/S: J – 483.13(c) – Prohibit Mistreatment/neglect/misappropriatn has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(c) and 1919(g)(5)(c) of the Social Security Act and 42 CFR 488.325(b) require that the attending physician of the affected resident, who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with §488.325(g), you are required to provide this office with the name and address of the attending physician of the affected residents in your facility within 10 working days of your receipt of this letter. Please note that, in accordance with §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of alternative remedies.

As a result of the survey, this Agency is forwarding a copy of the CMS-2567 to the Centers for Medicare and Medicaid Services (CMS) and a copy of these results to you.



Excel Rehabilitation And Health Center , 2015

Page 2

You will not receive a copy of this letter and attachments in the mail; you will only receive this faxed report.

CMS will communicate with you after they have received this documentation.

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to
 ensure that the deficient practice does not recur; and.
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur. i.e. what quality assurance program will be put into place.

Recommended Remedies:

Remedies will be recommended for imposition by CMS or the State Medicaid Agency.

- . Civil Money Penalty, in an amount and duration to be determined by CMS.
- Discretionary denial of payment for new admissions Medicare/Medicaid as soon as notice requirements are met.
- Termination of the Medicare Agreement effective , 2015.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Attention: IDR Coordinator Agency for Health Care Administration 2727 Mahan Drive, Mail Stop 9-A Tallahassee, Florida 32308 FAX (850) 414-6946 or

Phone number: (850) 412-4301 IDRCoordinator@ahca.myflorida.com

The IDR request must be sent during the same 10 days you have for submitting a Plan of Correction for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.mwflorida.com/Publications/Forms.shtml as a first step in providing a web-based

Excel Rehabilitation And Health Center , 2015

Page 3

interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

If you have questions, please contact Jill Sutter at (727) 552-2000.

Sincerely,

Patricia Reid Caufman Field Office Manager

PRC/rd Enclosure