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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS SKILLED NURSING FACILITY COMPLAINT INVESTIGATION CCR#2015005834 was conducted on ..... Immediate Jeopardy was identified at F-155 S/S: J; F-156 S/S J; F-224 S/S: J; F-281 S/S: J; F-282 S/S: J; F-490 S/S: J Substandard Quality of Care was identified at F-224 (J) A Partial Extended Survey was conducted on ..... The Administrator was informed of the Immediate Jeopardy on ..... at 5:31 PM. It was determined that the Immediate Jeopardy was removed on ..... Excel Rehabilitation and Health Care Center is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Amended ..... per CMS to add F-520 (J) QA&A.	F 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 correction is prepared and submitted solely because of the requirements under State and Federal law. **This plan of correction will serve as the Facility's allegation of substantial compliance.**	
F 155 SS=J	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.	F 155	Accepted 8/15	

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

Administrator

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 155 Continued From page 1

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.

This REQUIREMENT is not met as evidenced by:

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 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.

F 155

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.
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 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 . Any identified areas of concern have been addressed. All current residents advance directives are being acknowledged per their request.

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F 155	Continued From page 2	F 155		

The facility did not initiate as per the resident ' s wishes and his Health Care Proxy ' s wishes. The facility failed 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 record but wished to have a order ( ).

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 reduced to a D.

Findings include:

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 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.

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 re-educated 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 on completion of the Admission Agreement and Documentation in the medical

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F 155 Continued From page 3

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 , Wednesday, for skilled services with diagnoses that included but not limited to: ( ), and . Review 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 failure, HCAP (Healthcare-associated), advance , VRE (-Resistant Enterococci) ( ) and (Methicillin-resistant) ( ). 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

F 155 record regarding resident Advance Directives. Education was provided by the Staff Development Coordinator/DON/ Administrator 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 re-discussion at their quarterly care reviews.

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F 155	Continued From page 4	F 155		

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 Living: ... 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. ... rate 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 Status): ... of one person assistance required for bed mobility and dressing; total dependence required for eating and personal hygiene. Under Section H (... and Bowel): Always ... of bowel and ... Under Section I (Active Diegnoses): ... failure and ... 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):

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 QAPI Committee.

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F 155	Continued From page 5	F 155		

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

Per the Nurse ' s Notes dated at 5:45 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).

On 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 wasn ' 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 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 pulse and , he was 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 for a order, she stated, I looked at his chart after I called the doctor to tell him the resident

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F 155	Continued From page 6	F 155		

had and I didn't see a . Honestly when I saw the 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 been 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 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 are DNR 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 yes, one-on-one with the Director of Nursing (DON) on , advance directives, Code Blue, and mock drills. The DON reviewed

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F 155	Continued From page 7	F 155		

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

On 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 and 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 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

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F 155	Continued From page 8	F 155		

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 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 , 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.

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 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

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F 155	Continued From page 9	F 155		

. The last time I saw him he was in the hospital, and then someone called and said he was .

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 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. " 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. -Indicates that, in case of or failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no ( ) or other life-saving methods are to be used. "

Review of the resident '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

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F 155	Continued From page 10	F 155		

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, 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 .

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

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F 155	Continued From page 11	F 155		

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 .../.../....

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 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 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 3/ readmission to the facility.

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 155	Continued From page 12 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. Review of Resident #1 ' s medical record 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 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.	F 155		

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 155	Continued From page 13	F 155		

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 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 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 . The NHA stated in her opinion the ADON should have looked at the chart and initiated .

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 attending physician on , but doesn ' t

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

PRINTED: 08/07/2015
FORM APPROVED
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F 155	Continued From page 14	F 155		

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 [illegible], she stated, " I apologize, but I don ' t remember. "

On [illegible] 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 [illegible] issues, [illegible] (_ _ _), and [illegible]. " 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 [illegible] 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 [illegible] on their chart, [illegible] would be initiated and 911 called. My expectation is that the nurse would start [illegible] if a [illegible] was not on the chart. "

On [illegible] at 12:00 PM, an interview was conducted with the Medical Director. When asked if his expectation was for a nurse to perform [illegible] on a Full Code resident, he stated, " [illegible] should be done. " He has been the Medical Director for almost 4 years. " If the resident was unresponsive they have to do [illegible]. Code Blue is for all non- [illegible] residents. "

2. Review of the medical record for Resident #2 revealed she was a [illegible] admitted originally on [illegible] (Friday) discharged on [illegible] against medical advice and was re-admitted on [illegible] (Thursday) from the hospital, diagnoses included [illegible] ([illegible]) and lung [illegible]

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 155	Continued From page 15	F 155		

Review of the resident ' s Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 13; indicating the resident was intact.

Review of Resident #2 ' s Admission Agreement dated (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 !5: admitted for ; History of lung (remission); ; 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 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 code; 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 an Admission Evaluation Tool dated (Thursday): arrived via stretcher from hospital due to

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 bed mobility. for transfers, dressing, toileting, personal hygiene; on upper arms; alert and oriented x 3.

Review of Resident #2 ' s medical record revealed a Social Service Admission Evaluation Tool dated at 5:32 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.

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 . 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

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 155	Continued From page 17	F 155		

non-distended oriented to , signed by the Unit manager.

On (one week after admission) at 7:45 AM an interview was conducted with Resident # 2. She was observed sitting in a wheelchair at the bedside. When the resident was asked about her wishes for if needed, she stated she did not want . 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 wanted , she stated, " don ' t want that. " " Don ' t want my family to suffer through that. "

On 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 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.

Review of Resident #2 ' s medical record revealed Social Service Progress Note dated at 2:39 PM; which was a week after

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 18	F 155		

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 Resuscitation ( ) order was explained. Resident was agreeable at this time to sign order. Will follow up with order. Signed by SSD.

3. Review of the medical record revealed Resident #4 was an male admitted on (Friday) from the hospital with diagnoses that included dementia, , anemia and chronic kidney .

Review of Resident #4 ' s medical record, on , since admission ( ) revealed there was no form in the record.

Review of Resident #4 ' s Admission Agreement dated , revealed an Advanced Directives Acknowledgement form signed by the resident ' s daughter. All the blank lines on the form for initials to signify that the daughter had 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 were written on the line provided to designate the Code Status.

Review of Resident #4 ' s Admission Evaluation

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 19	F 155		

Tool dated (Sunday) (admission date of) revealed: arrived via wheel chair from hospital; diagnosis included , hematoma, , and chronic kidney ; advanced directives - no; resident appears to be capable of making healthcare decisions at this time; only speaks Spanish requiring a translator; requires limited assistance for bed mobility, transfers, dressing, toileting and personal hygiene; skin is pale, warm and dry; has poor balance and needs 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 years; rate regular; continent of and bowel; no pain; limited assist for ambulation; ¼ side rails 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 ( ) score of 6; indicating severe

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

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

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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
	105884	A. BUILDING _____ B. WING _____	C

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENTER	2611 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 20	F 155		

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 ' 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 at 11:45 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, spoken, /DNIs status noted. Skin has some abnormal findings right temple noted; nurse from hospital stated that a consult with / was ordered for bone shave/ Further review of the nurse ' s notes revealed at 2:30 PM: attending physician was called by the supervisor. Supervisor updated physician on re-admit. No new orders; it is okay to resume previous orders.

On 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, or on . She stated she took

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 21	F 155		

her father 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 about /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.

On 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 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 /DNI were 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

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

PRINTED: 08/07/2015
FORM APPROVED
OMB NO. 093 -0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 22	F 155		

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.

On at 1:49 PM an interview was 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. "

On 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 initiated for 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 dated at 2:46 PM (13 days after admission to the facility and 5 days after return 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 ( ) order was explained to the daughter. Resident #4 ' s daughter stated that she discussed with the entire family and family was agreeable to sign

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENTER	2511 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 23	F 155		

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

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 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 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 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,

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

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

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	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENTER	2511 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 24	F 155		

" 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 the NHA provided a " QA Book ". It 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 " ", " Advance 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 . The 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

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F 155	Continued From page 25	F 155		

code situation. Certified Nursing Assistants who are certified may be directed to assist with at the direction of the nurse. "

On signature sheets were provided for the following in-services, dated , 5/9, , , 6/7, , , and . In addition mock " Code Blue " drills were done on , , , , . 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:
On 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 the book. I would initiate until I determined if the resident had a order then I would stop . "

On 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

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

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F 155	Continued From page 26	F 155		

Code Blue drills a few months ago and again in . She also stated " If I found someone unresponsive; I would start , shout for someone to go to book. If they were a I would stop . I would call the physician and 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 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 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

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

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F 155	Continued From page 27	F 155		

right away, and if found they were a : would stop compressions. "

During the interview conducted on : at 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 : 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 : If they 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 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. " 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

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

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F 155	Continued From page 28	F 155		

, 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 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 for, 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 by the 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

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

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F 155	Continued From page 29	F 155		

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 were last reviewed, the 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:

On in-service signature sheets were reviewed for retraining of the nursing staff, regarding advance directives, , and 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

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

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F 155	Continued From page 30	F 155		

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.

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 advance directive, 100% of all admissions from 6/1/2015 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 to 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

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

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F 155	Continued From page 31	F 155		

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.

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

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F 155	Continued From page 32 Based on this information the Immediate Jeopardy was found to be removed on and the scope and severity was reduced to a D.	F 155		
F 156 SS=J	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during	F 156	1. Resident #1 Expired at the facility on 3-12-15. Advance Directives has been discussed with Resident's #2 and #4 6-25-15 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.	

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

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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, and 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 . Any identified areas of concern have been addressed. All current residents advance directives are being acknowledged per their request.

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

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F 156 Continued From page 34

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 receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on facility policy review, review of clinical records, and interviews with the facility staff, Medical Director, physician and family it was determined that the facility failed to implement their own policies and procedures for Advanced Directives, Emergency Procedure- ( ) and failed to honor the wishes to receive for one (#1) of 7 sampled residents of 61 residents identified as having Full Code status, according to an Advanced Directives List, provided by the facility and dated . The facility failed to initiate , in accordance with their Admission Agreement, on Resident #1, a male. The resident had a current physician order documenting his code status as " Full ", meaning that he wanted if found unresponsive.
On , Resident #1 was found unresponsive, without a pulse or less than 24 hours after admission. The Facility failed to honor the wishes of the resident to be . The facility failed to honor Resident #1 ' s advance directives and denied the resident the opportunity to receive emergency lifesaving services to profong his life.

F 156

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 re-educated related to Advance Directives, - , Code Blue Roles and Responsibilities on 6-23-15 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 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 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

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

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F 156	Continued From page 35	F 156		

Additionally, the facility failed to implement the Advance Directives policy for 2 (#2, #4) of 6 sampled residents out of a total of 29 residents listed as full code and recently admitted (after , 2015). Residents #2 and #4 wished to have a ( ) 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:

1. A review of the facility policy: " Advance Directives " (Revised April 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 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. " Policy Interpretation and Implementation, section " 5: In accordance with current OBRA definitions and guidelines

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 re-discussion at their quarterly care reviews.

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 36	F 156		

governing advance directives, our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to: b. -indicates that, in case of or failure, the resident, legal guardian, 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: " 1. 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 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 acute event (such as) differs substantially from the likelihood of recovering from that the end result of multi-system failure and advance irreversible or conditions. 5. Depending on the underlying cause, the chances of surviving SCA 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

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 QAPI Committee.

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 156	Continued From page 37	F 156		

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 /or external exists for that individual; "

Preparation for : "
1. Obtain and /or maintain American Red Cross or American Association certification in Basic Life Support (BLS/Cardiopulmonary ( ) 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 /BLS. 5. 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 administrating shall incorporate the steps

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

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F 156	Continued From page 38 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 if 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 . 6. 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 with a 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, , and 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 (MDS). " Steps in the Procedure: " 10. Determine if the resident has existing advance	F 156		

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 COMPLETED
	105984	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENTER	2611 CAMPUS HILL DR TAMPA, FL 33612

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F 156	Continued From page 39	F 156		

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. "

2. 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, 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

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

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F 156	Continued From page 40	F 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 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 .

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 readmission to the facility.

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 Review 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 failure, HCAP (Healthcare-associated), advance , VRE (-Resistant Enterococci) ( ) and

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 42	F 156		

(-resistant .)
(.). 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 or 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 , and . The resident has advance directives upon admission? NO. Are advance directives in the chart? NO. Activities of Daily Living: 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, rate 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,

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENTER	2611 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 43	F 156		

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 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 Status): of one person assistance required for bed mobility and dressing; total dependence required for eating and personal hygiene. Under Section H (and Bowel): Always of bowel and . Under Section I (Active Diagnoses): failure and . 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): A risk of developing . Under Section Q (resident ' s Overall Expectation): Expects to remain in this facility, by family.

Per the Nurse ' s Notes dated at 5:45

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 44	F 156		

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).

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 a Determination of Incapacity document dated and signed by his attending physician. It included the following language: As

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 COMPLE
	105884	A. BUILDING _____ B. WING _____	C

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 45 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. 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 ( ) 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, 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 wasn ' 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 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 pulse and , he was very cool to touch. He felt a little stiff in his upper	F 156		

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 46	F 156		

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 for a order, she stated, I looked at his chart after I called the doctor to tell him the resident had and I didn ' t see a . Honestly when I saw the 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 been 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 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 are or not. When asked what she would do in a situation wherein a resident is found

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 47	F 156		

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 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.

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 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 nospital, and then someone called and said he was .

On 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 and 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

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 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. 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.

On 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

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 156	Continued From page 49	F 156		

#1 she stated the DON informed her that the ADON had found the resident unresponsive and did not perform . 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 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 12:00 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, " 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 for all non- residents. "

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 50	F 156		

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, ( ), 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 on their chart, would be initiated and 911 called. My expectation is that the nurse would start if a 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 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 apologize, but I don ' t remember. "

3. Review of the medical record revealed Resident #4 was an male admitted on (Friday) from the hospital with diagnoses that included , hematoma, , and chronic kidney .

Review of Resident #4 ' s Admission Agreement, dated , revealed an Advanced Directives Acknowledgement form signed by the resident ' s daughter. All the blank lines on the form for initials to signify that the daughter had

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 were written on the line provided to designate the Code Status.

On 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 her father 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 about /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 ; advanced directives - NO; resident appears to be capable of making healthcare decisions at this time; only speaks Spanish requiring a translator; requires

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 52	F 156		

limited assistance for bed mobility, transfers, dressing, toileting and personal hygiene; skin is pale, warm and dry; has poor balance and needs 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 years; rate regular; continent of and bowel; no pain; limited assist for ambulation; ¼ side rails for bed mobility, signed by Employee C, an LPN.

Review of the Resident ' s 5 Minimum 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, lived 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 '

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 53	F 156		

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 at 11:45 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, spoken. /DNIs status noted. Skin has some abnormal findings right temple noted; nurse from hospital stated that a consult with / was ordered for bone shave/ . Further review of the nurse ' s notes revealed at 14:30: attending physician was called by the supervisor. Supervisor updated physician on re-admit. No new orders; it is okay to resume previous orders.

On at 1:00 PM (Thursday, 13 days after admission and 5 days after returning from overnight stay at hospital): an interview was conducted with the NHA, the DON, and the Corporate Nurse (CN). The NHA, the DON and the 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

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) DATE
F 156	Continued From page 54	F 156		

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 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 CN confirmed that the /DNI were 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.

On at 1:49 PM an interview was 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. "

On 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 initiated for her father. Employee G stated they are getting the paperwork together, and waiting on the incapacity certification from the physician.

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

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	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 CR...-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 55	F 156		

Review of Resident #4 ' s medical record revealed a Social Services (SS) progress note dated at 2:46 PM (13 days after admission to the facility and 5 days after return from overnight stay at hospital): 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 ( ) order was explained to the daughter. Resident #4 ' s daughter stated that she discussed with the entire family and family was agreeable to sign order for her father. SSD explained process of signing DNR, such as signing incapacity form, Health Care Proxy form and after that. Will follow up with order.

4. Review of the medical record for Resident #2 revealed she was a admitted originally on , discharged on against medical advice and was re-admitted on from the hospital, diagnoses included ( ) and lung .

Review of Resident #2 ' s Admission Agreement dated 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 .

Review of the resident ' s medical record revealed a 2015 Physician Order Sheet.

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 56	F 156		

under Code Status, there was a blank line. Neither Full Code nor were written on the line provided to designate the Code Status.

On (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 wishes for if needed, she stated she did not want . 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 wanted she stated, " don ' t want that. " " Don ' t want my family to suffer through that. "

Review of the Resident #2 ' s medical record since admission revealed there was no form in the record.

Review of Resident #2 ' s medical record (for her first admission) revealed an Admission Evaluation Tool dated : admitted for ; History of lung (remission); : 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 second admission) revealed an Admission Evaluation Tool dated : arrived via stretcher from hospital due to ; status post , smoker, lung ; advance directives - no; is the advance directives noted in the chart and communicated to staff - no;

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status ( ) score of 13; indicating the resident was intact.

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 code; 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 at 5:32 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 , lung . 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 Unit manager.

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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.

On 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.

On 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 ( )

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 59 order was explained. Resident was agreeable at this time to sign order. Will follow up with order. Signed by SSD. 5. 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 directives, , Code Blue 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 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 employees records for current she stated, " the Human Resource (HR) manager does an	F 156		

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 156	Continued From page 60	F 156		

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 the NHA provided a " QA Book ", it 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 " , " Advance 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 . The 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

From:7275521162 08/.. /.. 16:02 #065 P. ../..

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PRINTED: 08/07/2015
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F 156	Continued From page 61	F 156		

code situation. Certified Nursing Assistants who are certified may be directed to assist with at the direction of the nurse. "

On signature sheets were provided for the following in-services, dated , 3/21, 5/9, , 6/7, ; and In addition mock " Code Blue " drills were done on 5/28, 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:
On 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 the book. I would initiate until I determined if the resident had a order then I would stop "

On 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

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

PRINTED: 08/07/2015
FORM APPROVED
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F 156	Continued From page 62	F 156		

Code Blue drills a few months ago and again in .. She also stated " If I found someone unresponsive, I would start :, shout for someone to go to : book. If they were a I would stop :, I would call the physician and 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 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 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

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

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F 156	Continued From page 63	F 156		

right away, and if found they were a would stop compressions."

During the interview conducted on at 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 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 . If they 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 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." 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

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

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F 156	Continued From page 64	F 156		

, 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 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: DNR policy (which included what to look for, 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 by the 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

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

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F 156	Continued From page 65	F 156		

nursing staff that day.

On 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 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.

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

On in-service signature sheets were reviewed for retraining of the nursing staff, regarding advance directives, , , and 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

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

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FORM APPROVED
OMB NO. 0938-0391

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F 156	Continued From page 66	F 156		

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.

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 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 advance directive, 100% of all admissions contracts from : to 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 Clinical Nurse (CN). They stated they had initiated an audit on

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 COMPLETED
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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.

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

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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 SS=J 483.13(c) PROHIBIT 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 by:
Based on 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 failed to honor 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. 1. Resident #1 Expired at the facility on 3-12-2015. The family and physician were notified of the resident's passing.
2. 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.

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

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F 224	Continued From page 69	F 224		

, less than 24 hours after admission. The resident had a current physician order documenting his code status as " Full ", meaning that he wanted , if found 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 , resulted in 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 and : 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 prohibits , neglect, involuntary , and the misappropriation of property for all residents. "
. " 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

3. Policy and Procedure for and Neglect was reviewed by the QAPI Committee on and approved by the committee. Staff re-education was provided regarding the policy for , Neglect and Exploitation, Advance Directives, -Pulmonary and . All re-education will be completed by . This was provided by the ADON/Staff Development Coordinator. Mock Code Drills 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. Allegations of , Neglect and 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.

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 70	F 224		

serving the resident, family members or legal guardians, 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 488.301) "
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 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 constitutes , neglect and misappropriation of resident property. "
3. Prevention: Every effort is made on behalf of the resident to prevent . This includes an

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105684	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 71 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 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 any allegation of is for it to be brought immediately to the attention of the immediate supervisor. The supervisor is to notify the Social	F 224		

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 COMPLETED
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F 224	Continued From page 72	F 224		

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 , ...If the 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 guidelines 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 on (Wednesday) for skilled services with diagnoses that included but not limited to:

( ), and . Review of the Physician ' s Order Sheet (POS) dated and signed by the physician on revealed under Special Needs; Code Status: " Full " (handwritten).

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

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

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	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 224	Continued From page 73	F 224		

Per the Nurse ' s Notes dated at 5:45 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).

On 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 wasn ' 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 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 pulse and , he was 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 for a order, she stated, I looked at his chart after I called the doctor to tell him the resident had and I didn ' t see a ; Honestly when I saw the resident after the CNA called me he was cool to touch, I don ' t know if there was

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 74	F 224		

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 been 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 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 are 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 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.

On at approximately 5:00 PM an

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 224	Continued From page 75	F 224		

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

On 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 Assistant Director of Nursing (ADON) had found the resident unresponsive and did not perform . 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

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

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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 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 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, " should be done. " He has been the Medical Director for almost 4 years. " If the resident was	F 224		

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 224	Continued From page 77	F 224		

unresponsive they have to do . Code Blue is for all non- residents. "

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, ( ), 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 on their chart, would be initiated and 911 called. My expectation is that the nurse would start if a 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 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 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

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

PRINTED: 06/07/2015
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 COMPLETED
	105864	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 224	Continued From page 78	F 224		

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 designationsn(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 initialed by the resident and witnessed by Employee H on .

Review of the resident ' s Admissions peperwork 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

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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EXCEL REHABILITATION AND HEALTH CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 79	F 224		

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 .

Review of Resident #1 ' s medical record 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 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.

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

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 224	Continued From page 80	F 224		

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 readmission to the facility.

Review of Resident #1 ' s medical record 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 (Methicillin-resistant) (03/21/2014). During his hospital stay, a consultation was performed on due to

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

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

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EXCEL REHABILITATION AND HEALTH CENTER	2811 CAMPUS HILL DR TAMPA, FL 33612

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F 224	Continued From page 81	F 224		

having noted stools that were positive for occult . Laboratory data revealed hemoglobin of 8.6 and a platelet count of 335 indicating the patient was with occult ( ) loss. The patient did not show any signs or 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 ( ) form was present.

A review of the Nursing Admission Evaluation Tool dated at 3:00 PM revealed: patient 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 Living: 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. rate 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).

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

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

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F 224	Continued From page 82	F 224		

A review of Resident #1 ' s medical record, Social Service Admission Evaluation Tool document dated at 6:32 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 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 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 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):

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

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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
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 83 A risk of developing . Under Section Q (resident ' s Overall Expectation): Expects to remain in this facility; by family. On 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 and 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 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 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		

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 08/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 84	F 224		

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.

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 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. " 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 Resuscitate-Indicates that, in case of or failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no ( ) or other life-saving methods are to be used. "

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 85	F 224		

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: " 1. 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 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 acute event (such as) differs substantially from the likelihood of recovering from that the end result of multi-system failure and advance irreversible or conditions. 5. Depending on the underlying cause, the chances of surviving SCA 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:

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 86 a. it is known that a ( ) order that specifically prohibits and /or external exists for that individual. " Preparation for : " 1. Obtain and /or 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 /BLS. 5. 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 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 if the adult victim is unresponsive and not breathing	F 224		

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 87	F 224		

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 . 6. 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 with a 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, , and 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 (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

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 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 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 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 the NHA provided a " QA Book ", it

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 08/26/2015

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 89	F 224		

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 " " " Advance 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 . The 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 certified may be directed to assist with at the direction of the nurse. "

On signature sheets were provided for the following in-services, dated

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

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F 224	Continued From page 90	F 224		

3/21, 5/9, 5/20, , 6/7, , and 6/2 . In addition mock " Code Blue " drills were done on , 5/27, , . 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:

On 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 the book. I would initiate until I determined if the resident had a order then I would stop . "

On 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 someone to go to book. If they were a I would stop . I would call the physician and

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 91	F 224		

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 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 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 at 5:15 PM with the DON she stated that what she

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 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 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 if they 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 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 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 card after that. All nurses are supposed to be certified. " When asked if the facility had audited the

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 93	F 224		

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 for, 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 by the 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 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

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 94	F 224		

Procedure for advance directives and were 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:

On In-service signature sheets were reviewed for retraining of the nursing staff, regarding advance directives, , and 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 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

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 95	F 224		

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.

On 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 to 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

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 COMPLETED
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F 224	Continued From page 96	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 staff or if staff 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

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

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FORM APPROVED
OMB NO. 0938-0391

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F 224	Continued From page 97 and the scope and severity was reduced to a D.	F 224		
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on review of the Florida Nurse Practice Act, the Assistant Director of Nursing job description (Revised), resident record review and interviews with facility staff, Medical Director, a resident's father, and the attending physician, it was determined that the facility failed to ensure that services being provided met professional standards of quality relating to the initiation of ( ) as per the resident's wishes for one (#1) of 7 sampled residents of 81 total residents, identified as having Full Code orders, according to the facility's Advance Directive Audit List, provided by the facility and dated . On , Resident #1, a male, was observed by staff to be unresponsive and absent of vital signs, less than 24 hours after admission. The Assistant Director of Nursing did not initiate ( ) and ensure emergency medical services were provided. The clinical record contained a physician order for "Full" . The facility failed to follow their Policy and Procedure for "Emergency Procedures- ( )" (Revised 2011). The facility failed to honor Resident #1's advance	F 281	1. Resident #1 Expired at the facility on . Family and Physician were notified. 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 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 . Any 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.	

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

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OMB NO. 0938-0391

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F 281	Continued From page 98	F 281		

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 be limited to:
(a) " The observation, 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

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 re-educated 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 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

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

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F 281 Continued From page 99

upon the individual ' s educational preparation and experience in nursing. "

2. Review of the " Assistant Director of Nursing " job 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 nursing service department. Monitor the Facility ' s QI, QM and survey reports and provide the Director with recommendations that will be helpful in eliminating problem areas.

Committee Functions: Serve on the Quality

F 281

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 re-discussion at their quarterly care reviews.

From:7275521162

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

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

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	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 281	Continued From page 100	F 281		

Assurance and Assessment Committee, as directed. Assist the Director in preparing written and/or oral reports of the nursing service programs and activities to submit to such committee (s).
Personnel Functions: Assist the Director in determining the staffing needs of the nursing service department.
Nursing Care Functions: Provide the Director with information relative to the nursing needs of the resident and to the nursing services department ' s ability to meet those needs. Review nurses ' 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, , HIPAA, Prevention, Safety, 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

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 QAPI Committee.

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 COMPLETED
	105684	A. BUILDING _____ B. WING _____	C 06/26/2015

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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.

3. 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 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.

On at 1:00 PM an interview was conducted with the ADON, the nurse assigned to Resident #1 when he . She stated that she was taking care of him for the first time on

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 281	Continued From page 102	F 281		

; she took a shift because another employee called off. She stated the resident wasn ' 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 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 pulse and , he was 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 for a order, she stated, I looked at his chart after I called the doctor to tell him the resident had and I didn ' t see a . Honestly, when I saw the 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 been 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

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

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F 281	Continued From page 103	F 281		

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 are 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 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.

A review of the closed clinical record for Resident #1 revealed a Nurse ' s Note dated at 5:45 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).

Review of Resident #1 ' s 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 (Wednesday) for skilled

From:7275521162 ../.. 16:58 #056 P. .../...

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

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FORM APPROVED
OMB NO. 0938-0391

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	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 281	Continued From page 104	F 281		

services with diagnoses that included but not limited to: sepsis, ( ), and injury. Review of the Physician ' s Order Sheet (POS) dated and signed by the physician on revealed under Special Needs: Code Status: " Full " (handwritten).

Review of Resident #1 ' s physician orders dated revealed a Code Status of Full Code.

Review of Resident #1 ' s complete medical records revealed no ( ) form was present.

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 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 or 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

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

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F 281	Continued From page 105	F 281		

Tool dated at 3:00 PM revealed: patient 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 Living: 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. rate 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 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 revealed under Section C (Patterns): Staff Assessment for Mental Status: Short term memory: memory problem. Long term memory: memory problem. skills for Daily

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

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F 281	Continued From page 106	F 281		

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 Status): of one person assistance required for bed mobility and dressing; total dependence required for eating and personal hygiene. Under Section H (and Bowel): Always . of bowel and Under Section I (Active Diagnoses): failure and . 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): A risk of developing . Under Section Q (Resident ' s Overall Expectation); Expects to remain in this facility; by family.

On 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 and 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 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

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

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	105884	A. BUILDING _____ B. WING _____	C

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENTER	2611 CAMPUS HILL DR TAMPA, FL 33612

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F 281	Continued From page 107	F 281		

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 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 , 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.

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

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 COMPLETED
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F 281	Continued From page 108	F 281		

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 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 . 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 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. "

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	Continued From page 109	F 281		

The DON stated " the (ADON) decided on her own not to do ". The DON, stated " the nurse pronounced him "

On 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, " 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 for all non- residents. "

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.
( ), 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 DNR on their chart, would be initiated and 911 called. My expectation is that the nurse would start if a 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 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 apologize, but I don ' t remember. "

From:7275621162

08/07/2015 [illegible] 08/07/2015

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	105884	A. BUILDING _____ B. WING _____	C

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F 281	Continued From page 110	F 281		

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 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 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 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.

From:7275521162

16 19:03 #056 P.013/051

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F 281	Continued From page 111	F 281		

" Yes " .
On : the NHA provided a " QA Book " , it 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 " ", " Advance 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 : The 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 certified may be directed to assist with at the direction of the nurse. "

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

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F 281	Continued From page 112	F 281		

On signature sheets were provided for the following in-services, dated , 5/9, , 5/29, 6/7, , and . In addition mock " Code Blue " drills were done on , , , . 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:
On 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 the book. I would initiate until I determined if the resident had a order then I would stop ."

On 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 someone to go to book. If they were a

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

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F 281	Continued From page 113	F 281		

I would stop . I would call the physician and 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 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 DNR. " The training included: making sure we have advance directives, if resident is , speak with the family, check the chart for the 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 at

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 281	Continued From page 114	F 281		

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 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 if they 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 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. " 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 card after that. All nurses are supposed to be certified.

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

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F 281	Continued From page 115	F 281		

" 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 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 for, 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 by the 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 nursing staff that day.

On at 1:00 PM an interview was conducted with the NHA and the Corporate Nurse

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

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OMB NO. 0938-0391

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F 281	Continued From page 116	F 281		

(CN). When asked when the Policy and Procedure for advance directives and were 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:

On in-service signature sheets were reviewed for retraining of the nursing staff, regarding advance directives, , and 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 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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	Continued From page 117	F 281		

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.

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 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 to 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

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

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F 281	Continued From page 118	F 281		

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.

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	Continued From page 119 and the scope and severity was reduced to a D.	F 281		
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on review of facility ' s policies and procedures, resident record review, and interviews with facility staff, Medical Director, a resident ' s father, and the attending physician, it was determined that the facility failed to implement advance directives of ( ) in accordance with the written plan of care and physician ' s orders for one (#1) of 7 residents sampled, of 81 total residents, identified as having Full Code orders, according to the facility Advance Directive Audit List, provided by the facility and dated . On , Resident #1, a male, was discovered by the staff unresponsive, without pulse or less than 24 hours after admission. The facility failed to initiate ( ) or contact Emergency Medical Services as per the resident ' s wishes. The clinical record contained a physician order for full . The facility failed to follow their Policy and Procedure for " Advance Directives " (Revised 2008), and " Emergency Procedures-	F 282	1. Resident #1 Expired at the facility on 3-12-15. The family and physician were notified of the resident's passing. 2. A review was completed for advance directives on this included a review of current full code, and physician orders. A review as completed by to assure that all resident with advance directives also have Comprehensive Care Plans addressing the resident's advance directive wishes. A review will be 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.	

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 282 Continued From page 120

( ) " (Revised April 2011). The facility failed to honor Resident #1 ' s advance directives and denied the resident the opportunity to receive emergency lifesaving services to prolong his life.
The staff did not ensure the resident ' s advance directives, which were in effect for Full Code, were carried out in accordance with the resident ' s plan of care.

Additionally, interviews with 4 of 8 licensed nurses (Employees C, D, E, & F) on and revealed they would begin performing without first verifying the plan of care and physician orders in the event a resident was found without pulse or

Failure to follow the plan of care for Resident #1 and to ensure the facility staff correctly implemented advance directives and initiated resulted in Immediate Jeopardy, which was removed on , and the severity and scope was reduced to D.

Findings Include:

1. 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 (Wednesday) for skilled services with diagnoses that included but not limited to: ( ), and . Review of the Physician ' s Order Sheet (POS) dated and signed by the physician on revealed under Special Needs; Code Status: " Full " (handwritten).

F 282

3. Staff has been re-educated regarding following the resident's Comprehensive Care Plan and implementation of Physician's orders for advance directives including full code/ status. This will be completed by . This education was provided by the ADON/Staff Development Coordinator. All new admissions and residents who have obtained new orders for advance directives will be reviewed in the daily clinical meeting to assure that resident's wishes for advance directives are acknowledged and implemented. Mock Code Drills will continue as per the previous QAPI Plan, the most recent being 7-6-15. 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.
4. This area of care will be monitored by the Director of Nursing/Social Services Director/Designee weekly times four weeks and then quarterly. A Data Collection Tool will be utilized to complete the monitoring. This will also be over seen by the Administrator and the QAPI Committee for ongoing compliance.

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F 282	Continued From page 121	F 282		

Review of Resident #1 ' s physician orders dated 2/19/2015 revealed a Code Status of Full Code.

Review of Resident #1 ' s complete medical record including the closed record revealed no Do Not ( ) form was present.

A review of the Nursing Admission Evaluation Tool dated at 3:00 PM, patient 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 Living: 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. rate 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 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, , and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan and completing required assessment instruments, including the minimum date set (MDS). " Steps in the Procedure: " 10. Determine if the resident has existing advance directives. If so, initiate the process of obtaining a

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

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F 282	Continued From page 122	F 282		

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.

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 (Methicillin-resistant) ( ). 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 or 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 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

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

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F 282	Continued From page 123	F 282		

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, 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 .

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

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

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F 282	Continued From page 124	F 282		

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 .

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 a Determination of Incapacity document dated and signed by his attending

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105684	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 125	F 282		

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.

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 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. " 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. -Indicates that, in case of or failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no ( ) or other life-saving methods are to be used. "

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

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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
	105854	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 126 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 readmission to the facility. Review of Resident #1 ' s medical record 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 3/1 readmission to the facility. 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	F 282		

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

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F 282	Continued From page 127	F 282		

(MDS) assessment dated revealed under Section C (Patterns): Staff Assessment for Mental Status: Short term 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 Status): of one person assistance required for bed mobility and dressing; total dependence required for eating and personal hygiene. Under Section H (and Bowel): Always of bowel and . Under Section I (Active Diagnoses): failure and . 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): A risk of developing . Under Section Q (Resident ' s Overall Expectation): Expects to remain in this facility; by family.

Per the Nurse ' s Notes dated at 5:45 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).

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

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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 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 and got on " crack ". 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, after he get on that " crack. " 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 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 ( ) 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, the nurse assigned to

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

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FORM APPROVED
OMB NO. 0938-0391

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	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 282	Continued From page 129	F 282		

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 wasn ' 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 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 pulse and , he was 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 for a order, she stated, I looked at his chart after I called the doctor to tell him the resident had and I didn ' t see a . Honestly when I saw the 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 been 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

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 yellow 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 she 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.

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: " 1. 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 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

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENTER	2811 CAMPUS HILL DR TAMPA, FL 33612

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F 282	Continued From page 131	F 282		

acute event (such as) differs substantially from the likelihood of recovering from that the end result of multi-system failure and advance irreversible or conditions. 5. Depending on the underlying cause, the chances of surviving SCA 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 /or external exists for that individual; "

Preparation for :"
1. Obtain and /or 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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 132	F 282		

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 /BLS. 5. 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 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 If 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 . 6. 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 with a compression - ratio of 30:2. "

On at approximately 10:00 AM, an

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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	105884	A. BUILDING _____ B. WING _____	C

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F 282	Continued From page 133	F 282		

interview was conducted with Resident #1 ' s attending physician. The physician stated the resident had multiple problems including: multible 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 on their chart, would be initiated and 911 called. My expectation is that the nurse would start if a was not on the chart. "

On 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, " should be done. " He has been the Medical Director for almost 4 years. " If the resident was unresponsive they have to do CPR. Code Blue is for all non- residents. "

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 attending physician on , but doesn ' t remember the call as she states 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. "

On 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 and

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

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

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	105984	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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 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. 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.

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

PRINTED: 08/07/2015
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	105684	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 282	Continued From page 135	F 282		

On 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 . 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 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. The DON 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, 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 she reviewed the medical record and " 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 . "

2. 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

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

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FORM APPROVED
OMB NO. 0938-0391

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F 282	Continued From page 136	F 282		

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 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 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 March 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 the NHA provided a " QA Book ", it contained the Quality Assurance Performance Improvement Plan for review. The tool was

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

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

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F 282	Continued From page 137	F 282		

dated and signed by the Quality Assurance team including the Medical Director on . A review of the information provided revealed policy revisions dated for " " Advance Directives " which includes " Code Blue Roles and Responsibilities " " 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 . The 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 certified may be directed to assist with at the direction of the nurse. "

On signature sheets were provided for the following in-services. dated , 5/9, , 6/7, , and .

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

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	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 282	Continued From page 138	F 282		

. In addition mock " Code Blue " drills were done on , , 5/28, . 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:

On 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 the book. I would initiate until I 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 someone to go to book. If they were a I would stop . I would call the physician and family. If they were a full code I would keep going

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

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	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 282	Continued From page 139 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 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 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 at 5:15 PM with the DON she stated that what she would expect that if a resident was found	282		

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 COMPLETED
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F 282	Continued From page 140 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 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 if they 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 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. " 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 card after that. All nurses are supposed to be certified. " When asked if the facility had audited the employee records for current , she stated "	F 282		

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 COMPLETED
	105864	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 141	F 282		

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 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 for, 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 by the 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 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 were

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

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FORM APPROVED
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F 282	Continued From page 142	F 282		

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.

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

On in-service signature sheets were reviewed for retraining of the nursing staff, regarding advance directives, , and 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 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

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

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F 282	Continued From page 143	F 282		

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.

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 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 6/1/2015 to 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 went through all admission paperwork for

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENTER	2811 CAMPUS HILL DR TAMPA, FL 33612

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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.

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

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	105884	A. BUILDING _____ B. WING _____	C 08/26/2015

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F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490		

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy and procedure review for " Advance Directives ", " Emergency Procedures- ( ) ", " Code Blue Roles and Responsibilities " and " , Neglect and ", Nursing Home Administrator job description, and interviews with staff, family and physicians, it was determined the administration of the facility failed to use its resource management to ensure that the resident`s rights to receive emergency services ( ) and exercise advance directives was protected for one (#1) of 7 sampled residents of 61 residents identified as having Full Code status, according to the Advance Directive Audit Tool, provided by the facility and dated .
On Resident #1, a male, 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 . The facility'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

1. Resident #1 Expired at the facility on . The family and physician were notified of the resident's passing.
2. A full facility review was completed for advance directives on , this included a review of a current full code, and physician orders. Also a review was completed on 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.

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

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F 490 Continued From page 146

Long Term Care facilities related to implementing policies and procedures for [redacted] neglect prevention, and advance directives.
The administration ' s failure to ensure that the resident ' s expressed wishes related to advance directives and the right to receive was protected, led to the findings of Immediate Jeopardy which were removed 5 and the severity and scope was reduced to a D.

Findings include:
1. Review of the " Administrator " job description (Revision Date:) included: " The primary purpose of your position is to direct the day-to-day functions of the Facility in accordance with current federal, state and local standards guidelines and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times. As Administrator you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. "
Duties and Responsibilities:
Administrative Functions: " Review the Facility ' s policies and procedures at least annually and make changes as necessary to assure continued compliance with current regulations. Interpret the Facility ' s policies and procedures to employees, residents, family members, visitors, government agencies, etc., as necessary. Ensure that all employees, residents, visitors, and the general public follow the Facility ' s established policies and procedures. "
Committee Functions: " Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies.

F 490

3. The following policies and procedures were reviewed and revised as necessary, Advance Directives, - , Do Not Resuscitate Order, and Quality Assurance/Performance Improvement, at 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 by utilizing 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. Facility operations will be overseen by the Administrator/Medical Director on an ongoing basis.
4. Facility operations will be monitored by the Administrator and the Medical Director on a monthly basis and identified areas of concern will be addressed by them through the QAPI process.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 490	Continued From page 147	F 490		

Evaluate and implement recommendations from the Facility ' s committees as necessary. "
Personnel Functions: Ensure that an adequate number of appropriately trained licensed professional and non-licensed personnel are on duty at all times to meet the needs of the residents. Review and check competence of work force and make necessary adjustments or corrections as required or that may become necessary. Review and check competence of work force and make necessary adjustments or corrections as required or that may become necessary. Council and discipline personnel, as requested or as necessary. Inform the Medical Director of all suspected or known incidents of resident . "
Staff Development: " Assist department directors in the topic selection, planning, conducting, and scheduling of in-service trainings classes and on-the-job training and orientation programs to assure that current material and programs are continuously provided. "
Resident Rights: " Ensure that the resident ' s rights to fair and equitable treatment, self-determination, individuality, privacy, property, and civil rights, including the right to wage complaints, are well established and maintained at all times. Report all allegations of resident and/or misappropriation of resident property. "
A review of the facility policy: " , Neglect and : 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 prohibits , neglect, involuntary , and the misappropriation of property for all residents. "

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

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OMB NO. 0938-0391

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	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 490	Continued From page 148	F 490		

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 serving the resident, family members or legal guardians, 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 488.301) "
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 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.

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

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F 490	Continued From page 149	F 490		

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

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

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OMB NO. 0938-0391

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F 490	Continued From page 150	F 490		

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 protect any individual form ..., ...If the 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 guidelines 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

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

PRINTED: 09/07/2015
FORM APPROVED
OMB NO. 0938-0391

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F 490	Continued From page 151	F 490		

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. " 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. -Indicates that, in case of or failure, the resident, legal guardian, 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: " 1. is defined as inadequate resulting in insufficient flow throughout the body (pulseelessness). 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

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

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OMB NO. 0938-0391

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F 490	Continued From page 152	F 490		

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 from that the end result of multi-system failure and advance irreversible or conditions. 5. Depending on the underlying cause, the chances of surviving SCA 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 r 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 /or external exists for that individual; "

Preparation for Resuscitation: 1. Obtain and /or 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

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 COMPLETED
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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 /BLS. 5. 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 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 if 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 . 6. 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 with a compression - ratio of 30:2. "

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

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F 490	Continued From page 154	F 490		

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, , and 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 (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. "

2. On 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 Director of Nursing (DON) informed her that the Assistant Director of Nursing (ADON) had found the resident unresponsive and did not perform 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

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 490	Continued From page 155	F 490		

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. " DON stated " the (ADON) decided on her own not to do ". The DON, stated " the nurse pronounced him . "

On : at approximately 5:00 PM an interview was conducted via telephone with Employee A, the 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 ( ) 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, 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 wasn ' t verbal, he required total care and had been

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 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 pulse and , he was 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 for a order, she stated, I looked at his chart after I called the doctor to tell him the resident had and I didn ' t see a . Honestly when I saw the 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 been 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 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

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

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

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	105884	A. BUILDING _____ B. WING _____	C

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F 490	Continued From page 157	F 490		

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 are 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 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.

3. 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 Review 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 failure, HCAP (Healthcare-associated) advance , VRE (-Resistant Enterococci) ( ) and (Methicillin-resistant) ( ). During his hospital stay, a

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 490	Continued From page 158	F 490		

consultation was performed on due to having noted stools that were positive for occult . Laboratory data revealed hemoglobin of and a platelet count of 336 indicating the patient was with occult ( ) loss. The patient did not show any s nt 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 ambulance from hospital with and . The resident has advance directives upon admission? NO. Are advance directives in the chart? NO. Activities of Daily Living: 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. rate regular and audible, pulse rate equal and . Breath sounds clear. 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 included the following information: the resident was had resided with his father in the past, was a h school graduate and had been in the Marines for 10 years. It also included the

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 490	Continued From page 159	F 490		

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 . 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 Status): of one person assistance required for bed mobility and dressing; total dependence required for eating and personal hygiene. Under Section H (and Bowel): Always of bowel and . Under Section I (Active Diagnoses): failure and . 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): A risk of developing . Under Section Q (resident ' s Overall Expectation): Expects to remain in this facility; by family.

Per the Nurse ' s Notes dated at 5:45 AM: " this nurse called to Certified Nursing Assistant (CNA). Resident noted with no

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 COMPLETED
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F 490 Continued From page 160

, 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).

Review of Resident #1 ' s complete medical record including the closed record revealed no ( ) form was present.

On 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, " 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 for all non- residents. "

On 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 on their chart, would be initiated and 911 called. My expectation is that the nurse would start if a was not on the chart. "

F 490

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 490	Continued From page 161 On at 2:40 PM, a telephone interview was conducted with the covering physician who received the call regarding Resident #1 on 03/12/2015. 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 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. 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	F 490		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 490	Continued From page 162	F 490		

and witnessed by Employee H on 3/10/2014.

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 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 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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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EXCEL REHABILITATION AND HEALTH CENTER	2811 CAMPUS HILL DR TAMPA, FL 33612

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F 490	Continued From page 163	F 490		

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 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.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105984	A. BUILDING _____ B. WING _____	C

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 164	F 490		

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

Review of Resident #1 ' s medical record 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 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 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 490	Continued From page 165	F 490		

Assistant regarding Resident #1 ' s Social Service Admission Evaluation Tool dated and 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 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 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. 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

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 166 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 on (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 ( ) score of 13; indicating the resident was intact. Review of Resident #2 ' s Admission Agreement dated (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 ; History of lung (remission); : 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	F 490		

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 MPLETED
	105834	A. BUILDING _____ B. WING _____	C 1/26/2015

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 167 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 code; ... 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 an Admission Evaluation Tool dated ... (Thursday): arrived via stretcher from hospital due to ... status post ..., ..., smoker, lung ...; advance directives - no; is the advance directives noted in the chart and communicated to staff - no; independent in bed mobility, ... for transfers, dressing, toileting, personal hygiene; ... on upper ... arms; alert and oriented x 3. Review of Resident #2 ' s medical record revealed a Social Service Admission Evaluation Tool dated ... at 5:32 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. 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	F 490		

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 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

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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 , status post , , lung . 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 Unit manager.

On (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 wishes for if needed, she stated she did not want . 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 wanted , she stated, " don ' t want that. " " Don ' t want my family to suffer through that. "

On 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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 490	Continued From page 169	F 490		

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.

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 ( ) order was explained. Resident was agreeable at this time to sign order. Will follow up with order. Signed by SSD.

5. Review of the medical record revealed Resident #4 was an male admitted on (Friday) from the hospital with diagnoses that included , and hematoma, chronic kidney .

Review of Resident #4 ' s medical record, on , since admission ( ) revealed there was no form in the record.

Review of Resident #4 ' s Admission Agreement dated , revealed an Advanced Directives Acknowledgement form signed by the resident ' s daughter. All the blank lines on the form for initials to signify that the daughter had

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 490	Continued From page 170	F 490		

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 DNR were written on the line provided to designate the Code Status.

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 ; advanced directives - no; resident appears to be capable of making healthcare decisions at this time; only speaks Spanish requiring a translator; requires limited assistance for bed mobility, transfers, dressing, toileting and personal hygiene; skin is pale, warm and dry; has poor balance and needs 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 years; rate regular; continent of and bowel; no pain; limited assist for ambulation; ¼ side rails 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; indicating severe

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

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

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F 490	Continued From page 171	F 490		

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 ' 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 at 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, spoken, /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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. BUILDING _____ B. WING _____	C

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 490	Continued From page 172	F 490		

Supervisor updated physician on re-admit. No new orders; it is okay to resume previous orders.

On 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, or on . She stated she took her father 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 about /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.

On 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

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 490	Continued From page 173	F 490		

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 /DNI were 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.

On at 1:49 PM an interview was 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. "

On 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 initiated for 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 dated at 2:46 PM (13 days after admission to the facility and 5 days after return

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 490	Continued From page 174	F 490		

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 ( ) order was explained to the daughter. Resident #4 ' s daughter stated that she discussed with the entire family and family was agreeable to sign order for her father. SSD explained process of signing , such as signing Incapacity form, Health Care Proxy form and after that. Will follow up with order.

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 directives, ( ), Code Blue 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 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

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

PRINTED: 06/07/2015
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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

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F 490	Continued From page 175	F 490		

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 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 cards. " 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 dated and signed by the Quality Assurance team including the Medical Director on . A review of the information provided revealed policy revisions dated for " Do Not Order ", " Advance Directives " which includes " Code Blue Roles and Responsibilities " and " Emergency Procedure - Resuscitation. "

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

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EXCEL REHABILITATION AND HEALTH CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 176	F 490		

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 . The 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 certified may be directed to assist with at the direction of the nurse. "

On signature sheets were provided for the following in-services, dated , 5/9, , 6/7, , and . In addition mock " Code Blue " drills were done on , , . 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:
On 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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENTER	2811 CAMPUS HILL DR TAMPA, FL 33612

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F 490	Continued From page 177	F 490		

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 the book. I would initiate until I determined if the resident had a order then I would stop ."

On 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 someone to go to book. If they were a , I would stop . I would call the physician and 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 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. "

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 178	F 490		

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

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

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

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	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 490	Continued From page 179	F 490		

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. " 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 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 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. "

On 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

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 490	Continued From page 160	F 490		

for, ... 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 ... by the 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 nursing staff that day.

On ... st 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 ... were 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.

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

On ... in-service signature sheets were reviewed for retraining of the nursing staff, regarding advance directives, ... , and

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 490	Continued From page 181	F 490		

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 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.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 490	Continued From page 182	F 490		

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 to 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 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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 490	Continued From page 183 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 Immediate Jeopardy was found to be removed on 06/26/2015 and the scope and severity was reduced to a D.	F 490		
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		

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

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

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F 520 Continued From page 184

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary, and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on interviews with facility staff, the Attending Physician, the Medical Director, facility administration, resident record review, QAA (Quality Assessment and Assurance) review, and review of the facility' s policy and procedures related to its " Advance Directives " (Revised ... 2008), " Emergency Procedure- " (Revised ... 2011) and " , Neglect and ... " (no date) it was determined the facility failed to demonstrate a system to implement plans of action to correctly identify deficiencies regarding honoring the resident ' s rights to have ( ) in the event of . The facility failed to demonstrate a system to implement plans of action to identify and correct quality deficiencies following the survey of as well as the survey on , which resulted in findings of Immediate Jeopardy. During the

F 520

1. Resident #1 expired at the facility on ... The family and physician were notified of the resident's passing.
2. A full facility review was completed for advance directives on ; this included a review of all current full code, and physicians 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 advance directives, implementation of ... " ... and ... are currently implemented and resident wishes for advance directives are being honored by the facility staff.

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 COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

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F 520 Continued From page 185

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 quality of care.

During the survey on , 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 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 failed to honor the resident ' s Advanced Directive and he without the opportunity to be by receiving the services of .

The facility failed to follow through on measures to ensure sustained compliance with standards of practice (F281); care plan implementation (F282) and the of Administration to manage resources effectively (F490). The lack of a sustained Quality Assurance Plan (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:

F 520

3. The following policies and procedures were reviewed and revised as necessary, Advance Directives, - Resuscitation, Do Not Order, /Neglect/ , Grievances and Quality Assurance/Performance Improvement, at 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 utilizing 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 bi monthly times 2 months, then monthly. Facility operations will be overseen by the Administrator/Medical Director on an ongoing basis.
4. 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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 520	Continued From page 186	F 520		

1. The Plan of Correction, following the survey of , with a completion date of , for F 490, the facility administration failing to administer effectively and utilize resources to assure residents were safe and received quality of care regarding education and training of staff on QAPI, provided that: " Education has been provided to the QAPI committee including the Administrator on the QAPI process by the Nurse Consultant on utilizing CMS QAPI at a Glance educational materials. The QAPI Committee will utilize this for continued identification, analysis and planning for identified opportunities for improvement in the facility. The Medical Director also participated in this educational program and is current with the QAPI . Identified opportunities for improvement will be brought to the QAPI Committee for review and implementation of the QAPI process. Meetings are currently being held on weekly basis times eight weeks and then bi-monthly times eight weeks and the monthly. Facility operations will be overseen by the Administrator/ Medical Director on an ongoing basis. Facility operations will be monitored by the administrator and the Medical Director on a monthly basis and identified areas of concern will be addressed by them through the QAPI Process. The Plan of Correction for F F282, following the survey of , with a completion date of , for the facility failing to ensure care planning interventions / approaches were implemented to assure resident safety and quality of care revealed: " nursing staff has been re-educated on 5-19, 20, 21, and 22, 2015 on assuring that the resident ' s comprehensive care plans are being followed. "
Additionally, the Plan of Correction for F 282,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105684	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 187	F 520		

following the survey of , with a completion date of , for the facility failing to identify, implement and monitor a known deficient system revealed: " Education has been provided to the QAPI Committee including on utilizing CMS QAPI at a Glance educational materials. The QAPI Committee will utilize this for continued identification, analysis and planning for identified opportunities for improvement in the facility. The Medical Director also participated in this educational program and is current with the QAPI . 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 on a weekly basis times eight weeks and then bi-monthly times eight weeks and the monthly. QAPI will be monitored by the Nurse Consultant bi-monthly for three months and then quarterly. This program will also be over seen by the Administrator and the Medical Director on an ongoing basis. "

2. On at 5:00 PM, an interview was conducted with the NHA regarding the facility ' s response to the event of Resident #1 not receiving on when found unresponsive. 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 for . We interviewed 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
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 188	F 520		

.....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 ".

3. On the NHA provided a " QA Book. " It 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 " ", " Advance Directives " which includes " Code Blue Roles and Responsibilities " and " Emergency Procedure -

Review of these revisions revealed the following

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 520	Continued From page 189	F 520		

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 . The 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 ... certified may be directed to assist with ... at the direction of the nurse. "

On signature sheets were provided for the following In-services, dated , , ..., 5/8, 5/20, 5/29, 6/7, 6/18, 6/19, and ... In addition mock " Code Blue " drills were done on , , , . 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.

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

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

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	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 520	Continued From page 190	F 520		

4. 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:

On 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 the book. I would initiate until I determined if the resident had a order then I would stop ."

On 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 someone to go to book. If they were a I would stop . I would call the physician and 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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 191	F 520		

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 yellow DNR 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. "

5. During the interview conducted on at 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 class. " When asked if that was in the facility policy, she

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105684	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 192	F 520		

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 if they 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 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. " 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 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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105984	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 193	F 520		

direction I got was to do education, and do mock codes, and file a federal report. "

On : 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 for, 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 by the 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 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 were 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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENTER	2811 CAMPUS DR TAMPA, FL 33612

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F 520	Continued From page 194	F 520		

6. 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 , Wednesday, for skilled services with diagnoses that included but not limited to: ( ), and brain injury. Review 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 failure, HCAP (Healthcare-associated), advanca , VRE (-Resistant Enterococci) ( ) and (-resistant) (-). 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 sepsis and

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 195	F 520		

. The resident has advance directives upon admission? NO. Are advance directives in the chart? NO. Activities of Daily Living: 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. rate 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.

Review of Resident #1 ' s complete medical record including the closed record revealed no form was present.

Review of Resident #1 ' s physician orders dated revealed a Code Status of Full Code.

A review of the Admission Minimum Data Set

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 520	Continued From page 196	F 520		

(MDS) assessment dated 03/ ; 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 Status): of one person assistance required for bed mobility and dressing; total dependence required for eating and personal hygiene. Under Section H (and Bowel): Always of bowel and . Under Section I (Active Diagnoses): failure and . 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): A risk of developing . Under Section Q (Resident ' s Overall Expectation): Expects to remain in this facility, by family.

Per the Nurse ' s Notes dated ; at 5:45 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).

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 197	F 520		

On 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 wasn ' 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 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 pulse and , he was 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 for a order, she stated, I looked at his chart after I called the doctor to tell him the resident had and I didn ' t see a . Honestly when I saw the 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 been 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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

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F 520	Continued From page 198	F 520		

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 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 are 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 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.

On at approximately 5:00 PM an interview was conducted via telephone, with Employee A, the 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 (_ _) on Resident #1 and that she did not recall anything else about the resident.

On at 1:15 PM an interview was

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C

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F 520	Continued From page 199	F 520		

conducted with Employee G a Social Services Assistant regarding Resident #1 ' s Social Service Admission Evaluation Tool dated and 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 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 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. 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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 200 Full Code since his original admission in of 2014 and had never had a paper in his medical record. 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 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 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 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	F 520		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 201	F 520		

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 [illegible]. The DON stated "the [illegible]

On [illegible] 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 [illegible], the day Resident #1 [illegible] she stated the DON informed her that the ADON had found the resident [illegible] unresponsive and did not perform [illegible]. The NHA stated in her opinion the ADON should have looked at the chart and initiated [illegible].

On [illegible] at 2:40 PM, a telephone interview was conducted with the covering physician who received the call regarding Resident #1 on [illegible]. She stated she was covering for the attending physician on [illegible], 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 [illegible], she stated, "I apologize, but I don't remember."

On [illegible] 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 [illegible] issues, ([illegible]), and [illegible]. "He did not look well at all. He was thin and looked 90. He was new to

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

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

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	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 202	F 520		

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 on their chart, would be initiated and 911 called. My expectation is that the nurse would start if a was not on the chart. "

On 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, " 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 for all non- residents. "

Review of the resident ' 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, Do Not

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FORM APPROVED
OMB NO. 0938-0391

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

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F 520	Continued From page 203	F 520		

. . . . . Order/ /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 initialed 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 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 .

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

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FORM APPROVED
OMB NO. 0938-0391

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

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	105884	A. BUILDING _____ B. WING _____	C 06/26/2015

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F 520	Continued From page 204	F 520		

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 readmission to the facility.

Review of Resident #1 ' s medical record 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.

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,

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	Continued From page 205	F 520		

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 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 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.

7. A review of the facility policies:

A review of the facility policy: " , Neglect and : 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 prohibits , neglect, involuntary , and the misappropriation of property for all residents. "

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 serving the resident, family members or legal guardians, 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

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

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F 520	Continued From page 206	F 520		

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 488.301) "
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 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 constitutes ..., neglect 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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 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. 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
FORM APPROVED
OMB NO. 0938-0391

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

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F 520	Continued From page 208	F 520		

protect any individual form ...., ...If the 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 ... guidelines will also be followed by the ... reporting designee.

A review of the facility policy: " Advance Directives " (Revised ... 2006), 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 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. " Policy Interpretation and implementation, section " 5: In accordance with current OBRA definitions and guidelines

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

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F 520	Continued From page 209	F 520		

governing advance directives, our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to: b. -Indicates that, in case of or failure, the resident, legal guardian, 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: " 1. 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 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 acute event (such as) differs substantially from the likelihood of recovering from that the end result of multi-system failure and advance irreversible or conditions. 5. Depending on the underlying cause, the chances of surviving SCA 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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	Continued From page 210	F 520		

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 (DNR) order that specifically prohibits and /or external exists for that individual; "

Preparation for : "
1. Obtain and /or maintain American Red Cross or American Association certification in Basic Life Support (BLS/Cardiopulmonary ( ) 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 /BLS. 5. 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

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

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F 520	Continued From page 211	F 520		

administrating shall incorporate the steps covered in the 2010 American Association Guidelines for Care or facility and Emergency 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 if 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 . 6. 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 with a 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, , and 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 (MDS). " Steps in the Procedure: " 10.Determine if the resident has existing advance

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F 520	Continued From page 212	F 520		

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:

On in-service signature sheets were reviewed for retraining of the nursing staff, regarding advance directives, , and 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.

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

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N 000	INITIAL COMMENTS SKILLED NURSING FACILITY COMPLAINT INVESTIGATION CCR#2015005834 was conducted on Excel Rehabilitation and Health Care Center had deficiencies found at the time of the visit. Class I was identified at N0201 The Administrator was informed of the Class I on at 5:31 PM.	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 correction is prepared and submitted solely because of the requirements under State and Federal law. **This plan of correction will serve as the Facility's allegation of substantial compliance.**	/
N 201 SS=J	400.022(1)(l), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on facility and resident record review, interviews with the facility ' s nursing and administrative staff, family, the Medical Director and review of the facility policies, it was determined that the facility failed to ensure health care and support services consistent with life sustaining wishes for one (#1) of 7 sampled residents of 81 total residents, Identified as having Full Code status according to the Advance Directives Audit tool dated . The	N 201	1. Resident #1 Expired at the facility on . The family and physician were notified of the resident's passing. 2. A full facility 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 Advance Directives, Implementation of and are currently implemented and resident wishes for advance directives are being honored by the facility staff. Accepted 7/20/15	/

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7/16/15

STATE FORM 6899 J5QX11 If continuation sheet 1 of 28

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 201	Continued From page 1 facility failed to initiate ( ) on Resident #1, who was a male. The clinical record contained a physician order for Full . On Resident #1 was discovered unresponsive, without pulse or . The facility failed to ensure that or Emergency Medical Services were contacted to honor the advance directives and wishes of the resident. The facility failed to protect the rights of Resident #1 by denying the resident the opportunity to receive emergency lifesaving services to prolong his life. Findings include: 1. A review of the facility policy: " , Neglect and : 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 prohibits , neglect, involuntary , and the misappropriation of property for all residents. " 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 serving the resident, family members or legal guardians, 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	N 201	3. The facility's policy and procedures for Advance Directives, - and was reviewed and revised by the QAPI Committee on . Licensed Nursing Staff has been re-educated related to Advanced Directives, - , Code Blue Roles and Responsibilities on . Re-education will be provided again and will be completed by . This has been provided by the ADON/Staff Development Coordinator. When a resident is admitted to the facility the Social Services Director/Designee with provide the resident with written info ,("Questions about Health Care Advanced Directives"). The resident/responsible party will sign an acknowledgement form confirming that they have received this information. A meeting was held with the Resident Council by , the Social Services Director will provide education regarding Advance Directives, Resident Rights and Responsibilities and . The facility policies for these areas of care were reviewed. All new admissions and residents who have obtained new orders for advance directives will be reviewed at the daily clinical meeting to assure that resident wishes for advance directives are acknowledged and implemented. 4. This will be monitored by the Social Services Director/Designee weekly times four weeks and then monthly utilizing a Data Collection Tool. This will also be over seen by the Administrator and the QAPI Committee for ongoing compliance.	

Agency for Health Care Administration

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N 201	Continued From page 2 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 488.301) " 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 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 constitutes , neglect 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	N 201		

Agency for Health Care Administration

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N 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 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 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 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 protect any individual form , ...If the allegation of is against a team member, the team member will be immediately removed from duty during the investigation, and until it is complete.	N 201		

Agency for Health Care Administration

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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 , neglect, and , guidelines 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 on (Wednesday) for skilled services with diagnoses that included but not limited to: , , , ( ), and . Review of the Physician ' s Order Sheet (POS) dated and signed by the physician on revealed under Special Needs; Code Status: " Full " (handwritten). Per the Nurse ' s Notes dated at 5:45 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	N 201		

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N 201	Continued From page 5 Nursing (ADON). On at 1:00 PM an interview was conducted with the ADON, the nurse assigned to the resident when he l. 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 wasn ' 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 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 pulse and , he was 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 for a order, she stated, I looked at his chart after I called the doctor to tell him the resident had l and I didn ' t see a , Honestly when I saw the 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 l and stiff; I did not know how long he had been 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.	N 201		

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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 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 are 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 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.

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

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N 201	Continued From page 7	N 201		

On 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 Assistant Director of Nursing (ADON) had found the resident unresponsive and did not perform . 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 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

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N 201	Continued From page 8 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 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, " 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 for all non- residents. " 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, ( ), 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 on their chart, would be initiated and 911 called.	N 201		

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N 201	Continued From page 9 My expectation is that the nurse would start if a 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 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 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, 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:	N 201		

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N 201	Continued From page 10 Physician Statement of Incapacity, Funeral Home Selection. The form was initialed 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 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 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 Review of Resident #1 ' s medical record 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 lacks the capacity to give informed consent to make medical decisions	N 201		

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N 201	Continued From page 11 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 readmission to the facility. Review of Resident #1 ' s medical record	N 201		

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	62932	A. BUILDING: _____ B. WING _____	C

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N 201	Continued From page 12 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 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 or 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 ( ) form was present.	N 201		

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N 201	Continued From page 13 A review of the Nursing Admission Evaluation Tool dated at 3:00 PM revealed: patient 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 Living: 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. rate 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 revealed under Section C (Patterns): Staff Assessment for Mental Status: Short term memory: memory problem. Long term memory:	N 201		

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	62932	A. BUILDING: _____ B. WING _____	C 06/26/2015

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N 201	Continued From page 14 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 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 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): A risk of developing . Under Section Q (resident ' s Overall Expectation): Expects to remain in this facility; by family. On 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 and 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 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	N 201		

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N 201	Continued From page 15 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 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 , 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. 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 or surgical treatment, and the right to formulate	N 201		

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	62932	A. BUILDING: _____ B. WING _____	C

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N 201	Continued From page 16 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: b. -Indicates that, in case of or failure, the resident, legal guardian, 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: " 1. 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 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 acute event (such as) differs substantially from the likelihood of recovering from that the end result of multi-system failure and advance irreversible or conditions. 5. Depending on the underlying cause, the chances of surviving SCA	N 201		

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N 201	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 /or external exists for that individual; " Preparation for : " 1. Obtain and /or 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 /BLS. 5. 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	N 201		

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N 201	Continued From page 18 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 if 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 . 6. 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 with a 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, , and 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	N 201		

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N 201	Continued From page 19 (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 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 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 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	N 201		

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N 201	Continued From page 20 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 the NHA provided a " QA Book ", it 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 " ", " Advance 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 . The 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	N 201		

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N 201	Continued From page 21 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 certified may be directed to assist with at the direction of the nurse. " On signature sheets were provided for the following in-services, dated , , 5/9, , , 6/7, , , and . In addition mock " Code Blue " drills were done on , , , . 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: On 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 the book. I would initiate until I determined if the resident had a order then I would stop . "	N 201		

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N 201	Continued From page 22 On 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 someone to go to book. If they were a I would stop . I would call the physician and 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 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 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	N 201		

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N 201	Continued From page 23 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 at 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 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 if they 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 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. " When asked if training had been performed in the past, stated, " Yes, the	N 201		

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N 201	Continued From page 24 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 for, 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 by the surveyor which revealed the nurses would start prior to knowing the resident ' s code status was discussed. The DON stated, " That is not	N 201		

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N 201	Continued From page 25 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 were 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. On in-service signature sheets were reviewed for retraining of the nursing staff, regarding advance directives, , , and 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 their wishes in their first 14 days of admission	N 201		

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N 201	Continued From page 26 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. 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 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 to 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	N 201		

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N 201	Continued From page 27	N 201		

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.

CLASS I

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 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
N0201 -- S/S: J -- 400.022(1)(l), 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 Provided Meet Professional Standards
F0282 -- S/S: J -- 483.20(k)(3)(ii) -- 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.

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
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Youtube.com/AHCAFlorida
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SlideShare.net/AHCAFlorida

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.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based

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