STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EXCEL CARE CENTER	**2811 CAMPUS HILL DR TAMPA, FL 33612**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record & policy review, the facility failed to provide care and services related to [MEDICAL TREATMENT] for 3 of 3 sampled residents (#1, #3, and #4). Residents #1, #3 and #4 lacked documentation of an assessment of the resident before and after [MEDICAL TREATMENT] treatments as well as ongoing communication and collaboration with the [MEDICAL TREATMENT] facility. Resident #1 lacked consistent transportation to the [MEDICAL TREATMENT] center. Findings included: 1. Resident #1 was admitted on [DATE] and discharged on [DATE], per the Transfer/Discharge form. The record reflected a [DIAGNOSES REDACTED]. Record review of the 5-day Minimum Data Set ((MDS) dated [DATE] found a Brief Interview for Mental Status (BI[CONDITION]) score of 11 (moderately impaired). The resident required extensive assistance of one for bed mobility, eating and toileting and extensive assistance of two for transfers. The resident was on [MEDICAL TREATMENT]. Record review of physician orders [REDACTED].#1 did not attend [MEDICAL TREATMENT] today due to transportation issues. Documentation on 12/29/20 at 18:46 (6:46 p.m.) indicated the ARNP was notified the resident did not attend [MEDICAL TREATMENT]. New orders included to check her vital signs every 4 hours for 24 hours. On 01/06/20 at 17:04 (5:04 p.m.) showed the resident was already checked and changed while waiting for [MEDICAL TREATMENT] transport. The resident and daughter were notified of [MEDICAL TREATMENT] transportation in route. The daughter requested the resident be put back to bed to recheck the resident's buttock dressing. The [MEDICAL TREATMENT] transportation arrived at the facility while the dressing was being changed. The writer asked the transportation to wait while she finished the dressing change. After 10 minutes, it was discovered that the transportation had left without notification. On 01/07/20 at 6:45 a.m. the nurse had been informed by the Unit Manager that the resident was attending [MEDICAL TREATMENT] this a.m. with her daughter who was going to transport the resident. On 01/15/20 at 23:16 (11:16 p.m.) the record reflected showed the resident had not been transported to [MEDICAL TREATMENT] as a result of a scheduling mix-up. A call was placed to the physician. Record review of the care plans (Date initiated 12/29/2019) showed the resident had potential complications related to [MEDICAL TREATMENT] for treatment of [REDACTED]. The resident received [MEDICAL TREATMENT] on Monday, Wednesday, and Friday at 3:00 p.m. Interventions included but were not limited to establish and manage transportation arrangements for [MEDICAL TREATMENT] and have the resident ready on [MEDICAL TREATMENT] days. Complete [MEDICAL TREATMENT] communicate tool on [MEDICAL TREATMENT] days and review upon return from [MEDICAL TREATMENT]. Review of the Treatment Sheet for Facility from the [MEDICAL TREATMENT] Center showed Resident #1 was absent from [MEDICAL TREATMENT] on 01/29/19, 01/06/20 and 01/15/20. On 03/04/20 the facility staff stated the [MEDICAL TREATMENT] Communication Forms were scanned onto the e-chart. The following were present on 03/04/20: January 03, 07, 08, 10, 27 and February 05, 07, 10, 12, 14, 7, 19. On 03/05/20 the facility presented a copy of the following dated [MEDICAL TREATMENT] Communication Forms: January 03, 06, 08, 10, 13, 15, 17, 20, 22, 24, 27, 29, 31 and February 03, 05, 07, 10, 12, 14, 17, 19, 21 (they did not give a copy of the 01/07 form that was in the e-chart). Record review of the 01/06/20 [MEDICAL TREATMENT] Communication Form showed the following documentation: transported by daughter, left at 2 p.m., respirations 18, blood pressure 132/76, pulse 80, temperature 98.2, and was signed by a LPN. The section for the [MEDICAL TREATMENT] Center to document in was blank. The section the facility was to complete on return showed: arrived at 7 p.m., with a blood pressure of 122/70, pulse 82, no pain, access shunt intact, bruit yes, no bleeding, signed and dated on 01/06/20. The [MEDICAL TREATMENT] Communication Form showed the resident left at 2 p.m., transported, respiration 18, blood pressure 132/70, pulse 68, temperature 98.4 and was signed by an LPN and dated 01/15/20. The section for the [MEDICAL TREATMENT] Center to document in was blank. The section the facility was to complete on return showed: arrived at 8 p.m., with a blood pressure of 136/80, pulse 76, respirations 20, no pain, access shunt intact, bruit yes, no bleeding and was signed by Staff C, RN, ADON and dated 01/15/20. During an interview on 03/05/20 at 9:25 a.m. the Nursing Home Administrator (NHA) stated that the daughter was very involved in Resident #1's care. He stated that they allowed the daughter set-up the resident's transportation. On 01/06/20 they told transportation it would be 10-15-minute wait because the daughter wanted the resident put back to bed so she could see the resident's wound. The transport did not stay, and the resident missed the transportation. Staff D, Licensed Practical Nurse (LPN) had called for another transport. They came to the front door and the resident and daughter were at the side door. The daughter would not let us take the resident to the front door and the resident missed the transport again. The transport was arranged for the next day, 01/07/20. The resident went to [MEDICAL TREATMENT] on 01/07. During an interview on 03/04/20 at 12:45 p.m. the NHA stated that they did have a transport van for wheelchair access. He stated that they have had issues with some residents not being realistic about pick-up times from [MEDICAL TREATMENT]. He stated that he had hired a second driver. The NHA stated that he put a QAPI in place for transportation on 01/07 because of Resident #1. Resident #1's transport was set-up for 01/07 as per the resident's wishes. The NHA stated that they checked with other residents that are transported and had no other issues at that time. He stated that the Assistant Director of Nursing (ADON) educated the staff on resident rights regarding to the [MEDICAL TREATMENT] transport. A full-time facility transport driver was hired and started on 02/14. The NHA stated that he will monitor grievances for accuracy and efficiency of transports weekly. The audits will continue for 90 days or until substantiated compliance was achieved. During an interview on 03/04/20 at 4:35 p.m. the facility's corporate nurse stated that they could only find one more [MEDICAL TREATMENT] Communication Form for Resident #1. She stated that they were going to call the [MEDICAL TREATMENT] center for the actual dates the resident visited the center. During an interview on 03/05/20 at 11:00 a.m. Staff B Licensed Practical Nurse (LPN) stated that she used to work the 3-11 p.m. shift and had just recently moved to the 7 a.m. -3 p.m. shift. She stated that Resident #1 went to [MEDICAL TREATMENT] 3 times a week. She stated that the resident would leave about 2 p.m. to go to [MEDICAL TREATMENT]. The resident took the [MEDICAL TREATMENT] Communication Forms with her. She stated that due to her working the 3-11 shift at the time, she never sent the resident to [MEDICAL TREATMENT]. She took care of her when she returned. Staff B, LPN stated that she would check the resident post [MEDICAL TREATMENT]; take her vital signs and check her port. She stated that the family set up her transportation. She stated that the resident would get back about 7:30 p.m. Staff B, LPN said the resident would, sometimes, not come back with her [MEDICAL TREATMENT] Communication Forms, the daughter would keep them. They would ask her if we could have a copy of them and she would not let us. Both the physician and [MEDICAL TREATMENT] center were aware. During an interview on 03/05/20 at 11:55 a.m. Staff A, Registered Nurse (RN), Unit Manager (UM) stated that Resident #1 was a very sweet lady. She stated that there was an issue with transportation. Staff A stated that she did not know how many [MEDICAL TREATMENT] visits Resident #1 missed. The Resident did go to the [MEDICAL TREATMENT] center with the Daily Communication Forms. She stated that she was not sure if the forms came back or not. On 03/05/20 at 12:55 p.m., the Director of Nursing (DON) was interviewed related to receiving of the [MEDICAL TREATMENT] Communication Forms for Resident #1. He stated that Staff A, RN, UM had given the forms to him that a.m. The Administrator was informed that yesterday, on 03/04, the surveyor was told that all of the [MEDICAL TREATMENT] Communication Forms had been scanned into the e-chart. The DON was told that the medical records clerk had stated that all of the Forms had been scanned. Also, the DON was told that, yesterday, the following was requested from the Corporate

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

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 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Nurse: a list of the dates that the resident attended [MEDICAL TREATMENT] and if there were any more [MEDICAL TREATMENT] Communication Forms. The DON was told that there were 12 Communication Forms available 03/04 in the e-chart and now 23 [MEDICAL TREATMENT] Communication Forms had been provided. The resident was admitted on ,[DATE] and did not go to [MEDICAL TREATMENT] on 12/29. The DON was told that, based on the Treatment Sheet for Facility forms sent from the [MEDICAL TREATMENT] center, Resident #1 was absent from [MEDICAL TREATMENT] on 12/29/19, 01/06/20, and 01/15/20. When asked how there were [MEDICAL TREATMENT] Communication Forms filled out by the nursing staff for 01/06 and 01/15 when the resident did not go? The DON stated that the signature was the same nurse and he did not know the signature. He stated, either they are asleep at the wheel or they falsified the documentation. When asked how the number of [MEDICAL TREATMENT] Communication Forms doubled since yesterday? The DON did not answer. The DON was informed that Staff B, LPN had stated that the [MEDICAL TREATMENT] Communication Forms did not always come back because the daughter kept them. On 03/05/20 at 1:00 p.m. the NHA stated they did a QAPI on the transportation due to Resident #1. The QAPI Transportation 01/07/20 reflected Resident #1's transport was set-up. Resident #1 was taken to [MEDICAL TREATMENT] on 01/07/20 per resident wishes. Other residents with transports were checked and no other issues at this time. The ADON educated staff on resident rights regarding [MEDICAL TREATMENT] transport. A full-time facility transport driver was hired and started on 02/14/20. The NHA will monitor grievances for accuracy and efficiency of transports weekly. Audits will continue for 90 days or until substantial compliance was achieved. During an interview on 03/05/20 at 1:14 p.m. Staff A, RN, UM stated that she did not know anything about the [MEDICAL TREATMENT] Communication Forms for 01/06 and 01/15. She stated that she came to the 400 floor as the UM on 01/07. She stated that she does not know who the nurse was that signed the forms but Staff C RN, ADON was the ADON that signed on 01/15. During an interview on 03/05/20 at 1:25 p.m., Staff C, RN, ADON stated that she usually filled in the vital signs on the [MEDICAL TREATMENT] Communication Forms. She stated that the nurses were too busy to do it. She stated that she only plugged in the vital signs but not the other parts of the assessment. Staff C, RN, ADON stated that yes, there was no division showing that she only filled in the vital signs and another nurse had performed the post [MEDICAL TREATMENT] assessment. Staff C stated, again, that she was just filling in the vital signs for the nurses. During an interview on 03/05/20 at 1:30 p.m. the NHA stated that if the ADON was going to sign the [MEDICAL TREATMENT] Communication Form as receiving the resident then she needed to sign the form as such. He stated what nurse signs a form without checking for another nurse signature. The NHA stated that his expectation was to do correct documentation. The NHA stated that there was an issue if the resident did not go to [MEDICAL TREATMENT] and had documentation as if they did go. During an interview on 03/05/20 at 4:54 p.m. the DON entered the conference room and stated that Staff C, RN, ADON had been suspended. She told me she was only signing the [MEDICAL TREATMENT] sheets for the vital signs. I told her if that were the case, I would have made sure it was noted on the [MEDICAL TREATMENT] form. The NHA came in and stated that the Staff C, RN, ADON had been suspended due to the [MEDICAL TREATMENT] Communication Forms for Resident #1. He stated that she should not have filled the sheets out for the nursing staff. If she was just filling out the vital signs, as she said, she should have documented it that way. 2. Resident #3 was admitted on [DATE] and readmitted on [DATE], per the Admission Record. Record review of the [DIAGNOSES REDACTED]. Review of the MDS dated [DATE] showed a BI[CONDITION] score of 15 (cognitively intact). The resident was totally dependent for bed mobility, transfers, and extensive assistance for toileting. The resident was receiving [MEDICAL TREATMENT]. Record review of the care plans (Date initiated 9/7/2018) showed the resident was at risk for complications related to [MEDICAL TREATMENT] for treatment of [REDACTED]. The e-chart lacked any [MEDICAL TREATMENT] Communication Forms. The Corporate Nurse verified the lack of documentation. Record review of the [MEDICAL TREATMENT] Communication Forms from 0[DATE] and 03/02/20 showed the following forms missing: 01/15, 24, 27; 02/10, 12, 14, 17, 21, 24, and 28; as well as 03/02. Review of the [MEDICAL TREATMENT] Communication Forms showed the following forms did not have the Facility section filled out by the nursing staff: 01/29, 31, 02/03, 05, 07, 14, 19, and 26. During an interview on 03/05/20 at 3:30 p.m. Resident #3 was sitting in a wheelchair at his bedside. He was dressed and groomed. He stated that he went to [MEDICAL TREATMENT] on Monday, Wednesday, and Fridays. He stated that he did not take any paperwork to [MEDICAL TREATMENT]. During an interview on 03/05/20 at 4:40 p.m. Staff A, RN, UM, located Resident #3's [MEDICAL TREATMENT] notebook. She verified that there were missing [MEDICAL TREATMENT] Communication Forms and some of the forms lacked documentation related to the facility post [MEDICAL TREATMENT] assessment section on return of the resident. 3. Resident #4 was admitted on [DATE] and readmitted on [DATE], per the Admission Record. Record review of the [DIAGNOSES REDACTED]. Review of the MDS, dated [DATE], showed a BI[CONDITION] score of 14 (cognitively intact). The resident required extensive assistance for bed mobility, transfers, and limited assistance for toileting. The resident was receiving [MEDICAL TREATMENT] Record review of the care plans (Initiated [DATE]) reflected the resident was at risk for complications related to [MEDICAL TREATMENT] for treatment of [REDACTED]. Review of the e-chart only showed [MEDICAL TREATMENT] Communication Forms for 01/03, 01/13 and 02/07. The Corporate Nurse verified this lack of documentation. During an interview on 03/05/20 at 4:40 p.m. Resident #4 was sitting in a wheelchair in the smoking area. He was dressed and groomed for the day. He stated that he went to [MEDICAL TREATMENT] on Mondays, Wednesday, and Fridays. He stated that he takes paperwork with him. During an interview on 03/05/20 at 4:40 p.m. Staff A, RN, UM, located Resident #4's [MEDICAL TREATMENT] notebook. She verified that the notebook was empty. 4. Record review of the facility's [MEDICAL TREATMENT] Contract showed B. Obligations of Long Term Care Facility and / or Owner: 2. Interchange of Information: the Long Term Care Facility shall provide for the interchange of information useful or necessary for the care of the [MEDICAL CONDITION] Residents, including a contact person at the Long Term Care Facility whose responsibilities include assisting with the coordination of [MEDICAL TREATMENT] Services for [MEDICAL CONDITION] residents; 4. Preparation of [MEDICAL CONDITION] Residents. The Long Term Care Facility shall ensure that [MEDICAL CONDITION] Residents are prepared to spend an extended length of time at the [MEDICAL CONDITION] [MEDICAL TREATMENT] Unit and have received proper nourishment and any medications prescribed for reasons other than the treatment of [REDACTED]. 5. Transport and Referral of [MEDICAL CONDITION] Residents. The Long Term Care Facility shall be responsible for arranging for suitable and timely transportation of the [MEDICAL CONDITION] Residents to and from the [MEDICAL CONDITION] [MEDICAL TREATMENT] Unit, including the selection of eh mode of transportation qualified personnel to accompany the [MEDICAL CONDITION] Residents, transportation equipment usually associated with this type of transfer or referral in accordance with the applicable federal and state laws and regulations and all costs or transportation expenses associated with such transfer. The Long Term Facility shall be responsible for ensuring that the [MEDICAL CONDITION] Residents are medically stable to undergo such transportation and medically suitable to receive treatment at the [MEDICAL CONDITION] [MEDICAL TREATMENT] Unit. E. Mutual Obligations: 1. Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Long Term Care Facility and [MEDICAL CONDITION] [MEDICAL TREATMENT] Unit. Documentation shall include but not limited to, participation, as members of an interdisciplinary team, in care conferences, continual quality improvements program, annual review of infection of policies and procedures, and the signature of team members from both parties on a Short Term Care Plan (STCP) and Long Term Care Plan (LTCP). Team members shall include the physician, nurse, social worker, an dietician from the [MEDICAL CONDITION] [MEDICAL TREATMENT] Unit and a representative from the Long Term Care Facility. The [MEDICAL CONDITION] [MEDICAL TREATMENT] Unit shall keep the original STCP and LTCP in the medical record of the [MEDICAL CONDITION] Resident and the Long Term Care Facility shall maintain a copy. Record review of the facility's policy, [MEDICAL CONDITION], Care of a Resident with, revised September 2010, showed agreements between this facility and the contracted [MEDICAL CONDITION] facility include all aspects of how the resident's care will be managed, including: a. How the care plan will be developed and implemented; b. How information will be exchanged between the facilities. Record review of the facility's policy, Care Plans, Comprehensive Person-Centered, revised December 2016, showed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan will: a. include measurable objectives and time frames; b. describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.