

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/03/2025
NAME OF PROVIDER OR SUPPLIER  Excel Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0676  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.  (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record review, the facility failed to ensure incontinent care was provided for four residents (#7, #8, #9, #10) out of five residents sampled. Findings Included: On 12/02/25 at 9:37 a.m., Resident #10 was observed and interviewed lying in bed waiting for incontinent care. Resident #10 stated they have been asking for help going to the bathroom all morning and most days they are left sitting in their wet incontinent product for long periods of time. Review of Resident #10's admission record revealed an admission date of 10/20/25, with diagnoses to include Parkinson's disease, diabetes mellitus, hypertension, dementia, anxiety, dizziness, and muscle weakness. A review of Resident #10's Minimum Data Set (MDS) dated [DATE] revealed: a brief interview for mental status (BIMS), a score of 6, meaning severe impairment. Functional Abilities, dependent for toileting hygiene and lower body dressing; partial/moderate assistance for toilet transfers. Bladder and Bowel revealed Resident #10 as incontinent for urinary and bowel continence. A review of Resident #10's bladder continence task log dated 11/04/25-12/02/25, revealed the resident was approached for incontinent product changes only once in an eight-hour shift on the following dates: 11/07/25, 11/12/25, 11/16/25, 11/17/25, 11/24/25, and 11/30/25. Resident #10 was approached for incontinent product changes one time in twelve hours on the following dates: 11/15/25 and 11/21/25. Resident #10 was approached for incontinent product changes once in 24 hours on the following date: 11/29/25. A review of Resident #10's bowel continence/movements task log, dated 11/04/25-12/02/25, revealed the resident was approached for incontinent product changes one time in an eight-hour shift on the following dates: 11/07/25, 11/12/25, 11/16/25, 11/17/25, 11/24/25, and 11/30/25. Resident #10 was approached for incontinent product changes one time in twelve hours on the following dates: 11/15/25 and 11/21/25. Resident #10 was approached for incontinent product changes once in 24 hours on the following date: 11/29/25. A review of Resident #10's care plan, dated 10/20/25, revealed that the resident, has an alteration in elimination as evidenced by (AEB): is incontinent of bowel and bladder due to impaired cognition does not recognize toileting needs, is at risk for constipation due to decreased mobility. Requires staff assistance with incontinent/toileting needs. Resident #10's care plan's focus revealed the resident will be clean, dry, and odor free daily. Interventions included checking on the resident upon arising, before/after meals and at night for incontinence, and to observe and notify the physician for changes in bowel/bladder function. Resident #10 requires assistance by one person with toileting. Further review of Resident #10's care plan revealed the resident is dependent and requires assistance with toileting hygiene. No documentation of a care plan for behaviors and refusal of care was found. A review of Resident #10's progress notes dated 11/02/25-12/03/25 revealed no documentation of the resident refusing toileting/hygiene care. On 12/02/25 at 9:52 a.m., an observation and interview of Resident #8 lying in bed waiting for incontinent care was made. Resident #8 stated it takes staff a long time to complete incontinent care. The resident said the night shift is when wait times take the longest. Review of Resident #8's admission record revealed an admission date of 11/08/25. Resident #8 was admitted to the facility with a diagnosis to include: acute kidney failure, urinary tract infection, repeated falls, colostomy, weakness and severe sepsis with septic shock. A review of Resident #8's MDS dated [DATE], revealed a BIMS score of 9, meaning moderately impaired. Functional Abilities revealed substantial/maximal assistance toileting hygiene and lower body dressing; toilet transfer and R#8 is always incontinent of urine. A review of Resident #8's bladder continence task log, dated 11/08/25-12/03/25, revealed the resident was approached for incontinent product changes one time in an eight-hour shift on the following dates: 11/12/25, 11/17/25, 11/24/25 and 11/25/25. Resident #8 was approached for incontinent product changes once in twelve hours on the following dates: 11/21/25 and 11/27/25 to 11/29/25. Resident #8 was approached for incontinent product changes once in 24 hours on the following date: 12/01/25. A review of Resident #8's care plan, dated 11/08/25, revealed the following, the resident has an alteration in elimination AEB: has a colostomy in place and is incontinent of urine, requiring enhanced barrier precautions and assistance of one with toileting hygiene. Resident #8's care plan focus revealed the resident will be clean, dry, and odor free daily. Interventions included: check on resident upon arising, before/after meals and at HS for incontinence, and to observe and notify the physician for changes in bowel/bladder function. Resident #8 requires assistance x1 with toileting hygiene. Resident #8's care plan revealed no history of resident refusing care. A review of Resident #8's progress notes revealed no documentation of the resident having a history of refusing incontinent/hygiene care. On 12/02/25 at 9:59 a.m. an observation and interview</p>		