STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105498	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Susanna Wesley Health Center	5300 W 16th Avenue Hialeah, FL 33012

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, interviews and record reviews the facility failed to protect residents' information on the third floor as evidenced by, an observation of a computer screen unattended with residents' information visible and easily accessible. There were 118 residents residing in the facility at the time of survey. The findings included: On 6/12/25 at 10:28 AM while ambulating along the third floor hallway, the observed a the screen of an unattended computer with residents' information visible. Interview on 6/12/25 at 10:33 AM Staff J, Registered Nurse (RN) was asked about protecting resident information and protocol for the computer screen when unattended. Staff , RN stated: The cart is to be locked, and the computer is screen is to be closed when I walk away. To protect the privacy of all residents. Sometimes I minimize the screen and if the cart is moved it opens up again. Interview on 6/12/25 at 1:33 PM, the Director of Nursing revealed nurses were instructed on locking the computer screen when leaving the medication cart and not to minimize screen with resident information because it can easily be opened by someone else. Review of the facility's Policy titled Confidentiality of Personal and Medical Records. Date Implemented: 6/20/2020 and Reviewed/Revised: 12/2024 indicated: Policy: This facility honors the residents' right to secure and confidential personal and medical records. This includes the right to confidentiality of all information contained in a resident's records, regardless of the form of storage or location of the record. Policy Explanation and Compliance Guidelines: I. Personal and medical records include all types of records the facility might keep on a resident, whether they are medical, social, fund accounts, automated, or other. 2.Keep confidential is defined as safeguarding the content of information including written documentation, video, audio, or other computer stored information from unauthorized disclosure without the consent of the individual and/or the individual's surrogate or representative. (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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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Paper notes or reminders with resident's personal or medical information shall not be left unattended or viewable by unauthorized persons. These paper notes and reminders will be disposed of in a way that will not compromise resident's personal or medical information.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observations, interviews and record review the facility failed to code a Minimum data set that accurately reflects resident's status for one (Resident #275) out of one sampled resident as evidenced by the MDS not coded for indwelling urinary catheter, despite Resident #275 having an indwelling urinary catheter since admission. There were seven residents with indwelling urinary catheter at the time of the survey. The findings included: On 6/09/25 at 10:13 AM, Resident #275 was observed seated in the activities area with an indwelling urinary catheter in place. On 6/11/25 at 4:29 PM, Resident #275 was observed in bed watching tv, an indwelling urinary catheter was in place, inside a dignity bag. Review of Resident 275 clinical records revealed admissions dated 4/16/25 and 5/22/25. Clinical diagnosis: Encounter for other orthopedic aftercare. Record review of a physician's order sheet revealed an order dated: 5/22/23 for Indwelling urinary catheter for Diagnosis Obstructive Uropathy Review of an admission Minimum Data Set (MDS) reference dated 5/28/25 indicate in Section C for Cognitive status revealed the resident is cognitively intact. Section H: Bowel and bladder: H0100. Appliances: Check all that apply-Z revealed None of the above- was checked. Record review of a care plan initiated on 6/05/25 revealed Resident #275 was at risk for Urinary tract infection due to an indwelling urinary catheter usage related to Obstructive Uropathy with an intervention that included: Keep indwelling catheter below the bladder and keep drainage bag away from the floor. Interview on 6/11/25 at 4:12 PM, Staff F, Registered Nurse, MDS Coordinator was asked what should be coded under Section H in Resident # 275's MDS, Staff F stated: Under section H in the MDS, an indwelling urinary catheter should have been coded. It was an error. Record review of a Policy titled Conducting an Accurate Resident Assessment Date Implemented: 03/20/2025 Date Reviewed/Revised: 12/2024 revealed Policy: The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observations, record review and interviews, the facility failed to revise a tube feeding care plan for one (Resident #97) out of one sampled resident as evidenced by the care plan interventions included abdominal binder despite no physician order for an abdominal binder. There were nine residents with tube feedings at the time of survey. The findings included: On 6/09/25 at 9:53 AM Resident #97 was observed in bed with the head of bed elevated and a tube feeding in progress. Record review of Resident #97's demographic sheet revealed an admission date of 2/17/25 clinical diagnosis including Dysphagia following cerebral infarction and Encounter for attention to gastrostomy. Record review of a Scheduled 5-day Minimum Data Set (MDS) reference dated 2/3/25 revealed Resident #97 had a Brief Interview of Mental Status score s 00, indicating severe cognitive impairment, was dependent on staff for Activities of Daily Living, and had a feeding tube. Record review of a care plan started on: 2/18/25, last reviewed/revised: 6/02/25 revealed Resident #97 has the potential for complications related to use of gastrostomy tube feeding; interventions included: Abdominal binder at all times, remove during care and inspect skin for any abnormalities and report to Medical Doctor promptly. Record review of Resident#97's physician's order sheet revealed no orders pertaining to an abdominal binder. On 6/12/25 at 12:40 PM, a side-by-side observation with Staff I, Licensed Practical Nurse (LPN) and the surveyor of Resident #97 revealed no abdominal binder on the resident. Staff I, LPN was asked about the intervention in the care plan for an abdominal binder, Staff I, LPN stated: Since I have been assigned to this resident, I have not seen an abdominal binder in use. I was not aware this was in the care plan. On 6/12/25 at 12:43 PM Staff H, Certified Nursing assistant (CNA) stated, I am usually assigned to this resident and have never seen a binder on. Interview on 6/12/25 at 1:06 PM, Staff G, Registered Nurse (RN)/ MDS Coordinator stated: This resident was newly admitted in February of 2025 with a new gastrostomy tube and the abdominal binder intervention was included in the care plan by mistake. [Resident#97] does not have a current physician's order for an abdominal binder and does not need a binder. I reviewed the care plans quarterly or as needed whenever there is a change. The last quarterly review was done on 5/15/25 and the intervention for abdominal binder was overlooked. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a policy titled Comprehensive Care Plans Date Implemented: 06/2020 Date Reviewed/Revised: 12/2024 revealed Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide supervision to prevent accident hazards for one (Resident #275) out of one resident sampled, as evidenced by a fire lighter in a transparent bag observed next to Resident #275 while resident was seated in the activities area where other residents were gathered. There were 118 residents residing in the facility at the time of survey. The findings included: On 6/09/25 at 10:13 AM Resident # 275 was observed seated in a wheelchair in The activities room amongst other residents. Surveyor observed a fire lighter inside a transparent bag next to Resident #275 (photographic evidence). The surveyor asked Resident #275 what the lighter is used for and Resident # 275 stated: My business. The Registered Nurse Manager was immediately notified and retrieved the lighter from Resident #275 and stated: [Resident #275] is not allowed to have this lighter and is not a smoker. Interview on 6/09/25 at 10:15 AM, Staff K, the assigned Certified Nursing Assistant (CNA) revealed: I am assigned this resident every day. I don't know if the resident smokes. I did not see a lighter in his belongings. Record review of Resident #275's clinical records revealed the resident was admitted on [DATE] and readmitted on [DATE], clinical diagnosis include encounter for other orthopedic aftercare. Record review of an admission Minimum Data Set (MDS) reference dated 5/28/25 revealed Resident #275 is cognitively intact, required partial/moderate assistance for eating, and no tobacco use. During an interview on 6/10/25 at 10:30 AM, the Director of Nursing (DON) stated: We do rounds daily and look for and remove any hazardous materials. This resident (Resident #275) was previously homeless and doesn't like for staff to touch his belongings. I am not sure why this resident (Resident #275) had a lighter because this resident is not a smoker. Review of the facility's policy titled Accidents and Supervision; Implemented 11/12/2024, Reviewed/Revised 12/2024 revealed: Policy: The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring effectiveness and modifying interventions when necessary.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observations, interviews and record review, the facility failed to demonstrate effective action plans were implemented to correct identified quality deficiencies in the problem area related to prevent repeated deficient practice for F641- Accuracy of assessment. As evidenced by inaccurate MDS coding. The findings included: Review of the facility's survey history revealed, during a recertification survey with exit dated 02/15/ 2024, F641- Accuracy of assessment was cited related to the facility's failure to accurately code the Minimum Data Set (MDS) assessment for two out of four residents reviewed for assessments. During this survey with an exit dated 06/12/2025, repeated deficient practice was identified for F641- Accuracy of assessment, related to failure to code indwelling urinary catheter under section H for Resident # 275. During an interview on 06/12/2025, at 2:30 PM, the Director of Nursing and Administrator revealed Quality Assurance and Performance Improvement (QAPI)/Quality Assessment and Assurance (QAA) committee meets monthly, and the last meeting was held on May 21, 2025. The QAPI/QAA committee includes all required interdisciplinary team members and is responsible for identifying, prioritizing, and addressing care issues using data from audits, staff reports, and daily meetings. Review of the facility's policy titled Quality Assurance and Performance Improvement Date: 02/28/25 indicate: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility's staff failed to implement infection prevention control policies and procedures to ensure a sanitary environment and failed to provide proper perineal and catheter care to help prevent Urinary Tract Infections (UTI); as evidenced two clear plastic bags containing trash on the third-floor hallway and during perineal care staff did not change gloves and wash hands when transitioning from a contaminated area to a clean area and did not change water in the basin between cleaning steps. There were 116 residents residing in the facility at the time of the survey. The findings included: On 06/09/2025 08:46 AM, during observational tour, of the third floor two clear plastic bags containing trash was observed on the third-floor hallway next to a residents' room. (photographic evidence). Interview on 06/12/2025 at 01:38 PM, Staff M, Certified Nursing Assistant (CNA) regarding the trash and soiled supplies on the hallway. Staff M revealed the soiled linen bag, or trash should be placed inside the grey bin inside the soiled utility room immediately. Observation on 06/11/25 at 02:23 PM of Staff A, Certified Nursing Assistant performing perineal care for Resident # 68 revealed: Staff A washed her hands and gathered the necessary supplies (plastic basin, adult brief, gauzes, and soap). After washing her hands again, she donned gloves and removed the resident's soiled brief. Using wet gauzes with soap that was applied outside the basin, she cleaned the perineal area in the following order: right side of the vagina, left side, middle, and then the catheter by cleaning away from the resident and ensuring the indwelling catheter was not dislodged. A new gauze was used for each area. She repeated the same sequence using only water from the bin, without soap, and then again with dry gauzes. The resident was then turned, and Staff A cleaned the anal area using the same method. After completing care, soiled supplies were discarded in the appropriate receptacles in the biohazard room. Staff A did not adhere to proper infection control protocols. She did not change her gloves or wash her hands when transitioning from a contaminated area to a clean area or when needed. Additionally, she did not change the water in the basin between cleaning steps, which is also a deviation from standard infection control practices. Record review of Resident # 68's medical records revealed the resident was initially admitted to the facility on April15, 2025, with clinical diagnoses, including but not limited to: urinary tract infection (UTI), acute vaginitis, bacterial infection, recurrent UTIs, overactive bladder, and neuromuscular dysfunction of the bladder and indwelling catheter in place upon admission due to neurogenic bladder. Review of the physician orders for June 2025 revealed physician orders dated 06/7/25 and 06/10/25, for Ciprofloxacin 500 mg (milligrams) every 12 hours for UTI treatment, routine catheter care every shift, weekly indwelling urinary catheter bag changes, and enhanced barrier precautions related to catheter and feeding tube use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident # 68's admission Minimum Data Set (MDS) dated [DATE], Section C for cognitive pattern indicated a Brief Interview for Mental Status score of 03 out of 15 meaning Resident #68 is severely impaired cognitively. For functional status the resident is dependent on staff for all Activities of Daily Living (ADL). Incontinent of bowel and indwelling urinary catheter. with no active bowel or bladder toileting program. Review of a care plan initiated on 04/25/25, and revised 05/01/25, identified the resident's elevated risk for UTI related to indwelling urinary catheter. Interventions adherence to infection control procedures. Interview on 06/11/25 at 02:58 PM, Staff A revealed for hand hygiene during perineal care she only needs to wash her hands at the beginning and at the end of the procedure and does not change gloves during the process unless the gloves break or become visibly soiled with feces; it is not necessary to change the water in the basin during care, because the she applies the soap outside the basin and the water only needs to be changed if it appears visibly dirty. Interview on 06/11/25 at 03:04 PM Staff B, Licensed Practical Nurse revealed, during perineal care, it is essential to follow proper infection control practices, which include removing gloves and performing hand hygiene when moving from a contaminated area to a clean one, failure to follow these protocols puts residents at increased risk for infections, particularly urinary tract infections, especially in those with indwelling catheters. Interview on 06/12/25 at 9:58 AM Staff C, Infection Control Preventionist acknowledged the identified concerns and revealed, Resident # 68 is currently being treated for a urinary tract infection (UTI) because the urine culture collected on 06/05/25 tested positive for E. coli (Escherichia coli (E. coli), a type of bacteria commonly found in the gastrointestinal tract) Staff C reported staff are required to change gloves and wash their hands between perineal care and catheter care to prevent catheter-associated urinary tract infection (CAUTI). Review of the facility's policy dated 02/28/25-titled: Infection Prevention and Control Program This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.