STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105560	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Annes Nursing Center, St Annes Residence Inc	11855 Quail Roost Drive Miami, FL 33177

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to create comprehensive, resident-centered individualized care plans for two (Resident #1 and Resident #4) out of two sampled residents as evidenced by their care plans containing generic interventions not tailored to their specific health needs and functional status. The findings include: Review of the facility document_ Subject: Care PlanningEffective: 12/3/2004Revised: 2/22/2006Reviewed: 10/16/2024POLICY:Care, treatment and services are planned to ensure that they are appropriate to the residents' needs. Therefore, it is the policy of this Facility to provide an individualized, interdisciplinary plan of care for all residents that is appropriate to the resident's needs, strengths, limitations and goals. Care planning will be implemented through the integration of assessment findings, consideration of the prescribed treatment plan and development of goals for the resident that are reasonable and measurable.PROCEDURE: Item 3- The plan of care shall be individualized, based on the diagnosis, resident assessment and personal goals of the resident and his/her family. Item 6 -Developing a plan for care, treatment and services that includes resident care goals that are reasonable and measurable. Item 15 Monitoring the effectiveness of care planning and the provision of care, treatment and services. Item 16 The plan of care will be individualized to the needs of the resident. Item 17 The plan of care will be evaluated at 90-day intervals or more frequently, based on the resident's clinical condition, care goals and the plan for treatment, care and services, and revised as needed to meet the needs of the resident's changing condition. Resident #1On 09/18/2025 at 9:19 AM and 11:15 AM Resident #1 was observed in bed with eyes closed. Bed in lowest position and bilateral safety mats on floor.Review of resident #1's clinical records revealed an initial admission dated 6/26/2023 and readmitted on [DATE] (resident was hospitalized from [DATE] to 8/30/2025). Clinical diagnoses include but not limited to Dementia.Record review of Resident #1's Care plans revealed:PROBLEM: 07/05/2023 [Resident #1] has the potential for falls related to decreased safety awareness09/28/2023: Quarterly Review-Resident has impaired mobility, mostly bed/chair bound12/19/2023: Quarterly Review02/14/2024 Update: The resident was observed as per nurse's documentation on floor lying on the right side, head at the foot of the bed, no injury noted, see orders/nurses' notes.03/14/2024- Update: clarification about the fall 2-14-2024. The resident was observed after the fall with skin tear to the right hip, wound care nurse evaluation ordered also XRAY to bilateral hip see nurse notes. 03/15/2024Quarterly Review 06/03/2024 Significant Change Review.Resident # 1's Problem remained the same from 08/19/2024 to the Quarterly Review dated 08/03/2025.Problem dated 08/26/2025 Update: On 8/25/2025-Resident noted with fall from bed, hematoma noted to occipital area. Neuro checks initiated. See nurse's notes. Transferred to hospital for further evaluation.GOALInjuries related to falls will be minimized with daily intervention, re-directing and the use of assistive devices during the next 90 days.Estimated Date: 11/04/2025INTERVENTIONS:Evaluation as needed by rehab and nursing for safety equipmentand interventions to reduce fall risk. Monitor clinical concerns that may contribute to poor safety awareness such as: UTI (Urinary Tract Infections), hydration, medications, acute anemia, physical limitation and coping methods. Evaluate the effectiveness and continual need for safety equipment on a quarterly basis and/or as condition changes. Staff to anticipate and prioritize needs: reduce time in room alone, encourage activities, one of the last residents put to bed, reduce naps in daytime hours, personal items within reach, call light within reach, report poor sleeping patterns, etc. Follow code star protocol, keep floor clean, dry and free of debris: encourage use of non-skid soles and use of appropriate device with assistance for ambulation and transfers. Keep call light within reach and remind resident not to get up unassisted. Resident #4Observation on 09/18/2025 at 9:25 AM of Resident #4's morning care provided by Certified Nursing Assistants Staff C and D and revealed the resident was confused at times and communicated in English and Spanish at the same time.Record review of Resident #4's clinical records revealed the resident was initially admitted on [DATE] and readmitted [DATE]; clinical diagnoses included but not limited to: Alzheimer's disease, Chronic obstructive pulmonary disease, Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, Review of Resident # 4 Care Plans indicated:PROBLEM:- Review dated 05/25/2022 [Resident #4] has the potential for falls related to decreased safety awareness, use of psychotropic medications, impaired mobility. Dx (diagnoses)includes anxiety, Alzheimer's, and dementia.Resident # 4's Care Plan Problems remained the same from 08/18/2022 to 01/31/2023.On 03/02/2023 Update: late entry for 2/21/2023- Resident observed on floor in room. See nurses' notes. No apparent injuries noted at the time. Neuro checks

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations records reviewed and interviews, the facility failed to provide adequate supervision and safety measures for two (Resident #1 and Resident #4) out of four sampled residents as evidence by Resident #1 has severe cognitive impairment experienced a fall out of bed due to lack of supervision during personal care, resulting in a head injury. 2)During Resident #4's personal care, staff failed to use fall prevention devices properly, leaving the resident at risk of falling. There were 186 residents residing in the facility at the time of the survey. The findings include:Review of the facility's organization's policy titled, Accident Hazards/Supervision/Devices revised February 2025 documented: Policy Statement: 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 hazards and risks, 2) Evaluating and analyzing hazards and risks, 3) Implementing interventions to reduce hazards and risks and 4) Monitoring effectiveness and modifying interventions. Resident #1On 09/18/2025 at 9:19 AM and 11:15 AM Resident #1 was observed in bed with eyes closed. Bed in lowest position and bilateral safety mats on floor.Review of resident #1's clinical records revealed an initial admission dated 6/26/2023 and readmitted on [DATE] (resident was hospitalized from [DATE] to 8/30/2025). Clinical diagnoses include but not limited to Dementia, Pressure-induced deep tissue damage of right heel and Constipation, unspecified.Review of Resident #1's Physician Order (POS) for August to September 2025 included but not limited to Eliquis 2.5 mg (milligrams) 1 tablet BID (twice daily) ASA (aspirin) 81 mg QD (daily) and Lactulose 10gm/15 ml (10 milligrams per 15 milliliters) -20gm/30ml QD for constipation.Review of nurse's notes dated 8/27/2025 timestamped 01:02:04 incident dated 08/25/2025time of incident: 03:50 incident type-Fall: CNA reported while providing morning care, patient rolled over the bed and fell, striking the back of the head large hematoma to the occipital area noted. Large amount of blood noted. CNA remain at the bedside throughout the event. Patient remained alert able to speak to staff and 911 no s/s of distress noted or loss of consciousness observed patient was transferred to [NAME] south via 911Review of Resident #1's Quarterly Minimum Data Set (MDS) dated [DATE] cognitive Section's Brief Interview for Mental Status (BIMS) documented a score of 00 on a scale of 0 to 15, which indicates severe cognitive impairment.Review of Resident #1's Care Plan dated 08/03/2025 Quarterly Review updated 08/26/2025 documented: On 8/25/2025-Resident noted with fall from bed, hematoma noted to occipital area. Neuro checks initiated. Transferred to hospital for further evaluation. Interventions added on 9/12/2025 indicated: Bilateral bed wedges when in bed as ordered and an intervention added on 9/16/2025 indicated Bilateral floor mats when in bed as ordered. Review of Resident #1's hospital records documented: pt (patient) brought by [local rescue] for fall or rollover from St [NAME] Nsg. (Nursing) Home today about 30 minutes ago, pt has hx. (history) of dementia. It was noticed on arrival that pt was on blood thinners Eliquis once she was in the ED (Emergency Department) room. Code resuscitation called on arrival after pt was bedded. (Emergency Services) asked St [NAME]'s staff multiple times if she was on anticoagulants. Staff at St [NAME]'s told them no but once she arrived at ED it was on her med rec. Pt arrived with scalp laceration and bleeding. General: . Scalp: puncture woundCT (Computerized Tomography) Brain:1. No acute intracranial hemorrhage, midline shift, or mass effect.2. There is a right posterior parietal laceration, contusion and hematoma.Discharge Patient, 08/30/2025 06:27:00 EDT (Eastern Daylight Time), Fall I Syncope I Atrial fibrillation I GIB (gastrointestinal bleeding).Interview on 09/08/2025 at 2:41PM The Risk Manager revealed Resident #1's first fall in the facility happened in 2024 and no staff was involved. The second fall occurred on 08/25/2025, the resident rolled from the bed when the CNA (Certified Nursing Assistant) went to change gloves, the resident fell from the bed, the fall was just a normal hematoma. The CNA was working alone, it depends on the patient, then they work in pairs. At that time the resident did not have wedges on the side of the bed and the CNA said she had her in the middle of the bed. On average each CNA is assigned 10-12 patients at night (11:00PM to 7:00AM shift) and they work in pairs. The resident was in the hospital for a little over a week. When asked if the fall could have been prevented; the Risk Manager stated: She (Resident #1) is not a very active maybe the fall could not have been prevented. The Risk Manager revealed the incident was reported as an adverse incident and not negligence.Interview on 09/08/2025 at 2:29 PM the Assistant Director of Nursing (ADON) revealed: As far as I know the CNA was providing care and turned around to change gloves and the resident fell of the bed. The staff had the bed at required level. I was not here so I only went by what