

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105560	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2025
NAME OF PROVIDER OR SUPPLIER St Annes Nursing Center, St Annes Residence Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility's staff neglected to use a mechanical lift to transfer one (Resident #1) of the three sampled residents who required transfers with a mechanical lift. Staff G, a Certified Nursing Assistant, did not use a mechanical lift as ordered to transfer Resident #1 from the bed to the wheelchair. This deficient practice resulted in Resident #1 sustaining multiple fractures to the right lower extremity. Ninety-three residents in the facility required transfer using a mechanical lift. The findings include: Observation on 10/22/2025 at 10:22 AM, revealed Resident #1 receiving a bed bath without any apparent distress. The right leg was completely covered with a bandage wrap dressing. Record review revealed documentation indicating that on 10/9/2025 at 6:00 AM, Staff G, a Certified Nursing Assistant, informed Staff J, a Registered Nurse (RN) that Resident #1 had complained of leg pain after being transferred from bed to wheelchair. Review of the Nurses Notes created by Staff J, RN dated 10/09/2025 timestamped 6:58 AM indicated: Change in condition- while the patient was being transferred to her wheelchair to go to dialysis, the patient started complaining about pain on her right lower extremity. [provider] was called and a new order for a STAT X-Ray on the patient's right hip, knee, ankle, and foot was placed. When Resident #1 returned, Staff I, Advanced Practice Registered Nurse (APRN), assessed the resident due to the reported pain and noted a light green discoloration below the knee. The resident reported pain to touch and movement, with no swelling noted and no fall reported; Staff I ordered an X-ray to rule out fracture or dislocation. On 10/10/2025, the X-ray results revealed a proximal right tibia fracture with diffuse osteopenia. Staff I, ARNP had the resident transferred to the hospital for further evaluation. The resident's hospital record showed acute comminuted fractures of the right fibular shaft and an acute oblique fracture of the right proximal tibia shaft. Review of Resident # 1's clinical records revealed the resident was admitted to the facility on [DATE], clinical diagnoses included but not limited to End Stage Renal Disease and Dependence on Renal Dialysis. Review of Resident #1's Physician's Orders Sheet for October 2025 revealed an order for fall precautions, safety precautions and to transfer patient with use of mechanical lift. Record review of Resident #1 's Significant Change Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status Score 03, on a 0-15 scale indicating the resident is cognitively impaired. Section GG for Functional Abilities documented supervision for eating, dependent on toileting, showering, lower body dressing, sit to lying for substantial assistance and upper body dressing for partial assistance. Record review of Resident #1's Care Plans Annual Review dated 09/12/25 revealed the resident is at risk of falls due to: Decreased mobility and unsteady gait. Interventions include but not limited to keeping floor clean, dry and free of debris: encourage use of non-skid soles and use of appropriate device with assistance for ambulation and transfers. Interview on 10/22/25 at 11:06 AM. Staff C, Certified Nursing Assistant (CNA) stated: I work with [Resident #1] and I was informed that she has a broken leg. I always have assistance from another CNA when transferring her to the wheelchair. We place a pillow under her leg and use the [mechanical lift] to transfer her safely to the chair. I have never transferred residents who requires a [mechanical lift] without using it. Interview on 10/22/2025 at (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 105560	If continuation sheet Page 1 of 7

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F 0600 Level of Harm - Actual harm Residents Affected - Few	12:02 PM, the Risk Manager revealed that on 10/09/2025 Resident #1 started complaining of pain in the long bone of the lower leg. An X-ray was attempted on the first day, but completed the following day, which revealed a fracture. The CNA had transferred the resident without using a lift, during which the resident's leg was twisted. The CNA admitted she is at fault and was suspended facing termination. The resident was sent to the hospital but did not undergo surgery due to age and overall health; an immobilizer was applied instead. The resident has since returned to the facility. Observation on 11/12/2025 at 12:35 PM, revealed Resident #1 sitting in a chair eating lunch, a cast was noted on Resident #1's right lower leg and a dressing on her left foot. Interview on 11/12/2025 at 11:20 AM, Staff G, CNA stated: In the early morning I entered the resident's room to prepare her for dialysis. I cleaned her up, and while turning her, she began screaming in pain. I had used proper body mechanics to transfer her from the bed to the wheelchair by holding the resident and placing one leg between the resident and twisting the resident into the chair. When I lifted her feet to place them on the footrests, she cried out in pain and kept moving her feet off the rests. I repositioned her feet and took her to the nurse. When I returned the following night, I made it clear that I had never dropped a resident. The resident was supposed to be transferred using a mechanical lift; however, I was only trained to transfer her from the bed to the wheelchair without using the lift. I understand that using the mechanical lift is a two-person procedure. I received my CNA license in December 2024. The facility has a document that provides instructions for each resident's care, but I did not review that paper for [Resident #1] at the time because I usually only read it for new residents. This was not my first time working with [Resident #1], and I was aware that she required a mechanical lift. Although the resident has dementia, she was usually compliant with care. I did not notice any discoloration or visible changes in her condition after the transfer. After the incident, I was sent home and asked to return the following week to complete an incident report. I was later given a 15-day suspension and subsequently terminated. I believe this incident could have been avoided if I had received proper training. Interview on 11/12/2025 at 12:40 PM Staff H, Registered Nurse (RN) Unit Manager stated: I have been the Unit Manager for three years. We do have patients who require the use of a mechanical lift for transfers. The CNAs are responsible for checking each patient's transfer order, which specifies how the patient should be transferred, whether by mechanical lift, minimal assistance, or other methods. If a patient normally transfers without the lift but feels tired or weak on a particular day, staff are instructed to use the lift for safety. The mechanical lift transfers always require two staff members. During change-of-shift rounds, CNAs are informed about each patient's transfer status, and there is also a transfer sheet available for reference. CNAs are expected to review the transfer sheet at the start of every shift. We conduct frequent in-service trainings and always encourage staff to use the lift whenever it is ordered. A return demonstration is required during training to ensure proper technique. We also held transfer training not long ago. The transfer form has always been in place. Interview on 11/12/2025 at 2:46 PM Staff I, APRN (Advanced Practice Registered Nurse) stated: I saw the resident after the incident was reported. An X-ray was performed, which showed a fracture, and the resident was sent to the hospital for further evaluation. I was informed that the resident had swelling and reported pain. I am not certain what specifically caused the fracture. I did not speak with the CNA involved, as she was not present at the time. The resident was prescribed Tylenol for pain, which she only experienced during movement. The resident was recently seen by orthopedics and now has a cast. The hospital decided not to perform surgery; the resident initially had a splint, which was later replaced with a cast and is not receiving therapy due to the cast. Telephone interview on 12/18/2025 at 2:11 PM Staff J, RN revealed on 10/09/2025 at around 6:00 AM before Resident #1 left for dialysis; Staff G, CNA had the patient in the wheelchair and reported the patient was complaining of pain in the right leg and because Resident #1 was wearing pants she did not see the legs but gave Tylenol for pain, and the resident left for dialysis. I called [company] and reported the change in condition, and a stat X-ray was ordered. Review of the facility's policy and procedure regarding Suspected Adult, Disabled Person or Elderly Abuse/Neglect/ Exploitation (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	12/03/2004.Purpose: Residents have the right to be free from mental, physical, sexual, and verbal abuse, neglect, misappropriation of resident's property, corporal punishment, involuntary seclusion and exploitation. It is the policy of this facility to protect residents from real or perceived abuse, neglect or exploitation from anyone, including staff members, students, volunteers, consultants, other residents, staff of other agencies serving the residents, visitors, friends. family members or legal guardians, or other individuals.Policy: The facility will implement processes for screening and training employees on protection of neglect, mistreatment and misappropriation of property. This facility mandates that, under residents and for the prevention, identification, investigation, and reporting of abuse, the guidance of applicable laws, any healthcare worker having reasonable cause to believe that any person is in the state of abuse, exploitation or neglect shall report the information to the appropriate regulatory agency and necessary corrective action will be implemented.Review of the facility's policy titled- Subject; Patient Mechanical Lift - Proper Use in Resident Transfer; Effective: 4/6/2005.POLICY: It is the policy of CHS [Catholic Health Systems) Facilities that all resident transfers/lifting is done safely and appropriately to protect the employee and patient from injury. All patient lifting, shifting or transferring will be done with Mechanical Lifting Equipment when appropriate. Failure to follow the guidelines established by this policy will result in disciplinary action being taken.PURPOSE: An injury to a health care professional from patient transfer/lifting activities directly affects the quality of life for our staff members and patients. Therefore, it is crucial that healthcare professionals practice safe lifting, transporting and proper body mechanics at all times. Mechanical Patient Lifts are a key component in this effort.PROCEDURES: Patients who require a mechanical lifting device for transfers will be identified in the CNA module of the Facility's EMR (Electronic Medical Records) system.Throughout the facility there are certain patients who have been determined to require assistance for all moves. For the protection of the staff member as well as the patient a mechanical lifting device will be used in transferring these patients. The designated mechanical lifting device will be designated MANDATORY for use in moving the patient, due to their inability to assist effectively and safely during transfers.		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed ensure one (Resident #1) out of three sampled residents received higher level of care and treatment in a timely manner, as evidenced by Resident # 1 who has bilateral contracted upper extremities was noted on 10/24/2025 with swelling to her left arm that progressively got worst with swelling and discoloration throughout the inner portion of the left arm and was no longer contracted. Resident #1 was eventually transferred to a local hospital on [DATE] (two days after changes were noted). Hospital Xray of Resident #1's left arm revealed an acute mid humerus spiral fracture with displacement. There were 197 residents residing in the facility at the time of the survey. The findings include. Observation on 11/13/2025 at 09:52 AM, revealed Resident #1 in bed awake and alert in in no apparent distress and stated she was okay, a sling was noted on the left arm. Record review of Resident #1 clinical records revealed an admission date of 06/19/2023 with diagnoses including Degenerative Disease of the Nervous System and Palliative Care status. Record review of a nursing progress note created by Staff O, Registered Nurse (RN) on 10/24/2025 at 10:07 PM documented: Patient observed with mild edema to the left arm, area was assessed, skin warm and intact no signs of discoloration. Hospice nurse was notified regarding the finding and order to continue monitoring the affected area. Will continue to observe and document any changes. Review of progress note dated 10/25/2025 at 11:35 PM created by Staff O, RN indicated: During the 3-11 shift Tylenol was administered to the resident regarding the edema in case of pain. The oncoming nurse was informed for follow-up Record review revealed statements on 10/25/25 [Staff F, Registered Nurse] 7-3 shift received in report that the resident had slight edema of the left arm, when doing rounds the edema was noted very minimal, her arms were contracted towards her body as usual and no bruising was seen. I was told hospice was made aware and to continue to monitor. I gave report to the 3-11 nurse. Statement on 10/25/25 [Staff G, RN] 3-11 shift: The morning shift gave me report of the edema to the left arm. The arm was elevated on a pillow and to monitor. Around 8:00 PM I decided to give Tylenol in case of pain. The resident is nonverbal. I gave report to the night nurse. There is no documentation of bruising or discoloration. Documented 10/26/25 statement from the 11-7 shift Nurse [Staff H, RN]: The resident was noted with edema to the left arm. Upon assessment the resident left arm was noted with swelling throughout the arm along with discoloration to the inner portion of the arm. The arm is a contracted arm that was observed to not be contracted at that moment. The supervisor was immediately called to come evaluate the resident. Hospice was then called at 12:50 AM and as per Hospice Triage Nurse [Staff B, RN] she will send a local hospice nurse to come evaluate the resident. At 2:25 AM the local hospice nurse, [Staff C, Licensed Practical Nurse] arrived to evaluate the resident. After the evaluation the family was called for permission to send out the resident, in which she was sent out to [local hospital]; [ambulance service] was called at 3:35 AM with an ETA (Estimated Time of Arrival) of 20 minutes; [local hospital] was called at 3:40 AM in which I spoke to the charge nurse to make them aware of the resident going to their facility. The [ambulance company] arrived at 3:58 AM and left with the resident at 4:05 AM. On 10/26/25, 3-11 nurse [Staff H, RN] The resident returned to the facility at 5:21 PM. The resident was noted with her left arm in a splint and sling. Will continue to monitor. Record review revealed: 10/25/25 statement, Staff A, Hospice Certified Nursing Assistant Bathe the patient around 8:00 AM. Normal as usual her arms were contracted had no complaints. I didn't see anything unusual in her arms or elbows. She (Resident #1) seemed fine, and we left her comfortable in bed. Review of statement dated 10/25/25- Staff B, Hospice CNA: At approximately 8:00 AM. I was in [Resident #1] room to give her a bath at that time the patient seemed in normal she didn't look agitated or that she was in pain. I finished given the bath and left the patient comfortable. Review of statement dated: 10/25/25 Staff L, CNA 3-11; During my shift I noticed the arm more swollen the shift before I report it to nurse. The arm was elevated on a pillow. She had pain and the nurse gave her (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Tylenol. Review of documented statement -10/26/25 Staff D, CNA 11-7 shift: On 10/26/25 while assisting a nurse (Staff H, RN) from the night shift with a resident, we went to [room number] so the nurse could assess the resident's left arm. I received report from the previous shift instructing me to keep to the resident's left hand elevated due to edema. During the nurse's assessment. I observed bruising and noted that the resident ?s arm was not contracted as it had previously been. I informed the nurse that the arm condition appeared abnormal since the resident is typically contracted, and her arm was not supposed to be moving that manner. The nurse and I were both very concerned by the finding, and she proceeded to contact the supervisor for further evaluation/instructions. Review of the Physician Orders include but not limited to: Two staff to provide personal care every shift daily (11/04/2025). Transfer with total assistance using a mechanical lift (01/25/2024). Application of sling and swathe to the left arm daily (10/27/2025); Tylenol 650 milligrams PRN (as needed) every 4 hours (02/17/2025); Apply bilateral hand rolls; may remove for hygiene (03/06/2025).Record review of the Minimum Data Set (MDS) Quarterly dated 07/28/2025 Section for cognitive Status indicate Resident #1 is severely impaired cognitively; Section functional status revealed upper extremity impairment, with the resident dependent on staff for eating, oral hygiene, toileting hygiene, bathing, upper and lower body dressing, and personal hygiene. Section J-Health Conditions indicated the resident received scheduled and PRN pain medications with no shortness of breath and no history of falls. Section P- Restraints and Alarms indicated no restraints or alarms were used. On 11/13/2025 at 12:30 PM, Resident #1 was observed in bed grimacing, the surveyor asked the resident if she was in pain and the resident stated her arm was hurting, and she had not eaten lunch. At 12:32 PM, the surveyor pressed the call light to alert the staff. At 12:44 PM, Staff P, a Registered Nurse, entered Resident #1's room and assessed her, who reported a pain level of 7 on a scale of 0-10. Shortly thereafter, Resident #1's assigned nurse Staff Q, RN entered the room and went to get the pain medication.During an interview on 11/13/2025 at 10:54 AM, Hospice CNAs Staff A and B revealed they did not notice anything abnormal on 10/24/2025, the resident did not exhibit any signs of pain. They mentioned that her arm was contracted, had no color difference, no swelling.Interview on 11/13/2025 at 11:52 AM, Hospice Staff C, a Licensed Practical Nurse (LPN) revealed a report was received from Staff O, Registered Nurse (RN) about swelling on the left arm and went to the facility to perform an assessment. Hospice Staff C, LPN reported she arrived at the facility at around dawn and entered the resident's room accompanied by the facility Staff O, RN; the resident was lying on the bed facing upward, the left shoulder appeared swollen, with bruising noted on the inner arm, and the area was warm to touch and the resident grimaced when the arm was touched. Hospice Staff C, LPN revealed she contacted Resident #1's son to inform him that the resident would be transferred to [Local Hospital] as the physician could not be reached and the son requested the transfer. Interview on 11/13/2025 at 2:35 PM Staff D, Certified nurse assistant (CNA) night shift reported receiving a shift handoff from the previous shift's CNA, who reported that the resident had edema and to keep arm elevated on a pillow. During rounds, the resident was observed to have bruising and was able to move her arm, although she had previously been unable to move her hand. Staff D, CNA then stated that she immediately notified the nurse, who went into the room to assess the resident. When the nurse assessed the arm around 12:00-12:30 AM, the resident grimaced or cried. Staff D, CNA indicated that when assisting the resident, she uses a draw sheet and requests help from another staff member as needed. Interview on 11/13/2025 at 2:40 PM, Staff F Registered Nurse (RN) 7:00 AM to 3:00 PM shift stated: I worked the 7:00 AM to 3:00 AM shift on October 25th with her (Resident #1) on that day she was as normal as she usually is with her arms contracted. The report I received from night shift was that she had slight edema of her left arm; and when I rounded on her and gave her medications and took her blood sugar everything looked normal there was no bruising that I noticed or any pitting edema she also didn't seem to be in any pain. The CNA was able to change and reposition her there was no complaints. Staff F, RN was asked about the facility's policy and procedure if a resident that receives hospice services that is not on Crisis Care has a change in condition; Staff F, stated: We call (continued on next page)		

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