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	04/10/2025

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51537 Based on observation, record review and interview, the facility failed to accurately the code Minimum Data Set (MDS) for one (Resident #200) out of five sampled residents; as evidenced by the resident was discharged to an Assisted Living Facility, and the MDS was coded to indicate that the resident was discharged to a Short-Term General Hospital. The findings included. Review of Resident #200's clinical records revealed the resident was admitted to the facility on [DATE] from a Short-Term General Hospital (acute hospital) Medical diagnosis included but not limited to: Other specified injuries of head, subsequent encounter. Review of orders dated 01/17/2024 noted Resident #1 to be discharged to the St. [NAME] Residence. Assisted Living Facility (ALF. The discharge/transfer was scheduled for January 18, 2025. Review of Resident # 200's discharge Assessment MDS reference dated 01/18/2025 indicated in the section for cognitive pattern that the resident is cognitively intact. The entry/discharge reporting section indicated: Discharge Assessment-return not anticipated. Type of discharge: Planned. The section for discharge status coded resident was discharged to a Short-Term General Hospital (acute hospital). Review of a Nurses Notes dated 01/18/2025 at 10:52:00 documented: Resident discharged to Adult Living Facility St. [NAME] ALF, on 01/18/2025 transported via wheelchair. During an interview on 04/10/2025 at 3:40 PM, Staff F, MDS Coordinator revealed, the Social Services department is responsible for inputting the discharge information, while the MDS department is tasked with verifying that the information is submitted in a timely manner. Staff F acknowledged that an error had occurred in this process and accepted responsibility on behalf of the department. Review of the facility policy and procedure effective April 6, 2005, regarding resident assessments stated, it is the policy of this facility that each resident admitted to the institution shall receive a complete head-to-toe admission observation/assessment by a qualified individual so that plan of care can be developed to best meet the needs of the resident. The observation/ assessment of the care or treatment required to meet the needs of the resident will be ongoing throughout the resident's facility stay, with the observation/assessment process individualized to meet the needs of the resident population.

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51537 Based on observation, record review and interview, the facility failed to accurately complete a Level I Preadmission Screening and Resident Review (PASRR) for one (Resident #166) out of 5 residents investigated for Level I PASRR. There were 190 residents residing in the facility at the time of the survey. The findings included. Record review of a demographic sheet for Resident #166 revealed an admitted [DATE] with diagnosis that included: Depression, unspecified. Further review revealed Admissions Minimum Data Set (MDS) reference dated 3/18/25 Section A1500. Preadmission Screening and Resident Review (PASRR), Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? - No. Section I revealed anxiety disorder, and Depressive Disorder. Section N revealed Resident#166 was taking antipsychotic and antianxiety medications and Section O revealed Resident#166 received no Psychological Therapy. Record review of a physician's order sheet revealed orders dated 3/12/25 directions: Lorazepam one (1) milligram (mg) tablet dose via Percutaneous Endoscopic Gastrostomy (PEG) tube every twelve (12) hours for anxiety, and 3/21/25 Seroquel 25 mg tablet via PEG tube for Psychosis. Further review revealed a Psychiatric evaluation note dated 3/14/25 indicated medication included: Seroquel 25 mg at bedtime and the chief complaint included depression, anxiety and a history of psychosis. Record review of Resident #166's PASRR dated 3/11/25 revealed Section I: PASRR Screen Decision- Making A. MI or suspected MI (check all that apply): no diagnosis was checked. On 4/10/2025 at 4:34 PM, review of the most recent PASRR provided by the Social Services Director for Resident#166, dated 3/11/2025 revealed: Section I: PASRR Screen Decision- Making A. MI or suspected. MI (check all that apply): no diagnosis was checked. During an interview on 4/10/2025 at 5:00 PM, the Social Services Director, revealed Resident #166 was admitted on [DATE] and received a psychiatric evaluation on 3/14/25 and a resident review was scheduled to occur within 30 days of the psychiatric evaluation to assess any changes in the patient's condition. The Social Services Director acknowledged the discrepancies. During an interview on 4/10/2025 at 5:32 PM, the Director of Care Coordination stated: Any significant changes in a resident's condition are typically evident through behavioral changes and the facility continuously reviews the PASRRs within 30 days for further evaluation. If I was aware of these circumstances for earlier, I would have initiated a new resident review for [Resident#166] to include all the mental illness diagnosis to ensure appropriate care and documentation. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Policy and Procedure titled, Subject: Pre-Admission Screening and Resident Review (PASRR) Program revealed It is the policy of the facility to ensure compliance with Federal Regulation (CFR)483.100-483.138, which requires completion of the Pre-Admission Screen and Resident Review (PASRR) screen prior to admission to the facility. Purpose: The Level | and II PASRR Screening and Determination process is mandated by Federal Regulation (CFR) 483.100-483.138. The PASRR evaluation is designed to prevent inappropriate placement of residents/patients in a Skilled Nursing Facility (SNF). Level | Pre-Admission Screen and Determination applies to ALL new admissions and must be completed prior to resident admission by the acute care hospital or transferring

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on observations, interviews and record reviews, the facility failed to develop and implement a fall care plan for two (Resident #25 and Resident #52) out of 13 residents who have orders for floor mats. record review revealed no interventions for floor mats for Resident#25, observations revealed one floor mat in place for Resident#52; and failed to implement a respiratory care plan for one (Resident #95) out of two sampled residents receiving oxygen, as evidenced by Resident #95 oxygen flow rate note in progress at 1.25 Liters Per Minute (LPM) instead of the ordered rate of 2 LPM. The findings included: Resident#25 Observation on 4/07/25 at 10:00 AM, Resident #25 was in bed; one floor mat was noted on the floor at the left side of the bed. Staff A, Registered Nurse (RN) Supervisor revealed: This Resident need two floor mats. Staff A, RN Supervisor, was unable to find another floor mat in the room. Staff E, Certified Nursing Assistant (CNA) approached the surveyor and was interviewed about floor mats and protocol. Staff E stated: I am the Certified Nursing Assistant assigned to [Resident #25] today. [Resident #25] usually only has one floor mat in place. My responsibility is to make sure the floor mats are placed on each side and the bed is low because they have tried to get out or have fallen. Record review of a demographic sheet revealed Resident #25 was admitted on [DATE] with diagnosis that include: Presence of Right artificial hip joint; End stage renal disease, S/P-operative repair of hip fracture; Muscle Weakness (generalized and Alzheimer disease. Record review of nursing notes dated 7/31/24 revealed Resident #25 was found on the floor and on 10/22/24 revealed Resident#25 was found on the floor. Record review of a Quarterly Minimum Data Set (MDS) reference dated 2/1/25 revealed Resident#52 is severely cognitively impaired; dependent for Activities of Daily Living (ADL), has impairment on upper and lower extremities . Record review of a physician order sheet (POS) revealed Resident#25 had order dated 4/6/25 for bilateral floor mats when in bed every shift. Record review Resident#25's care plan dated 8/6/24 and reviewed on 2/7/25 revealed Resident#25 complained of pain to right leg after a fall on 7/31/24 and X-ray results were positive for a fracture to femur. Further review revealed interventions included: maintain bed in lowest position, monitor every 2-3 hours and as needed (PRN) when in room for safety and comfort, keep call light within reach and remind the resident not to get up unassisted. No interventions for floor mats were included. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/7/25 at approximately 11:00 AM, Staff F, MDS Coordinator, was asked if floor mats should be included in the care plan; Staff F went to check then returned and presented a care plan to that now included intervention floor mat as ordered (4/7/25). Resident#52 On 4/07/25 at 9:46 AM Resident#52 observed in bed with eyes closed, no apparent distress, bed low, one floor mat was in place on resident's right side and the other floor mat was folded up and leaning against the nightstand (Photographic evidence). Staff E, Certified Nursing Assistant (CNA) entered the room and was asked how many floor mats are required for Resident #52. Staff E stated: [Resident #52] is supposed to have two floor mats down, when I assisted the resident, I put one up. Record review of a demographic sheet revealed Resident #52 was admitted on [DATE] with diagnosis that include: Fracture unspecified part of neck of femur, Vitamin D deficiency and muscle weakness. Record review of a Physician Order Sheet (POS) revealed Resident #52 had an order dated 2/29/24 directions: Bilateral floor mats when in bed every shift. Record review of a Nursing note dated 3/22/25 revealed at 3:15 AM Resident #52 was found by CNA on the floor mat in the bedroom. Further review of nursing notes revealed on 3/14/25 Resident #52 was found on the floor next to the bed on the floor mattress. During an interview on 4/7/25 at 10:18 AM, Staff B, Registered Nurse (RN) revealed: I am the nurse for this resident. When I come on shift, I do rounds in each room on my assignment. I do frequent rounds. They have floor mats because they try to get out of bed without assistance. I did not communicate with the assigned CNA this morning the amount of floor mats needed. In general, I communicate with the CNAs. During an interview on 4/10/25 at 8:54 AM, the DON was asked about the protocols for floor mats. The DON stated: The falling star program to identify how a fall was caused and to help prevent further falling. Some interventions include floor mats to prevent them from hitting a hard surface. If a resident has floor mats there is a physician order for it and during huddles at the end of each shift staff discuss the fall prevention interventions . The residents are supposed to have two floors mats the only time the floor mat should be removed is during care. The staff are to fold it up during care, so they are not standing on it and place it back before they walk away. Resident #95 On 4/08/25 9:40 am Resident #95 was observed in bed with eyes closed, oxygen in progress at 1.25 Liters per minute via nasal cannula. (Photographic evidence). On 04/08/25 at 11:40 AM Resident #95 was observed in bed with no apparent distress, oxygen was in progress at 1.25 Liters per minute via nasal cannula (photo). Staff C, Registered Nurse (RN) was asked what the prescribed rate for oxygen delivery for Resident #95 and stated, It should be at 2 Liters per minute as needed. Staff C, Registered Nurse (RN) entered the room with surveyor, visualized the oxygen level and adjusted to the prescribed rate. Staff C, Registered Nurse (RN) checked Resident #95's oxygen saturation, and it was 76%. Staff C, Registered Nurse (RN) revealed Hospice would be notified. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/08/25 at 12:00 PM Staff D, Hospice Registered Nurse (RN) evaluated Resident #95 and revealed a new oxygen saturation rate of 96%. Staff C, Registered Nurse (RN) stated, I did round this morning, but I did not visualize if the oxygen was at the ordered level. Record review of a demographic sheet revealed Resident #95 was admitted on [DATE] with diagnosis that included: Acute chronic diastolic congestive heart failure (CHF) and nonrheumatic aortic valve stenosis. Record review of a Quarterly Minimum Data Set (MDS) reference dated 3/9/25 revealed Resident #95 had a Brief Interview of Mental Status (BIMS) score of 7, indicating severe cognitive impairment, dependent on ADLs (Activities of Daily Living), received hospice care and oxygen therapy. Record review of a Care Plan dated 03/12/2023 and revised 4/08/25 revealed Resident #95 had the potential for shortness of breath, alteration in respiratory status due to Chronic Obstructive Pulmonary Disease, CHF, End stage of Cardiac disease with interventions that included: Administer oxygen and nebulizer treatments as ordered, apply oxygen via nasal cannula Oxygen 2.0 liter per min continuous as ordered. Record review of a Physicians Order Sheet revealed Resident #95 had orders dated 10/30/24 to apply humidified oxygen via nasal cannula at 2.0 liter per min as needed and an order dated 4/08/25 to apply humidified oxygen via nasal cannula at 2.0 liter per min continuous. On 4/10/25 at 9:08 AM The Director of Nursing was interviewed about the oxygen protocol and stated, Oxygen is to be delivered at the prescribed rate whether it is continuous or as needed. Record review of a Policy Subject: Care Planning Policy#2046 Effective: 12/3/2024 Revised: 2/22/2006 Reviewed: 10/16/2024 POLICY: Care, treatment and services are planned to ensure that they are appropriate to the resident's 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. The plan of care will be documented through the use of computerized care planning. PROCEDURE: The plan of care shall be individualized, based on the diagnosis, resident assessment and personal goals of the resident and his/her family. The planning for care, treatment and services will include the following: The plan of care will be individualized to the needs of the resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on observations, interviews and record reviews, the facility failed to provide appropriate treatment and services to prevent Urinary Tract Infection (UTI) for one (Resident #182) out of one resident reviewed for an indwelling urinary catheter, a evidenced by inappropriate placement of the urinary drainage bag anchored on the side rail above the resident's head increasing the risk for UTI and dislodgement. The findings included: On 4/07/25 at 9:46 AM Resident#184 observed lying in bed. An indwelling urinary catheter drainage bag was observed anchored to the side rail above near the resident's head. The surveyor requested to speak with the supervisor in the room. Staff A, Registered Nurse (RN) Supervisor entered the room and was asked if the indwelling urinary device drainage bag was positioned correctly. Staff A, Registered Nurse (RN) Supervisor stated, The drainage bag should be lower than the bladder. Staff A, RN Supervisor then performed hand hygiene and donned gloves, adjusted the indwelling urinary drainage bag and secured it below the bladder level to the bed frame. Staff A, RN stated, I don't know why as that high because haven't done rounds in this room yet. Record review of a demographic sheet revealed Resident#182 was admitted on [DATE] with diagnosis that included: Benign Prostate Hyperplasia (BPH) with lower urinary tract symptoms. Record review of physician order sheet revealed Resident#184 had order dated 2/7/25 to provide indwelling urinary catheter care every shift . Record review of an Admission Minimum Data Set (MDS) reference dated 2/13/25 revealed Resident#184 is cognitively intact. Requires partial/moderate assistance for toileting hygiene/personal hygiene/transfers, has an indwelling catheter, diagnosis of BPH and obstructive uropathy, has a PU (Pressure Ulcer) injury Record review of care plan dated 2/25/25 reveled Resident #184 was at an increased risk for infection related to indwelling catheter due to urinary retention with interventions that included: Maintain anchoring device to prevent dislodgement of catheter or pulling against meatus and monitor site of anchor for skin integrity. Interview on 4/7/25 at 10:18 AM Staff B, RN was notified of the identified concern and asked about the protocol for positioning of the urinary drainage bag. Staff B, RN stated: When I come on shift, I do rounds in each room on my assignment and do frequent rounds throughout shift. This morning [Resident#184's] indwelling urinary catheter was in place. The [] bag should be below the body. The purpose is to facilitate urine flow because it could cause the urine to back flow and cause infection. On 4/10/25 at 8:59 AM, the Director of Nursing stated: If a resident is in bed the drainage bag is hung below the level of the bladder. Staff are educated about how to position drainage bags. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Policy Subject: [brand] Catheter Care, Policy # 2032, Effective: 4/6/2005, Revised: 8/12/2019, Reviewed: 10/16/2024 revealed Policy: It is the policy of this facility that catheter care will be provided to all residents with indwelling catheters at least daily and more often as needed due to soiling with feces or when it is deemed necessary by the nurse .The purpose of catheter care is to prevent possible urinary tract infections from bacteria spreading from the perineal area and external catheter into the bladder. BASIC PROCEDURES: The catheter and drainage bag should be kept as a closed system with the drainage bag kept at a level lower than the bladder to allow drainage by gravity.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on observations, interviews and record review the facility failed to provide appropriate respiratory care consistent with professional standards of practice, for one (Resident #95) out of two sampled residents receiving oxygen as evidenced by observations of oxygen in progress at 1.25 liters per minute despite a physician's order for 2 liters per minute for Resident #95. The findings included: On 4/08/25 9:40 am Resident #95 was observed in bed with eyes closed, oxygen in progress at 1.25 Liters per minute via nasal cannula. (Photographic evidence). On 04/08/25 at 11:40 AM Resident #95 was observed in bed with no apparent distress, oxygen was in progress at 1.25 Liters per minute via nasal cannula (photo). Staff C, Registered Nurse (RN) was asked what the prescribed rate for oxygen delivery for Resident #95 and stated, It should be at 2 Liters per minute as needed. Staff C, Registered Nurse (RN) entered the room with surveyor, visualized the oxygen level and adjusted to the prescribed rate. Staff C, Registered Nurse (RN) checked Resident #95's oxygen saturation, and it was 76%. Staff C, Registered Nurse (RN) revealed Hospice would be notified. On 4/08/25 at 12:00 PM Staff D, Hospice Registered Nurse (RN) evaluated Resident #95 and revealed a new oxygen saturation rate of 96%. Staff C, Registered Nurse (RN) stated, I did round this morning, but I did not visualize if the oxygen was at the ordered level. Record review of a demographic sheet revealed Resident #95 was admitted on [DATE] with diagnosis that included: Acute chronic diastolic congestive heart failure (CHF) and nonrheumatic aortic valve stenosis. Record review of a Quarterly Minimum Data Set (MDS) reference dated 3/9/25 revealed Resident #95 had a Brief Interview of Mental Status (BIMS) score of 7, indicating severe cognitive impairment, dependent on ADLs (Activities of Daily Living), received hospice care and oxygen therapy. Record review of a Care Plan dated 03/12/2023 and revised 4/08/25 revealed Resident #95 had the potential for shortness of breath, alteration in respiratory status due to Chronic Obstructive Pulmonary Disease, CHF, End stage of Cardiac disease with interventions that included: Administer oxygen and nebulizer treatments as ordered, apply oxygen via nasal cannula Oxygen 2.0 liter per min continuous as ordered. Record review of a Physicians Order Sheet revealed Resident #95 had orders dated 10/30/24 to apply humidified oxygen via nasal cannula at 2.0 liter per min as needed and an order dated 4/08/25 to apply humidified oxygen via nasal cannula at 2.0 liter per min continuous. On 4/10/25 at 9:08 AM The Director of Nursing was interviewed about the oxygen protocol and stated, Oxygen is to be delivered at the prescribed rate whether it is continuous or as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Policy Subject: Oxygen Concentrators, Policy#2012, Effective: 3/1/2008, Revised: 9/6/2013, Reviewed: 10/16/2024 revealed Policy: Oxygen Concentrators will be used for patients and residents that require oxygen with a liter flow rate of 1 to 5 liters per minute. PURPOSE: The device is a means of delivering oxygen to the patients and residents in small mobile units that extract oxygen from room air and provides continuous supply of oxygen without refilling. PROCEDURES: This equipment is to be used on all patients and residents that require oxygen with a liter flow rate of 1 to 5 liters per minute. Turn the knob of the flowmeter until the ball is centered on the line that indicates the prescribed flow rate. To increase the flow, turn the knob counterclockwise; to decrease the flow rate, turn the knob clockwise.

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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 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. 45019 Based on observations, interview and record review, the facility's quality assurance and assessment committee failed to demonstrate an effective plan of action was implemented to correct an identified quality deficiency in the problem area related to repeated deficient practice for F 880-Infection Prevention & Control. As evidenced by: F 880 was cited during a Recertification survey ending 11/09/23 when the facility failed to implement infection control procedures for one (Resident #430) as evidenced by Respiratory equipment (Nebulizer and tubing) stored uncovered on bedside table next to a live plant. There were 190 residents residing in the facility at the time of the survey. The findings included: Record review of the facility's survey history revealed, during a recertification conducted on November 06, 2023, through November 09, 2023, at the facility. F 880 Infection Prevention & Control was cited as the facility failed to implement infection control procedures for one (Resident #430) as evidenced by Respiratory equipment (Nebulizer and tubing) stored uncovered on bedside table next to a live plant. Review of the facility policy and procedures titled Quality Assurance and Performance Improvement (QAPI) revision date 10/25/24 states: As part of catholic Health Services, Our Mission is to provide health care and services to those in need, to minimize human suffering, to assist people to wholeness and to nurture an awareness of their relationship with God. Our vision is to strive to improve the health, independence and spiritual life of the elderly, the poor, and the needy in the archdiocese, through innovative and proactive approaches to: Managing care and providing services. Facilitating transitions across levels of care. Community partnerships and collaboration. Advocacy efforts. The primary objective of Quality Assurance & Performance Improvement (QAPI) is to monitor, assess and improve the performance of critical focus areas, improve healthcare outcomes and reduce and prevent medical/health care errors on a continuous basis throughout the facility. Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated 01/15/2025,2/19/25, and 3/19/25 documented the facility have QAA Committee meetings monthly. Attendees included: Administrator, Medical Director, Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Control Preventionist/Risk Manager, Dietary Manager, Clinical Dietician, Director of Housekeeping, Director of Maintenance, Director of therapy, Director of Human resources, Director of admissions, Director of Business office, Director of Social Services, Director of Activities, MDS (Minimum Data Set) Coordinator. (continued on next page)

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	04/10/2025

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/10/2025 at 5:56 AM with Administrator (NHA) stated the QAA Committee meets every month on the last Thursday of the month, the last meeting was held in the month of 03/2025. The committee consists of the Medical Director, Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Preventionist and all interdisciplinary team members. The purpose of QAA is looking at processes to implement improvements, monitoring what we can improve to benefit our residents, knowing what our residents' needs are and meeting them. Continuously updating the facility assessment based on the care needs of the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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** 48906 Based on observations, interviews and record review the facility failed to implement infection prevention and control practices and standards for three (Resident #84, Resident #41 and Resident #73) out of seven sampled residents as evidenced by Incentive Spirometer was observed on Resident #84's nightstand bedside with no protective covering. Staff failed to clean the cuff on the vital signs machine between residents. There were 190 residents residing in the facility at the time of the survey. The findings included: Resident #84 On 4/07/25 at 8:19 AM Resident #84 was observed in bed. An incentive Spirometer that was not in use at that time with no protective covering was observed on the nightstand next to the resident. (photographic evidence). Staff B, Registered Nurse (RN) was asked if Resident #84 uses an incentive Spirometer; Staff B stated: Yes, this resident (Resident #84) uses the Spirometer for respiratory issues since she came from the hospital. Staff B, RN was asked about the protocol for storing respiratory supplies when not in use; stated: It should be stored in a plastic bag and dated when not in use. Staff B, RN was notified about the observation and entered the room with the surveyor and observed the Incentive Spirometer that was not bagged on nightstand. Record review of a demographic sheet revealed Resident#84 was admitted to the facility on [DATE] with diagnosis that include COPD (Chronic Obstructive Pulmonary Disease) with acute exacerbation and other pulmonary embolism without acute Cor pulmonale. Record review of a Minimum Data Set (MDS) reference dated 3/9/25 revealed Resident #84 is moderately impaired cognitively, required set up clean up assistance for eating/oral hygiene, had no impairment of upper extremities. Record review of a care plan dated 10/02/24 revealed Resident #84 had the potential for shortness of breath, alteration in respiratory status due to S/P (Status Post) hospitalization due to chest pain and SOB (Shortness of Breath), noted pneumonia and pulmonary embolism, suggestive atelectasis on the right and left lower lobe, needs continuous oxygen. Interview on 4/10/25 at 9:01 AM, the Director of nursing (DON) was interviewed about the protocol for proper storage of respiratory devices while not in use; the DON stated: we don't have a protocol for storing the incentive Spirometer but is to be stored in a plastic when not in use for infection control, but is kept not in bag so it can be readily available to the resident. Resident#41 (continued on next page)

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	105560	A. Building B. Wing	04/10/2025

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St Annes Nursing Center, St Annes Residence Inc	11855 Quail Roost Drive Miami, FL 33177

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/07/25 at 9:15 AM Resident #41 was observed seated in a wheelchair in the room. Staff B, RN entered the room with a vitals machine and was observed while Resident # 41's blood pressure (B/P)was measured, Staff B, RN placed the B/P cuff on the resident's right arm and measured the blood pressure then removed the cuff and placed it on the vitals machine and performed hand hygiene and exit the room. Staff B, RN then re-entered room with a handheld sphygmomanometer (Blood Pressure machine) and placed the cuff on Resident #41's arm and measured the B/P. Staff B, RN then administered medications, performed hand hygiene and exited room. Staff, RN did not disinfect either cuff. There were no disinfectant wipes on the machine. Resident#73 On 4/07/25 at 9:35 AM Staff B, RN entered Resident#73's room with the same vitals machine and explained to resident the procedure to measure B/P, performed hand hygiene and proceeded to place cuff on Resident #73's left arm and was stopped by the surveyor and asked to step outside the resident's room. Staff B, RN was asked about the protocol for cleaning/disinfecting the shared blood pressure cuff; Staff B, RN stated: I usually disinfect the B/P cuff after each use, but I was nervous. During an interview on 4/10/25 at 9:13 AM, the DON revealed: Staff are to clean the vitals machine with bleach wipes between residents to prevent infection. Record review of a Policy Subject: Infection Control Surveillance Policy#4011 Effective: 12/3/2004 Revised: 5/25/2016 Reviewed: 10/25/2024 revealed INTRODUCTION: The intent of any surveillance method is to measure outcomes and processes of care as a component of an overall resident safety and the Performance Improvement Program. Surveillance requires an integrated, collaborated effort throughout the organization to achieve the goals of the Infection Control Program. These goals are: To reduce the risk of infection between healthcare personnel and residents. Reduce the risk of nosocomial infections developing in residents related to the use of devices and required procedures.