

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2025
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 04/08/2025
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	<p>Initial Comments</p> <p>During an unannounced Fire & Life Safety recertification survey conducted on 04/07/2025-04/08/2025 at St. Anne's Nursing Center/St. Anne's Residence Inc., a nursing home in Miami, Florida, Emergency Preparedness was reviewed.</p> <p>St. Anne's Nursing Center/St. Anne's Residence Inc. is in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities.</p>	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/09/2025

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2025
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 01 - MAIN FED B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
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	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted 04/07/2025-04/08/2025 at St. Anne's Nursing Center/St. Anne's Residence Inc., a nursing home in Miami, Florida. The Facility is not in compliance with 42 CFR 483.90 (a), and National Fire Protection Association (NFPA) 101 (2012 edition), NFPA 99 (2012) requirements for nursing homes. Initial Plan Review: 1987 Existing NFPA 220 Construction Type: II (211) Number of beds: 213 Census: 190	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		5/16/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/09/2025

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2025
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 01 - MAIN FED B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
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	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain automatic sprinkler system in accordance with NFPA 101.</p> <p>The findings included:</p> <p>During the Life Safety Survey tour of the facility between 11:00 am and 4:30 pm on 04/08/2025 with the Maintenance Director, it was observed as follows:</p> <p>1:48 pm Kitchen: there were 8 of 28 sprinklers covered by foreign material, corroded, and damaged.</p> <p>3:00 pm 1st Floor Mechanical Room across the Chapel: there was lack of 1 of 1 spare dry sprinkler for freezer nor means to restore service.</p> <p>3:15 pm 1st Floor Main Entrance: there were 2 of 3 sprinklers covered by foreign material and corroded.</p> <p>During the Staff Interview between 11:00 am and 4:30 pm on 04/08/2025, the Maintenance Director acknowledged these findings. These findings were also discussed and acknowledged by the Administrator during the exit conference.</p> <p>NFPA 101 (2012 Edition) 19.3.5, 9.7.5 NFPA 25 (2011 Edition) 5.2.1.1.1 through 5.2.1.1.2 and 5.4.1.4.2.1</p>	K 353		
K 712 SS=D	<p>Fire Drills</p> <p>CFR(s): NFPA 101</p> <p>Fire Drills</p>	K 712		5/16/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2025
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 01 - MAIN FED B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
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	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 2 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on records review and staff interview, the facility failed to perform fire drills in accordance with NFPA 101. Findings included: During the records review process of the facility between Noon on 04/07/2025 and 5:00 pm on 04/08/2025 with the Maintenance Director, it was revealed that there was lak of documentation for 1 of 4 fire drills performed in 2024 (3rd Quarter / 2nd Shift). During the Staff Interview between Noon on 04/07/2025 and 5:00 pm on 04/08/2025, the Maintenance Director acknowledged this finding. This finding was also discussed and acknowledged by the Administrator during the exit conference. NFPA 101 (2012 Edition) 19.7.1.6	K 712		
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage	K 923		5/16/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2025
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 01 - MAIN FED B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
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	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	<p>Continued From page 3</p> <p>Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.</p> <p>>300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.</p> <p>Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain gas equipment-cylinder</p>	K 923		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2025
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 01 - MAIN FED B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2025
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 923	<p>Continued From page 4 and container storage in accordance with NFPA 101.</p> <p>Findings included:</p> <p>During the Life Safety Survey tour of the facility between 11:00 am and 4:30 pm on 04/08/2025 with the Maintenance Director, it was observed as follows:</p> <p>2:06 pm Dialysis Room: there was 1 of 1 unsecured oxygen cylinders in use by a resident. It was secured during survey.</p> <p>During the Staff Interview between 11:00 am and 4:30 pm on 04/08/2025, the Maintenance Director acknowledged this finding. This finding was also discussed and acknowledged by the Administrator during the exit conference.</p> <p>NFPA 101 (2012 Edition) 19.7.6, 4.6.12, 4.6.12.1 NFPA 99 (2012 Edition) 11.7.3.1 through 11.7.3.2</p>	K 923			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 111343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST ANNES NURSING CENTER, ST ANNES RESIDENC	STREET ADDRESS, CITY, STATE, ZIP CODE 11855 QUAIL ROOST DRIVE MIAMI, FL 33177
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

K 000	<p>INITIAL COMMENTS</p> <p>A re-licensure survey was conducted on 04/07/2025-04/08/2025 at St. Anne's Nursing Center/St. Anne's Residence Inc., a nursing home in Miami, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2021 edition) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69A-3, F.A.C. 69A-53, F.A.C. 59A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2021 edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2.</p> <p>The following is a description of the deficiencies found at the time of the visit.</p>	K 000		
K 353 SS=E	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler</p>	K 353		5/16/25

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Electronically Signed

05/09/25

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 111343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST ANNES NURSING CENTER, ST ANNES RESIDENC	STREET ADDRESS, CITY, STATE, ZIP CODE 11855 QUAIL ROOST DRIVE MIAMI, FL 33177
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 353	<p>Continued From page 1</p> <p>system.</p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This Statute or Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain automatic sprinkler system in accordance with NFPA 101.</p> <p>The findings included:</p> <p>During the Life Safety Survey tour of the facility between 11:00 am and 4:30 pm on 04/08/2025 with the Maintenance Director, it was observed as follows:</p> <p>1:48 pm Kitchen: there were 8 of 28 sprinklers covered by foreign material, corroded, and damaged.</p> <p>3:00 pm 1st Floor Mechanical Room across the Chapel: there was lack of 1 of 1 spare dry sprinkler for freezer nor means to restore service.</p> <p>3:15 pm 1st Floor Main Entrance: there were 2 of 3 sprinklers covered by foreign material and corroded.</p> <p>During the Staff Interview between 11:00 am and 4:30 pm on 04/08/2025, the Maintenance Director acknowledged these findings. These findings were also discussed and acknowledged by the Administrator during the exit conference.</p> <p>NFPA 101 (2021 Edition) 19.7.6, 4.6.12, 4.6.12.1 NFPA 25 (2020 Edition) 5.2.1.1.1 and 5.4.1.5 through 5.4.1.5.3</p> <p>Class III</p>	K 353		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 111343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST ANNES NURSING CENTER, ST ANNES RESIDENC	STREET ADDRESS, CITY, STATE, ZIP CODE 11855 QUAIL ROOST DRIVE MIAMI, FL 33177
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 712 K 712 SS=D	<p>Continued From page 2</p> <p>NFPA 101 Fire Drills</p> <p>Fire Drills</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>18.7.1, 19.7.1, 4.7</p> <p>This Statute or Rule is not met as evidenced by: Based on records review and staff interview, the facility failed to perform fire drills in accordance with NFPA 101.</p> <p>Findings included:</p> <p>During the records review process of the facility between Noon on 04/07/2025 and 5:00 pm on 04/08/2025 with the Maintenance Director, it was revealed that there was lack of documentation for 1 of 4 fire drills performed in 2024 (3rd Quarter / 2nd Shift).</p> <p>During the Staff Interview between Noon on 04/07/2025 and 5:00 pm on 04/08/2025, the Maintenance Director acknowledged this finding. This finding was also discussed and acknowledged by the Administrator during the exit conference.</p> <p>NFPA 101 (2021 Edition) 19.7.1.6</p>	K 712 K 712		5/16/25

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 111343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER ST ANNES NURSING CENTER, ST ANNES RESIDENC		STREET ADDRESS, CITY, STATE, ZIP CODE 11855 QUAIL ROOST DRIVE MIAMI, FL 33177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 712	Continued From page 3 Class III	K 712		
K 923 SS=D	NFPA 99 Gas Equipment - Cylinder and Container Storage Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion.	K 923		5/16/25

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 111343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST ANNES NURSING CENTER, ST ANNES RESIDENC	STREET ADDRESS, CITY, STATE, ZIP CODE 11855 QUAIL ROOST DRIVE MIAMI, FL 33177
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 923	<p>Continued From page 4</p> <p>Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>This Statute or Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain gas equipment-cylinder and container storage in accordance with NFPA 101.</p> <p>Findings included:</p> <p>During the Life Safety Survey tour of the facility between 11:00 am and 4:30 pm on 04/08/2025 with the Maintenance Director, it was observed as follows:</p> <p>2:06 pm Dialysis Room: there was 1 of 1 unsecured oxygen cylinders in use by a resident. It was secured during survey.</p> <p>During the Staff Interview between 11:00 am and 4:30 pm on 04/08/2025, the Maintenance Director acknowledged this finding. This finding was also discussed and acknowledged by the Administrator during the exit conference.</p> <p>NFPA 101 (2021 Edition) 19.7.6, 4.6.12, 4.6.12.1 NFPA 99 (2021 Edition) 11.7.3.1 through 11.7.3.2</p> <p>Class III</p>	K 923		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2025
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 04/08/2025
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	<p>Initial Comments</p> <p>During an unannounced Fire & Life Safety recertification survey conducted on 04/07/2025-04/08/2025 at St. Anne's Nursing Center/St. Anne's Residence Inc., a nursing home in Miami, Florida, Emergency Preparedness was reviewed.</p> <p>St. Anne's Nursing Center/St. Anne's Residence Inc. is in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities.</p>	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
05/09/2025

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2025
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 01 - MAIN FED B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
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	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted 04/07/2025-04/08/2025 at St. Anne's Nursing Center/St. Anne's Residence Inc., a nursing home in Miami, Florida. The Facility is not in compliance with 42 CFR 483.90 (a), and National Fire Protection Association (NFPA) 101 (2012 edition), NFPA 99 (2012) requirements for nursing homes. Initial Plan Review: 1987 Existing NFPA 220 Construction Type: II (211) Number of beds: 213 Census: 190	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		5/16/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/09/2025

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2025
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 01 - MAIN FED B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
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	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain automatic sprinkler system in accordance with NFPA 101.</p> <p>The findings included:</p> <p>During the Life Safety Survey tour of the facility between 11:00 am and 4:30 pm on 04/08/2025 with the Maintenance Director, it was observed as follows:</p> <p>1:48 pm Kitchen: there were 8 of 28 sprinklers covered by foreign material, corroded, and damaged.</p> <p>3:00 pm 1st Floor Mechanical Room across the Chapel: there was lack of 1 of 1 spare dry sprinkler for freezer nor means to restore service.</p> <p>3:15 pm 1st Floor Main Entrance: there were 2 of 3 sprinklers covered by foreign material and corroded.</p> <p>During the Staff Interview between 11:00 am and 4:30 pm on 04/08/2025, the Maintenance Director acknowledged these findings. These findings were also discussed and acknowledged by the Administrator during the exit conference.</p> <p>NFPA 101 (2012 Edition) 19.3.5, 9.7.5 NFPA 25 (2011 Edition) 5.2.1.1.1 through 5.2.1.1.2 and 5.4.1.4.2.1</p>	K 353	<p>Immediate Action: A Certified Fire Protection contractor completed an inspection of the building on 4/8/2025. The proposal was signed April 30, 2025 to replace corroded and damaged sprinklers. The contract company is pending material availability which includes spare dry sprinkler for freezer.</p> <p>Identification of Residents with potential to be affected: All in-house residents have the potential to be affected.</p> <p>System Changes: The facility reviewed the preventive maintenance program to include a visual inspection of sprinkler heads is conducted monthly. Maintenance staff were retrained / educated on identifying signs of corrosion and damage to the sprinkler heads during the visual inspections.</p> <p>Monitoring: Director of Maintenance / designee will maintain a log of inspections and report will be present in the monthly Quality Assurance Performance Improvement committee meeting.</p> <p>Responsible Party: Director of Maintenance</p>	
K 712 SS=D	<p>Fire Drills CFR(s): NFPA 101</p>	K 712		5/16/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2025
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 01 - MAIN FED B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
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	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	<p>Continued From page 2</p> <p>Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on records review and staff interview, the facility failed to perform fire drills in accordance with NFPA 101.</p> <p>Findings included:</p> <p>During the records review process of the facility between Noon on 04/07/2025 and 5:00 pm on 04/08/2025 with the Maintenance Director, it was revealed that there was lak of documentation for 1 of 4 fire drills performed in 2024 (3rd Quarter / 2nd Shift).</p> <p>During the Staff Interview between Noon on 04/07/2025 and 5:00 pm on 04/08/2025, the Maintenance Director acknowledged this finding. This finding was also discussed and acknowledged by the Administrator during the exit conference.</p> <p>NFPA 101 (2012 Edition) 19.7.1.6</p>	K 712	<p>Immediate Action: A fire drill was conducted on the missed shift on May 9, 2025 to ensure that staff on the second shift are trained and prepared for emergency situations.</p> <p>Identification of Residents with potential to be affected: All in-house residents have the potential to be affected.</p> <p>System Changes: A Fire Drill schedule / calendar was created for the entire year which clearly indicates the required monthly drill shift.</p> <p>Monitoring: The Director of Maintenance will ensure the facility documentation is accurate regarding the scheduled shift. The schedule / calendar will be submitted to the monthly Quality Assurance Performance Improvement committee meeting.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2025
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 01 - MAIN FED B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
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	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 3	K 712		
K 923 SS=D	<p>Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101</p> <p>Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.</p> <p>>300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.</p> <p>Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure</p>	K 923	<p>Responsible Party: The Director of Maintenance</p>	5/16/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2025
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 01 - MAIN FED B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
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	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	<p>Continued From page 4</p> <p>considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain gas equipment-cylinder and container storage in accordance with NFPA 101.</p> <p>Findings included:</p> <p>During the Life Safety Survey tour of the facility between 11:00 am and 4:30 pm on 04/08/2025 with the Maintenance Director, it was observed as follows:</p> <p>2:06 pm Dialysis Room: there was 1 of 1 unsecured oxygen cylinders in use by a resident. It was secured during survey.</p> <p>During the Staff Interview between 11:00 am and 4:30 pm on 04/08/2025, the Maintenance Director acknowledged this finding. This finding was also discussed and acknowledged by the Administrator during the exit conference.</p> <p>NFPA 101 (2012 Edition) 19.7.6, 4.6.12, 4.6.12.1 NFPA 99 (2012 Edition) 11.7.3.1 through 11.7.3.2</p>	K 923	<p>Immediate Action: Oxygen cylinder was secured upon identification. A facility wide audit was conducted to identify unsecured cylinder holders.</p> <p>Identification of Residents with potential to be affected: All in-house residents have potential to be affected.</p> <p>System Changes: All oxygen cylinder holders without a safety mechanism were removed from circulation. The safety mechanism was install on those holders. Education for oxygen cylinder safety training was conducted with licensed staff. Upon identification of unsure holder they must remove the holder from circulation and report to maintenance via worx hub.</p> <p>Monitoring: Daily audits of all oxygen cylinder holders in storage areas to ensure all oxygen cylinder holders are secure prior to use. Results of the daily audit will be reported to Monthly Quality Assurance Performance Improvement Committee meeting for the next 90 days or until the committee agrees substantial compliance is met.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2025
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 01 - MAIN FED B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2025
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 923	Continued From page 5	K 923	Responsible Party: Director of Maintenance or designee		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 111343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST ANNES NURSING CENTER, ST ANNES RESIDENC	STREET ADDRESS, CITY, STATE, ZIP CODE 11855 QUAIL ROOST DRIVE MIAMI, FL 33177
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

K 000	<p>INITIAL COMMENTS</p> <p>A re-licensure survey was conducted on 04/07/2025-04/08/2025 at St. Anne's Nursing Center/St. Anne's Residence Inc., a nursing home in Miami, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2021 edition) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69A-3, F.A.C. 69A-53, F.A.C. 59A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2021 edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2.</p> <p>The following is a description of the deficiencies found at the time of the visit.</p>	K 000		
K 353 SS=E	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler</p>	K 353		5/16/25

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Electronically Signed

05/09/25

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 111343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER ST ANNES NURSING CENTER, ST ANNES RESIDENC		STREET ADDRESS, CITY, STATE, ZIP CODE 11855 QUAIL ROOST DRIVE MIAMI, FL 33177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 353	<p>Continued From page 1</p> <p>system.</p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This Statute or Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain automatic sprinkler system in accordance with NFPA 101.</p> <p>The findings included:</p> <p>During the Life Safety Survey tour of the facility between 11:00 am and 4:30 pm on 04/08/2025 with the Maintenance Director, it was observed as follows:</p> <p>1:48 pm Kitchen: there were 8 of 28 sprinklers covered by foreign material, corroded, and damaged.</p> <p>3:00 pm 1st Floor Mechanical Room across the Chapel: there was lack of 1 of 1 spare dry sprinkler for freezer nor means to restore service.</p> <p>3:15 pm 1st Floor Main Entrance: there were 2 of 3 sprinklers covered by foreign material and corroded.</p> <p>During the Staff Interview between 11:00 am and 4:30 pm on 04/08/2025, the Maintenance Director acknowledged these findings. These findings were also discussed and acknowledged by the Administrator during the exit conference.</p> <p>NFPA 101 (2021 Edition) 19.7.6, 4.6.12, 4.6.12.1 NFPA 25 (2020 Edition) 5.2.1.1.1 and 5.4.1.5 through 5.4.1.5.3</p> <p>Class III</p>	K 353	<p>Immediate Action:</p> <p>A Certified Fire Protection contractor completed an inspection of the building on 4/8/2025. The proposal was signed April 30, 2025 to replace corroded and damaged sprinklers. The contract company is pending material availability which includes spare dry sprinkler for freezer.</p> <p>Identification of Residents with potential to be affected: All in-house residents have the potential to be affected.</p> <p>System Changes: The facility reviewed the preventive maintenance program to include a visual inspection of sprinkler heads is conducted monthly. Maintenance staff were retrained / educated on identifying signs of corrosion and damage to the sprinkler heads during the visual inspections.</p> <p>Monitoring: Director of Maintenance / designee will maintain a log of inspections and report will be present in the monthly Quality Assurance Performance Improvement committee meeting.</p> <p>Responsible Party: Director of Maintenance</p>	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 111343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER ST ANNES NURSING CENTER, ST ANNES RESIDENC		STREET ADDRESS, CITY, STATE, ZIP CODE 11855 QUAIL ROOST DRIVE MIAMI, FL 33177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 712	Continued From page 3 Class III	K 712	Performance Improvement committee meeting. Responsible Party: The Director of Maintenance	
K 923 SS=D	NFPA 99 Gas Equipment - Cylinder and Container Storage Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full	K 923		5/16/25

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 111343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER ST ANNES NURSING CENTER, ST ANNES RESIDENC		STREET ADDRESS, CITY, STATE, ZIP CODE 11855 QUAIL ROOST DRIVE MIAMI, FL 33177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 923	<p>Continued From page 4</p> <p>cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>This Statute or Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain gas equipment-cylinder and container storage in accordance with NFPA 101.</p> <p>Findings included:</p> <p>During the Life Safety Survey tour of the facility between 11:00 am and 4:30 pm on 04/08/2025 with the Maintenance Director, it was observed as follows:</p> <p>2:06 pm Dialysis Room: there was 1 of 1 unsecured oxygen cylinders in use by a resident. It was secured during survey.</p> <p>During the Staff Interview between 11:00 am and 4:30 pm on 04/08/2025, the Maintenance Director acknowledged this finding. This finding was also discussed and acknowledged by the Administrator during the exit conference.</p> <p>NFPA 101 (2021 Edition) 19.7.6, 4.6.12, 4.6.12.1 NFPA 99 (2021 Edition) 11.7.3.1 through 11.7.3.2</p> <p>Class III</p>	K 923	<p>Immediate Action: Oxygen cylinder was secured upon identification. A facility wide audit was conducted to identify unsecured cylinder holders.</p> <p>Identification of Residents with potential to be affected: All in-house residents have potential to be affected.</p> <p>System Changes: All oxygen cylinder holders without a safety mechanism were removed from circulation. The safety mechanism was installed on those holders. Education for oxygen cylinder safety training was conducted with licensed staff. Upon identification of unsure holder, they must remove the holder from circulation and report to the Maintenance Department via Worx hub.</p> <p>Monitoring: Daily audits of all oxygen cylinder holders in storage areas to ensure all oxygen cylinder holders are secure prior to use. Results of the daily audit will be reported to Monthly Quality Assurance Performance Improvement Committee meeting for the next 90 days or until the</p>	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 111343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER ST ANNES NURSING CENTER, ST ANNES RESIDENC		STREET ADDRESS, CITY, STATE, ZIP CODE 11855 QUAIL ROOST DRIVE MIAMI, FL 33177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 923	Continued From page 5	K 923	committee agrees substantial compliance is met. Responsible Party: Director of Maintenance or designee	