Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 111343 | A. BUILDING: _____ B. WING _____ | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ST ANNES NURSING CENTER, ST ANNES RESIDENC | 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 |
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| N 000 | INITIAL COMMENTS<br><br>A re-licensure survey in conjunction with complaint investigation numbers 2025004613 and 2025004738 was conducted at St. Annes Nursing Center on , , through , . Deficiencies were identified at the time of the survey | N 000 | | |
| N 054 SS=D | 59A-4.107(5), FAC Follow Physician Orders<br><br>All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift.<br><br>This Statute or Rule is not met as evidenced by: Based on observations, interviews and record review the facility failed to follow physician orders for two (#25, #52) out of 13 residents who have orders for floor mats; failed to provide , , as prescribed for one (Resident #95) out of two sampled residents receiving , , as evidenced by observations of , , in progress at 1.25 liters per minute despite a physician's order for 2 liters per minute for Resident #95.<br><br>The findings included:<br><br>Resident#25<br><br>Observation on 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 | N 054 | | |

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| N 054 | Continued From page 1<br><br>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 ."<br><br>Record review of a demographic sheet revealed Resident #25 was admitted on with diagnosis that include: Presence of Right , , ; , S/P- , repair of , ; (generalized and .<br><br>Record review of nursing notes dated revealed Resident #25 was found on the floor and on revealed Resident#25 was found on the floor.<br><br>Record review of a Quarterly Minimum Data Set (MDS) reference dated revealed Resident#52 is severely ; dependent for Activities of Daily Living (ADL), has on upper and lower extremities ...<br><br>Record review of a physician order sheet (POS) revealed Resident#25 had order dated for floor mats when in bed every shift.<br><br>Resident#52<br><br>On at 9:46 AM Resident#52 observed in bed with 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 | N 054 | | |

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| N 054 | Continued From page 2<br><br>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."<br><br>Record review of a demographic sheet revealed Resident #52 was admitted on with diagnosis that include: unspecified part of of , D deficiency and<br><br>Record review of a Physician Order Sheet (POS) revealed Resident #52 had an order dated directions: floor mats when in bed every shift.<br><br>Record review of a Nursing note dated 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 Resident #52 was found on the floor next to the bed on the floor mattress.<br><br>During an interview on 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."<br><br>During an interview on at 8:54 AM, the DON revealed: "The falling star program to identify how a 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 | N 054 | | |

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| N 054 | Continued From page 3<br><br>shift staff discuss the 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 before they walk away."<br><br>Resident # 95<br><br>On 9:40 am Resident #95 was observed in bed with closed, in progress at 1.25 Liters per minute via . (Photographic evidence).<br><br>On at 11:40 AM Resident #95 was observed in bed with no apparent distress, was in progress at 1.25 Liters per minute via (photo). Staff C, Registered Nurse (RN) was asked what the prescribed rate for 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 level and adjusted to the prescribed rate. Staff C, Registered Nurse (RN) checked Resident #95's saturation, and it was 76%. Staff C, Registered Nurse (RN) revealed Hospice would be notified.<br><br>On at 12:00 PM Staff D, Hospice Registered Nurse (RN) evaluated Resident #95 and revealed a new saturation rate of 96%. Staff C, Registered Nurse (RN) stated, "I did round this morning, but I did not visualize if the was at the ordered level."<br><br>Record review of a demographic sheet revealed Resident #95 was admitted on with diagnosis that included: Acute diastolic | N 054 | | |

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| N 054 | Continued From page 4<br><br>( ) and valve .<br><br>Record review of a Quarterly Minimum Data Set (MDS) reference dated revealed Resident #95 had a Brief Interview of Mental Status ( ) score of 7, indicating severe , dependent on ADLs (Activities of Daily Living), received hospice care and .<br><br>Record review of a Care Plan dated and revised revealed Resident #95 had the potential for , alteration in status due to of with interventions that included: Administer and treatments as ordered, apply via 2.0 liter per min continuous as ordered.<br><br>Record review of a Physicians Order Sheet revealed Resident #95 had orders dated to apply humidified via at 2.0 liter per min as needed and an order dated to apply humidified via at 2.0 liter per min continuous.<br><br>On at 9:08 AM The Director of Nursing was interviewed about the protocol and stated, " is to be delivered at the prescribed rate whether it is continuous or as needed."<br><br>Class III | N 054 | | |

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| N 071 | Continued From page 5 | N 071 | | |
| N 071 SS=D | 59A-4.109(1), FAC Components of Care Plan<br><br>(1) Each resident admitted to the nursing home facility must have a plan of care. The plan of care must consist of:<br>(a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential.<br>(b) A preliminary nursing evaluation with physician's orders for immediate care, completed upon admission.<br>(c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment must be:<br>1. Reviewed no less than once every 3 months;<br>2. Reviewed promptly after a significant change, which is a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem, in the resident's physical or mental condition; and,<br>3. Revised as appropriate to assure the continued accuracy of the assessment.<br><br>This Statute or Rule is not met as evidenced by:<br>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.<br><br>The findings included. | N 071 | | |

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| N 071 | Continued From page 6<br><br>Review of Resident #200's clinical records revealed the resident was admitted to the facility on from a Short-Term General Hospital (acute hospital) Medical diagnosis included but not limited to: Other specified injuries of , subsequent encounter. Review of orders dated noted Resident #1 to be discharged to the St. Annes Residence. Assisted Living Facility (ALF. The discharge/transfer was scheduled for<br><br>Review of Resident # 200's discharge Assessment MDS reference dated indicated in the section for pattern that the resident is . The entry/discharge reporting section indicated: Discharge Assessment-return not . Type of discharge: Planned. The section for discharge status coded resident was discharged to a Short-Term General Hospital (acute hospital).<br><br>Review of a Nurses Notes dated at 10:52:00 documented: Resident discharged to Adult Living Facility St. Annes ALF, on transported via wheelchair.<br><br>During an interview on 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.<br><br>Review of the facility policy and procedure effective , regarding resident assessments stated, it is the policy of this facility | N 071 | | |

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| N 071 | Continued From page 7<br><br>that each resident admitted to the institution shall receive a complete -to- 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.<br><br>Class III | N 071 | | |
| N 072 SS=D | 59A-4.109(2), FAC; Comprehensive Care Plans<br><br>59A-4.109 FAC<br>(2) The nursing home licensee develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment.<br><br>This Statute or Rule is not met as evidenced by: Based on observations, interviews and record review the facility failed to develop and implement a care plan for two (#25, #52) out of 13 residents who have orders for floor mats and a care plan for one (#95) out of one resident receiving as evidenced by record review revealed no interventions for floor mats for Resident#25, observations revealed one floor mat in place for Resident#52 despite interventions for | N 072 | | |

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| N 072 | Continued From page 8<br><br>two and , , in progress at 1.25 liters per minute despite a physician's order for 2 liters per minute for Resident#95. There were 190 residents residing in the facility at the time of survey.<br><br>The findings included:<br><br>Resident#25<br><br>1.On at 10:00 AM, Resident#25 was observed in bed on the floor to the left side of the bed on floor mat was noted. Staff A, Registered Nurse (RN) Supervisor stated: "This Resident needs two floor mats." Staff A,was unable to find another floor mat in the room. Staff E, Certified Nursing Assistant (CNA) was asked about the protocol for floor mats. Staff E, Certified Nursing Assistant (CNA) replied, "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 ."<br><br>Record review of a demographic sheet revealed Resident#25 was admitted on with diagnosis that included: and , .<br><br>Record review of a Quarterly Minimum Data Set (MDS) reference dated revealed Resident#52 had a Brief Interview of Mental Status ( ) score of 6, indicated severe on lower extremity, transfer, was taking , , , | N 072 | | |

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| N 072 | Continued From page 9<br>in the last 7 days.<br><br>Record review Resident#25's care plan dated and reviewed on revealed Resident#25 complained of to right after a on and results were positive for a to . Further review revealed interventions included: maintain bed in lowest position, monitor every hours and 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.<br><br>On around 11am, Staff F, MDS Coordinator was asked if floor mats should be included in the care plan and told the surveyor she would go and check. Staff F, MDS Coordinator returned and presented surveyor with a the same care plan that now included intervention floor mat as ordered ( ).<br><br>Record review of a physician order sheet (POS) revealed Resident#25 had order dated for floor mats when in bed every shift.<br><br>Record review of nursing notes dated revealed Resident#25 was found on the floor and revealed Resident#25 was found on the floor.<br><br>Resident#52<br><br>2. On at 9:46am Resident#52 observed in bed with 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. No staff were present. Staff E, Certified Nursing Assistant | N 072 | | |

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| N 072 | Continued From page 10<br><br>(CNA) entered the room and was asked by surveyor how many floor mats are required for Resident#52 and replied, "Resident#52 is supposed to have two floors mats down, when I assisted the resident I put one up."<br><br>On at 10:18am Staff B, Registered Nurse (RN) was interviewed about the floor mat protocol and stated, 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 for the amount of floor mats needed. In general, I communicate with the CNAs."<br><br>On at 8:54 AM, The DON was interviewed about the protocol for floor mats and stated, "The falling star program to identify how a 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 prevention interventions. We also provide education for the staff about prevention. 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 before they walk away."<br><br>Record review of a demographic sheet revealed Resident#52 was admitted on with diagnosis that included: unspecified part of of , D deficiency,<br><br>Record review of a Quarterly Minimum Data Set | N 072 | | |

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| N 072 | Continued From page 11<br><br>(MDS) reference dated revealed Resident#52 had a score of 4, indicated severe on one side of lower extremity, dependent for ADLs and substantial/maximal assistance for bed/chair transfers, always of , had a since admission or the prior assessment with no injury, and was taking , medication in last 7 days.<br><br>Record review of a care plan dated revealed Resident#52 was observed by CNA on the floor by nurse report, on was observed on floor next to the bed on the floor mattress, no apparent injury, continue to observe with interventions that included: floor matt as ordered.<br><br>Record review of a POS revealed Resident#52 had an order dated directions: floor mats when in bed every shift.<br><br>Record review of a Nursing note dated revealed at 3:15 am Resident#52 was found by CNA on the floor matt in the bedroom. Further review of nursing notes revealed on Resident#52 was found on the floor next to the bed on the floor mattress.<br><br>Resident #95<br><br>3. On 9:40 am Resident#95 was observed in bed with closed, in progress at 1.25 Liters per minute via , no apparent distress observed (see photo).<br><br>On at 11:40 AM Resident#95 was observed in bed with no apparent distress, was in progress at 1.25 Liters per minute | N 072 | | |

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| N 072 | Continued From page 12<br><br>via (see photo). Staff C, Registered Nurse (RN) was asked what the prescribed rate for 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 level and adjusted to the prescribed rate. Staff C, Registered Nurse (RN) checked Resident#95's saturation and it was 76%. Staff C, Registered Nurse (RN) revealed to the surveyor that Hospice would be notified.<br><br>On at 12:00 PM Staff D, Hospice Registered Nurse (RN) evaluated Resident#95 and revealed a new saturation rate of 96%. Staff C, Registered Nurse (RN) stated, "I did rounds this morning but I did not visualize if the was at the ordered level."<br><br>Record review of a demographic sheet revealed Resident#95 was admitted on with diagnosis that included: Acute diastolic ( ) and valve .<br><br>Record review of a Quarterly Minimum Data Set (MDS) reference dated revealed Resident#95 had a Brief Interview of Mental Status ( ) score of 7, indicated severe , was dependent for ADLs, had no , received hospice care and .<br>Record review of a Care Plan dated and revised revealed Resdeint#95 had the potential for , alteration in , status due to of with interventions that included: Administer and treatments as ordered, apply via | N 072 | | |

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| | 111343 | A. BUILDING: _____ B. WING _____ | 04/10/2025 |

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| ST ANNES NURSING CENTER, ST ANNES RESIDENC | 11855 QUAIL ROOST DRIVE MIAMI, FL 33177 |

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| N 072 | Continued From page 13<br><br>2.0 liter per min continuous as ordered.<br><br>Record review of a POS revealed Resident#95 had orders dated to apply humidy ,,, via at 2.0 liter per min as needed and to apply humidy ,,, via . . . . . at 2.0 liter per min continuous.<br><br>On . . . at 9:08 AM The Director of Nursing was interviewed about the ,,, protocol and stated, " ,,, is to be delivered at the prescribed rate whether it is continuous or as needed."<br><br>Record review of a Policy Subject: Care Planning Policy#2046 Effective: Revised: Reviewed: 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.<br><br>Class III | N 072 | | |

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| N 201 | Continued From page 14 | N 201 | | |
| N 201 SS=D | 400.022(1)(l), FS Right to Adequate and Appropriate Health Care<br><br>(l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to provide adequate and appropriate healthcare and treatment services to prevent ( ) for one (Resident #182) out of one resident reviewed for an , a evidenced by inappropriate placement of the drainage bag anchored on the side rail above the resident's increasing the risk for and dislodgement.<br><br>The findings included:<br><br>On at 9:46 AM Resident#184 observed lying in bed. An drainage bag was observed anchored to the side rail above near the resident's . 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 device drainage bag was positioned correctly. Staff A, Registered Nurse (RN) Supervisor stated, "The drainage bag should be lower than the ." Staff A, RN Supervisor then performed hygiene and donned gloves, adjusted the drainage bag and | N 201 | | |

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| N 201 | Continued From page 15<br><br>secured it below the 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."<br><br>Record review of a demographic sheet revealed Resident#182 was admitted on with diagnosis that included: Hyperplasia ( ) with lower , tract symptoms.<br><br>Record review of physician order sheet revealed Resident#184 had order dated to provide care every shift.<br><br>Record review of an Admission Minimum Data Set (MDS) reference dated revealed Resident#184 is . Requires partial/ for toileting hygiene/personal hygiene/transfers, has an , diagnosis of and , has a PU ( ) injury<br><br>Record review of care plan dated reveled Resident#184 was at an increased risk for related to due to , retention with interventions that included: Maintain anchoring device to prevent dislodgement of or pulling against and monitor site of anchor for skin integrity.<br><br>Interview on at 10:18 AM Staff B, RN was notified of the identified concern and asked about the protocol for positioning of the , 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 | N 201 | | |

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| N 201 | Continued From page 16<br><br>[Resident #184's] was in place. The [] bag should be below the body. The purpose is to facilitate flow because it could cause the to flow and cause ."<br><br>On 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 . Staff are educated about how to position drainage bags."<br><br>Record review of a Policy Subject: [brand] Care, Policy # 2032, Effective: , Revised: , Reviewed: revealed Policy: It is the policy of this facility that care will be provided to all residents with 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 care is to prevent possible from spreading from the area and external into the .<br><br>BASIC PROCEDURES: The and drainage bag should be kept as a closed system with the drainage bag kept at a level lower than the to allow drainage by gravity.<br><br>Class III | N 201 | | |

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| F 000 | INITIAL COMMENTS<br><br>A recertification survey in conjunction with complaint investigation numbers 2025004613 and 2025004738 was conducted at St. Annes Nursing Center on , , , through , , . The complaint allegations were unsubstantiated. The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities. | F 000 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>The findings included.<br><br>Review of Resident #200's clinical records revealed the resident was admitted to the facility on from a Short-Term General Hospital (acute hospital) Medical diagnosis included but not limited to: Other specified injuries of , subsequent encounter.<br>Review of orders dated noted Resident #1 to be discharged to the St. Annes Residence. Assisted Living Facility (ALF. The discharge/transfer was scheduled for , , | F 641 | | |

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

Electronically Signed /2025

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| F 641 | Continued From page 1 | F 641 | | |

Review of Resident # 200's discharge Assessment MDS reference dated indicated in the section for ⌣ pattern that the resident is ⌣ , . The entry/discharge reporting section indicated: Discharge Assessment-return not , . . 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 at 10:52:00 documented: Resident discharged to Adult Living Facility St. Annes ALF, on transported via wheelchair.
During an interview on 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 , . . , regarding resident assessments stated, it is the policy of this facility that each resident admitted to the institution shall receive a complete -to- 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.

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| F 645 SS=D | Continued From page 2<br>PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental and individuals with intellectual .<br><br>§483.20(k)(1) A nursing facility must not admit, on or after , any new residents with:<br>(i) Mental as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br>(ii) Intellectual , as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual or authority has determined prior to admission-<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual .<br><br>§483.20(k)(2) Exceptions. For purposes of this section-<br>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide | F 645<br>F 645 | | |

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| F 645 | Continued From page 3 | F 645 | | |

for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental if the individual has a serious mental defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual , if the individual has an intellectual , as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
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.

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| F 645 | Continued From page 4<br>The findings included.<br><br>Record review of a demographic sheet for Resident #166 revealed an admission date of with diagnosis that included: , , unspecified.<br><br>Further review revealed Admissions Minimum Data Set (MDS) reference dated 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 , or a related condition? - No. Section I revealed , and , . Section N revealed Resident#166 was taking , , and , medications and Section O revealed Resident#166 received no , , , .<br><br>Record review of a physician's order sheet revealed orders dated directions: , one (1) milligram (mg) tablet dose via , , ( ) tube every twelve (12) hours for , , and , 25 mg tablet via for , .<br>Further review revealed a , evaluation note dated indicated medication included: , 25 mg at bedtime and the chief complaint included , , , and a history of , , .<br><br>Record review of Resident #166's PASRR dated .<br><br>revealed Section I: PASRR Screen Decision-Making A. or suspected (check all that apply): no diagnosis was checked. | F 645 | | |

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| F 645 | Continued From page 5<br>On at 4:34 PM, review of the most recent PASRR provided by the Social Services Director for Resident#166, dated revealed: Section I: PASRR Screen Decision-Making A. or suspected. (check all that apply): no diagnosis was checked.<br><br>During an interview on at 5:00 PM, the Social Services Director, revealed Resident #166 was admitted on and received a , , evaluation on and a resident review was scheduled to occur within 30 days of the , , evaluation to assess any changes in the patient's condition. The Social Services Director acknowledged the discrepancies.<br><br>During an interview on 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."<br><br>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.<br>Purpose: The Level I and II PASRR Screening and Determination process is mandated by Federal Regulation (CFR) 483.100-483.138. The | F 645 | | |

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| F 645 | Continued From page 6<br>PASRR evaluation is designed to prevent inappropriate placement of residents/patients in a Skilled Nursing Facility (SNF).<br>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 | F 645 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and , ˛ needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and , ´ well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>( )In consultation with the resident and the resident's representative(s)- | F 656 | | |

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(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and -informed.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to develop and implement a 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 care plan for one (Resident #95) out of two sampled residents receiving as evidenced by Resident #95 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 at 10:00 AM, Resident #25 was in bed; one floor mat was noted on the

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| F 656 | Continued From page 8 | F 656 | | |

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 ."

Record review of a demographic sheet revealed Resident #25 was admitted on with diagnosis that include: Presence of Right , S/P- , repair of , ; (generalized and .
Record review of nursing notes dated revealed Resident #25 was found on the floor and on revealed Resident#25 was found on the floor.

Record review of a Quarterly Minimum Data Set (MDS) reference dated revealed Resident#52 is severely , , ; dependent for Activities of Daily Living (ADL), has , on upper and lower extremities ...
Record review of a physician order sheet (POS) revealed Resident#25 had order dated for floor mats when in bed every shift.

Record review Resident#25's care plan dated and reviewed on revealed Resident#25 complained of , to right after a on and , results were positive

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| F 656 | Continued From page 9<br>for a to . Further review revealed interventions included: maintain bed in lowest position, monitor every 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.<br><br>On 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 ( ).<br><br>Resident#52<br>On at 9:46 AM Resident#52 observed in bed with , 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."<br><br>Record review of a demographic sheet revealed Resident #52 was admitted on with diagnosis that include: unspecified part of of , D deficiency and .<br><br>Record review of a Physician Order Sheet (POS) revealed Resident #52 had an order dated directions: floor mats when in bed every shift. | F 656 | | |

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| F 656 | Continued From page 10 | F 656 | | |

Record review of a Nursing note dated 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 Resident #52 was found on the floor next to the bed on the floor mattress.

During an interview on 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 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 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 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 before they walk away."

Resident #95

On 9:40 am Resident #95 was observed in bed with , closed, , in progress at 1.25 Liters per minute via .

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| F 656 | Continued From page 11<br>(Photographic evidence).<br><br>On at 11:40 AM Resident #95 was observed in bed with no apparent distress, was in progress at 1.25 Liters per minute via (photo). Staff C, Registered Nurse (RN) was asked what the prescribed rate for 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 level and adjusted to the prescribed rate. Staff C, Registered Nurse (RN) checked Resident #95's saturation, and it was 76%. Staff C, Registered Nurse (RN) revealed Hospice would be notified.<br><br>On at 12:00 PM Staff D, Hospice Registered Nurse (RN) evaluated Resident #95 and revealed a new saturation rate of 96%. Staff C, Registered Nurse (RN) stated, "I did round this morning, but I did not visualize if the was at the ordered level."<br><br>Record review of a demographic sheet revealed Resident #95 was admitted on with diagnosis that included: Acute diastolic ( ) and valve .<br><br>Record review of a Quarterly Minimum Data Set (MDS) reference dated revealed Resident #95 had a Brief Interview of Mental Status ( ) score of 7, indicating severe , dependent on ADLs (Activities of Daily Living), received hospice care and .<br><br>Record review of a Care Plan dated | F 656 | | |

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| F 656 | Continued From page 12 | F 656 | | |

and revised revealed Resident #95 had the potential for , alteration in , status due to of with interventions that included: Administer and treatments as ordered, apply via 2.0 liter per min continuous as ordered.

Record review of a Physicians Order Sheet revealed Resident #95 had orders dated to apply humidified via at 2.0 liter per min as needed and an order dated to apply humidified via at 2.0 liter per min continuous.

On at 9:08 AM The Director of Nursing was interviewed about the protocol and stated, " 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: Revised: Reviewed: 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

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| F 656 | Continued From page 13<br>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. | F 656 | | |
| F 690 SS=D | / , ,<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) .<br>§483.25(e)(1) The facility must ensure that resident who is of and on admission receives services and assistance to maintain unless his or her clinical condition is or becomes such that is not possible to maintain.<br><br>§483.25(e)(2)For a resident with , based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an is not unless the resident's clinical condition demonstrates that was necessary;<br>(ii) A resident who enters the facility with an or subsequently receives one is assessed for removal of the as soon as possible unless the resident's clinical condition demonstrates that is necessary; and<br>(iii) A resident who is of receives appropriate treatment and services to prevent and to restore to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal , based on the resident's | F 690 | | |

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| F 690 | Continued From page 14 | F 690 | | |

comprehensive assessment, the facility must ensure that a resident who is of receives appropriate treatment and services to restore as much normal function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to provide appropriate treatment and services to prevent ( ) for one (Resident #182) out of one resident reviewed for an , a evidenced by inappropriate placement of the drainage bag anchored on the side rail above the resident's increasing the risk for and dislodgement.

The findings included:

On at 9:46 AM Resident#184 observed lying in bed. An drainage bag was observed anchored to the side rail above near the resident's . 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 device drainage bag was positioned correctly. Staff A, Registered Nurse (RN) Supervisor stated, "The drainage bag should be lower than the ." Staff A, RN Supervisor then performed hygiene and donned gloves, adjusted the drainage bag and secured it below the 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 with

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| F 690 | Continued From page 15 | F 690 | | |

diagnosis that included:
Hyperplasia ( ) with lower tract symptoms.
Record review of physician order sheet revealed Resident#184 had order dated to provide care every shift...

Record review of an Admission Minimum Data Set (MDS) reference dated revealed Resident#184 is . Requires partial/ for toileting hygiene/personal hygiene/transfers, has an , diagnosis of and , has a PU ( ) injury

Record review of care plan dated reveled Resident #184 was at an increased risk for related to due to retention with interventions that included: Maintain anchoring device to prevent dislodgement of or pulling against and monitor site of anchor for skin integrity.

Interview on at 10:18 AM Staff B, RN was notified of the identified concern and asked about the protocol for positioning of the 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] was in place. The [] bag should be below the body. The purpose is to facilitate flow because it could cause the to flow and cause ."

On at 8:59 AM, the Director of Nursing

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| F 690 | Continued From page 16<br>stated: "If a resident is in bed the drainage bag is hung below the level of the . Staff are educated about how to position drainage bags."<br><br>Record review of a Policy Subject: [brand] Care, Policy # 2032, Effective: , Revised: , Reviewed: revealed Policy: It is the policy of this facility that care will be provided to all residents with 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 care is to prevent possible from spreading from the area and external into the .<br><br>BASIC PROCEDURES: The and drainage bag should be kept as a closed system with the drainage bag kept at a level lower than the to allow drainage by gravity. | F 690 | | |
| F 695 SS=D | / Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) care, including care and suctioning.<br>The facility must ensure that a resident who needs care, including care and suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews and record review the facility failed to provide appropriate care consistent with professional standards of practice, for one ( Resident #95) out | F 695 | | |

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| F 695 | Continued From page 17 | F 695 | | |

of two sampled residents receiving , , as evidenced by observations of , , 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 9:40 am Resident #95 was observed in bed with , closed, , , in progress at 1.25 Liters per minute via . (Photographic evidence).

On at 11:40 AM Resident #95 was observed in bed with no apparent distress, , , was in progress at 1.25 Liters per minute via (photo). Staff C, Registered Nurse (RN) was asked what the prescribed rate for , , 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 , , level and adjusted to the prescribed rate. Staff C, Registered Nurse (RN) checked Resident #95's , , saturation, and it was 76%. Staff C, Registered Nurse (RN) revealed Hospice would be notified.

On at 12:00 PM Staff D, Hospice Registered Nurse (RN) evaluated Resident #95 and revealed a new , , saturation rate of 96%. Staff C, Registered Nurse (RN) stated, "I did round this morning, but I did not visualize if the , , was at the ordered level."

Record review of a demographic sheet revealed Resident #95 was admitted on with diagnosis that included: Acute diastolic

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| F 695 | Continued From page 18<br>( ) and valve .<br><br>Record review of a Quarterly Minimum Data Set (MDS) reference dated revealed Resident #95 had a Brief Interview of Mental Status ( ) score of 7, indicating severe , dependent on ADLs (Activities of Daily Living), received hospice care and .<br><br>Record review of a Care Plan dated and revised revealed Resident #95 had the potential for , alteration in status due to of with interventions that included: Administer and treatments as ordered, apply via 2.0 liter per min continuous as ordered.<br><br>Record review of a Physicians Order Sheet revealed Resident #95 had orders dated to apply humidified via at 2.0 liter per min as needed and an order dated to apply humidified via at 2.0 liter per min continuous.<br><br>On at 9:08 AM The Director of Nursing was interviewed about the protocol and stated, " is to be delivered at the prescribed rate whether it is continuous or as needed."<br><br>Record review of a Policy Subject: Concentrators, Policy#2012, Effective: , Revised: , Reviewed: revealed Policy: Concentrators will be used for patients and residents that require | F 695 | | |

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| F 695 | Continued From page 19<br>,.. with a liter flow rate of 1 to 5 liters per minute.<br>PURPOSE: The device is a means of delivering ,.. to the patients and residents in small mobile units that extract ,.. from room air and provides continuous supply of ,.. without refilling.<br>PROCEDURES: This equipment is to be used on all patients and residents that require ,.. 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. | F 695 | | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but | F 867 | | |

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| F 867 | Continued From page 20 | F 867 | | |

not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the [redacted] and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies [redacted]:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to

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| F 867 | Continued From page 21<br>ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.<br><br>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and , , of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) | F 867 | | |

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| F 867 | Continued From page 22 | F 867 | | |

functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
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- Prevention & Control. As evidenced by: F 880 was cited during a Recertification survey ending when the facility failed to implement control procedures for one (Resident #430) as evidenced by , , , equipment ( 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 , through , , at the facility. F 880 Prevention & Control was cited as the facility failed to implement control procedures for one (Resident #430) as evidenced by , , equipment ( and tubing) stored

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| ST ANNES NURSING CENTER, ST ANNES RESIDENCE INC | 11855 QUAIL ROOST DRIVE MIAMI, FL 33177 |

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| F 867 | Continued From page 23<br>uncovered on bedside table next to a live plant.<br><br>Review of the facility policy and procedures titled "Quality Assurance and Performance Improvement (QAPI)" revision date 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.<br>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:<br>Managing care and providing services.<br>Facilitating transitions across levels of care.<br>Community partnerships and collaboration.<br><br>Advocacy efforts.<br>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.<br><br>Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated , , and documented the facility have QAA Committee meetings monthly. Attendees included: Administrator, Medical Director, Director of Nursing (DON), Assistant Director of Nursing (ADON), Control Preventionist/Risk Manager, Dietary Manager, Clinical Dietician, Director of Housekeeping, Director of Maintenance, Director of , , Director of Human resources, Director of admissions, Director of Business office, Director | F 867 | | |

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| F 867 | Continued From page 24<br>of Social Services, Director of Activities, MDS (Minimum Data Set) Coordinator.<br><br>Interview on 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 . The committee consists of the Medical Director, Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), 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. | F 867 | | |
| F 880<br>SS=D | Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Control<br>The facility must establish and maintain an prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable and .<br><br>§483.80(a) prevention and control program.<br>The facility must establish an prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling and communicable for all residents, | F 880 | | |

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| F 880 | Continued From page 25<br>staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable or before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable or should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of ;<br>( )When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the ; and<br>(vi)The hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. | F 880 | | |

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| F 880 | Continued From page 26<br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of<br>.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews and record review the facility failed to implement 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.<br><br>The findings included:<br><br>Resident #84<br><br>On 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 , , issues since she came from the hospital. Staff B, RN was asked about the protocol for storing , , supplies when not in use; stated: "It should be stored in a plastic bag and dated when not in use. Staff B, RN was | F 880 | | |

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| F 880 | Continued From page 27<br>notified about the observation and entered the room with the surveyor and observed the Incentive Spirometer that was not bagged on nightstand.<br><br>Record review of a demographic sheet revealed Resident#84 was admitted to the facility on with diagnosis that include ( ) with acute exacerbation and other without acute .<br><br>Record review of a Minimum Data Set (MDS) reference dated revealed Resident #84 is moderately , required set up clean up assistance for eating/oral hygiene, had no of upper extremities.<br><br>Record review of a care plan dated revealed Resident #84 had the potential for , alteration in status due to S/P (Status Post) hospitalization due to and ( ), noted and suggestive atelectasis on the right and left lower , needs continuous .<br><br>Interview on at 9:01 AM, the Director of nursing (DON) was interviewed about the protocol for proper storage of 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 control, but is kept not in bag so it can be readily available to the resident."<br><br>Resident#41<br>On at 9:15 AM Resident #41 was observed seated in a wheelchair in the room. | F 880 | | |

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| F 880 | Continued From page 28 | F 880 | | |

Staff B, RN entered the room with a vitals machine and was observed while Resident # 41's (B/P)was measured, Staff B, RN placed the B/P cuff on the resident's right arm and measured the then removed the cuff and placed it on the vitals machine and performed hygiene and exit the room. Staff B, RN then re-entered room with a handheld sphygmomanometer ( machine) and placed the cuff on Resident #41's arm and measured the B/P. Staff B, RN then administered medications, performed hygiene and exited room. Staff, RN did not either cuff. There were no wipes on the machine.

Resident#73
On 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 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/ the shared cuff; Staff B, RN stated: "I usually the B/P cuff after each use, but I was nervous."

During an interview on at 9:13 AM, the DON revealed: "Staff are to clean the vitals machine with bleach wipes between residents to prevent ."

Record review of a Policy Subject:
Control Surveillance Policy#4011 Effective:
Revised: Reviewed:
revealed INTRODUCTION: The intent of any surveillance method is to measure outcomes and processes of care as a component

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| F 880 | Continued From page 29<br>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 Control Program. These goals are: To reduce the risk of between healthcare personnel and residents. Reduce the risk of developing in residents related to the use of devices and required procedures. | F 880 | | |

Agency for Health Care Administration

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| N 000 | INITIAL COMMENTS<br><br>A re-licensure survey in conjunction with complaint investigation numbers 2025004613 and 2025004738 was conducted at St. Annes Nursing Center on , , through , . Deficiencies were identified at the time of the survey | N 000 | | |
| N 054 SS=D | 59A-4.107(5), FAC Follow Physician Orders<br><br>All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observations, interviews and record review the facility failed to follow physician orders for two (#25, #52) out of 13 residents who have orders for floor mats; failed to provide , as prescribed for one (Resident #95) out of two sampled residents receiving as evidenced by observations of in progress at 1.25 liters per minute despite a physician's order for 2 liters per minute for Resident #95.<br><br>The findings included:<br><br>Resident#25<br><br>Observation on 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 | N 054 | Immediate Action:<br>Resident sample # 25- care plan was reviewed and revised to include implementation of floor mats per physician orders by the MDS Nurse .<br>Resident sample # 52 floor mat was placed as per physician orders. The Nurse and CNA were educated by the Nurse Manager on expectation of following physician orders and/or implementing the identified appropriate care plan interventions for floor mats.<br>Resident sample #95 The was increased from 1.25 liters per minute to 2 Liters per minute as per physician orders. saturation was checked and reported to the Hospice team. The Nurse was educated by the Nurse Manager on expectation of following physician orders and/or implementing the identified appropriate care plan interventions for use.<br><br>Identification of Residents with potential to | |

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| N 054 | Continued From page 1<br><br>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 ."<br><br>Record review of a demographic sheet revealed Resident #25 was admitted on with diagnosis that include: Presence of Right ; , S/P- , repair of ; (generalized and .<br><br>Record review of nursing notes dated revealed Resident #25 was found on the floor and on revealed Resident#25 was found on the floor.<br><br>Record review of a Quarterly Minimum Data Set (MDS) reference dated revealed Resident#52 is severely ; dependent for Activities of Daily Living (ADL), has on upper and lower extremities ...<br><br>Record review of a physician order sheet (POS) revealed Resident#25 had order dated for floor mats when in bed every shift.<br><br>Resident#52<br><br>On at 9:46 AM Resident#52 observed in bed with 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 | N 054 | be affected:<br>All residents in the facility have the potential to be affected. Interdisciplinary review and verification of care plan interventions and orders for floor mats and use.<br><br>System Changes:<br>The facility Prevention Policy and Medication Administration Policy were reviewed for accuracy.<br>Nurses and CNAs were educated and trained on the Falling Star Program and use of floor mats and resident use as indicated in the physician orders by the Director of Nursing and Risk Manager.<br>Licensed nursing staff are to verify and document in the Treatment Administration Record the use of floor mats and orders for use every shift.<br>Licensed nursing staff were educated by the Director of Nursing and the Assistant Director of Nursing on medication administration with emphasis on right dosage for use.<br><br>Monitoring:<br>Surveillance Rounds by Nurse Manager/designee to audit for compliance the residents with orders for floor mats and residents with use 3x a week for 90 days.<br>The results of the rounds will be reported to the monthly Quality Assurance Performance Improvement Committee.<br><br>Responsible Party:<br>Unit Managers, Supervisor, Risk Manager, ADON and DON | |

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| N 054 | Continued From page 2<br><br>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."<br><br>Record review of a demographic sheet revealed Resident #52 was admitted on with diagnosis that include: unspecified part of of , D deficiency and<br><br>Record review of a Physician Order Sheet (POS) revealed Resident #52 had an order dated directions: floor mats when in bed every shift.<br><br>Record review of a Nursing note dated 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 Resident #52 was found on the floor next to the bed on the floor mattress.<br><br>During an interview on 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."<br><br>During an interview on at 8:54 AM, the DON revealed: "The falling star program to identify how a 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 | N 054 | | |

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| N 054 | Continued From page 3<br><br>shift staff discuss the 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 before they walk away."<br><br>Resident # 95<br><br>On 9:40 am Resident #95 was observed in bed with closed, in progress at 1.25 Liters per minute via . (Photographic evidence).<br><br>On at 11:40 AM Resident #95 was observed in bed with no apparent distress, was in progress at 1.25 Liters per minute via (photo). Staff C, Registered Nurse (RN) was asked what the prescribed rate for 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 level and adjusted to the prescribed rate. Staff C, Registered Nurse (RN) checked Resident #95's saturation, and it was 76%. Staff C, Registered Nurse (RN) revealed Hospice would be notified.<br><br>On at 12:00 PM Staff D, Hospice Registered Nurse (RN) evaluated Resident #95 and revealed a new saturation rate of 96%. Staff C, Registered Nurse (RN) stated, "I did round this morning, but I did not visualize if the was at the ordered level."<br><br>Record review of a demographic sheet revealed Resident #95 was admitted on with diagnosis that included: Acute diastolic | N 054 | | |

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| N 054 | Continued From page 4<br><br>( ) and valve .<br><br>Record review of a Quarterly Minimum Data Set (MDS) reference dated revealed Resident #95 had a Brief Interview of Mental Status ( ) score of 7, indicating severe , dependent on ADLs (Activities of Daily Living), received hospice care and .<br><br>Record review of a Care Plan dated and revised revealed Resident #95 had the potential for , alteration in status due to of with interventions that included: Administer and treatments as ordered, apply via 2.0 liter per min continuous as ordered.<br><br>Record review of a Physicians Order Sheet revealed Resident #95 had orders dated to apply humidified via at 2.0 liter per min as needed and an order dated to apply humidified via at 2.0 liter per min continuous.<br><br>On at 9:08 AM The Director of Nursing was interviewed about the protocol and stated, " is to be delivered at the prescribed rate whether it is continuous or as needed."<br><br>Class III | N 054 | | |

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

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| N 071 | Continued From page 5 | N 071 | | |
| N 071 SS=D | 59A-4.109(1), FAC Components of Care Plan<br><br>(1) Each resident admitted to the nursing home facility must have a plan of care. The plan of care must consist of:<br>(a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential.<br>(b) A preliminary nursing evaluation with physician's orders for immediate care, completed upon admission.<br>(c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment must be:<br>1. Reviewed no less than once every 3 months;<br>2. Reviewed promptly after a significant change, which is a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem, in the resident's physical or mental condition; and,<br>3. Revised as appropriate to assure the continued accuracy of the assessment.<br><br>This Statute or Rule is not met as evidenced by:<br>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.<br><br>The findings included. | N 071 | Immediate Action:<br>The Minimal Data Set dated for sample resident #200 was modified for discharge status to an Assisted Living Facility in section A 2105 on was resubmitted on .Responsible staff member was re-educated on accurate Minimal Data Set completion by the MDS Nurse.<br><br>Identification of Residents with potential to | |

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| N 071 | Continued From page 6<br><br>Review of Resident #200's clinical records revealed the resident was admitted to the facility on from a Short-Term General Hospital (acute hospital) Medical diagnosis included but not limited to: Other specified injuries of , subsequent encounter. Review of orders dated noted Resident #1 to be discharged to the St. Annes Residence. Assisted Living Facility (ALF. The discharge/transfer was scheduled for<br><br>Review of Resident # 200's discharge Assessment MDS reference dated indicated in the section for pattern that the resident is . The entry/discharge reporting section indicated: Discharge Assessment-return not . Type of discharge: Planned. The section for discharge status coded resident was discharged to a Short-Term General Hospital (acute hospital).<br><br>Review of a Nurses Notes dated at 10:52:00 documented: Resident discharged to Adult Living Facility St. Annes ALF, on transported via wheelchair.<br><br>During an interview on 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.<br><br>Review of the facility policy and procedure effective , regarding resident assessments stated, it is the policy of this facility | N 071 | be affected:<br>All residents that are discharged have the potential to be affected.<br><br>The discharge assessment- return not and return MDSs completed since , will be audited for discharge location accuracy and modified per Resident Assessment Instrument Manuel. Inaccuracies identified will be corrected and resubmitted.<br><br>System Changes:<br>All resident discharges will be discussed by the Interdisciplinary Team on the next business day to determine discharge disposition. Discharges will be completed by the MDS Nurses in the entirety as of .<br><br>Monitoring:<br>Monthly audits of all Discharge Assessments will be audited weekly for accuracy for the next 3 months. An audit sheet will be maintained to demonstrate accurate completion of section A2105. Results will be reported monthly to the Quality Assurance Performance Improvement committee. At the end of 3 months, the Quality Assurance Performance Improvement Committee will reassess the need for ongoing audit frequency and duration.<br><br>Responsible Party:<br>MDS Nurses/ Coordinators | |

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| N 071 | Continued From page 7<br><br>that each resident admitted to the institution shall receive a complete -to- 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.<br><br>Class III | N 071 | | |
| N 072 SS=D | 59A-4.109(2), FAC; Comprehensive Care Plans<br><br>59A-4.109 FAC<br>(2) The nursing home licensee develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observations, interviews and record review the facility failed to develop and implement a care plan for two (#25, #52) out of 13 residents who have orders for floor mats and a care plan for one (#95) out of one resident receiving as evidenced by record review revealed no interventions for floor mats for Resident#25, observations revealed one floor mat in place for Resident#52 despite interventions for | N 072 | Immediate Action:<br>Resident sample # 25- care plan was reviewed and revised to include implementation of floor mats per physician orders by the MDS Nurse.<br>Resident sample # 52 floor mat was placed as per physician orders and care plan. The Nurse and CNA were educated by the Nurse Manager on | |

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| N 072 | Continued From page 8<br>two and ,, in progress at 1.25 liters per minute despite a physician's order for 2 liters per minute for Resident#95. There were 190 residents residing in the facility at the time of survey.<br><br>The findings included:<br><br>Resident#25<br><br>1.On at 10:00 AM, Resident#25 was observed in bed on the floor to the left side of the bed on floor mat was noted. Staff A, Registered Nurse (RN) Supervisor stated: "This Resident needs two floor mats." Staff A,was unable to find another floor mat in the room. Staff E, Certified Nursing Assistant (CNA) was asked about the protocol for floor mats. Staff E, Certified Nursing Assistant (CNA) replied, "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 ."<br><br>Record review of a demographic sheet revealed Resident#25 was admitted on with diagnosis that included: and , .<br><br>Record review of a Quarterly Minimum Data Set (MDS) reference dated revealed Resident#52 had a Brief Interview of Mental Status ( ) score of 6, indicated severe on lower , , , , extremity, transfer, was taking , , . | N 072 | expectation of following physician orders and/or implementing the identified appropriate care plan interventions for floor mats.<br>Resident sample #95 The ,, was increased from 1.25 liters per minute to 2 Liters per minute as per physician orders and care plan. ,, saturation was checked and reported to the Hospice team. The Nurse was educated by the Nurse Manager on expectation of following physician orders and/or implementing the identified appropriate care plan interventions for ,, use.<br><br>Identification of Residents with potential to be affected:<br>All residents in the facility have the potential to be affected. Interdisciplinary review and verification of care plan interventions and orders for floor mats and ,, use.<br><br>System Changes:<br>The facility Prevention Policy and Medication Administration Policy were reviewed for accuracy.<br>Nurses and CNAs were educated and trained on the Falling Star Program and use of floor mats and resident ,, use as indicated in the physician orders and care plan by the Director of Nursing and Risk Manager.<br>Licensed nursing staff are to verify and document in the Treatment Administration Record the use of floor mats and orders for ,, use every shift.<br>Licensed nursing staff were educated by the Director of Nursing and the Assistant Director of Nursing on medication | |

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| N 072 | Continued From page 9<br><br>in the last 7 days.<br><br>Record review Resident#25's care plan dated and reviewed on revealed Resident#25 complained of to right after a on and results were positive for a to . Further review revealed interventions included: maintain bed in lowest position, monitor every hours and 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.<br><br>On around 11am, Staff F, MDS Coordinator was asked if floor mats should be included in the care plan and told the surveyor she would go and check. Staff F, MDS Coordinator returned and presented surveyor with a the same care plan that now included intervention floor mat as ordered ( ).<br><br>Record review of a physician order sheet (POS) revealed Resident#25 had order dated for floor mats when in bed every shift.<br><br>Record review of nursing notes dated revealed Resident#25 was found on the floor and revealed Resident#25 was found on the floor.<br><br>Resident#52<br><br>2. On at 9:46am Resident#52 observed in bed with 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. No staff were present. Staff E, Certified Nursing Assistant | N 072 | administration with emphasis on right dosage for use.<br><br>Monitoring:<br>Surveillance Rounds by Nurse Manager/designee to audit for compliance of the residents with orders and care plans for floor mats and residents with use, 3x a week for 90 days.<br>The results of the rounds will be reported to the monthly Quality Assurance Performance Improvement Committee.<br><br>Responsible Party:<br>Unit Managers, Supervisor, Risk Manager, ADON and DON | |

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| N 072 | Continued From page 10<br><br>(CNA) entered the room and was asked by surveyor how many floor mats are required for Resident#52 and replied, "Resident#52 is supposed to have two floors mats down, when I assisted the resident I put one up."<br><br>On at 10:18am Staff B, Registered Nurse (RN) was interviewed about the floor mat protocol and stated, 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 for the amount of floor mats needed. In general, I communicate with the CNAs."<br><br>On at 8:54 AM, The DON was interviewed about the protocol for floor mats and stated, "The falling star program to identify how a 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 prevention interventions. We also provide education for the staff about prevention. 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 before they walk away."<br><br>Record review of a demographic sheet revealed Resident#52 was admitted on with diagnosis that included: unspecified part of of , D deficiency,<br><br>Record review of a Quarterly Minimum Data Set | N 072 | | |

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| N 072 | Continued From page 11<br><br>(MDS) reference dated revealed Resident#52 had a score of 4, indicated severe on one side of lower extremity, dependent for ADLs and substantial/maximal assistance for bed/chair transfers, always of , had a since admission or the prior assessment with no injury, and was taking , medication in last 7 days.<br><br>Record review of a care plan dated revealed Resident#52 was observed by CNA on the floor by nurse report, on was observed on floor next to the bed on the floor mattress, no apparent injury, continue to observe with interventions that included: floor matt as ordered.<br><br>Record review of a POS revealed Resident#52 had an order dated directions: floor mats when in bed every shift.<br><br>Record review of a Nursing note dated revealed at 3:15 am Resident#52 was found by CNA on the floor matt in the bedroom. Further review of nursing notes revealed on Resident#52 was found on the floor next to the bed on the floor mattress.<br><br>Resident #95<br><br>3. On 9:40 am Resident#95 was observed in bed with closed, in progress at 1.25 Liters per minute via , no apparent distress observed (see photo).<br><br>On at 11:40 AM Resident#95 was observed in bed with no apparent distress, was in progress at 1.25 Liters per minute | N 072 | | |

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| N 072 | Continued From page 12<br><br>via (see photo). Staff C, Registered Nurse (RN) was asked what the prescribed rate for 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 level and adjusted to the prescribed rate. Staff C, Registered Nurse (RN) checked Resident#95's saturation and it was 76%. Staff C, Registered Nurse (RN) revealed to the surveyor that Hospice would be notified.<br><br>On at 12:00 PM Staff D, Hospice Registered Nurse (RN) evaluated Resident#95 and revealed a new saturation rate of 96%. Staff C, Registered Nurse (RN) stated, "I did rounds this morning but I did not visualize if the was at the ordered level."<br><br>Record review of a demographic sheet revealed Resident#95 was admitted on with diagnosis that included: Acute diastolic ( ) and valve .<br><br>Record review of a Quarterly Minimum Data Set (MDS) reference dated revealed Resident#95 had a Brief Interview of Mental Status ( ) score of 7, indicated severe , was dependent for ADLs, had no , received hospice care and .<br>Record review of a Care Plan dated and revised revealed Resdeint#95 had the potential for , alteration in , status due to of with interventions that included: Administer and treatments as ordered, apply via | N 072 | | |

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| N 072 | Continued From page 13<br><br>2.0 liter per min continuous as ordered.<br><br>Record review of a POS revealed Resident#95 had orders dated to apply humidy ,,, via at 2.0 liter per min as needed and to apply humidy ,,, via . . . . . at 2.0 liter per min continuous.<br><br>On . . . at 9:08 AM The Director of Nursing was interviewed about the ,,, protocol and stated, " ,,, is to be delivered at the prescribed rate whether it is continuous or as needed."<br><br>Record review of a Policy Subject: Care Planning Policy#2046 Effective: Revised: Reviewed: 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.<br><br>Class III | N 072 | | |

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| N 201 | Continued From page 14 | N 201 | | |
| N 201 SS=D | 400.022(1)(l), FS Right to Adequate and Appropriate Health Care<br><br>(l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to provide adequate and appropriate healthcare and treatment services to prevent , ( ) for one (Resident #182) out of one resident reviewed for an , , a evidenced by inappropriate placement of the , drainage bag anchored on the side rail above the resident's increasing the risk for and dislodgement.<br><br>The findings included:<br><br>On at 9:46 AM Resident#184 observed lying in bed. An , , drainage bag was observed anchored to the side rail above near the resident's . 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 , device drainage bag was positioned correctly. Staff A, Registered Nurse (RN) Supervisor stated, "The drainage bag should be lower than the ." Staff A, RN Supervisor then performed hygiene and donned gloves, adjusted the , drainage bag and | N 201 | Immediate Action:<br>Drainage bag for affected sample resident #184 was immediately repositioned below level of the to prevent .<br>Care plan reviewed for accuracy.<br><br>Identification of Residents with potential to be affected:<br>All residents with , using a drainage system, have potential to be affected.<br><br>System Changes:<br>Control Policy was reviewed for accuracy<br>All licensed Nursing staff were educated and trained by the Control Preventionist, Director of Nursing, and the Assistant Director of Nursing in care with emphasis on proper placement of , Drainage appliance/bag. They were required to demonstrate return demonstration on proper placement on drainage appliance/bag.<br><br>Monitoring: | |

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| N 201 | Continued From page 15<br><br>secured it below the 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."<br><br>Record review of a demographic sheet revealed Resident#182 was admitted on with diagnosis that included: Hyperplasia ( ) with lower tract symptoms.<br><br>Record review of physician order sheet revealed Resident#184 had order dated to provide care every shift.<br><br>Record review of an Admission Minimum Data Set (MDS) reference dated revealed Resident#184 is . Requires partial/ for toileting hygiene/personal hygiene/transfers, has an , diagnosis of and , has a PU ( ) injury<br><br>Record review of care plan dated reveled Resident#184 was at an increased risk for related to due to retention with interventions that included: Maintain anchoring device to prevent dislodgement of or pulling against and monitor site of anchor for skin integrity.<br><br>Interview on at 10:18 AM Staff B, RN was notified of the identified concern and asked about the protocol for positioning of the 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 | N 201 | Daily audits on all residents with being completed ensuring proper placement of drainage appliance/bag.<br>Audit findings are to be presented at the monthly Quality Assurance Performance Improvement Committee meeting as part of the Control Practitioner report for 90 days or until committee agrees substantial compliance is achieved.<br><br>Responsible Party:<br>Control Practitioner<br>Unit Managers<br>Supervisor<br>Director Nursing<br>Assistant Director of Nursing | |

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| N 201 | Continued From page 16<br><br>[Resident #184's] was in place. The [] bag should be below the body. The purpose is to facilitate flow because it could cause the to flow and cause ."<br><br>On 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 . Staff are educated about how to position drainage bags."<br><br>Record review of a Policy Subject: [brand] Care, Policy # 2032, Effective: , Revised: , Reviewed: revealed Policy: It is the policy of this facility that care will be provided to all residents with 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 care is to prevent possible from spreading from the area and external into the .<br><br>BASIC PROCEDURES: The and drainage bag should be kept as a closed system with the drainage bag kept at a level lower than the to allow drainage by gravity.<br><br>Class III | N 201 | | |

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| F 000 | INITIAL COMMENTS<br><br>A recertification survey in conjunction with complaint investigation numbers 2025004613 and 2025004738 was conducted at St. Annes Nursing Center on , , through , , . The complaint allegations were unsubstantiated. The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities. | F 000 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>The findings included.<br><br>Review of Resident #200's clinical records revealed the resident was admitted to the facility on from a Short-Term General Hospital (acute hospital) Medical diagnosis included but not limited to: Other specified injuries of , subsequent encounter.<br>Review of orders dated noted Resident #1 to be discharged to the St. Annes Residence. Assisted Living Facility (ALF. The discharge/transfer was scheduled for , , . | F 641 | Immediate Action:<br>The MDS Set dated for sample resident #200 was modified for discharge status to an Assisted Living Facility in section A 2105 on was resubmitted on .Responsible staff member was re-educated on accurate MDS completion by MDS Nurse.<br><br>Identification of Residents with potential to be affected:<br>All residents that are discharged have the potential to be affected.<br><br>The discharge assessment- return not , and return , MDSs completed since , , will be audited for discharge location accuracy and modified per Resident Assessment Instrument Manuel.Inaccuracies identified will be corrected and resubmitted. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Electronically Signed | | /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.

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| F 641 | Continued From page 1<br><br>Review of Resident # 200's discharge Assessment MDS reference dated indicated in the section for pattern that the resident is . The entry/discharge reporting section indicated: Discharge Assessment-return not . Type of discharge: Planned. The section for discharge status coded resident was discharged to a Short-Term General Hospital (acute hospital).<br><br>Review of a Nurses Notes dated at 10:52:00 documented: Resident discharged to Adult Living Facility St. Annes ALF, on transported via wheelchair.<br>During an interview on 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.<br><br>Review of the facility policy and procedure effective , regarding resident assessments stated, it is the policy of this facility that each resident admitted to the institution shall receive a complete -to- 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. | F 641 | System Changes:<br>All resident discharges will be discussed by the Interdisciplinary Team on the next business day to determine discharge disposition. Discharges will be completed by the MDS Nurses in the entirety as of .<br><br>Monitoring:<br>Monthly audits of all Discharge Assessments will be audited weekly for accuracy for the next 3 months. An audit sheet will be maintained to demonstrate accurate completion of section A2105. Results will be reported monthly to the Quality Assurance Performance Improvement Committee. At the end of 3 months, the Quality Assurance Performance Improvement Committee will reassess the need for ongoing audit frequency and duration.<br><br>Responsible Party:<br>MDS Nurses/ Coordinators | |

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| F 645 SS=D | Continued From page 2<br>PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental and individuals with intellectual .<br><br>§483.20(k)(1) A nursing facility must not admit, on or after , any new residents with:<br>(i) Mental as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br>(ii) Intellectual , as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual or authority has determined prior to admission-<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual .<br><br>§483.20(k)(2) Exceptions. For purposes of this section-<br>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide | F 645<br>F 645 | | |

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| F 645 | Continued From page 3<br>for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.<br>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-<br>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,<br>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and<br>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.<br><br>§483.20(k)(3) Definition. For purposes of this section-<br>(i) An individual is considered to have a mental if the individual has a serious mental defined in 483.102(b)(1).<br>(ii) An individual is considered to have an intellectual , if the individual has an intellectual , as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>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. | F 645 | Immediate Action:<br>The Pre Admission Screening and Resident Review for sample resident #166 was reviewed, updated, and submitted to the appropriate state agency on . Confirmation of update and receipt of determination has been obtained and was filed in residents chart. | |

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| F 645 | Continued From page 4<br>The findings included.<br><br>Record review of a demographic sheet for Resident #166 revealed an admission date of with diagnosis that included: , , unspecified.<br><br>Further review revealed Admissions Minimum Data Set (MDS) reference dated 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 , or a related condition? - No. Section I revealed , , and , . Section N revealed Resident#166 was taking , , and , medications and Section O revealed Resident#166 received no , , .<br><br>Record review of a physician's order sheet revealed orders dated directions: , one (1) milligram (mg) tablet dose via , ( ) tube every twelve (12) hours for , and , 25 mg tablet via for , .<br>Further review revealed a , evaluation note dated indicated medication included: , 25 mg at bedtime and the chief complaint included , , , and a history of , , .<br><br>Record review of Resident #166's PASRR dated .<br><br>revealed Section I: PASRR Screen Decision-Making A. or suspected (check all that apply): no diagnosis was checked. | F 645 | The staff member responsible received a 1:1 education on procedure for completing the Pre Admission Screening and Resident Review by Corporate Director of Social Service.<br><br>Identification of Residents with potential to be affected:<br>All residents have the potential to be affected.<br><br>System Changes:<br>The PASRR Policy was reviewed with all Social Work Staff responsible for completing PASRR Level I and requirement.<br>All newly admitted residents will have the Pre Admission Screening and Resident Review reviewed for accuracy and resubmitted when inaccuracies are identified.<br><br>Monitoring:<br>A Pre Admission Screening and Resident Review audit for all admissions and present residents are being reviewed by the Social Work Director to ensure accurate completion.<br>The Audit results will be submitted to the monthly Quality Assurance Performance Improvement Team for review. The audit will continue for 90 days or until the committee agrees substantial compliance is achieved.<br><br>Responsible Party:<br>Director of Social Work<br>Corporate Director of Social Work/ Care Coordinator | |

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| F 645 | Continued From page 5<br>On at 4:34 PM, review of the most recent PASRR provided by the Social Services Director for Resident#166, dated revealed: Section I: PASRR Screen Decision-Making A. or suspected. (check all that apply): no diagnosis was checked.<br><br>During an interview on at 5:00 PM, the Social Services Director, revealed Resident #166 was admitted on and received a , , evaluation on and a resident review was scheduled to occur within 30 days of the , , evaluation to assess any changes in the patient's condition. The Social Services Director acknowledged the discrepancies.<br><br>During an interview on 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."<br><br>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.<br>Purpose: The Level I and II PASRR Screening and Determination process is mandated by Federal Regulation (CFR) 483.100-483.138. The | F 645 | | |

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| F 645 | Continued From page 6<br>PASRR evaluation is designed to prevent inappropriate placement of residents/patients in a Skilled Nursing Facility (SNF).<br>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 | F 645 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and , ˛ needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and , ´ well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>( )In consultation with the resident and the resident's representative(s)- | F 656 | | |

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| F 656 | Continued From page 7<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and -informed. This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to develop and implement a 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 , , care plan for one (Resident #95) out of two sampled residents receiving , , as evidenced by Resident #95 , , flow rate note in progress at 1.25 Liters Per Minute (LPM) instead of the ordered rate of 2 LPM.<br>The findings included:<br><br>Resident#25<br><br>Observation on at 10:00 AM, Resident #25 was in bed; one floor mat was noted on the | F 656 | Immediate Action:<br>Resident sample # 25- care plan was reviewed and revised to include implementation of floor mats per physician orders by MDS Nurse.<br>Resident sample # 52 floor mat was placed as per physician orders. The Nurse and CNA were educated by Nurse Manager on expectation of following physician orders and/or implementing the identified appropriate care plan interventions for floor mats.<br>Resident sample #95 The , , was increased from 1.25 liters per minute to 2 Liters per minute as per physician orders. , , saturation was checked and reported to the Hospice team. The Nurse was educated by the Nurse Manager on expectation of following physician orders and/or implementing the identified appropriate care plan interventions for | |

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| F 656 | Continued From page 8<br>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 ."<br><br>Record review of a demographic sheet revealed Resident #25 was admitted on with diagnosis that include: Presence of Right , S/P- , repair of ; (generalized and .<br>Record review of nursing notes dated revealed Resident #25 was found on the floor and on revealed Resident#25 was found on the floor.<br><br>Record review of a Quarterly Minimum Data Set (MDS) reference dated revealed Resident#52 is severely ; dependent for Activities of Daily Living (ADL), has on upper and lower extremities ...<br>Record review of a physician order sheet (POS) revealed Resident#25 had order dated for floor mats when in bed every shift.<br><br>Record review Resident#25's care plan dated and reviewed on revealed Resident#25 complained of to right after a on and results were positive | F 656 | use.<br><br>Identification of Residents with potential to be affected:<br>All residents in the facility have the potential to be affected. Interdisciplinary review and verification of care plan interventions and orders for floor mats and use.<br><br>System Changes:<br>The facility Prevention Policy and Medication Administration Policy were reviewed for accuracy.<br>Nurses and CNAs were educated and trained on the Falling Star Program and use of floor mats and resident use as indicated in the physician orders by the Director of Nursing and Risk Manager.<br>Licensed nursing staff are to verify and document in the Treatment Administration Record the use of floor mats and orders for use every shift.<br>Licensed nursing staff were educated by the Director of Nursing and Assistent Director Of Nursing on medication administration with emphasis on right dosage for use.<br><br>Monitoring:<br>Surveillance Rounds by Nurse Manager/designee to audit for compliance the residents with orders for floor mats and residents with use 3x a week for 90 days.<br>The results of the rounds will be reported to the monthly Quality Assurance Performance Improvement Committee. | |

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| F 656 | Continued From page 9<br>for a to . Further review revealed interventions included: maintain bed in lowest position, monitor every 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.<br><br>On 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 ( ).<br><br>Resident#52<br>On at 9:46 AM Resident#52 observed in bed with , 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."<br><br>Record review of a demographic sheet revealed Resident #52 was admitted on with diagnosis that include: unspecified part of of , D deficiency and .<br><br>Record review of a Physician Order Sheet (POS) revealed Resident #52 had an order dated directions: floor mats when in bed every shift. | F 656 | Responsible Party:<br>Unit Managers, Supervisor, Risk Manager, ADON and DON | |

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| F 656 | Continued From page 10 | F 656 | | |

Record review of a Nursing note dated 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 Resident #52 was found on the floor next to the bed on the floor mattress.

During an interview on 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 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 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 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 before they walk away."

Resident #95

On 9:40 am Resident #95 was observed in bed with , closed, , in progress at 1.25 Liters per minute via .

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| F 656 | Continued From page 11<br>(Photographic evidence).<br><br>On at 11:40 AM Resident #95 was observed in bed with no apparent distress, was in progress at 1.25 Liters per minute via (photo). Staff C, Registered Nurse (RN) was asked what the prescribed rate for 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 level and adjusted to the prescribed rate. Staff C, Registered Nurse (RN) checked Resident #95's saturation, and it was 76%. Staff C, Registered Nurse (RN) revealed Hospice would be notified.<br><br>On at 12:00 PM Staff D, Hospice Registered Nurse (RN) evaluated Resident #95 and revealed a new saturation rate of 96%. Staff C, Registered Nurse (RN) stated, "I did round this morning, but I did not visualize if the was at the ordered level."<br><br>Record review of a demographic sheet revealed Resident #95 was admitted on with diagnosis that included: Acute diastolic ( ) and valve .<br><br>Record review of a Quarterly Minimum Data Set (MDS) reference dated revealed Resident #95 had a Brief Interview of Mental Status ( ) score of 7, indicating severe , dependent on ADLs (Activities of Daily Living), received hospice care and .<br><br>Record review of a Care Plan dated | F 656 | | |

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| F 656 | Continued From page 12 | F 656 | | |

and revised revealed Resident #95 had the potential for , alteration in , status due to of with interventions that included: Administer and treatments as ordered, apply via 2.0 liter per min continuous as ordered.

Record review of a Physicians Order Sheet revealed Resident #95 had orders dated to apply humidified via at 2.0 liter per min as needed and an order dated to apply humidified via at 2.0 liter per min continuous.

On at 9:08 AM The Director of Nursing was interviewed about the protocol and stated, " 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: Revised: Reviewed: 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

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| F 656 | Continued From page 13<br>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. | F 656 | | |
| F 690 SS=D | / , ,<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) .<br>§483.25(e)(1) The facility must ensure that resident who is of and on admission receives services and assistance to maintain unless his or her clinical condition is or becomes such that is not possible to maintain.<br><br>§483.25(e)(2)For a resident with , based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an is not unless the resident's clinical condition demonstrates that was necessary;<br>(ii) A resident who enters the facility with an or subsequently receives one is assessed for removal of the as soon as possible unless the resident's clinical condition demonstrates that is necessary; and<br>(iii) A resident who is of receives appropriate treatment and services to prevent and to restore to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal , based on the resident's | F 690 | | |

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| F 690 | Continued From page 14<br>comprehensive assessment, the facility must ensure that a resident who is of receives appropriate treatment and services to restore as much normal function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to provide appropriate treatment and services to prevent ( ) for one (Resident #182) out of one resident reviewed for an , a evidenced by inappropriate placement of the drainage bag anchored on the side rail above the resident's increasing the risk for and dislodgement.<br><br>The findings included:<br><br>On at 9:46 AM Resident#184 observed lying in bed. An drainage bag was observed anchored to the side rail above near the resident's . 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 device drainage bag was positioned correctly. Staff A, Registered Nurse (RN) Supervisor stated, "The drainage bag should be lower than the ." Staff A, RN Supervisor then performed hygiene and donned gloves, adjusted the drainage bag and secured it below the 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."<br><br>Record review of a demographic sheet revealed Resident#182 was admitted on with | F 690 | Immediate Action:<br>Drainage bag for affected sample resident #184 was immediately repositioned below level of the to prevent .<br>Care plan reviewed for accuracy.<br><br>Identification of Residents with potential to be affected:<br>All residents with Cathetors, using a drainage system, have potential to be affected.<br><br>System Changes:<br>Control Policy was reviewed for accuracy.<br>All licensed nursing staff were educated and trained in care with emphasis on proper placement of Drainage appliance/bag by the Control Preventionist, Director of Nursing, and Assistant Director of Nursing. They were required to demonstrate return demonstration on proper placement on drainage appliance/bag.<br><br>Monitoring:<br>Daily audits on all residents with being completed ensuring proper placement of drainage appliance/bag.<br>Audit findings are to be presented at the monthly Quality Assurance Performance | |

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| F 690 | Continued From page 15<br>diagnosis that included: Hyperplasia ( ) with lower tract symptoms.<br>Record review of physician order sheet revealed Resident#184 had order dated to provide care every shift...<br><br>Record review of an Admission Minimum Data Set (MDS) reference dated revealed Resident#184 is . Requires partial/ for toileting hygiene/personal hygiene/transfers, has an , diagnosis of and , has a PU ( ) injury<br><br>Record review of care plan dated reveled Resident #184 was at an increased risk for related to due to retention with interventions that included: Maintain anchoring device to prevent dislodgement of or pulling against and monitor site of anchor for skin integrity.<br><br>Interview on at 10:18 AM Staff B, RN was notified of the identified concern and asked about the protocol for positioning of the 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] was in place. The [] bag should be below the body. The purpose is to facilitate flow because it could cause the to flow and cause ."<br><br>On at 8:59 AM, the Director of Nursing | F 690 | Improvement Committee meeting as part of the Control Practitioner report for 90 days or until committee agrees substantial compliance is achieved.<br><br>Responsible Party:<br>Control Preventionist<br>Unit Managers<br>Supervisor<br>Director Nursing<br>Assistant Director of Nursing | |

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| F 690 | Continued From page 16<br>stated: "If a resident is in bed the drainage bag is hung below the level of the . Staff are educated about how to position drainage bags."<br><br>Record review of a Policy Subject: [brand] Care, Policy # 2032, Effective: , Revised: , Reviewed: revealed Policy: It is the policy of this facility that care will be provided to all residents with 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 care is to prevent possible from spreading from the area and external into the .<br><br>BASIC PROCEDURES: The and drainage bag should be kept as a closed system with the drainage bag kept at a level lower than the to allow drainage by gravity. | F 690 | | |
| F 695 SS=D | / Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) care, including care and suctioning.<br>The facility must ensure that a resident who needs care, including care and suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews and record review the facility failed to provide appropriate care consistent with professional standards of practice, for one ( Resident #95) out | F 695 | Immediate Action:<br>For sample resident # 95 was increased from 1.5 liters per minute to 2 liters per minute as ordered by the | |

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| F 695 | Continued From page 17<br>of two sampled residents receiving ,, as evidenced by observations of ,, in progress at 1.25 liters per minute despite a physician's order for 2 liters per minute for Resident #95.<br><br>The findings included:<br><br>On 9:40 am Resident #95 was observed in bed with , closed, ,, in progress at 1.25 Liters per minute via . (Photographic evidence).<br><br>On at 11:40 AM Resident #95 was observed in bed with no apparent distress, ,, was in progress at 1.25 Liters per minute via (photo). Staff C, Registered Nurse (RN) was asked what the prescribed rate for ,, 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 ,, level and adjusted to the prescribed rate. Staff C, Registered Nurse (RN) checked Resident #95's ,, saturation, and it was 76%. Staff C, Registered Nurse (RN) revealed Hospice would be notified.<br><br>On at 12:00 PM Staff D, Hospice Registered Nurse (RN) evaluated Resident #95 and revealed a new ,, saturation rate of 96%. Staff C, Registered Nurse (RN) stated, "I did round this morning, but I did not visualize if the ,, was at the ordered level."<br><br>Record review of a demographic sheet revealed Resident #95 was admitted on with diagnosis that included: Acute diastolic | F 695 | physician. ,, saturation checked and reported to the hospice team.<br><br>Identification of Residents with potential to be affected:<br>All residents on ,, had the potential to be affected.<br><br>System Changes:<br>All nurses were trained and educated in medication administration with emphasis on correct dosage by the Assistant Director of Nursing and Director of Nursing.<br>Licensed staff will document on medication administration record the liters per minute every shift as ordered by physician.<br><br>Monitoring:<br>Surveillance rounds will be conducted weekly and documented. Findings will be reported to the monthly Quality Assurance Performance Improvement Committee, until the committee agrees substantial compliance has been met.<br><br>Responsible Party:<br>Supervisor<br>Risk manager<br>ADON DON<br>Unit Managers | |

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| F 695 | Continued From page 18<br>( ) and valve .<br><br>Record review of a Quarterly Minimum Data Set (MDS) reference dated revealed Resident #95 had a Brief Interview of Mental Status ( ) score of 7, indicating severe , dependent on ADLs (Activities of Daily Living), received hospice care and .<br><br>Record review of a Care Plan dated and revised revealed Resident #95 had the potential for , alteration in status due to of with interventions that included: Administer and treatments as ordered, apply via 2.0 liter per min continuous as ordered.<br><br>Record review of a Physicians Order Sheet revealed Resident #95 had orders dated to apply humidified via at 2.0 liter per min as needed and an order dated to apply humidified via at 2.0 liter per min continuous.<br><br>On at 9:08 AM The Director of Nursing was interviewed about the protocol and stated, " is to be delivered at the prescribed rate whether it is continuous or as needed."<br><br>Record review of a Policy Subject: Concentrators, Policy#2012, Effective: , Revised: , Reviewed: revealed Policy: Concentrators will be used for patients and residents that require | F 695 | | |

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| F 695 | Continued From page 19<br>,.. with a liter flow rate of 1 to 5 liters per minute.<br>PURPOSE: The device is a means of delivering ,.. to the patients and residents in small mobile units that extract ,.. from room air and provides continuous supply of ,.. without refilling.<br>PROCEDURES: This equipment is to be used on all patients and residents that require ,.. 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. | F 695 | | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but | F 867 | | |

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| F 867 | Continued From page 20 | F 867 | | |

not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the [redacted] and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies [redacted]:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to

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| F 867 | Continued From page 21<br>ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.<br><br>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and , , of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) | F 867 | | |

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| F 867 | Continued From page 22<br>functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>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- Prevention & Control. As evidenced by: F 880 was cited during a Recertification survey ending when the facility failed to implement control procedures for one (Resident #430) as evidenced by , , , equipment ( 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.<br><br>The findings included:<br><br>Record review of the facility's survey history revealed, during a recertification conducted on , through , , at the facility. F 880 Prevention & Control was cited as the facility failed to implement control procedures for one (Resident #430) as evidenced by , , equipment ( and tubing) stored | F 867 | Immediate Action:<br>All leadership and department heads received training/ education on the Quality Assurance Performance Improvement program and its objectives on perfornce improvements projects by the Administrator. The Quality Assurance Performance Team also initiated a Performance Improvement Project in which the facility would complete a root cause analysis on control deficient practice.<br><br>Identification of Residents with potential to be affected:<br>All in-house residents have the potential to be affected.<br><br>System Changes:<br>Licensed nurses were educated on classification of , , equipment to follow proper control practices by the Control Preventionist. A Performance Improvement Project Inventory will be completed monthly. In the Quality Assurance Performance | |

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| F 867 | Continued From page 23<br>uncovered on bedside table next to a live plant.<br><br>Review of the facility policy and procedures titled "Quality Assurance and Performance Improvement (QAPI)" revision date 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.<br><br>Advocacy efforts.<br>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.<br><br>Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated , , and documented the facility have QAA Committee meetings monthly. Attendees included: Administrator, Medical Director, Director of Nursing (DON), Assistant Director of Nursing (ADON), Control Preventionist/Risk Manager, Dietary Manager, Clinical Dietician, Director of Housekeeping, Director of Maintenance, Director of , , Director of Human resources, Director of admissions, Director of Business office, Director | F 867 | Improvement Committee meeting the team will ensure the measures implemented are appropriate and effective.<br><br>Monitoring:<br>In the monthly Quality Assurance Performance Improvement Committee meeting the team will monitor the effectiveness of the changes and ensure continued compliance. Progress reports will be included in the Quarterly Quality Management Council meetings and presented to the Governing Board.<br><br>Responsible Party:<br>Administrator<br>Director of Nursing<br>Medical Director | |

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| F 867 | Continued From page 24<br>of Social Services, Director of Activities, MDS (Minimum Data Set) Coordinator.<br><br>Interview on 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 . The committee consists of the Medical Director, Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), 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. | F 867 | | |
| F 880<br>SS=D | Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Control<br>The facility must establish and maintain an prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable and .<br><br>§483.80(a) prevention and control program.<br>The facility must establish an prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling and communicable for all residents, | F 880 | | |

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| F 880 | Continued From page 25<br>staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable or before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable or should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of ;<br>( )When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the ; and<br>(vi)The hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. | F 880 | | |

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| F 880 | Continued From page 26<br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of<br>.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews and record review the facility failed to implement 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.<br><br>The findings included:<br><br>Resident #84<br><br>On 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 , , issues since she came from the hospital. Staff B, RN was asked about the protocol for storing , , supplies when not in use; stated: "It should be stored in a plastic bag and dated when not in use. Staff B, RN was | F 880 | Immediate Action:<br>The assigned nursing staff received 1:1 education on the , cuff prior to use on each resident by the Nurse Manager.<br>For sample resident #84 the incentive spirometer was discarded, and the resident was provided with a new incentive spirometer device. A clear plastic bag was placed over the device for protection and placed within easy reach of resident.<br><br>Identification of Residents with potential to be affected:<br>All residents with orders for incentive spirometers have the potential to be affected.<br><br>System Changes:<br>The facility Control Policy was reviewed for accuracy.<br>The Licensed Nursing staff received education on Control with emphasis on , , appliance protection bythe Control Preventionist.<br>Laminated reminders were placed on each vital sign machine to remind staff to | |

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| F 880 | Continued From page 27<br>notified about the observation and entered the room with the surveyor and observed the Incentive Spirometer that was not bagged on nightstand.<br><br>Record review of a demographic sheet revealed Resident#84 was admitted to the facility on with diagnosis that include ( ) with acute exacerbation and other without acute .<br><br>Record review of a Minimum Data Set (MDS) reference dated revealed Resident #84 is moderately , required set up clean up assistance for eating/oral hygiene, had no of upper extremities.<br><br>Record review of a care plan dated revealed Resident #84 had the potential for , alteration in status due to S/P (Status Post) hospitalization due to and ( ), noted and , suggestive atelectasis on the right and left lower , needs continuous .<br><br>Interview on at 9:01 AM, the Director of nursing (DON) was interviewed about the protocol for proper storage of 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 control, but is kept not in bag so it can be readily available to the resident."<br><br>Resident#41<br>On at 9:15 AM Resident #41 was observed seated in a wheelchair in the room. | F 880 | cuff prior to use.<br><br>Monitoring:<br>The Control Preventionist or designee will conduct random control audits weekly for 12 weeks then monthly to ensure compliance with control standards. Results will be reported in the monthly Quality Assurance Performance Improvement committee meeting.<br><br>Responsible Party:<br>Control Preventionist<br>DON<br>ADON | |

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Staff B, RN entered the room with a vitals machine and was observed while Resident # 41's (B/P)was measured, Staff B, RN placed the B/P cuff on the resident's right arm and measured the then removed the cuff and placed it on the vitals machine and performed hygiene and exit the room. Staff B, RN then re-entered room with a handheld sphygmomanometer ( machine) and placed the cuff on Resident #41's arm and measured the B/P. Staff B, RN then administered medications, performed hygiene and exited room. Staff, RN did not either cuff. There were no wipes on the machine.

Resident#73
On 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 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/ the shared cuff; Staff B, RN stated: "I usually the B/P cuff after each use, but I was nervous."

During an interview on at 9:13 AM, the DON revealed: "Staff are to clean the vitals machine with bleach wipes between residents to prevent ."

Record review of a Policy Subject:
Control Surveillance Policy#4011 Effective:
Revised: Reviewed:
revealed INTRODUCTION: The intent of any surveillance method is to measure outcomes and processes of care as a component

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| F 880 | Continued From page 29<br>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 Control Program. These goals are: To reduce the risk of between healthcare personnel and residents. Reduce the risk of developing in residents related to the use of devices and required procedures. | F 880 | | |