STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105560	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST ANNES NURSING CENTER, ST ANNES RESIDENCE INC	**11855 QUAIL ROOST DRIVE MIAMI, FL 33177**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** Based on Observations, interviews and record reviews the facility failed to ensure the call lights were within reach for 3 residents (resident # 500 resident #83 and resident #170) out of 28 residents sampled. This deficient practice has the potential to affect all resident in the facility. There were 199 residents residing in the facility at the time of this survey. The findings included: On 03/02/2020 at 10:32am resident #170 was observed in room. The call light was hanging off the left side off the top of the bed and the resident could not reach the call light. On 03/03/2020 at 9:21am resident #170 was observed in room, the call light was out of the resident' s reach and was hanging on the left side of the bed close to the door. An observation of resident #83 on 03/02/20 12:13 PM revealed the call light was on top of the floor mattress placed against the wall next to the bed. The resident was sitting in her wheelchair on the other side of the room. An observation of resident #500 on 03/02/20 at 10:34 am the resident was in bed and the call light was hanging down on the left side of the bed and out of reach. Resident #500 revealed she needed to be changed and could not reach the call light located on left side of bed. 03/04/2020 at 10:13 am Staff C and Staff D Certified Nursing Assistants (CNA) revealed The call lights are placed next to the side of the resident that is easier for the resident to reach. Staff C stated the call lights should be placed on the bed the resident's side and not hanging down or by the wall The call light needs to be on top of the bed. Staff D stated it was a concern that the call light was not within the resident's reach because if a resident needed to call or had an emergency, they will not be able to reach it. On 03/5/2020 at 9:41 am staff E, CNA revealed. The call lights were supposed to be on the bed where the resident can reach them or on top of the table depending on where the resident is. On 3/5/2020 at 3:32pm Director of Nursing revealed; the Certified Nursing Assistants are supposed to place the call lights on the bed. She revealed We educate them on how to position the call lights and where to place them. They are always to be placed within reach . We educate them when they are walking out of the room to make sure the call light is within reach . we educated them to make sure that they place them on the bed before they leave. Review of the facility's Call Bells-Lights Policy effective 08/12/2019 revealed: Staff will ensure the call buttons are always within the reach of the resident . If a resident is out of the room, the call light must be positioned on the bed so that they are easily accessible when the resident enters the room.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews the facility failed to implement a care plan for one resident (resident #25) out one resident reviewed for hearing aids. The findings included: On 03/03/20 at approximately 09:40 am resident #25 was observed in her room awake, alert and watching tv. Resident #25 revealed that she was unable to hear what the surveyor was saying because she was not wearing her hearing aids. Resident #25 stated I wear the hearing aids all day because I can't hear anything and at night the nurse takes them off and takes them. Today they have not brought it to me yet. Observation revealed the resident did not have her hearing aids in place. Record review of physician's Telephone order dated 12/ 9 revealed Sensory treatment: Apply hearing aid (s) to both ears Shift: day Review of Nurses notes dated [DATE] revealed hearing aid is used. Hearing aid in place to bilateral ears in good working condition, incoming nurse made aware. Review of quarterly Minimum Data Set ((MDS) dated [DATE] revealed resident #25 was coded for wearing Hearing aid. Hearing moderate difficulty-speaker has to increase volume and speak distinctly. The Care plan dated 01/18/2019 and updated on 07/02/2019 revealed resident #25 can hear adequate when she has her hearing aids on. On 03/4/2020 at 10:59am Staff A Certified Nursing Assistant (CNA) revealed, resident #25 is very alert and understands directions, when she tells her to wait, she listens, it is rare that the resident is disoriented. Staff A stated that at 8:00 am resident is assisted with getting up and preparing her for the day. Staff A reported that when she provides the breakfast for resident #25 she asks the resident if she has her ear devices, and if the resident states no then she tells the nurse. Staff A reported that sometimes the residents touches her ears to let her know that she does not have the hearing devices and by making signs because she is unable to hear. On 03/04/2020 at 11:13am staff B Registered Nurse (RN) revealed, resident #25 is alert and oriented to place, the situation, can tell when her son is coming and at what time he is coming. Staff B stated resident #25 likes to be up before breakfast, and they put her hearing aids. Staff B stated that resident #25 is able to communicate her needs. Staff B stated that the CNA is supposed to let the nurse know that the resident needs her hearing aids. Staff B stated Usually when she gets up and she is in her chair, we place the hearing aids on. We usually put her hearing aids after care is provided. The nurse explained that the hearing aids are kept in the narcotics box and the family and staff aware that the hearing aids are kept there. Staff B stated, she won't leave her room without the hearing aids. She is very picky with her hearing aids and she'll tell three or four times a day to have the staff put them on.
F 0685 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist a resident in gaining access to vision and hearing services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews the facility failed to ensure hearing aids were in place in a timely manner as ordered resident (resident #25) out one resident . As evidence by resident inability to hear adequately without hearing device. The findings included: On 03/03/20 at approximately 09:40 am resident #25 was observed in her room awake, alert and watching TV. Resident #25 revealed that she was unable to hear what the surveyor was saying because she was not wearing her hearing aids. Resident #25 stated I wear the hearing aids all day because I can't hear anything and at night the nurse takes them off and takes them. Today they have not brought it to me yet. Observation revealed the resident did not have her hearing aids in place. Record review of physician's Telephone order dated 12/ 9 revealed Sensory treatment: Apply hearing aid (s) to both ears Shift: day Review of Nurses notes dated [DATE] revealed hearing aid is used. Hearing aid in place to bilateral ears in good working condition, incoming nurse made aware. Review of quarterly Minimum Data Set ((MDS) dated [DATE] revealed resident #25 was coded for wearing Hearing aid. Hearing moderate difficulty-speaker has to increase volume and speak distinctly. The Care plan dated 01/18/2019 and updated on 07/02/2019 revealed resident #25 can hear adequate when she has her hearing aids on. On 03/4/2020 at 10:59 am Staff A Certified Nursing Assistant (CNA) revealed, resident #25 is very alert and understands directions, when she tells her to wait, she listens, it is rare that the resident is disoriented. Staff A stated that at 8:00 am resident is assisted with getting up and preparing her for the day. Staff A reported that when she provides the breakfast for resident #25 she asks the resident if she has her ear devices, and if the resident states no then she tells the nurse. Staff A reported that sometimes the residents touches her ears to let her know that she does not have the hearing devices and by making signs because she is unable to hear. On 03/04/2020 at 11:13 am staff B Registered Nurse (RN) revealed, resident #25 is alert and oriented to place, the situation, can tell when her son is coming and at what time he is coming. Staff B stated resident #25 likes to be up before breakfast,

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

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 0685 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) and they put her hearing aids. Staff B stated that resident #25 is able to communicate her needs. Staff B stated that the CNA is supposed to let the nurse know that the resident needs her hearing aids. Staff B stated Usually when she gets up and she is in her chair, we place the hearing aids on. We usually put her hearing aids after care is provided. The nurse explained that the hearing aids are kept in the narcotics box and the family and staff aware that the hearing aids are kept there. Staff B stated, she won't leave her room without the hearing aids. She is very picky with her hearing aids and she'll tell three or four times a day to have the staff put them on.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and record review the facility failed 1) to avoid cross-contamination as evidenced by staff failure to practice hand hygiene during the cleaning of dishes. 2) Failed to maintain proper temperature for the high temperature dishwashing machine as evidenced by dishwasher machine not reaching the proper temperature during the dish washing process. This deficient practice has the potential to affect one-hundred eighty-six residents eating by mouth, out of one-hundred ninety-nine residents living in the facility during the time of this survey. The findings included 1)Review of the Sanitation and Infection Prevention Control Policies and Procedures for Hand Hygiene (undated) revealed that In the Food & Nutrition Service Department: All associates associated with the handling of food shall wash hands. Hands are washed with soap and water at the following times . Before handling food or clean utensils/dishes/equipment . Observation on 03/04/20 at 10:12 AM revealed that Staff F, Dietary Aide was in the washing area scraping and pre-washing the dishes and utensils. Staff F placed the rack with dirty dishes into the dishwasher machine. Staff F then walked over to the clean area where the racks with cleaned dishes were accumulated on the countertop. Staff F proceeded to put the cleaned dishes on the drying rack and did not perform hand hygiene that included washing of hands with water and soap. On 03/04/20 at 10:29 AM Staff F, Dietary Aide explained that one staff scrapes and pre-washes the dishes. another staff gets the cleaned dishes. Staff F revealed that today he was assigned to scrape and pre-wash the dishes. After the dishes were washed, if they were not cleaned properly, the catcher should return the dishes to him. However, today he caught the washed silverware to put back in the dishwasher machine because the catcher was checking the dishwasher machine temperature at that time and they usually wash the silverware twice. In addition, he stated that he caught some cleaned dishes and put them into rack to dry. Staff F stated that he was using gloves and he washed his hands with water in the sink at the pre-washed area. 2) Record review of the Cleaning Food and nonfood contact surfaces Policy and Procedures (undated) revealed that Dish machine: Hot water is used to wash, rinse and sanitize dishes, following the temperature guidelines in Policy F019: Dish Machine Temperatures. During observation and interview on 03/04/20 approximately at 10:15 AM Staff G, Dietary Aide revealed that the facility used a high temperature dishwasher machine. The screen of the dishwasher machine revealed temperature for wash of 110 degrees Fahrenheit (F), for rinse of 144 degrees F and final rinse of 197 degrees F. Staff G stated that the dishwasher machine minimum temperature should be 150 degrees F for wash, 160 degrees F for rinse, and 180 degrees F for final rinse. He turned the machine off to change the water and after some minutes, the dishwasher machine was still under the minimum temperature. At that time, the dishwasher machine temperature was 109 degrees F for wash, 144 degrees F for rinse, and 168 degrees F for final rinse and was not increasing in temperature. On 03/04/20 at 10:24 AM Staff H, Maintenance Engineer revealed that the dishwasher machine temperature was not working well because the boiler was turned off. Staff H reported that the boiler could stop automatically. On 03/04/20 at 10:37 AM the Maintenance Engineer Director revealed that the machine had a booster heater that raised the temperature for final temperature of 180 to 200 degrees F. He reported in the morning the dishwasher machine was working. However, he adjusted the boiler from 141 to 160 degrees F for the dishwasher machine to reach the proper temperature. On 03/04/20 at 10:46 AM the Food Service Manager, (FSM) revealed that the dishwasher machine's temperature is checked three times per day. The temperature was checked at 9:15 AM and the dishwasher machine was working well. The minimum temperature for the dishwasher machine should be 150 degrees F for wash, 160 degrees F for rinse, and 180 degrees F for final rinse respectively. If the machine is not working properly, the staff would wash all the dishes again. In case the dishwasher machine was not working properly, they would use disposable dishes. The FSM explained the washing area policy and procedures. The FSM revealed that the facility used to have two staff for the washing area. One staff doing dirty dishes, that means scraping and pre -washing the dishes, and another staff to catch the cleaned dishes. The FSM explained that the person that was doing pre-washing was not supposed to catch the cleaned dishes. On 03/04/20 approximately at 11:00 AM the FSM informed that the dishwasher machine was working with the proper temperatures, but after some time, the boiler dropped again, and the dishwasher machine was not reaching the proper temperature. They were going to use disposable dishes for lunch time today. The FSM reported that the facility had contacted a company that would be coming the same day (3/4/20) to check the machine.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review the facility failed 1) to avoid cross-contamination as evidenced by staff failure to practice hand hygiene during the cleaning of dishes. 2) Failed to maintain proper temperature for the high temperature dishwashing machine as evidenced by dishwasher machine not reaching the proper temperature during the dish washing process. This deficient practice has the potential to affect one-hundred eighty-six residents eating by mouth, out of one-hundred ninety-nine residents living in the facility during the time of this survey. The findings included 1)Review of the Sanitation and Infection Prevention Control Policies and Procedures for Hand Hygiene (undated) revealed that In the Food & Nutrition Service Department: All associates associated with the handling of food shall wash hands. Hands are washed with soap and water at the following times . Before handling food or clean utensils/dishes/equipment . Observation on 03/04/20 at 10:12 AM revealed that Staff F, Dietary Aide was in the washing area scraping and pre-washing the dishes and utensils. Staff F placed the rack with dirty dishes into the dishwasher machine. Staff F then walked over to the clean area where the racks with cleaned dishes were accumulated on the countertop. Staff F proceeded to put the cleaned dishes on the drying rack and did not perform hand hygiene that included washing of hands with water and soap. On 03/04/20 at 10:29 AM Staff F, Dietary Aide explained that one staff scrapes and pre-washes the dishes. another staff gets the cleaned dishes. Staff F revealed that today he was assigned to scrape and pre-wash the dishes. After the dishes were washed, if they were not cleaned properly, the catcher should return the dishes to him. However, today he caught the washed silverware to put back in the dishwasher machine because the catcher was checking the dishwasher machine temperature at that time and they usually wash the silverware twice. In addition, he stated that he caught some cleaned dishes and put them into rack to dry. Staff F stated that he was using gloves and he washed his hands with water in the sink at the pre-washed area. 2) Record review of the Cleaning Food and nonfood contact surfaces Policy and Procedures (undated) revealed that Dish machine: Hot water is used to wash, rinse and sanitize dishes, following the temperature guidelines in Policy F019: Dish Machine Temperatures. During observation and interview on 03/04/20 approximately at 10:15 AM Staff G, Dietary Aide revealed that the facility used a high temperature dishwasher machine. The screen of the dishwasher machine revealed temperature for wash of 110 degrees Fahrenheit (F), for rinse of 144 degrees F and final rinse of 197 degrees F. Staff G stated that the dishwasher machine minimum temperature should be 150 degrees F for wash, 160 degrees F for rinse, and 180 degrees F for final rinse. He turned the machine off to change the water and after some minutes, the dishwasher machine was still under the minimum temperature. At that time, the dishwasher machine temperature was 109 degrees F for wash, 144 degrees F for rinse, and 168 degrees F for final rinse and was not increasing in temperature. On 03/04/20 at 10:24 AM Staff H, Maintenance Engineer revealed that the dishwasher machine temperature was not working well because the boiler was turned off. Staff H reported that the boiler could stop automatically. On 03/04/20 at 10:37 AM the Maintenance Engineer Director revealed that the machine had a booster heater that raised the temperature for final temperature of 180 to 200 degrees F. He reported in the morning the dishwasher machine was working. However, he adjusted the boiler from 141 to 160 degrees F for the dishwasher machine to reach the proper temperature. On 03/04/20 at 10:46 AM the Food Service Manager, (FSM) revealed that the dishwasher machine's temperature is checked three times per day. The temperature was checked at 9:15 AM and the dishwasher machine was working well. The minimum temperature for the dishwasher machine should be 150 degrees F for wash, 160 degrees F for rinse, and 180 degrees F for final rinse respectively. If the machine is not working properly, the staff would wash all the dishes again. In case the dishwasher machine was not working properly, they would use disposable dishes. The FSM explained the washing area policy and procedures. The FSM revealed that the facility

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) used to have two staff for the washing area. One staff doing dirty dishes, that means scraping and pre -washing the dishes, and another staff to catch the cleaned dishes. The FSM explained that the person that was doing pre-washing was not supposed to catch the cleaned dishes. On 03/04/20 approximately at 11:00 AM the FSM informed that the dishwasher machine was working with the proper temperatures, but after some time, the boiler dropped again, and the dishwasher machine was not reaching the proper temperature. They were going to use disposable dishes for lunch time today. The FSM reported that the facility had contacted a company that would be coming the same day (3/4/20) to check the machine.