STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105232	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Maria Nursing Center	1050 NE 125th Street North Miami, FL 33161

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews and interviews, the facility neglected to provide a secure environment for one (Resident #1) out of three sampled resident that displayed exit seeking behaviors and intent of elopement. As evidenced by cognitively impaired Resident #1 whose diagnoses include Dementia, and unsteady gait exited the facility undetected by staff on 8/04/2025 at 4:24 PM and ambulated 0.7 miles from the facility in temperatures that temperature ranged between a high of 92 degrees and a low of 80 degrees Fahrenheit according to AccuWeather, and was found by law enforcement at 4:46 PM wandering in a neighborhood that has high traffic volume and busy intersections. These deficient practices increased the risk for Resident #1 to be hit by an automobile and suffer major injury based on the facility's location and where Resident #1 was found are in areas with high traffic volume and busy intersections.Refer to F689.The findings included:Record review of the facility's policy titled, Suspected Adult, Disabled Person or Elderly Abuse/Neglect/ Exploitation protocol implementation date was on 12/2000, the policy documented: The facility will provide a safe resident environment and protect all residents from abuse. Therefore, each resident has the right to be free from abuse, neglect and corporal punishment of any type by anyone. Neglect means failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. A prompt thorough investigation will be conducted by the facility immediately. Review of the Demographic Face Sheet for Resident #1 documented the resident was initially admitted on [DATE] with a diagnosis of Dementia, Pneumonia, and unsteadiness on feet.Review of Resident #1's Elopement care plan dated 7/21/2025 documented the resident is an elopement risk as evidenced by wandering with diagnosis of dementia; Goal: Resident will have no unauthorized departure from facility through next review date; Interventions: Place photograph on wander list; Redirect attention away from exit areas when wandering; Prompt and assist with meaningful activity attendance daily to keep occupied and Identify resident as an elopement risk and alert staff to monitor location on unit.Review of the facility's timeline of events documented the following: On 8/4/2025 a code pink was activated.Missing [Resident #1] was playing Bingo around 3:00 PM in auditorium. Activity concluded at 4:00 PM. Patient was waiting to be transported to his room. Upon staff's arrival, staff found empty wheelchair. The surrounding areas by wheelchair was checked. Patient's room was also checked. Code Pink was called at 4:45 PM. Search throughout whole facility, patio, parking lot. Social Worker called 911 to file police report. At 5:41 PM. [local law enforcement] returned Social Worker's phone call to notify Social Worker that patient was in [residential neighborhood], police called [local emergency services] and the patient was transported to [local hospital] via ambulance. Social Worker notified all staff members. Nurse manager notified daughter. Daughter relieved patient was found safe and is medically stable. Resident Returned to facility on 8/4/2025 at around 9:30 PM accompanied by the daughter. Review of the Physician's Order Sheets (POS) and Medication Administration Records (MAR) for July 2025 and August 2025 documented the resident was receiving the following medications: Donepezil HCL (hydrochloric acid) 10mg (milligrams) tab (tablet) 1 tab PO (by mouth) HS (at night) for dementia; Meclizine HCL 12.5mg tab 1 tab PO TID (three times a day) for dizziness and Memantine HCL 10mg tab 1 tab PO daily for Alzheimer's disease.Review of the Elopement Risk Assessment/Evaluation dated 7/21/2025 documented: The resident was at high risk for elopement and wandering. Keep one copy of patient's/resident's photograph in the medical record and another at the security gate; Place a PINK armband on the resident.On 9/04/25 at 3:10 PM the Risk Manager stated, On 08/04/2025 in the afternoon between 4:30 PM we were called by the staff that they couldn't find the patient, and he was not in the wheelchair. We let the staff activate Code Pink. When she realized he was not in his wheelchair, she called the nurse and told the nurse to check in the patient's room because he is not down here in the wheelchair. The nurse proceeded to check the room, and he was not there. Once they came down to the patio and realized he was not there, Code Pink was activated. After 30 minutes he was not found, the police department was called and notified. I went to the security guard and asked if he saw anything. There was a transport van leaving the facility and a visitor that had come early. He opened the gate for the van and the visitor. He said he did not see the resident. At the same time, there was a car at the gate trying to enter and he was taking care of that. I told the security that they can only open one gate at a time from now on. The police department called back the Social Worker to let us know that the resident was found at 4:46 PM and [local emergency] was called to send the resident to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews and interviews, the facility failed to provide a secure environment that with adequate supervision and an effective monitoring system; for one (Resident #1) out of three sampled residents that displayed exit seeking behaviors and intent of elopement; as evidenced by: 8/04/2025 at 4:24 PM Resident #1 who is impaired cognitively with diagnoses of Dementia and unsteady gait left the facility undetected by staff and was found at 4:46 PM on 8/04/25 by law enforcement 0.7 miles from the facility wandering in a neighborhood that has high traffic volume and cross streets this deficient practice increased the risk for the resident to be hit by an automobile that could have resulted in the likelihood of an adverse outcomes, sustained serious injury, serious harm or death. According to Accu weather.com on that day the temperature ranged between a high of 92 degrees and a low of 80 degrees Fahrenheit that could have caused Resident #1 to succumb to heat stroke. Refer to F600. The findings include: Record review of the facility's policy titled, Elopement/Code Pink revised May 2012 and reviewed August 2025 documented: Policy Statement: It is the policy of the Facility to provide a safe and secure environment for all residents. Purpose: 1) To assure the safety and security of all residents, 2) To establish policies and procedures in the event of a missing resident and 3) To train and maintain staff awareness of the importance of resident safety and security.Review of the facility's policy titled, Accident Hazards/Supervision/Devices revised February 2025 documented: Policy Statement: The resident environment will remain as free of accident hazards as is possible.Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes:1) Identifying hazards and risks, 2) Evaluating and analyzing hazards and risks, 3) Implementing interventions to reduce hazards and risks and 4) Monitoring effectiveness and modifying interventions. Review of the Demographic Face Sheet for Resident #1 documented the resident was initially admitted on [DATE] with a diagnosis of Dementia, Pneumonia, and unsteadiness on feet.Review of Resident's #1's Elopement care plan dated 7/21/2025 documented the resident is an elopement risk as evidenced by wandering with diagnosis of dementia; Goal: Resident will have no unauthorized departure from facility through next review date; Interventions: Place photograph on wander list; Redirect attention away from exit areas when wandering; Prompt and assist with meaningful activity attendance daily to keep occupied and Identify resident as an elopement risk and alert staff to monitor location on unit. Review of the facility's timeline of events documented the following: On 8/4/2025 a code pink was activated.Missing Resident #1 was playing Bingo around 3:00 PM in auditorium. Activity concluded at 4:00 PM. Patient was waiting to be transported to his room. Upon staff's arrival, staff found empty wheelchair. The surrounding areas by wheelchair was checked. Patient's room was also checked. Code Pink was called at 4:45 PM. Search throughout whole facility, patio, parking lot. Social Worker called 911 to file police report at 5:41 PM. [Local law enforcement] returned Social Worker's phone call to notify Social Worker that patient was in [residential neighborhood], police called [local emergency services] and the patient was transported to [local hospital] via ambulance. Social Worker notifiedall staff members. Nurse manager notified daughter. Daughter relieved patient was found safe and is medically stable. Resident Returned to facility 8/4/2025 at around 9:30 PM accompanied by the daughter.Review of the Physician's Order Sheets (POS) and Medication Administration Records (MAR) for July 2025 and August 2025 documented the resident was receiving the following medications: Donepezil HCL (hydrochloric acid) 10mg (milligrams) tab (tablet) 1 tab PO (bymouth) HS (at night) for dementia; Meclizine HCL 12.5mg tab 1 tab PO TID (three times a day) for dizziness and Memantine HCL 10mg tab 1 tab PO daily for Alzheimer's disease. Review of the Elopement Risk Assessment/Evaluation dated 7/21/2025 documented: The resident was at high risk for elopement and wandering. Keep one copy of patient's/resident's photograph in the medical record and another at the security gate; Place a PINK armband on the resident.On 9/04/25 at 3:10 PM the Risk Manager stated, On 8/04/2025 in the afternoon between 4:30 PM we were called by the staff that they couldn't find the patient, and he was not in the wheelchair. We let the staff activate Code Pink. When she realized he was not in his wheelchair, she called the nurse and told the nurse to check in the patient's room because he is not down here in the wheelchair. The nurse proceeded to check the room, and he was not there. Once they came down to the patio and realized he was not there, Code pink was activated. After 30 minutes he was not found, the police department was called and notified. I went to the security guard and asked if he saw anything. There was a transport van leaving the facility and a visitor that had come early. He opened the gate

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews the facility's administration failed to implement, provide and ensure an effective and efficient preventative measures were in place to prevent the neglect and elopement of one resident (Resident #1) out of three sampled residents who displayed exit seeking behaviors. As evidenced by inadequate safety measures that included failure to ensure residents were not able to leave the premise of the facility and failure by staff to implement assigned level of supervision for resident #1 who was a high risk for elopement. These deficient practices enabled resident #1 to exit the facility undetected at 4:24 PM through an electronic gate in the front of the facility on foot on 8/04/25 placing the resident at risk for harm and or injury. There were 191 residents residing in the facility at the time of the survey.The findings included:Record review of the facility's policy titled, Suspected Adult, Disabled Person or Elderly Abuse/Neglect/ Exploitation protocol implementation date was on 12/2000, the policy documented: The facility will provide a safe resident environment and protect all residents from abuse. Therefore, each resident has the right to be free from abuse, neglect and corporal punishment of any type by anyone. Neglect means failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. A prompt thorough investigation will be conducted by the facility immediately.Record review of the facility's policy titled, Elopement/Code Pink revised May 2012 and reviewed August 2025 documented: Policy Statement: It is the policy of the Facility to provide a safe and secure environment for all residents. Purpose: 1) To assure the safety and security of all residents, 2) To establish policies and procedures in the event of a missing resident and 3) To train and maintain staff awareness of the importance of resident safety and security.Review of the Job Description for the Executive Director (Nursing Home Administrator) documented: The Administrator is responsible for developing, managing and supervising the overall functions of the facility in accordance with current Federal, state and local standards and established nursing policies and procedures. He/she is also responsible for providing a positive, caring and homelike environment for the residents.Review of the Job Description for the Director of Nursing documented: The Director of Nursing is responsible for planning, organizing, developing and directing the day to day functions of the nursing department in accordance with current Federal, state and local standards and established nursing policies and procedures. He/she is also responsible for providing a positive, caring and homelike environment for the residents.Review of the Job Description for the Activities Assistant documented: The Activities Assistant is responsible for instructing and leading various activity/recreation programs and transporting and assisting residents to and from activity/recreational programs.Review of the Job Description for the Risk Manager documented: The Risk Manager is responsible for coordinating programs for risk identification, risk analysis, risk control and risk reduction.Review of the Job Description for the Security Officer documented: The Security Officer is responsible to maintain safe and secure environment for customers and employees by patrolling, monitoring and guarding entrance points and gate of the facility.Review of the Job Description for the Receptionist documented: The Receptionist is responsible for answering the telephone, directs visitors and residents, maintains security by following safety procedures and oversees the front reception area.Based on observational tour of the facility's parameter increased risk factors included the fact that, the facility is located in an area that has high traffic volume and busy intersections. Both locations where the facility is located and the location where the resident was found later that day, are high traffic areas with busy two laned roads and four laned cross streets.According to Accu weather.com on that day of August 4, 2025, the temperature ranged between a high of 9 degrees and a low of 80 degrees Fahrenheit.Review of the Demographic Face Sheet for Resident #1 documented the resident was initially admitted on [DATE] with a diagnosis of dementia, pneumonia, hypertension and unsteadiness on feet.Review of Resident's #1 Elopement care plan dated 7/21/25 documented the resident is an elopement risk as evidenced by wandering with diagnosis of dementia; Goal: Resident will have no unauthorized departure from facility through next review date; Interventions: Place photograph on wander list; Redirect attention away from exit areas when wandering; Prompt and assist with meaningful activity attendance daily to keep occupied and Identify resident as an elopement risk and alert staff to monitor location on unit. Review of the facility's timeline of events documented the following: On 8/4/2025 a code pink was activated. Missing Resident #1 was playing Bingo around 3:00 PM in auditorium. Activity concluded at 4:00 pm. Patient was waiting to be transported to his

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interviews, the facility's quality assurance and assessment committee failed to identify quality concerns to implement effective plans of action related to adequate supervision resulting in repeated deficient practice. The facility's history includes deficient practice for failing to supervise residents resulting in possible accidents. The facility was cited for Free of Accident Hazards, Supervision, Devices, Administration and Quality Assurance and Assessment on July 31, 2025. On 8/04/2025, the facility was negligent and failed to provide adequate supervision and effective services to prevent the elopement of one (Resident #1) out of three sampled residents with exit seeking behaviors, resulting in Resident #1 eloping from the facility at 4:24 PM, through an electronic gate in the front of the facility on foot undetected. These repeated deficient practices have the potential to affect any of the 191 residents residing in the facility.The findings included: Record review of the facility's Quality Assurance Performance Improvement (QAPI) Program Policy and Procedure (implemented December 2004) documented the following: Policy-This facility shall develop, implement and maintain an effective, comprehensive, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents; QAPI purpose is a type of quality management program which takes a systematic, interdisciplinary, comprehensive and data-driven approach to maintaining and improving safety and quality. Guidelines for Governance and Leadership: 1) The QAPI program includes the establishment of a Quality Assessment and Assurance (QAA) Committee and a written QAPI Plan; 2) The QAA Committee shall be interdisciplinary and shall: b) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program; 3) b) Policies and procedures for feedback, data collection systems and monitoring, c) Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: i.) Tracking and measuring performance, iii.) Identifying and prioritizing quality deficiencies, iv.) Systematically analyzing underlying causes of systemic quality deficiencies and v.) Developing and implementing corrective action or performance improvement activities. Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated 6/17/25, 7/15/25 and 8/19/25 documented the facility had a QAA Committee meeting monthly. Attendees included: Executive Director, DON, Medical Director, Director of Social Services, Director of Activities, Dietitian, MDS Coordinator, Director of Case Management, Director of Housekeeping/Laundry Services, Risk Manager, Infection Control, Director of Health Information Management, Fiscal Services, Pharmacist, Data Analyst, Laboratories and Community Liaison.Interview with the Director of Nursing/QAA on 9/05/25 at 2:27 PM. She stated, The QAA Committee meet monthly and we meet on the third Tuesday of the month. The committee members consist of the Administrator, DON, Medical Director and Department Heads. The purpose of the QAA committee is to bring forth any concerns that we may have and that we may need to address patient concerns and quality of care.