

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2025
NAME OF PROVIDER OR SUPPLIER  Villa Maria Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observations, interviews and records reviewed, the facility failed to ensure one (Resident #72) out of the eleven residents that eat independently had a dignified dining experience. As evidence by during the lunch meal in the dining room Resident # 72 did not receive a meal tray while the table mate had received her meal and had started eating. The findings included: During dining observation on 07/28/2025 there were 11 residents in the dining room, seated with two residents per table. At approximately 11:55 AM when the meal cart arrived staff members distributed the meal trays. Resident #72 was seated with another resident when the meal cart arrived. The resident seated with Resident #72 was served and had started eating but Resident #72 was not served. On 07/28/2025 at 12:22 PM, Staff A, Certified Nursing Assistant (CNA), reported that Resident #72's tray had not been included in the cart, due to an error in the kitchen. A review of the seating arrangements confirmed that Resident #72 was assigned to table #3. This designation is part of the facility's established dining plan, ensuring residents are seated according to structured guidelines during meal services. Interview with Staff A Certified Nursing Assistant (CNA) on 07/28/2025 at 12:32 PM revealed the resident did not receive a meal during the scheduled dining period. She reported that the kitchen staff had failed to deliver Resident #72's meal tray to the dining room as expected and the oversight originated in the kitchen, resulting in the absence of the resident's meal. Interview with Director of Nursing (DON) on 07/31/2025 at 11:45 AM. She stated the resident was present in the dining room during meal service, despite not being assigned to dine in that location. This occurrence was the result of an error, and Resident # 72's presence there was unintentional. Interview on 07/31/2025 at 1:05 PM, the Food Service Director revealed the kitchen staff served meal trays based on a list provided by the charge nurse. This list indicated which residents were assigned to eat in the dining room. During tray line service, the trays were distributed according to the information specified on that list to ensure proper meal delivery. However, he was not certain about the specific events that occurred on that day. Record review of the Policy and Procedures for Residents Rights revised on 11/28/2016 revealed: Residents Rights a) The resident has a right to a dignified existence, self-determination and communication with and access to person and services inside and outside the facility including those specified in this section. 1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 105232
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to provide housekeeping and maintenance services to ensure a sanitary clean homelike environment as evidenced by six resident areas observed unsanitary and in disrepair on the facility's third floor (North Unit and East Unit). The findings include. Observation on 07/28/25 starting at 08:30 AM during the initial resident and room screenings on the facility's 3rd floor North/East Unit revealed: room [ROOM NUMBER]- The wall was water damaged, water noted on the floor under the air conditioner, the base board was detached, and the air condition unit was falling off the wall (Photographic evidence).room [ROOM NUMBER] - Wall damaged on the outside of the room, the hand sanitizer dispenser had been ripped off the wall and the concrete underlayer of the wall visible (Photographic evidence).room [ROOM NUMBER]- Heavily stained bedside chair, the air conditioning unit noted falling off the wall. (Photographic evidence).room [ROOM NUMBER]- The air conditioning unit detached from wall. room [ROOM NUMBER]- Water on the floor at the base of the air conditioning unit.room [ROOM NUMBER]- Water on the floor at the base of the air condition unit. Interview on 07/30/2025 at 08:45 AM, the Director of Environmental services stated: I schedule five (5) female housekeepers for 7:00AM to 3:00 PM shift, two (2) housekeepers for 2:00 PM to10:00 PM shift, for laundry three (3) staff in the morning and 3 three in the afternoon. Housekeepers that work on the floor clean and sanitize the residents' rooms, bathrooms and common areas and pick up the garbage daily. The house keepers also are responsible for cleaning all furniture in the residents' room daily. We are currently working on replacing some of the residents' bedside chairs. Interview on 07/30/2025 at 8:56 AM, the Director of Maintenance stated: If there is a maintenance issue the staff place a ticket in the [] system that we used at the facility for staff to report maintenance issues. After the maintenance issue is reported, the maintenance staff is alerted via telephone of the issue, the technician on duty will immediately check out the issue, maintenance staff would replace or fix the issue in a timely manner. We have had some reports of issues with the air condition units, I am not sure of the specific rooms, there are some air condition units in residents' rooms that need to be fixed, I personally make rounds to check and make sure issues are fixed/resolved. Review of the facility policy and procedure titled Resident Environment revision date 10/16/24 states: The organization creates and maintains a supportive environment for all residents, which preserves dignity and facilitates a positive self-image. Any electrical appliances brought must be checked by the engineering department and approved for use.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed provide a safe environment in accordance with the facility's policy related to accident hazards for two vulnerable residents (Resident #10 and Resident #73) out of five sampled residents; as evidenced Resident #10 who is at risk for falls was observed in bed with the right-side floor mat positioned against the wall, presenting a potential safety hazard and an unattended open container with disinfecting wipes with ingredients that pose serious health and safety risks observed on Resident #73's bedside table. The findings include:</p> <p>Resident #10</p> <p>On 07/18/25 at 09:17 AM during observation Resident #10 in bed, one (1) floor mat on left side facing the bed, one (1) 1 floor mat positioned against the wall on right side (Photographic evidence).</p> <p>Review of the medical records for Resident #10 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Muscle weakness,</p> <p>Bilateral primary osteoarthritis of knee, Unspecified open angle glaucoma, Abnormalities of gait and mobility.</p> <p>Review of the Physician's Orders Sheet for July 2025 revealed Resident #10 had orders that included but not limited: Bilateral floor mats when in bed every shift.</p> <p>Record review of Resident # 10's Significant Change Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental status Score (BIMS) 3 on a 0-15 scale, indicating the resident is cognitively impaired.</p> <p>Section E for Behaviors documented no behaviors exhibited. Section GG for Functional Abilities documented the resident is dependent for care. Section J for Health Conditions documented one (1)-fall without injury since prior assessment.</p> <p>Record review of Resident # 10's Care Plans Reference Date 02/12/25 revealed the Resident has potential for falls related to decreased safety awareness&amp;hellip;</p> <p>Interview on 07/30/2025 at 09:30 AM Licensed Practical Nurse (LPN), (Staff D) assigned nurse for Resident #10 stated: &amp;ldquo;We check on those residents at least every hour&amp;hellip; Every morning all staff have to check the fall list to see which residents have floor mats and make sure the floor mats are in place when the residents are in bed.&amp;rdquo;</p> <p>Interview on 07/30/2025 at 09:39 AM, Staff E, Certified Nursing assistant (CNA) stated: &amp;ldquo;I am assigned to [Resident #10] &amp;hellip;for my assigned residents with floor mats, I check on them at least every hour. When the resident is in bed, I make sure the floor mats are on each side of the bed, when the resident is out of bed the floor mats are stored in a plastic bag against the wall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy and procedure titled "Falls Program" revision date 10/16/24 states: The falls program is a facility wide, multi-disciplinary program whose purpose is to properly identify residents who are at risk for falls and potential environmental risks which may facilitate accidents resulting in resident injury.</p> <p>Resident #73</p> <p>Observation on 07/28/2025 at 09:37 AM, Resident #73 was in bed with eyes closed; an open container of disinfectant wipes [] was observed on the resident's bedside table.</p> <p>Record review of Resident #73's demographic sheet revealed the resident was admitted on [DATE] with diagnoses that include Cerebral Infarction (CVA) and Unspecified Dysphagia.</p> <p>Record review of a Quarterly Minimum Data Set (MDS) Section for cognitive patterns revealed a Brief Interview of Mental Status (BIMS) summary score was 7 out of 15 which indicates severe cognitive impairment. The section for Functional abilities revealed the resident was dependent on Activities of daily living (ADLs).</p> <p>Record Review of a care plan 01/27/2025 revealed Resident #73 required total maximum assistance with most ADL tasks and mobility due to functional decline status post CVA. Goal: Will maintain highest practicable level of participation without decline over the next 90 days. Interventions: Hot liquids handling requires assistance as ordered</p> <p>Review of the disinfectant wipes [] container information revealed manufacturer warning and contents that included: Quaternary/high-alcohol formula (14.85%, Ethyl Alcohol 72.50%, Quaternary Ammonium Compounds 0.33%. Hazardous Identification included: Acute toxicity- Inhalation (Category 4), Flammable Liquids (Category 2), Serious Eye Damage/Eye Irritation (Category 2A), Specific Organ Toxicity (Single Exposure- Category 3). Container should be kept tightly closed and stored locked up. Potential exists for harm if used inappropriately including but not limited to, ingestion.</p> <p>Interview on 07/31/2025 at 01:22 PM, when asked about the open container of disinfectant wipes on Resident # 73's bedside table; the Nursing Supervisor stated: Any harmful objects like scissors or anything sharp cannot be kept inside a patient's room. No disinfectant wipes can be kept inside any patients' rooms. The reason is because some patients are disoriented or not alert and can put those wipes in their mouth. To ensure patient's safety and prevent hazardous items from being kept inside patients' rooms, I make rounds first thing in the morning and every 2 hours after that.</p> <p>Interview on 07/31/2025 at 12:55 PM, Staff G, Licensed Practical Nurse (LPN) was asked about the use and storage of the disinfectant wipes; Staff G, LPN stated: We use the disinfectant like [brand] to clean the blood pressure machines only. That is the alcohol type disinfectant, and it should also only be kept with the blood pressure machines not inside patients' rooms. If I see a disinfectant wipes bottle at the patient's bedside, I will definitely remove it immediately; disinfectant wipes are not allowed to be kept inside the patient's room because it is like a chemical and some patients who are not alert and oriented, might place them inside their mouths and possibly cause harm.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/31/2025 at 03:04 PM, the Director of Nursing (DON) stated: Disinfectant wipes are not allowed to be kept in patients' rooms but if residents cannot move, then I do not see how they can be at risk.</p> <p>Record Review of the facility policy and procedure titled Accident Hazards/Supervision/Devices, undated indicates the following: The facility must ensure that the resident environment remains as free from accident hazards as possible. The facility ensures that all staff (e.g. interdisciplinary/nursing/professional, administrative, maintenance, etc.) are involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. The facility ensures that reasonable efforts to identify hazards and risk factors for each resident.</p> <p>Protocol: This facility established and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. Identification of Hazards and Risks- the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to ensure oxygen therapy was delivered as prescribed for one (Resident #44) out of one resident who has a primary diagnosis of acute respiratory failure. As evidenced by observations of Resident # 41's Nasal Canula not in the resident's nostrils increasing the resident's risk for respiratory distress. The findings include: During an observation on 07/28/2025 at 8:48 AM, revealed Resident # 41's Oxygen (O2) running at 2 Liters per minute (lpm) with the via nasal canula (NC) not positioned in the resident's nostrils. The surveyor alerted Certified Nursing Assistant (CNA) to position the NC in the resident's nostril. Staff C revealed Resident #41 is her patient and she checks on the resident frequently during her shift. Observation on 07/30/2025 at 8:51 AM revealed Resident #41 in bed awake, with O2 running at 2 lpm the NC was not in the resident's nostril and was observed in the resident's mouth. The surveyor alerted assigned CNA, (Staff C) who reported she was just in the resident's room, and she had placed the oxygen tubing correctly in the resident's nostrils. Review of medical records for Resident #41 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Acute Respiratory Failure. Review of the Physician's Orders Sheet for July 2025 revealed Resident #41 had orders that included but not limited to: Apply oxygen via nasal cannula at 2 Liters per minute continuously. Record review of Resident # 41's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental status Score (BIMS)-unable to determined. Section J for Health Conditions documented Shortness of breath or trouble breathing with exertion, when sitting at rest, when lying flat. Section O for Special Treatments documented resident is receiving oxygen therapy. Record review of Resident #1 's Care Plans Reference dated 07/28/25 revealed: Resident has the potential for shortness of breath and alteration in respiratory status due to respiratory failure. Interventions include-Administer oxygen, respiratory treatments as ordered, document as needed use and effectiveness. Monitor for episodes of shortness of breath. Monitor frequency, duration, activity level and interventions that are successful. Monitor for signs and symptoms of respiratory distress: increased secretions, cough, increased shortness of breath, wheezing, elevated temperature. Interview on 07/31/2025 at 8:25 AM Licensed Practical Nurse (LPN), (Staff B) stated she is the assigned nurse for Resident #41, she does rounds for the residents every hour rotating with the assigned Certified Nursing Assistant to check on all the residents, vital signs including the oxygen saturation for residents are completed every shift and as needed. The last time she checked Resident #41's oxygen saturation was during her shift yesterday and the resident was within her normal limits and during frequent rounds the resident showed no distress. Stated she completed her start of shift rounds today and the resident was in no distress; she has not started checking her assigned residents' vital signs for her shift as yet. Review of the facility policy and procedures titled, Respiratory Therapy Services revision date 10/16/24 states: It is the policy of the facility to provide respiratory services to patients/residents when ordered by a physician. To ensure that all residents/patients in the facility have access to prescribed respiratory therapy services when medically indicated.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>Based on observations, interviews, and record review, the facility failed to demonstrate that effective actions were implemented through its Quality Assurance and Performance Improvement (QAPI) program to correct previously identified quality deficiencies under F550 (Resident Rights) related to failing to ensure Resident # 72 had a dignified dining experience, as evidenced by Resident #72 was not provided with a meal tray in a timely manner while her table mate was served and had started eating. The findings included: Review of the facility's survey history revealed during a recertification survey with exit dated 03/15/2024 the facility was cited F550 related to dignity concerns related to an indwelling urinary catheter drainage collection bag that was not fully covered with the privacy bag. During this survey with exit date 07/31/2025, the facility was again cited F550 for failing to ensure dignity during dining related to Resident #72 who was seated at a table for two in the dining room and was not provided with a meal tray while her table mate was served and had started eating. On 07/31/2025 at 2:20 PM, the Director of Nursing and the Administrator revealed the QAA committee includes interdisciplinary members and meetings are held monthly, and the last meeting was held on 07/15/2025. The interdisciplinary members use daily meetings, incident reports, and audit tools to track concerns. Review of the Policy and procedure titled Quality Assurance and Performance Improvement revealed, the primary objectives of the QAPI program are to monitor the quality of care and services provided, identify areas requiring improvement, and implement effective, data-driven changes throughout the facility to ensure high standards of resident-centered care. The program emphasizes active engagement of facility leadership, staff, residents, family representatives, and other relevant stakeholders in the quality improvement process. It outlines the establishment of systematic processes to evaluate care and services, determine when in-depth analysis is necessary, and address root causes of identified issues. Additionally, the policy supports the implementation of sustainable improvements and sets clear expectations related to patient safety, quality of care, individual rights, personal choice, and respect for all residents.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to ensure infection control standards and procedures were followed for two out of two residents (#25 and Resident #201) sampled for tube feeding. As evidenced by enteral feeding caps were noted stored uncovered on Resident #25 bedside chair and Resident #201's enteral feeding tube line open stored with the open end uncapped. The findings include:</p> <p><b>Resident # 201</b></p> <p>Observation on 07/28/2025 at 11:23 AM revealed Resident #201 in bed with eyes closed; the feeding tube was left uncapped leaking on the feeding pump. Dry residue was noted on the pump surface [Photographic evidence].</p> <p>Record review of Resident # 201 medical records revealed the resident was admitted on [DATE]. Clinical diagnoses include multiple sclerosis and gastrostomy status.</p> <p>Review of physician orders for July 2025 revealed orders for Jevity 1.5 @45 ml x 20 hrs on at 1300 (1:00 PM) off at 0900 (9:00 AM) via Enteral tube every shift.</p> <p>Review of the care plan, reviewed on 05/18/2025 documented resident #201 was at risk for gastrointestinal distress and aspiration due to the gastrostomy tube. Risk of complications related to GT placement&amp;hellip; cleansing the insertion site daily, and monitoring for signs of infection.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #201 is cognitively intact, dependent on activities of daily living and received more than 50% of nutritional intake via tube feeding.</p> <p><b>Resident #25</b></p> <p>On 7/28/2025 at 8:44 AM, Resident #25 in bed awake, Enteral Feeding inactive-Jevity, supplement, water and syringe dated 07/28/25, two (2) Enteral Feeding tubing caps observed on the bedside chair uncovered (Photographic evidence).</p> <p>On 07/29/2025 at 10:48 AM Resident #25 in bed asleep, Enteral Feeding not running. Two (2) Enteral Feeding tubing caps stored on the bedside chair uncovered (Photographic evidence).</p> <p>On 07/30/2025 at 8:56 AM Resident #25 in bed awake, Enteral Feeding running at correct rate, two (2) Enteral Feeding tubing caps observed on the bedside chair uncovered (Photographic evidence).</p> <p>Review of the medical records for Resident # 25 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Gastrostomy.</p> <p>Review of the Physician's Orders Sheet for July 2025 revealed Resident #25 orders that included but not limited to: Enteral Feeding-Jevity 1.5 at 55 milliners per hour (ml/hr.) x 22 hours daily, on at 12 Noon off at 10:00 AM. Water auto flush 45ml/hr. x 22 hours via enteral tube.</p> <p>(continued on next page)</p>		

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