

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105623	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER West Gables Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 SW 75th Avenue Miami, FL 33155	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety as evidenced by kitchen staff (Cook) not wearing a beard restraint while in the kitchen assisting with food services. There were 53 residents who ate by mouth residing in the facility at the time of survey. The findings included: Record review of the facility's policy titled Food and Nutrition dated 4/1/2015 revised 1/1/2021 indicate-Policy: Defines Food Service personnel standards regarding personal hygiene. Procedure: 7. Wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that cover all hair, including body hair. Wearing false eyelashes is not permitted, as they may become a physical contaminant. Observation on 09/10/25 at 11:04 AM during the kitchen tour revealed Staff A (Cook) pushing a cart in the kitchen. He wore a surgical mask and a hat, and parts of his beard was visible. When asked about the beard net, he stated, I don't wear a beard net because it makes me allergic. He then walked to the back of the kitchen, took off the mask, and put on a beard net. On 09/10/25 at 11:09 AM, the Kitchen Director stated, I have been the Director for a month. Anyone who enters the kitchen is required to wear a hairnet or beard net. Wearing a mask as opposed to the beard net is acceptable. Interview on 09/10/25 at 2:51 PM Staff A, stated: I have been The [NAME] for 18 years. I have received in-service about wearing hairnets and beard nets. The purpose of wearing it is to prevent contamination of the food and any possible infection transmission. It is appropriate to wear a mask and not a beard net if it is clean and covers my beard. The reason I did not wear a beard net is because it causes allergies and brings Asthmatic episodes. I reported my allergy to my previous supervisor, and he told me it was fine to wear a mask as long as my mouth and beard are covered. On 9/10/25 at 4:38 PM the Kitchen Director stated, I was aware that Staff A, [NAME] had an allergy to the beard restraint. If a mask is worn; that covers facial hair it is ok. I believe the mask prevents any hair from falling into the food. On 9/10/25 at 4:42 PM, the Administrator was notified about identified concern and stated, It is okay to wear the mask to prevent any hair from falling into the food. On 09/11/25 at 2:38 PM The Registered Dietician stated, I have been employed for about a year. I do rounds in the kitchen that include sanitation audits, expiration dates, temperature logs, and storage. I observe the passing of the trays on the floors to ensure all supplements and diet orders are correct. I looked at the vents and noticed condensation and the employee wiped the vents. Before entering the kitchen, hair nets, hats, beard guards and sanitize hands.		

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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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations records reviewed and interviews the facility failed to ensure a safe homelike environment, as evidenced by water dripping from ceiling and vents on the facility's fourth floors Wing A, D into large bins, one of the five bins was noted blocking the hallway; there was water on the floor next to the bin in front of the nurse's station closest to the elevator .This deficient practice increases the risk for safety hazard due to potential slip and fall accidents that could lead to injuries. There were 53 residents residing in the facility at the time of the surveys. The findings include. Observations on September 09, 2025, at 10:59 AM on the 4th floor near the elevator, there were dark brown stains on the ceiling tiles. The stains looked like watermarks and were about 3x5 inches, 1x3 inches, and 1x&frac12; inch in size. One ceiling tile with a security camera was sagging and not in place correctly. (Photographic evidence) On 9/9/2025 at 11:18 AM, in Wing A, North hallway, 13 ceiling tiles near the Wi-Fi router had dark brown stains that looked like watermarks (Photographic evidence) Observation on 9/9/2025 at 11:20 AM, in Wing D, East hallway, water was on the floor. A large yellow bin was placed in the hallway to catch water dripping from the ceiling. (Photographic evidence) Observation on 9/9/2025 at 11:21 AM, in the North hallway, water was also on the floor. Another large yellow bin was catching water. A second bin was at the nurse's station doing the same. (Photographic evidence) Observation on 09/09/2025 at 11:22 AM, in Wing B, East hallway, water droplets (condensation) were seen on the ceiling. Observation in 09/9/2025 at 12:10 PM, water damage and a black substance were seen around the edges of the air vents near the wall on the fourth floor. (Photographic evidence) Observation on 09/09/2025 at 2:43 PM revealed ceiling tiles that were replaced had new watermarks were already forming on them. (Photographic evidence) Observation on 09/10/2025 at 10:56 AM, revealed the ceiling tiles near the elevator that were replaced the day before now had new watermarks that were getting bigger. (Photographic evidence) Interview on 09/10/25 at 11:09 AM, the Kitchen director was asked about the condensation dripping onto tray line; he stated: I have been the director for a month. I recently noticed that condensation forming and dropping onto the tray line more this week due to the rain and we have been wiping the vent with cloth. We kept the tray line in the same position because we thought we could control the dripping with wiping. I informed the Maintenance department before this week, and they came looking at it informed us it was due to the machines and weather. We noticed the dripping on Monday, and we didn't know the vent could be moved until maintenance moved it yesterday from above tray line. On 9/10/2025 at 11:11 AM, the Kitchen Director showed a clean green cloth used to wipe the water. On 09/11/25 at 2:38 PM The Registered Dietician stated, I have been employed about a year. I do rounds in the Kitchen that include sanitation audits, expiration dates, temperature logs, and storage. I (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observe the passing of the trays on the floors to ensure all supplements and diet orders are correct. I have looked at the vents and noticed condensation and the employees wipe the vents. On 09/11/25 at 2:57 PM Staff C, Licensed Practical Nurse stated: I noticed dripping from the vents in July in the hallways and a resident's room when it rains. I notified the Maintenance or Administration. Ensure the safety of the residents by making sure no residents are in the area. On 09/11/25 at 1:45 PM Staff B, Certified Nursing Assistant stated, Today I noticed there are buckets to catch the dripping from vents. I haven't seen any water on the floors. I asked other staff why the buckets were there, and they informed me water was dripping from the vents. On 9/11/25 at 3:05 PM, the Environmental Service Supervisor stated, I check the fourth floor three times a day. I check the floors, walls and A/C Vents. When I check the vents, I ensure there is no dust. While checking the vents last week was the first time, I noticed condensation and dripping from the vents in the hallways and I reported to the Plant of Operation who is the Maintenance Director and my staff cleaned the vents with microfiber towels. I did not log the vent observation and cleaning. On 9/11/25 at 3:12 PM: the Director of Plant Operations stated, I am responsible for repairing any machinery. I noticed last week that there were condensation and dripping coming from the vents in kitchen last week due to the rain. This is caused by the high humidity coming into a cold place that causes condensation. I called the company that fixed our a/c to come and see why there is so much humidity and condensation in the vents. They came yesterday and informed us that there is a lot of air exchange and humidity into the building due to the opening and closing of the elevator doors. We have three elevator shafts because the hot air is getting caught in the shaft and bringing it to each floor. The kitchen would be affected due to the hot machinery inside and I moved some of the vents in the kitchen this week to avoid water from falling on the tray line. Some of the vents were moved last week but we didn't notice the vent directly over the tray line was dripping so much until this week. On 9/11/25 at 3:26 PM, the Surveyor showed the Director of Plant Operations a black stain observed around the vent in the dining area where residents have activities and meals. The Director of Plant Operations revealed that it could be caused by water dust or mildew. On 09/11/25 at 3:41 PM, the Maintenance Director stated, I first noticed condensation and dripping from the vents in the hallways about a month or two ago. The heat and the humidity determine how much condensation. When I noticed The Director of Plant Operations. I placed buckets and cones under the vents that had condensation. I have not received any reports of condensation or dripping in residents' rooms. I replaced the ceiling tile on front of the elevator due to condensation. I cleaned the vents in the dining room last month. On 09/11/25 at 3:36 PM, the Administrator stated: I do frequent rounds with Maintenance. The condensation varies depending on the weather; the frequency of the use of the elevator can cause an increase due to the shaft.		