

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105803	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Terrace of Hialeah, The		STREET ADDRESS, CITY, STATE, ZIP CODE 190 W 28th Street Hialeah, FL 33010	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure oxygen therapy was delivered as prescribed for five residents (#9, #90, #214, #240, and #258) out of 37 residents on oxygen therapy. As evidenced by oxygen observed being administered at incorrect rates via nasal cannula from concentrators. There were 235 residents residing in the facility at the time of the survey. The findings include. During observations on 12/02/25 at 10:13 AM, 12/03/25 at 08:46 AM Resident # 9 was in bed with oxygen (O2) running via nasal canula (NC) at 3.5 liters per minute (lpm). On 12/04/25 at 11:57 AM Resident # 9 was in bed with oxygen running via nasal canula at 3 liters per minute (lpm). Review of the medical records for Resident #9 revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Clinical diagnoses included but not limited to: Chronic Obstructive Pulmonary Disease (COPD). Review of the Physician's Orders Sheet for December 2025 revealed Resident # 9 had orders that included but not limited to: 07/13/25-oxygen (O2) at three (3) Liters per minute (lpm) via nasal canula (NC) continuously every shift. Record review of Resident # 9's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status Score (BIMS) unable to be determined. Section GG for Functional Abilities documented dependent for care. Section J for Health Conditions documented Shortness of breath or trouble breathing when lying flat. Section O for Special Treatments documented the resident is receiving hospice care. Review of Resident # 9's Care Plan Reference Date 11/23/25 revealed: Resident has potential for ineffective breathing pattern related to: Shortness of Breath, COVID+(resolved), (COPD), depends on continuous oxygen. Resident will have normal breathing pattern as evidenced by good skin color, and regular respiratory rate/pattern by next review date. Interventions include- Administer oxygen as ordered. During observation on 12/02/2025 at 9:35 AM Resident # 90 in bed, O2 running at 3 lpm via NC. On 12/03/2025 at 9:04 AM Resident # 90 observed in bed asleep O2 running at 2 lpm, no distress noted. On 12/04/2025 at 11:46 AM Resident # 90 observed in bed asleep O2 running at 2lpm via NC. Review of the medical records for Resident # 90 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Chronic Obstructive Pulmonary Disease (COPD). Respiratory disorders in diseases classified elsewhere, Acute and Chronic Respiratory failure with hypoxia, severe persistent Asthma with (acute) exacerbation. Review of the Physician's Orders Sheet for December 2025 revealed Resident # 90 had orders that included but not limited to: oxygen (O2) at two Liters per minute (lpm) via nasal canula (NC) continuously every shift. Record review of Resident # 90's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status Score (BIMS) unable to be determined. Section GG for Functional Abilities documented dependent for care. Section J for Health Conditions documented Shortness of breath or trouble breathing when lying flat. Section O for Special Treatments documented the resident is receiving oxygen therapy. Review of Resident # 90's Care Plan Reference Date 10/14/25 revealed: Resident is at risk for altered respiratory status/difficulty breathing r/t asthma, COPD, episodes of shortness of breath, pneumonia, Acute and chronic respiratory failure with Hypoxia. On oxygen continuously. The resident will maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory (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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rate/pattern through the review date. Interventions include- Administer oxygen as ordered. During observation on 12/02/2025 at 10:16 AM Resident # 214 in bed oxygen (O2) running at 2.5 lpm via NCO on 12/03/2025 at 8:48 AM Registered Nurse (Staff B) revealed Resident #214 went to the hospital last night for diagnosis of Pneumonia after review of lab results by the physician. Review of the medical records for Resident #214 revealed the resident was admitted to the facility on [DATE] and readmitted [DATE]. Clinical diagnoses included but not limited to: Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure. Morbid (severe) obesity with alveolar hypoventilation. Chronic Obstructive Pulmonary Disease, unspecified. Review of the Physician's Orders Sheet for December 2025 revealed Resident #214 had orders that included but not limited to: oxygen (O2) at three Liters per minute (lpm) via nasal canula (NC) continuously every shift. Record review of Resident # 214's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental status score (BIMS) 3, indicating the resident is cognitively impaired. Section GG for Functional Abilities documented dependent for care. Section J for Health Conditions documented Shortness of breath or trouble breathing when lying flat. Section O for Special Treatments documented the resident is on oxygen therapy. Review of Resident # 214's Care Plan Reference Date 11/03/25 revealed: Resident have potential for alteration in respiratory functioning related to Chronic Obstructive Pulmonary Disease (COPD), Obstructive Sleep Apnea, continuous O2, history of respiratory failure. Resident will be free from respiratory distress through next review date. Interventions include-Administer oxygen as ordered. During Observation on 12/02/2025 at 9:38 AM Resident #240 in bed asleep O2 running at 3 lpm via NC. During observation on 12/03/2025 at 9:03 AM Resident #240 was out of the facility for dialysis, and at 10:46 AM the resident was back from dialysis and in bed asleep with O2 at running at 2 lpm via NC. On 12/04/2025 at 11:45 AM Resident #240 in bed asleep, O2 running at 2 lpm via NC. Review of the medical records for Resident #240 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Other Sequelae of Cerebral Infarction. Review of the Physician's Orders Sheet for December 2025 revealed Resident #240 had orders that included but not limited to: oxygen (O2) at two Liters per minute (lpm) via nasal canula (NC) continuously every shift. Record review of Resident # 240's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental status score (BIMS) 10, indicating the resident is cognitively moderately impaired. Section GG for Functional Abilities documented dependent for care. Section J for Health Conditions documented no shortness of breath. Section O for Special Treatments documented the resident is receiving oxygen therapy and Dialysis. Review of Resident #240's Care Plan Reference Date 11/06/25 revealed: Resident is at risk for altered respiratory status/difficulty breathing related to Congestive Heart Failure, episodes of shortness of breath. O2 continuous. The resident will maintain normal breathing patterns as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern through the review date. Interventions include- Administer medication/inhalers/nebulizers as ordered. Administer oxygen as ordered. Monitor O2 saturations as ordered/as needed Encourage adequate rest periods in between tasks/activities. During observation on 12/02/2025 at 9:55 AM Resident #258 in bed asleep, O2 running at 2.5 lpm via NC. On 12/03/2025 at 8:58 AM Resident # 258 in bed, receiving care O2 running at 2 lpm via NC. On 12/04/2025 at 11:51 AM Resident # 258 moved to another room, O2 running at 2lpm via NC. Review of the medical records for Resident # 258 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Chronic Obstructive Pulmonary Disease (COPD) Review of the Physician's Orders Sheet for December 2025 revealed Resident #258 had orders that included but not limited to: oxygen (O2) at two (2) Liters per minute (lpm) via nasal canula (NC) continuously every shift. Record review of Resident # 258's admission Minimum Data Set (MDS) dated [DATE] revealed: MDS in progress. Review of Resident # 258's Care Plan Reference Date 12/01/25 revealed: Resident is at risk for altered respiratory status/difficulty breathing related to Anxiety, COPD, episodes of shortness of breath, pneumonia. The resident will maintain normal breathing patterns as evidenced by normal (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, interviews, and record review, the facility failed to develop and implement an effective Quality Assurance and Performance Improvement (QAPI) program. As evidenced by repeat citations related to F0584 - Housekeeping and Maintenance, F0645 - Pre-admission Screening and Resident Review (PASARR, F0695 - Respiratory Care and F0867- QAPI/Quality Assessment and Assurance (QAA) Improvement Activities). There were 235 residents residing in the facility at the time of the survey. The findings include. Review of the facility's survey history revealed during the recertification survey with an exit date of 06/26/2024, the facility was cited: F0584: Safe/Clean/Comfortable/Homelike Environment; F0645-PASARR (Preadmission Screening and Resident Review), for incomplete PASARR documentation, and F0695-Respiratory/Tracheostomy Care and Suctioning for failure to ensure prescribed respiratory care and F0867- QAPI/Quality Assessment and Assurance (QAA) Improvement Activities).During the current survey with an exit date of 12/05/2025, the surveyors identified repeated deficient practices for: F0584: Safe/Clean/Comfortable/Homelike Environment; F0645- PASARR (Preadmission Screening and Resident Review), and F0695: Respiratory/Tracheostomy Care and Suctioning. Interview with the Administrator on 12/05/2025 at 7:18 PM, revealed the QAA committee meets on the first Friday of each month and the last meeting was held on November 7, 2025 the committee includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Admissions, Social Services, MDS, Activities, Dietary, Wound Care, Restorative Nurse, Infection Preventionist, Therapy, Central Supply, Housekeeping, Maintenance, Committee Physician, and Pharmacy. the QAA committee is meant to improve the quality of care and services by reviewing practices, identifying problems or opportunities for improvement, and putting corrective actions in place. It's a team effort, and everyone's input is used to find solutions and make improvements. When asked how the committee knows when an issue comes up, staff said concerns are raised during daily morning meetings, through audits, or staff reporting processes and issues are reviewed by department heads during rounds, prioritized based on risk and resident impact, and addressed immediately if they are high risk. The QAA committee revisits interventions to make sure they are working, provides re-education if needed, and incorporates staff feedback to ensure corrective actions stay effective with setting a timeframe, usually about three months, and then review progress. Monitoring is ongoing through rounds, audits, teachable moments, monthly town halls, and safety committee activities. The committee tracks improvement using audits, observations, and comparing reports to previous data to make sure interventions are working. Review of the policy titled Quality Assurance and Performance Improvement (QAPI) and dated 11/28/2012 revealed that nursing home QAPI is the coordinated application of two mutually reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving. Quality Assurance (QA): QA is the specification of standards for quality of care, service and outcomes, and systems throughout the facility for assuring that care is maintained at acceptable levels in relation to those standards		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide housekeeping and maintenance services to ensure a sanitary, clean and homelike environment as evidenced by soiled stains on toilet seats in residents' bathroom, trash on floor in residents' bathroom, dirty hallway walls, and ripped bedside chair cushions in a resident's room. There were 235 residents residing in the facility at the time of the survey. The findings include: Observation on 12/02/25 starting at 09:48 AM during the initial resident and room screenings on the facility's [NAME] Unit revealed: Rooms 124 red and green colored stains on toilet seat in resident's bathroom. Rooms 122, 126-soiled trash on floor in resident's bathroom. room [ROOM NUMBER]-Ripped bedside chair cushion. Rooms 101-116 hallway walls with scruff marks, black spots, stains, scrapes, dents and dings on the walls. Interview on 12/05/2025 at 5:43 AM, the Director of Housekeeping revealed reported there are seven housekeeping staff that work 5:00 AM to 1:30 PM daily on the floor. Additionally, there is one person in the mornings and one person in the afternoon that work 1:00 PM to 9:30 PM whose job it is to remove the garbage from the soiled utility rooms in the facility. The morning housekeeping staff are responsible for cleaning the entire residents' rooms, bathrooms and hallways. After the surveyor showed the pictures of the dirty walls in the hallways on [NAME] unit, residents' bathrooms and the ripped chair, the Director of Housekeeping stated: We were in the process of waxing the walls when the survey began and we stopped for now, we will continue waxing and cleaning the walls starting next week Monday. After the residents' rooms are initially cleaned by housekeeping in the morning, the Certified Nursing Assistant (CNAs) are responsible for maintaining the cleanliness of the room. Interview on 12/05/2025 at 8:56 AM, the Director of Maintenance revealed the administrator is aware of the chairs in the facility that are old and in disrepair and have been replacing them. Interview on 12/05/2025 at 8:58 AM, the Administrator stated: We have been replacing the old chairs a few at a time, we are going to be starting construction in the facility in a few months and eventually all the old chairs will be replaced. Review of the facility policy and procedures titled Infection Control-environmental Services revision date 03/01/2007 states: The purpose is to control the spread of infection within the facility by maintaining a thoroughly clean and safe environment.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for one (Resident #9) out of 6 residents reviewed for resident assessments. As evidenced by inaccurate coding of MDS for Special Treatments, Procedures, and Programs related to Oxygen therapy for Resident #9. There were 235 residents residing in the facility at the time of this survey. The findings include. During several observations on 12/02/25, 12/03/25, 12/04/25 and 12/05/25 Resident#9 was in bed with oxygen running via nasal canula. Review of the medical records for Resident #9 revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Clinical diagnoses included but not limited to: Chronic Obstructive Pulmonary Disease (COPD) Review of the Physician's Orders Sheet for December 2025 revealed Resident #9 had orders that included but not limited to: 07/13/25-oxygen (O2) at three Liters per minute (LPM) via nasal canula (NC) continuously every shift. Record review of Resident # 9's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status Score (BIMS) unable to be determined. Section O for Special Treatments documented the resident is receiving hospice care. Oxygen therapy is not coded. Review of Resident #9's Care Plan Reference Date 11/23/25 revealed: Resident has potential for ineffective breathing pattern related to: Shortness of Breath, COVID+(resolved), (COPD), depends on continuous oxygen. Interventions include- Change Oxygen Tubing and Humidifier every night shift on Sunday. Administer oxygen as ordered. Interview on 12/05/2025 at 7:26 AM Minimum Data Set Coordinator (Staff A) stated: For assessments of the residents, we go to see the residents physically, read the residents' doctor orders, nurses' notes and medical documents of the residents to complete the assessment. The resident was not coded for oxygen therapy on the quarterly assessment dated [DATE]. The resident has an order in the system for continuous oxygen; a mistake was made in not coding the oxygen therapy in section O for Special treatments on the most recent quarterly assessment. Review of the facility policy and procedure titled MDS Assessment completion and Accuracy dated 09/2022 states: It is the policy of the facility to adhere to the following procedures related to the proper documentation and utilization of a resident's Minimum Data Set (MDS) to ensure a comprehensive and accurate assessment of residents will be completed in the format and in accordance with time frames stipulated by the Department of Health and Human Services Center for Medicare and Medicaid Services. This assessment system will provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacities and assist staff to identify health problems for care plan development.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to complete a Preadmission Screening and Resident Review (PASARR) for one (Resident # 16) out of two sampled residents, as evidenced by not including Serious Mental Illness (SMI) diagnosis on the resident's PASARR form. There were 235 residents residing in the facility at the time of the survey. The findings include. Record review of a policy titled Preadmission Screening and Resident Review (PASARR) revealed it is the policy of the facility to ensure that all residents receive a PASARR in accordance with State and Federal requirements and that the PASARR is updated whenever mental health diagnoses or conditions change. Observations on 12/02/25 at 10:43 AM Resident #16 was awake in low bed, on 12/03/25 at 11:58 AM and on 12/04/25 at 12:26 PM Resident #16 was observed in room being fed by staff no concerns noted. Resident #16 was initially admitted on [DATE] and re-entered the facility on 12/11/24 with medical diagnoses that included Parkinson's Disease without Dyskinesia, Mood Disorder due to a Known Physiological Condition (Unspecified), Bipolar Disorder, Generalized Anxiety Disorder, and Major Depressive Disorder, Single Episode, Unspecified. Record review of a Significant Change - No PPS MDS dated [DATE] revealed Section A had no mention of the PASARR. Section C documented a BIMS score of 6, indicating moderate to severe cognitive impairment. Section I showed the resident had diagnoses of Anxiety, Depression, and bipolar disorder. Section N showed the resident did not receive any antipsychotic medications but did receive antidepressant and anti-anxiety medications. Record review of the care plan, with a review start date of 12/10/25 and target completion date of 03/08/26 included a focus on the use of anti-anxiety medication for an anxiety disorder, use of antidepressant medication for depression and insomnia, with goals for the resident to remain free from adverse reactions related to therapy. Interventions included monitoring and documenting reactions such as drowsiness, confusion, impaired judgment .hostility or hallucinations .prevention of over-sedation . or suicidal thoughts and obtaining psychological services when needed. Record review of a physician's orders dated 08/21/25 showed an active order for Clonazepam 1 milligram (mg) tablet, to be given twice daily for anxiety. Record review revealed the admission PASARR provided by the hospital and the PASARR completed by the facility did not document the resident's mental health diagnoses of depression, anxiety, and bipolar disorder after these diagnoses became effective and began receiving treatment for these mental health conditions. During an interview on 12/02/25 at 6:53 PM the Social Services Director stated: Upon review of the admission PASARR completed at the facility and the PASARR provided by the hospital at the time of admission, findings were compared and verified. Neither PASARR contained the diagnoses listed in the medical record. The diagnoses of depression and anxiety were identified after admission and therefore were not reflected on the admission PASARR. The resident was later diagnosed with bipolar disorder. Social Services acknowledges that the PASARR should have been updated when these diagnoses became effective.		