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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>106080 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                 | (X3) DATE SURVEY COMPLETED<br><br>05/15/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Villa Maria West Skilled Nursing Facility |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8850 NW 122 St<br>Hialeah Gardens, FL 33018 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 10996</p> <p>Based on observation, record review and interview, the facility failed to develop a baseline care plan for oxygen use for one (Resident #78) out of one sampled resident reviewed for oxygen therapy.</p> <p>The findings included:</p> <p>During the observational tour on 05/13/24 at 08:10 AM, Resident #78 was observed in bed receiving oxygen(O2) via nasal cannula (NC) connected to the wall oxygen supply. The resident reported that he is on oxygen at 2 liters. An observation of the oxygen flow meter revealed the oxygen was set at 4 liters per minute. (Photo Obtained) The resident reported he fell at his house in April 2024, fractured five ribs and had a pneumothorax.</p> <p>On 05/13/24 at 11:51 AM, Resident #78 was observed sitting up in a wheelchair and looking at his phone. He had a garden salad from home on his bedside table and he reported he preferred the salad his wife brought him. The oxygen nasal cannula was observed on, but the level was not checked at this time.</p> <p>On 05/14/24 at 08:33 AM, Resident #78 was observed in bed awake. A staff person from the Physical Therapy (PT) was at the residents bedside. The PT staff person reports the resident did not want to get out of bed this morning so the physical therapy would be provided in the resident's room. Observation revealed, the O2 via NC was set at 2 liters on the wall oxygen flow meter.</p> <p>A review of Resident #78's electronic medical record revealed, an admitted [DATE] with diagnoses to include Acute Respiratory Failure, Congestive Heart Failure (CHF) Exacerbation, Chronic Obstructive Pulmonary Disease (COPD) Exacerbation and Pacemaker insertion. Review of the physician's orders revealed an order on 5/8/24 for O2 at 2 liters per minute.</p> <p>A review of Resident #78's electronic medical record revealed, a Baseline Care Plan and Summary that included the resident's admitted , diagnoses, code status, Physician, Diet order, allergies, Medications, Physical Therapy, Occupational Therapy, Consults, Problem and Care Plan Goals. The Baseline Care Plan did not include information about the resident's order for oxygen at 2 liters per minute.</p> <p>On 05/15/24 at 9:53 AM, interview and record with the Director of Nurses (DON) revealed that the oxygen was not included on the Baseline Care Plan and Summary and the Interim Care Plan-Admission. The DON contacted the Minimum Data Set (MDS) Coordinator for the care plan.</p> <p>(continued on next page)</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | [X6] DATE |
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| <p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 05/15/24 at 10:15 AM, the DON brought a comprehensive care plan that included a care plan for the potential for shortness of breath, alteration in respiratory status due to COPD, alteration in respiratory status due to status post (s/p) exacerbation of CHF and potential for hypoxia related diagnosis of CHF. The interventions included: Administer oxygen and nebulizer treatments as ordered.</p> <p>This information related to oxygen use was not included on the Baseline Care Plan and Summary and the Interim Care Plan-Admission.</p> |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 10996</p> <p>Based on observation, record review and interview, the facility failed to follow the urinary catheter care plan for one out of one (Resident #79) sampled resident reviewed for catheter care.</p> <p>The findings included:</p> <p>During tour on 05/13/24 at 08:55 AM, Resident #79 was observed sitting in a wheelchair at the sink in the resident's room. The resident was dressed, and a family member was at his bedside. A urinary catheter was observed on the right side of the wheelchair at the same level where the resident was sitting. The white side of the drainage bag was observed, and the drainage bag was not in a privacy bag. The resident's family member reported facility staff are going to give Resident #79 a leg bag for the catheter. The drainage bag was not observed to be below the resident's bladder.</p> <p>Observation on 05/13/24 at 09:02 AM revealed, Resident #79 being rolled out of the room in a wheelchair by a staff person from the therapy department. The urinary catheter was in the same position on the wheelchair.</p> <p>Observation on 05/13/24 at 09:20 AM revealed the resident was in the therapy room, sitting in the wheelchair. A gait belt was placed on him, the resident was observed standing and sitting with a therapy staff member at his side.</p> <p>Observation on 05/13/24 at 12:02 PM revealed, the resident sitting at bedside eating lunch. The urinary catheter bag was at the head of the resident bed and the tubing was on the resident's bed. The urinary catheter bag was observed next to the blue privacy bag. The drainage bag was not inside the privacy bag.</p> <p>Observation on 05/14/24 at 08:50 AM revealed, the resident was in bed, the urinary catheter was at the foot of the bed, below the bladder, the urine was amber, and appeared to have a small amount of mucous in in the tubing.</p> <p>A review of Resident #79's electronic medical record revealed, Resident #79 was admitted to the facility on [DATE] with diagnoses to include Urinary Retention due to an Enlarged Prostate. The resident had a physician order for 5/9/24 - Provide [ brand] catheter care every shift and on 5/10/24 - Diagnosis for [indwelling catheter] use: Urinary Retention due to enlarged prostate.</p> <p>A review of the residents Minimum Data Set (MDS) revealed the assessment was in the process of being completed.</p> <p>A review of the residents care plans revealed Care Plans for At Risk for an Infection due to the use of an indwelling catheter-dated 5/9/24. The Care Plan interventions included, Make sure drainage bag hangs below level of bladder and is covered when out of bed. This care plan was not followed.</p> <p>Interview on 05/14/24 at 01:49 PM with the Director of Nurses (DON) about the urinary catheter observations.</p> |  |  |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 10996</p> <p>Based on observation, record review and interview, the facility failed to follow the facility's policy and procedure for catheter care for one out of one resident (Resident #79) reviewed for urinary catheter care.</p> <p>The findings included:</p> <p>During tour on 05/13/24 at 08:55 AM, Resident #79 was observed sitting in a wheelchair at the sink in the resident room. The resident was dressed, and a family member was at his bedside. A urinary catheter was observed on the right side of the wheelchair at the same level where the resident was sitting. The white side of the drainage bag was observed, and the drainage bag was not in a privacy bag. The resident's family member reported that facility staff are going to give Resident #79 a leg bag for the catheter. The drainage bag was not observed to be below the residents bladder or in a privacy bag.</p> <p>Observation on 05/13/24 at 09:02 AM revealed, Resident #79 being rolled out of the room in a wheelchair by a staff person from the therapy department. The urinary catheter was in the same position on the wheelchair.</p> <p>Observation on 05/13/24 at 09:20 AM revealed the resident was in the therapy room, sitting in the wheelchair. A gait belt was placed on him, the resident was observed standing and sitting with a therapy staff member at his side.</p> <p>Observation on 05/13/24 at 12:02 PM revealed, the resident sitting at bedside eating lunch. The urinary catheter bag was at the head of the resident's bed and the tubing was on the resident bed. The urinary catheter bag was observed next to the blue privacy bag. The drainage bag was not inside the privacy bag.</p> <p>Observation on 05/14/24 at 08:50 AM revealed, the resident was in bed, the urinary catheter was at the foot of the bed, below the bladder, the urine was amber, and appeared to have a small amount of mucous in in the tubing.</p> <p>A review of Resident #79's electronic medical record revealed, Resident #79 was admitted to the facility on [DATE] with diagnoses to include Urinary Retention due to an Enlarged Prostate. The resident had a physician order for 5/9/24 - Provide [] catheter care every shift and on 5/10/24 - Diagnosis for [indwelling catheter] use: Urinary Retention due to enlarged prostate.</p> <p>A review of the residents Minimum Data Set (MDS) revealed the assessment was in the process of being completed.</p> <p>A review of the resident's care plans revealed, Care Plans for At Risk for an Infection due to the use of an indwelling catheter-dated 5/9/24. The Care Plan interventions included, Make sure drainage bag hangs below level of bladder and is covered when out of bed. This care plan was not followed.</p> <p>(continued on next page)</p> |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview on 05/14/24 at 01:49 PM with the Director of Nurses (DON) about the urinary catheter observations. The facility's policy for catheter care was requested.</p> <p>The facility policy and procedure for <input type="checkbox"/> Catheter Care, effective 5/28/2008 and reviewed 4/14/2024 revealed, Policy: It is the policy of this facility that catheter care will be provided to all residents with indwelling catheters at least daily and more often as needed due to soiling with feces or when it is deemed necessary by the nurse. The Purpose: The purpose of the catheter care is to prevent possible urinary tract infections from bacteria spreading from the perineal area and external catheter into the bladder. Basic Procedures: The catheter and drainage bag should be kept as a closed system with the drainage bag kept at a level lower than the bladder to allow drainage by gravity.</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> 10996</p> <p>Based on observation, record review and interview, the facility failed to ensure oxygen therapy was accurately administered as ordered by the physician for one (Resident #78) out of one resident reviewed for the use of oxygen.</p> <p>The finding included:</p> <p>During the observation tour on 05/13/24 at 08:10 AM, Resident #78 was observed in bed receiving oxygen(O2) via nasal cannula (NC) connected to the wall oxygen supply. The resident reported that he is on oxygen at 2 liters. An observation of the oxygen flow meter revealed the oxygen was set at 4 liters per minute. (Photo Obtained) The resident reported he fell at his house in April 2024, fractured five ribs and had a pneumothorax. The resident was working on a crossword puzzle and wasn't observed to be in distress.</p> <p>On 05/13/24 at 11:51 AM, Resident #78 was observed sitting up in a wheelchair and looking at his phone. He had a garden salad from home on his bedside table. He reported he preferred the salad his wife brought him. The oxygen's nasal cannula was observed on, but the level was not checked at this time.</p> <p>On 05/14/24 at 08:33 AM, Resident #78 was observed in bed awake. A staff person from the Physical Therapy (PT) was at the residents bedside. The PT staff person reported that the resident did not want to get out of bed this morning so the physical therapy would be provided in the resident's room. Observation revealed, the O2 via NC was set at 2 liters on the wall oxygen flow meter.</p> <p>A review of Resident #78's electronic medical record revealed, an admitted [DATE] with diagnoses to include Acute Respiratory Failure, Congestive Heart Failure (CHF) Exacerbation, Chronic Obstructive Pulmonary Disease (COPD) Exacerbation, Pacemaker insertion.</p> <p>A review of the physicians orders revealed an order on 5/8/24 for O2 2 liters/min (liters/minute).</p> <p>A review of Resident #78's Minimum Data Set (MDS) revealed it was incomplete and in the process of being completed.</p> <p>A review of Resident #78's electronic medical record revealed, a Baseline Care Plan and Summary that included the residents admitted , diagnoses, code status, Physician, Diet order, allergies, Medications, Physical Therapy, Occupational Therapy, Consults, Problem and Care Plan Goals. The Baseline Care Plan did not include information about the resident's order for oxygen at 2 liters per minute.</p> <p>On 05/15/24 at 9:53 AM, interview and record with the Director of Nurses (DON) revealed that the oxygen was not included on the Baseline Care Plan and Summary and the Interim Care Plan-Admission. The DON was informed the oxygen was observed at 4 liters per min on 05/13/24 and a photo was obtained. The DON contacted the Minimum Data Set (MDS) Coordinator for the care plan.</p> <p>(continued on next page)</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>On 05/15/24 at 10:15 AM, the DON brought a comprehensive care plan that included a care plan for the potential for shortness of breath, alteration in respiratory status due to COPD, alteration in respiratory status due to status post (s/p) exacerbation of CHF and potential for hypoxia related diagnosis of CHF. The interventions included Administer oxygen and nebulizer treatments as ordered.</p> <p>A review of the facility's policy and procedure for Respiratory effective 8/12/2019 and reviewed on 4/14/2024 revealed, Policy: It is the policy of the facility to provide respiratory therapy services to patients/residents when ordered by a physician. Purpose: To ensure that all patients/residents in the facility have access to prescribed respiratory therapy services when medically indicated. Procedures included: 2. Upon receipt of a physician order for Respiratory Therapy, the nurse will contact the respiratory therapist during the hours of respiratory therapy coverage. 3. Services provided by the respiratory therapist may include (but are not limited to) the following depending upon the clinical needs of the patient/resident: b. Provision and maintenance of respiratory equipment (e.g., O2 concentrator, O2 set-up nebulizer machine, suction machine, etc.)</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** 45019</b></p> <p>Based on observation, record review and interview the facility failed to follow infection control standards and procedures during blood glucose monitoring for one (Resident # 228) out of one resident reviewed. As evidenced by Licensed Practical Nurse (Staff A) taking the entire blood glucose monitoring machine in the kit along with all the supplies enclosed into the resident's room to perform blood glucose monitoring.</p> <p>The findings included:</p> <p>On 05/13/24 at 11:42 AM during blood glucose monitoring observation for Resident #228 with Licensed Practical Nurse (Staff A), Staff A checked Resident #228's blood glucose treatment orders, proceeded to enter the resident's room with the complete blood glucose monitoring machine kit/case, applied a barrier on the overbed table, placed the blood glucose monitoring kit/case the on barrier, identified resident, explained treatment, washed hands, donned gloves, opened the blood glucose monitoring kit/case containing the machine and supplies .performed blood glucose check .dispose of supplies in biohazard bag, cleaned the machine with disinfecting wipes, let dry, washed hands exited room. Disposed of the biohazard as required washed hands .etc.</p> <p>Review of Resident #228's the medical records revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Type II Diabetes Mellitus.</p> <p>Review of the Physician's Orders Sheet for May 2024 revealed Resident #228 had orders that included but not limited to: Insulin Solution Pen Injector Subcutaneous Dose: per sliding scale order before meals and at bedtime for Diabetes Mellitus.</p> <p>During an interview on 05/13/24 at 11:53 AM, Staff A was asked about taking the entire blood glucose monitoring kit/case into the resident's room, Staff A stated: I should only take the supplies I need into the resident's room to perform the treatment and when I leave the room, I would discard any leftover unused supplies that were taken in the room.</p> <p>Interview on 05/14/24 at 01:38 PM Director of Nursing (DON) revealed the facility's policy does not directly address whether or not the nurses can take the entire blood glucose monitoring kit/case into the room during treatment, usually the nurses will place the machine and the supplies they need for treatment on a tray and then enter the room. The nurses have been trained how to maintain infection control standards during the blood glucose checks to avoid any issues or contamination.</p> <p>Review of the facility policy and procedures titled Blood Glucose Monitoring . revision date 6/20/2018 states: Only an operator who has demonstrated competence may perform blood glucose monitoring, utilizing the [brand] Inform II, to determine a resident's blood glucose level. Testing shall be performed upon capillary, arterial, or venous whole blood and the results will be recorded in the patient's record. Quality control is performed by the nursing staff. Fingerstick Sample Collection: Step 1 Assemble all the materials you will need to collect a blood sample Glove, skin, preparation pad, auto disabling single use lancet device, gauze, or cotton ball.</p> |