

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: 106080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Villa Maria West Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 8850 NW 122 St 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to develop a baseline care plan that included respiratory care for Resident #49, as evidenced by: Resident #49, was admitted on [DATE] and receiving multiple respiratory treatments, did not have a baseline care plan developed until six days after admission. The findings included: On 09/09/2025 at 9:45 AM, Resident #49 was observed seated in a wheelchair watching television. The resident reported no concerns and revealed she had two weeks remained in rehabilitation following a fall at home. On 09/10/2025 at 8:34 AM, the resident actively participated in therapy, with no concerns noted or reported. During the observation on 09/11/2025 at 10:15 AM, the resident was again seated in a wheelchair, and no concerns were noted or reported. A review of the medical record for Resident #49 showed an admission date of 09/04/2025, with diagnoses including Encounter for other specified aftercare and Chronic Obstructive Pulmonary Disease (COPD). The admission Minimum Data Set (MDS) was in progress at the time of review. The Entry MDS was completed on 09/08/2025, and the Assessment Reference Date (ARD) was set for 09/10/2025. Review of Physician orders dated between 09/04/2025 and 09/09/2025 indicated that the resident received multiple active respiratory treatments. These included Budesonide (Pulmicort) 0.5 mg/2ml (0.5 milligrams per 0.5 milliliters) via nebulizer twice daily, Formoterol Tartrate (Brovana) 5 mcg/2 ml (5 micrograms per 2 milliliters) nebulization solution twice daily, and Ipratropium-Albuterol solution every six hours via nebulizer. A pulmonology consultation was ordered on 09/08/2025 for pneumonia. Additional orders included Prednisone 10 mg daily for five days, Cefuroxime 250mg orally twice daily for pneumonia, and an order dated 09/04/2025 to check oxygen saturation. Review of Progress notes from 09/07/2025 and 09/08/2025 documented treatment for pneumonia and COPD. On 09/10/2025 at 11:30 AM, the Manager of Clinical Reimbursement, MDS Registered Nurse confirmed that although the ARD was set for 09/10/2025 and baseline care plan initiation was scheduled for that day, the resident had been receiving multiple respiratory interventions since 09/04/2025. The MDS RN acknowledged that the baseline care plan had not been completed and lacked interim documentation outlining essential respiratory treatments or goals. Despite clear orders for multiple inhaled and oral medications, consults, and respiratory monitoring, the facility failed to develop or implement a baseline care plan within 48 hours of admission that addressed the resident's respiratory needs. Following the interview, on 09/10/2025 at 12:40 PM, the Director of Nursing (DON) entered the conference room and hand-delivered a newly created baseline care plan. This plan had been developed only after the surveyor's inquiry, confirming that the baseline care plan was not completed within the regulatory time frame and was created in response to surveyor involvement. A review of the facility's Policy and Procedures for Baseline Care Plan for Care Planning, effective 12/03/2004, revised 02/22/2026, and reviewed 10/16/2024, revealed the following: The policy indicated that care, treatment, and services are planned to ensure appropriateness to the resident's needs. The facility provides an individualized, interdisciplinary plan of care addressing all resident needs, strengths, limitations, and goals. Care planning is implemented through integration of assessment findings, prescribed treatment plans, and development of reasonable and measurable goals. Documentation is completed using computerized (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 106080	Facility ID: 106080 If continuation sheet Page 1 of 3

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care planning. The procedure specified that an interim care plan must be completed no later than 72 hours after admission.		

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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 observations, staff interviews, and records review, the facility failed to implement effective corrective actions to address previously identified deficiencies. This is evidenced by the repeated citation of F655 - Development of a Baseline Care Plan. Despite prior citations and the opportunity for corrective action, the facility did not demonstrate sustained compliance. At the time of the survey, 22 residents were residing in the facility. The findings included: Review of the facility's survey history revealed, during a recertification survey with exit date 05/15/ 2024, F655 Development of a baseline care plan was cited related to facility's failure to develop a baseline care plan for oxygen use for one resident. During this survey with exit dated 09/11/2025, the facility did not develop Resident #49's baseline care plan for respiratory care. On 09/11/2025, at 12:30 PM, a Quality Assurance and Performance Improvement (QAPI) review was conducted with the Director of Nursing and the Administrator. The facility's Quality Assurance and Performance Improvement (QAPI) policy and procedure dated February 14, 2025, was reviewed with no concerns noted. The facility has a Quality Assurance and Assessment (QAA) Committee that meets every month on the second Wednesday. The most recent meeting was on September 13, 2025. Sign-in sheets showed that all required team members attended, including representatives from nursing, therapy, social services, dietary, and environmental services. The committee's primary objective is to ensure a safe, person-centered care environment. through data-driven analysis, collaborative problem-solving. The team uses data, teamwork, and improvement plans to fix problems. Every day at 9:02 AM, staff meet to find and solve issues early. Staff can also report concerns in other ways, like talking to supervisors. The committee chooses projects based on risk and how much they affect residents and prioritizes projects based on risk and resident impact, using structured tools to help the team decide what to focus on. Progress is tracked through audits and staff feedback. Current improvement plans focus on hospital transfers and nutrition services. Other top issues include pressure ulcer prevention and fall reduction. All actions are checked and updated to make sure they work and stay in place and follow-up action revisions are conducted systematically to ensure accountability and sustained improvement. Review of the facility's Policy titled: Quality Assurance and Performance Improvement reviewed on 02/14/25I. Mission As part of Catholic Health Services, Our Mission is to provide health care and services to those in need, to minimize human suffering, to assist people to wholeness and to nurture an awareness of their relationship with God.II. Vision Our vision is to strive to improve the health, independence and spiritual life of the elderly, the poor, and the needy in the Archdiocese, through innovative and proactive approaches to: Managing care and providing services. Facilitating transitions across levels of care. Community partnerships and collaboration. Advocacy efforts.III. QAPI Objectives The primary objectives of Quality Assurance & Performance Improvement (QAP) is to monitor, assess and improve performance of critical focus areas, improve healthcare outcomes and reduce and prevent medical/health care errors on a continuous basis throughout the facility.		