

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER The Terrace of Delray Beach Nursing and Rehabilita		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 Linton Blvd Delray Beach, FL 33484	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain informed consent for residents prescribed psychotropic medications for 4 of 5 sampled residents reviewed for unnecessary medication review affecting Residents #4, #14, #87, #129. The findings included: Review of the facility's policy, titled, Use of Psychotropic Medication(s), with a reviewed/revised date of 02/05/25 included in part the following: A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. The resident has the right to accept or decline the initiation or increase of a psychotropic medication. 1. Record review revealed Resident #129 was admitted to the facility on [DATE] with diagnoses that included in part the following: Encephalopathy, Acute Osteomyelitis Right Ankle and Foot, Major Depressive Disorder Recurrent Moderate, and Anxiety Disorder. The Minimum Data Set (MDS) assessment dated [DATE] documented in Section C a Brief Interview of Mental Status (BIMS) score of 13 indicating an intact cognitive response. Review of the Physician's orders for Resident #129 revealed an order dated 01/18/26 for Duloxetine HCl (an antidepressant) oral capsule delayed release particles 30mg, give 1 capsule by mouth two times a day for Neuropathy. Review of the Informed Consent for Psychoactive Medication dated 01/18/26 signed by Resident #129 revealed no documentation of any drug, dose or frequency or an indication under Statement of Consent. During an interview conducted on 01/28/26 at 11:30 PM with Staff A, Licensed Practical Nurse (LPN), who was asked about residents who are prescribed psychotropic medications, she stated they need to have informed consent, and we monitor behaviors and side effects every shift. When asked about Resident #129, she acknowledged the resident was on an antidepressant and the informed consent had no medication listed. 2. Record review revealed Resident #87 was admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease on Dialysis, Anxiety, and Chronic Obstructive Pulmonary Disease (COPD). Review of the MDS assessment End of Prospective Payment System (PPS) Part A stay dated 01/06/26 revealed Resident #87 had a BIMS score of 15, indicating intact cognition. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's orders for Resident #87 revealed an order dated 12/31/25 for Mirtazapine (an antidepressant) 15 milligrams, give 1 tablet by mouth at bedtime for Depression. An additional Physician's order for Temazepam (a benzodiazepine) oral capsule 30 milligrams, give one capsule at bedtime for Insomnia was prescribed on 12/17/25. Review of the Informed Consent for Psychoactive Medication dated 12/09/25 signed by Resident #87 revealed no documentation of these drugs, dose or frequency or an indication under Statement of Consent. During an interview conducted with the Director of Nursing (DON) on 01/29/26 at 9:15 AM, she agreed that Mirtazapine and Temazepam should have been on the informed consent document but were not. 3. Record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses that included Atherosclerotic Heart Disease of Native Coronary Artery Without Complications, Type 2 Diabetes Mellitus, and Unspecified Atrial Fibrillation. Review of the quarterly MDS assessment dated [DATE] revealed Resident #4 had a BIMS score of 15, indicating intact cognition. Review of the Physician's orders for Resident #4 revealed an order dated 11/05/25 for Escitalopram (an antidepressant) 5 milligrams, give 1 tablet by mouth one time a day for Depression. Review of the Informed Consent for Psychoactive Medication, dated 09/30/25 signed by the resident, revealed no documentation of this drug, dose, or frequency. During an interview conducted with the DON on 01/29/26 at 9:15 AM, she agreed that Escitalopram should have been on the informed consent document but was not. 4. Record review revealed Resident #14 was admitted to the facility on [DATE] with a readmission on [DATE] with diagnoses that included: Atherosclerosis of Coronary Artery Bypass Graft(S) without Angina Pectoris, Dementia, Cognitive Communication Deficit; Mood [Affective] Disorder and Anxiety Disorder. Review of Section C of the MDS assessment dated [DATE] revealed Resident #14 had a BIMS of 11, indicating moderate cognitive impairment. Review of the Physician's orders documented Resident #14 had orders dated 12/02/25 for two psychotropic / psychoactive medications: Divalproex Sodium Oral Tablet Delayed Release 125 mg to give 1 tablet three times a day for Mood disorder and Mirtazapine Oral Tablet 15 mg to give 1 tablet at bedtime for Depression. On 01/15/26, Resident #14 had a physician's order to monitor side effects for psychotropics medication every shift. Review of Resident #14's Informed Consent for Psychoactive Medication revealed it was missing information including the name of the medications, dosage, frequency and the targeted behaviors. The consent form did not confirm whether or not the resident or representative agreed with the psychoactive therapy and was not signed or dated by the person completing the form.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on interviews, observations, and record review, the facility failed to allow residents to have consistent access to a functional telephone for communication with family members or an accessible television remote control to support personal choice and self-directed activities, for 1 of 2 sampled residents, Resident #12. The findings included: Review of Resident #12's medical record documented the following diagnoses: Dementia, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; Major Depressive Disorder, Anxiety Disorder, Poly-osteoarthritis; Waldenstrom Macroglobulinemia, Drug-induced pancytopenia; Muscle wasting and atrophy, and abnormal posture. Review of Resident #12's comprehensive care plan indicated the resident was assessed as able to communicate leisure needs and preferences, preferred a balance of social and independent activities, and was expected to remain engaged in leisure activities of choice. The plan directed staff to encourage in-room leisure activities, including television viewing and telephone or video communication with family and friends, and to support resident feedback regarding leisure preferences. Review of the Social Services care plan identified Resident #12 as a long-term care resident at risk for mood disturbances related to diagnoses of major depressive disorder and anxiety disorder. The plan included interventions directing staff to listen attentively to resident concerns, assess underlying causes of frequent complaints, collaborate with the resident to resolve issues, and communicate actions taken to improve resident satisfaction. On 01/27/26 at 10:02 AM, Resident #12 was observed lying in bed in her private room, dressed in a standard hospital gown. Resident #12 stated she did not have access to a working telephone to contact her relative. She stated that her personal cellular phone had been taken by another relative and that the telephone provided by the facility had not been functioning for nearly one week. The resident stated she did not have access to a television remote control and was therefore unable to change channels independently. Visual observation of the resident's room revealed no visible landline telephone or television remote control. Upon opening the resident's nightstand drawer at her request, a telephone was observed wrapped with its cord but there was no television remote control found. On 01/27/26 at 12:05 PM, Staff G, the Licensed Practical Nurse assigned to Resident #12, stated she was unaware of any issues related to the resident's telephone. She indicated that after speaking with the resident, she learned that the Certified Nursing Assistant (CNA) and housekeeping staff were reportedly aware of the issue but had not communicated it to her. On 01/27/26 at approximately 12:20 PM, the Maintenance Director stated he had been employed at the facility for nearly two years. He stated he was notified on or about 01/22/26 that the resident's telephone was not functioning. He indicated the phone line was operational earlier that week but subsequently stopped working for unknown reasons and attempts to resolve the issue were unsuccessful. He stated that upon contacting the telephone service provider, he was informed the signal for the resident's room could not be identified. When asked whether a cordless telephone had been considered as an interim solution, he stated that it had not been considered. He stated two cordless phones had been ordered for the kitchen and received on 01/27/26, and that one would be provided to Resident #12. The Maintenance Director also stated that due to the facility being at full census, relocating the resident to another room was not possible. He denied placing the telephone inside the resident's nightstand drawer. On 01/27/26 at approximately 3:34 PM, Staff H, Certified Nursing Assistant (CNA), stated she was familiar with Resident #12 and believed the resident had access to a telephone. She stated she was unaware that the phone was not functioning and that Resident #12 typically used the facility phone to contact her relative. Staff H acknowledged that it is the responsibility of CNAs to ensure residents have necessary items. She further stated the resident had a television remote control the previous day and was unaware that it was missing on 01/27/26. On 01/27/26 at approximately 3:45 PM, the Activity Director stated that an activity plan had been developed for Resident #12, but no documentation was maintained reflecting when activities were offered or provided. Review of activity progress notes confirmed the absence of (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recent documentation related to activity participation. The most recent social services documentation prior to the surveyor's interview was dated November 2025. On 01/28/26 at approximately 11:50 AM, Staff I, Registered Nurse, reported that staff had attempted on multiple occasions to encourage Resident #12 to get out of bed to attend activities, but the resident declined. Staff I stated they were unaware that the resident did not have a functioning telephone and believed the resident previously had a television remote control, though it was uncertain of its current location. Staff I stated the facility would ensure the identified issues were addressed. No additional information was provided up to the end of the exit conference on 01/29/26.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to provide showers per resident request for 1of 5 sampled residents reviewed for choices, Resident #87. The findings included:Record review revealed Resident #87 was admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease on Dialysis, Anxiety, and Chronic Obstructive Pulmonary Disease (COPD). Review of the Minimum Data Set (MDS) End of Prospective Payment System (PPS) Part A stay dated 01/06/26 revealed Resident #87 had a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. On 01/26/26 at 11:29 AM, an interview was conducted with Resident #87, who was asked about bathing preferences. The resident stated he thought he had one shower since he had been in the facility and he would like more, but they won't give him showers.Record review revealed physician orders for a shower on Monday, Wednesday, and Fridays on 3-11 (3PM - 11 PM shifts).An interview was conducted with Staff B, Certified Nursing Assistant (CNA), on 01/28/26 at 4:20 PM. Staff B stated she has been assigned to Resident #87 often and stated she is aware that he has showers scheduled but she was told he can't get showers because he has a port. (A dialysis port is a medical device used to provide access to the bloodstream for patients undergoing dialysis treatment, allowing for efficient blood filtration and treatment.) She was then asked who told her that and she responded that the wound care nurse told her that he can't have a shower because his port can't get wet.An interview was conducted with Staff C, Wound Care Registered Nurse (RN), on 01/28/26 at 4:27 PM, who was asked if residents on dialysis can have a shower. She asked if this was about Resident #87 because she was aware that he wanted to take showers. She stated she did tell Staff B that Resident #87 could not have a shower due to having a port for dialysis. She stated that this is her protocol. She was asked if this is the policy of the facility and she stated it was not. She was asked if she discussed this with the Director of Nursing (DON) and she stated she did not. She stated she does not have equipment (dressings) to cover the port to keep the area dry during showers, so he has to have a bed bath.An interview was conducted with the DON on 01/28/26 at 5:00 PM. She stated that residents on dialysis are allowed to take showers and she was unaware that Staff C was telling Staff B not to give Resident #87 a shower. She stated she would be ordering dressings to cover the port so he can have a shower as soon as the dressing comes in.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to follow resident's preferences for incontinence care for 1 of 1 sampled resident reviewed for Activities of Daily Living (ADLs), Resident #73. The findings included: Record review for Resident #73 revealed the resident was admitted to the facility with diagnoses that included: Chronic Obstructive Pulmonary Disease, Encounter for Palliative Care, Anxiety Disorder, Hemorrhoids, Constipation, Crohn's Disease of Large Intestine without Complications, Restlessness and Agitation. Review of Resident #73's Physician's orders revealed apply barrier cream to sacrum area and to Turn and Position every 2-3 hours as indicated, every shift AND as needed. Review of Section C of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73 had a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. Review of Section GG documented Resident #73 required substantial assistance for toileting hygiene and Section H revealed Resident #73 was always incontinent for urine and bowel. Section O revealed Resident #73 receives Hospice Care services. Review of Resident #73's care plan revealed a care focus of at risk for skin breakdown due to Immobility, Bowel/Bladder incontinence and included the following interventions: Encourage/assist resident to change position as often as possible and keep skin clean and dry. Another care focus documented Resident #73 has bowel and bladder incontinence and included the following interventions: Check resident every two hours and assist with toileting as needed and provide peritoneal care after each incontinent episode. Review of the Certified Nursing Assistant (CNA) Tasks for Resident #73 provide no information or task documenting when the resident was receiving peritoneal care or change of incontinence brief. An initial observation conducted on 01/26/26 at 10:09 AM noted Resident #73 was in bed and wearing a hospital gown. She stated that she was waiting for someone to come over and change her, but it wouldn't be until 11:00 AM and then the next scheduled change for the incontinence brief would be around 7:00 PM and then again at 5:00 AM. She then stated she would like someone to change her brief more often, but it is their [facility] policy. At 12:30 PM, Resident #73 was observed in bed, wearing a shirt, and she confirmed she was washed and changed around 11:00 AM. On 01/27/26 at 3:45 PM, Resident #73 was observed in bed wearing a different shirt. She stated that she was changed around 11:00 AM and no other time after that. On 01/28/26 at 4:30 PM, Resident #73 was observed in bed and was wearing a shirt. She stated that they have not changed her brief recently, but now it's almost dinner time and she will not be changed until dinner is finished. She stated she was changed around 11:00 [AM] this morning. She stated she has mentioned it [that she would like to be changed more often] to one of the staff but doesn't know what happened. An interview was conducted on 01/28/26 at 4:51 PM with Staff D, CNA, who stated she has worked at the facility for 3 years and is assigned to care for Resident #73. She stated she checks and provides incontinence care to the residents every 2 hours. She then stated the dinner trays were on the unit and she needed to start passing the trays. An interview was conducted on 01/28/26 at 4:57 PM with the Director of Nursing (DON) who stated she has worked 2 years at facility. She stated the Hospice CNA comes to the facility daily, however the facility staff would always provide care to the resident because she's part of the facility. On 01/29/26 at 9:44 AM, Resident #73 was observed in bed with a hospital gown on and there was no CNA or Hospice CNA in the room to provide care. At 10:35 AM, Resident #73 was again observed, and she stated no one has come to change her yet. At 11:23 AM, the resident had not been changed, and she had pressed the call light. A CNA was observed to then enter Resident #73's room and the surveyor overheard the resident asking the CNA are you here to change me? An interview was conducted on 01/29/26 at 10:22 AM with Staff F, CNA, who stated she has worked at the facility for 5 years. She stated she checks on the residents every 2 hours and provides care, changes the incontinence brief and repositions the resident. She stated she is assigned to Resident #73, and the resident is under Hospice services. Staff F acknowledged that Resident #73 gets baths (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and is changed every 2 hours. On 01/29/26 at 11:30 AM, Resident #73 was observed in bed and Staff F was in the room and the DON was present. Resident #73 stated she would like to be changed prior to 11:00 AM but not too early because then she would get changed at 7:00 PM or later and that's too long of a gap. Resident #73 also stated they (facility staff) used to change her prior to dinner because sometimes she would have a bowel movement and they would bring in her dinner tray; she would make a fuss and refuse to eat until they changed her. She stated she was not sure what happened that they went back to just changing her later, but she guessed that's their policy. Resident #73 again confirmed she would like to get changed more often during the day. The DON and Staff F were present.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to coordinate and implement structured activities for 1 of 2 sampled residents reviewed for activities, Resident #13. The findings included: Review of the clinical record documented Resident #13 was admitted to the facility on [DATE]. Review of the Brief Interview for Mental Status (BIMS) score was 5, indicating cognition was severely impaired. The resident's diagnoses included Dementia and Major Depressive Disorder. On 01/26/26 at 11:10 AM, Resident #13 was observed alone in her room with a stuffed animal and two pillows positioned on either side of her body. The television was turned off. Upon interview, as the surveyor prepared to exit the room, Resident #13 made a prayer request to the surveyor. On 01/26/26 at 2:51 PM, Resident #13 was again observed alone in her room with no stimulation other than a doll. She was noted to express herself fluently in a foreign language. The bedroom door was closed, and although the resident had a roommate, she was seen alone. At the same time, music activities were occurring in the activity room. On 01/27/26 at 3:07 PM, the Activity Director stated Resident #13 had a one-to-one (1:1) activity plan intended to be implemented by the Certified Nursing Assistants (CNAs) assigned to her care. The Activity Director stated she did not maintain progress notes or records of ongoing activities and although the activity plan was provided, it lacked specific details regarding scheduled or implemented activities. Review of completed task documentation related to activities for Resident #13 revealed only two entries in the activity log, dated 12/30/25 at 10:19 PM and 01/13/26 at 10:52 PM. There were no checkmarks or indicator present to identify the types of activities offered or completed. Review of the Care Plan (CP) dated 01/08/26 documented Resident #13 is a foreign-speaking woman who initially had difficulty adjusting to the facility but reportedly became accustomed to attending daily activities. The CP stated she prefers spending time with peers but experiences episodes of confusion and attempts to return to her room. Due to adjustment to a new environment and separation from family, she was identified as being at increased risk for anxiety and depression. The CP further documented that Resident #13 would participate in at least one morning activity and one afternoon activity daily and would receive 1:1 programming at least twice weekly for a minimum of 15 minutes per session. No evidence was provided to demonstrate that these activities occurred, and no supporting documentation was available. On 01/29/26 at 1:42 PM, Resident #13 was observed in her room lying in the same position as previously noted, not engaged in any activities. The television was on, but the volume was inaudible. The resident was observed in bed with a doll beside her. The findings were reviewed with the Administrator on 01/29/26. No additional information was provided.		