STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105598	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbours Edge	401 E Linton Blvd Delray Beach, FL 33483

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record and policy review; the facility failed to assess a resident timely after a fall for 1 of 3 sampled residents reviewed for falls (Resident #58), who suffered from a subdural hematoma, a fracture of the right pelvis, and fracture of the right hip. The findings included: Record review revealed Resident #58 was admitted to the facility on [DATE] and discharged and transferred to the hospital on [DATE]. Her admitting diagnoses included: Unspecified injury of head, subsequent encounter; Traumatic subdural hemorrhage without loss of consciousness; and for surgical aftercare following surgery on the nervous system. Resident #58 had a Brief Interview for Mental Status (BIMS) score of 15 on the admission Minimum Data Set (MDS) with an assessment reference date of 05/27/25. This indicated the resident had intact cognition. On the same MDS under section GG, the documentation revealed the resident needed substantial assistance for sit to stand and was dependent to walk 10 feet.The Physician's orders for Resident #58 revealed an order for Heparin Sodium Injection Solution 5000 unit/milliliter(ml) to inject 1 ml subcutaneously every 8 hours for DVT (deep vein thrombosis) prophylaxis for 30 days. (Heparin is a blood thinner. Among the most common side effects of Heparin is bleeding).Record review revealed on 06/23/25, the resident was resting in bed around 3:00 PM. At 3:45 PM, Staff H, a Licensed Practical nurse (LPN) who was assigned to Resident #58, heard the resident calling her name. She entered the resident's room and observed the resident on the floor on her back next to the front door. The resident's head was touching the door. The resident was assessed for pain or injury and was assisted off the floor with assistance of four staff members and into the bed.Record review revealed Resident # 58's care plans included: a). Date initiated 05/22/25-Focus: Risk for Falls; Goals: Resident will not sustain serious injury through the review date; Interventions included: Anticipate and meet the resident's needs; Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; and the resident needs prompt response to all requests for assistance. b). Date initiated 05/27/25-Focus: Resident is on an anticoagulant therapy related to DVT (Deep Vein Thrombosis), a condition where a blood clot forms in a deep vein; Goals: The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date; Interventions included: Provide fall prevention to minimize risk of injury. Review of the facility's policy titled, Change in a Resident's Condition or Status with a revised date of February 2021, included in part the following: Our community promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). 1) The nurse will notify the resident's attending physician or physician on call when there has been an: a) accident or incident involving the resident; Review of the facility's policy titled, Falls Prevention and Management Program with a revision date of 09/23/19, included in part the following: Post Fall: There are two key elements of the post-fall response and management: Initial post-fall evaluation. Documentation and follow-up - including ongoing monitoring for resident changes in condition where medically indicated. Initial Post-Fall Evaluation: 1) Date/time of fall. 2) Resident's/patient's description of fall (if possible). 3) Timely notification of provider and family/guardian. 4) Vital signs (temperature, pulse, respiration, blood pressure, orthostatic pulse and blood pressure - lying, sitting, and standing). 6) Resident/Patient assessment: a) Presence of Injury and reassessment for delayed injury identification. Documentation and Follow-up: 1) Determine the need for ongoing resident monitoring if there is a suspected head trauma or if the resident may have head trauma but it cannot be clearly determined. a) Perform neuro-checks according to organizational policy and guidelines. b) Immediately notify the attending physician and family or guardian of condition changes. c) Transfer the resident for further evaluation and treatment where medically indicated. 4) A detailed progress note should be entered into the resident/patient record including the results of the post-fall evaluation.An interview was conducted with Staff H on 07/23/25 at 11:01 AM regarding Resident # 58's fall on 06/23/25. She stated the resident went back to bed after lunch and was in bed until 3:00 PM. Staff H explained she was sitting across from her room. Staff H went to another resident's room to see a patient. When she was done, she went to the medication cart. Staff H was pulling meds for the afternoon, then she heard the resident calling her name. She walked into the room, and she saw her on the floor. Resident #58 was on her back, to the side of the wall, close to the front door of the room. She was not bleeding and denied pain. Resident #58 said she got up to go to the bathroom and did not tell anyone she got up. The call light was not active. Resident #58 said she did hit her head, but did not

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented and failed to initiate an EBP care plan for 1 of 12 residents requiring EBP (Resident #7) and failed to ensure Contact Precautions were implemented for 1 of 2 residents on Contact Precautions (Resident #18).The findings included: Review of the facility's policy titled, Enhanced Barrier Precautions with a revised date of 04/05/24 included in part the following: Facility adheres to Center for Disease Control (CDC) recommendations on implementing Enhanced Barrier Precautions (EBP) in our health centers. enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms. BP will be implemented for the following (including new admissions): Indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO (Multi-Drug Resistant Organism). Wounds. This generally includes residents with chronic wounds, not those with only shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers All team members will wear appropriate PPE (gown and gloves) for high-contact resident care but not limited to : Peri-care, Device care, wound care. Review of the facility’s policy titled, “Infection Prevention and Control Manual Transmission-Based Precautions” dated 2019 included in part the following: Under Section titled, “Procedure for Contact Precautions” Gowns 1) [NAME] gown upon entry into the room. Remove gown and observe hand hygiene before leaving the resident care environment. 2) After gown removal, ensure that clothing and skin do not contact potentially contaminated environmental surfaces that could result in the possible transfer of microorganism to other residents or environmental surfaces. 1. Record review for Resident #7 revealed the resident was originally admitted to the facility on [DATE], with most recent readmission on [DATE] with diagnoses that included in part the following: Dementia, Muscle Weakness, Cachexia, Repeated Falls, Pressure Ulcer of Right Heel Stage 4 and Generalized Anxiety Disorder. Review of the Minimum Data Set assessment for Resident #7 dated 06/26/25 documented in Section C a Brief Interview of Mental Status score of 0 indicating severe cognitive impairment. Review of the Physician's Orders for Resident #7 revealed no orders for Enhanced Barrier Precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders for Resident #7 dated 7/20/25 right heel wound: cleanse with NSS, pat dry, apply Santyl and then wrap with gauze and secure with tape. Apply triamcinolone cream to surrounding area every day shift. Review of the wound care documentation by the wound care physician dated 07/16/25 documented Wound progress: Improved evidenced by decreased surface area. The wound care physician was not available for interview this morning (07/23/25) as the wound care visit had been rescheduled. Review of the Care Plan for Resident #7 with initiated date of 08/24/20 and revised date of 01/25/24 with focus on the resident is at risk for alteration in skin integrity potential contributing factors: incontinence, behaviors (with combativeness), poor skin turgor, side effect of medications, aging organ (skin) [resident name] can be combative with staff at times with the potential risk for multiple skin injuries due to her striking out towards the staff. The goal was for the resident's wound will improve/heal by next review date. The interventions included: Heel protectors to bilateral heels when in bed. Review of the Care Plan for Resident #7 dated 03/24/25 with a focus on pressure resident has pressure ulcer to right heel stage 4. The goal was for the resident's pressure ulcer will show signs of healing and remain free from infection by/through review date. The interventions included: Administer medications as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Diet, supplement/vitamins/protein to promote wound healing. Heel protectors. Pressure relieving device to bed/chair, off load heels. Review of the Care Plan for Resident #7 revealed no care plan for Enhanced Barrier Precautions. On 07/22/25 at 4:00 PM an observation was made of Resident #7's room with no EBP signage on the door and no isolation cart (with PPE) near the door. On 07/23/2025 at 7:00 AM an observation was made of wound care performed by Staff E Registered Nurse (RN) for Resident #7. The RN gathered supplies. The resident was observed lying in bed with her legs off to the side of the mattress. There was no Enhanced Barrier Precaution sign on the resident's door nor was there an isolation cart nearby the resident's room. The closest isolation cart with Personal Protective Equipment supplies was more than half way down the adjacent hallway approximately 75 feet. There was a fall matt on the left side of the bed and air mattress functioning on the bed, also noted was wheelchair in bathroom with cushion on the seat. The RN performed hand washing, applied gloves, removed old dressing, performed wound care per the physician's orders with good technique, the RN covered the dressing per orders and dated the bandage with today’s date. The RN never put on a gown before or during the wound care treatment. During an interview conducted on 07/24/25 at 10:44 AM with Staff D Registered Nurse/Infection Preventionist (RN/IP) who stated she has worked at the facility for 4 months. The RN/IP stated she monitors for EBP by checking orders to see if any resident has wounds, catheter, IV or PEG tube then she will ensure an order is in the record for EBP as well as an EBP sign is on the resident's room door and bins with PPE are located next to the door of the resident room. She will also check to ensure a care plan for EBP is also in place. She also does random observations of staff wearing appropriate PPE for residents on EBP. When asked about Resident #7 she stated the resident has had the pressure ulcer to the left heel since 06/05/25, and she acknowledged she has no care plan for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #18 was admitted to the facility on [DATE] with diagnoses that included Displaced fracture of base of neck of left femur, subsequent encounter for closed fracture with routine healing, History of falling, and Pain in left hip. Review of the Physician's orders for Resident #18 revealed on 07/23/25 the resident was on contact precautions. On 07/23/25 at 9:19 AM, the door of Resident #18's room was observed with a sign indicating the resident was on contact precautions. At that time, the surveyor observed Staff J, a Registered nurse (RN) starting an intravenous (IV) administration of Ertapenem Sodium Injection Solution Reconstituted 1 gram for Resident #18. Staff J was wearing gloves but not a gown while starting the IV. According to the Centers for Disease Control (CDC) for a resident on contact precautions everyone must wear a gown and gloves for all interactions that may involve contact with the resident or the resident's environment. An interview was conducted with the Administrator and Director of Nursing on 07/23/25 at 4:00 PM and they acknowledged the findings.