

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105598	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Harbours Edge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide documentation of a discharge order and failed to ensure accurate discharge information was documented in the Discharge Planning Review Assessment, for 1 of 5 sampled residents (Resident #1) reviewed for discharge. The findings included: Record review revealed Resident #1 was admitted to the facility on [DATE]. His admitting diagnoses included Syncope and Collapse, Unspecified Injury of Face, History of Falling, Acute Kidney Injury, and Peripheral Vascular Disease. Resident #1 was discharged from the facility on 02/03/26. Review of a Brief Interview of Mental assessment dated [DATE], documented Resident #1's status score was 15.0. This indicated that Resident #1 was cognitively intact. Further record revealed there was no physician's order for Resident #1 to be discharged from the facility. Record review of the Discharge Planning Review Assessment that was signed by the Social Worker on 02/03/26 was incomplete. The assessment showed no signature or date on the lines for the Resident and the Resident's Representative to sign. The question that stated Who initiated discharge was not answered; Neither Resident, Facility, nor Other (with explanation) was checked off. The space below The Reason for Discharge was left blank. There was no reason for discharge that was listed on the Discharge Planning Assessment. The circle next to Home/Community was filled in to indicate the location that Resident #1 was discharged to. An interview on 07/07/26 at 4:40 PM with Resident #1's family member revealed that she and Resident #1 were informed by the Admissions Coordinator on 02/02/26, that the costs of his stay for rehabilitation services at the facility would not be covered by his insurance (Medicare). The Admissions Coordinator assisted the Resident with an alternate plan, and facilitated Resident #1's admission to another facility. The Resident and his family member were informed that an acute rehabilitation facility approved his admission and said his medical condition met their criteria insurance coverage. According to Resident #1's family member, she was mailed a copy of the discharge plan approximately 3 weeks after Resident #1 was discharged, and the discharge papers were inaccurate. The papers listed that Resident #1 was discharged home. The family member said that Resident #1 was not discharged home, he was admitted to another facility. An Interview with the DON on 07/08/26 at approximately 12:30 PM revealed that Resident #1 was discharged to a rehabilitation facility. An interview with the Admissions Coordinator on 07/08/26 at approximately 1:00 PM clarified that Resident #1 was discharged to an acute rehabilitation center that was part of a hospital. The admission Coordinator explained that Resident #1's medical needs met the requirements for insurance coverage at the acute rehabilitation center. An interview was conducted with a nurse, Staff A, on 07/08/26 at 3:05 PM. The surveyor asked Staff A whose responsibility it was to fill in the answers for who initiated the discharge and the reason for the discharge on the Discharge Planning Review. Staff A said that was the responsibility of the charge nurse. An interview (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was conducted with the charge nurse (Staff B) at the time of Resident #1's discharge. On 07/08/26 at 5:50 PM, when Staff B, RN (Registered Nurse) was asked who gave the order for Resident #1 to be discharged to the rehabilitation hospital, she said she wasn't sure if the Social Worker (SW) was there at that time. She added, the Social Worker usually initiated discharges, and when the SW wasn't there, the ADON (Assistant Director of Nursing) and the Administrator teamed together and initiated discharges. When asked if there was a physician's order that was required to be included in the medical records prior to a Resident's discharge, the RN answered yes. She said usually the physician's order was signed. She provided an example of a typical discharge order that said Resident may discharge home with home health Medicare services, Physical Therapy. When the RN was asked who was responsible for filling out the Discharge Planning Review, she said that the floor nurse picked up the discharge packet from the nurses station. Completion of the papers are usually done by the Social Worker and the ADON. An interview with the ADON was conducted on 05/08/26 at 5:20 PM. The ADON showed the surveyor the date she signed off on the completed discharge planning review packet for Resident #1 was 02/18/26. When asked when the Discharge Planning Review should have been completed, she answered at the time of discharge. [The discharge date was 02/03/26.] When asked if there was a physician's order in the medical record for Resident #1's discharge, the ADON answered no. When asked if the discharge planning review packet was supposed to be given to Resident #1 upon discharge, the ADON answered yes, it was. She added that the procedure was for the nurse to give the resident the discharge packet prior to discharge, and for the resident to sign the papers. After that copies are supposed to be made and submitted to medical records. When the ADON was asked to provide the surveyor with signed discharge papers for Resident #1's discharge on [DATE], the ADON said that there weren't any signed discharge papers signed by Resident #1.		