

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 07/24/2025
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record reviews, the facility failed to serve and prepare foods in a sanitary manner in accordance with standards for food safety professionals. The findings included: The facility's policy, Preventing Temperature Abuse 4.13 Thawing and Slacking, with a reference date of 10/01/22 documented: Proper thawing and slacking prevents microbial growth to unsafe levels in TCS (Time/temperature Controlled for Safety) foods.* Where available, thawing and slacking must always be conducted under manufacturers' labeling guidance. Note: Vacuum packed or hermetically sealed products such as fish, typically have manufacturer recommendations to expose the product to air during the thawing process. When thawing under running water, Never use warm water and do not thaw in standing water. During the initial kitchen tour, on 07/21/25 at 9:08 AM, accompanied by the Culinary Director, the Executive Chef and the Registered Dietitian (RD), the following were noted: 1. An accumulation of ice was observed the cooling unit in the back of the reach in freezer, by the exit of the kitchen, and dirty and discolored ice was noted in the floor of the reach in freezer. 2. In the walk in cooler, there was a full sized 2 inch deep hotel pan containing raw fish that was in reduced oxygen packaging resting in standing water. The instructions on the packaging instructed ?remove from package and thaw under refrigeration immediately before consumption. The Executive Chef acknowledged understanding the concern and instructed the [NAME] to discard the fish and replace with another fish after properly thawing. The Executive Chef stated that he had recently in-service staff regarding properly thawing potentially hazardous foods. 2. On a shelf over a food preparation table, there was a 5 quart container approximately half full of thickener. In the thickener was a 2 ounce souffle cup with no handle resting directly in the product. 3. In the Janitorial closet, cleaning implements, including brooms and a squeegee were stored in a manner that contaminants would run down the handle of the items. 4. The temperature of the water during the rinse cycle of the mechanical ware washing machine did not reach 180 degrees F (Fahrenheit) per the data plate on the machine that documented the recommended water temperature for hot water as a method for sanitizing wares. According to the reading of the temperature gauge on the machine, the water temperature ranged from 155-160 degrees F.		

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record and policy review, the nursing facility staff neglected to inform the medical staff that a resident on blood thinner hit her head during a fall and the lack of a timely nursing assessment. after a fall for 1 of 3 sampled residents reviewed for falls (Resident #58), who suffered from 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 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 moving from sitting to standing 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. An interview was conducted with Staff H on 07/23/25 at 11:01 AM regarding Resident # 58's fall on 06/23/25. 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 hit her head but did not complain of pain. Staff H stated she called for the charge nurse who assessed the resident. Staff H stated four of us got [Resident #58] up. She was put back to bed and Staff H and a certified nursing assistant (CNA) changed her. Then she complained of pain in one of the legs. They called for an x-ray. They were waiting for an x-ray. The resident had called her daughter, and the daughter arrived at the facility within 30 minutes. The daughter evaluated her mother, called the charge nurse and wanted her mother sent out to the hospital because Resident #58's leg did not look right. 911 was called by a nurse and Resident #58 was transported to the hospital. An interview was conducted with Staff J, a Registered Nurse (RN), on 07/23/25 at 2:05 PM. She stated she was one of the staff who picked her [Resident #58] up. They could not carry her to the bed because it was too far, so they put her in a wheelchair first then transferred her to bed. Staff J stated she did not notice the residents' legs were out of alignment. However, the resident was complaining of leg pain. Staff J did not notify the Physician or assess the resident. An interview was conducted with Staff I, RN, Charge Nurse, at 2:00 PM on 07/23/25. She stated she saw the leg of Resident #58 and one leg was shorter than the other and based on her judgement, she called 911. When asked if she knew that the resident hit her head, she stated she did not. If she did, she would call 911, text the doctor, and send the resident out, especially if they were on blood thinners. She stated she had not assessed Resident #58 until the resident's daughter came to the facility. Staff J made the daughter aware that the resident had a fall and x-rays were ordered, but she had not been to her room to assess her. An additional interview was conducted with Staff H on 07/23/25 at 3:10 PM, with another surveyor present. She was asked if she was aware that Resident #58 was on Heparin. She stated she was aware. She was asked again if she (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked the resident if she hit her head. Staff H stated she asked her, and the resident stated she did hit her head. Staff H was asked why she not told anyone that Resident #58 hit her head, and she could not give a reason. Staff H was asked what the policy is if a resident falls and hits their head. She stated if someone falls and hits their head, they will call 911. If it is an unwitnessed fall, they do neuro checks. Staff H stated she did neuro checks for Resident #58 but there was no evidence in the medical record. She stated she did vital signs at the time of the fall, but there was no evidence in the medical record. Staff H reported she sent a message via text to the doctor to let him know that the resident fell at 4:00 PM and they were going to do an x-ray. A message was sent to the doctor 45 minutes later that they were sending the resident out for possible dislocated hip. Staff H was asked if the resident was transferred to the wheelchair prior to being transferred to bed and she stated that she was. Staff H was asked why she put the resident into the wheelchair. Staff H stated she did not remember who made the decision to put her into the wheelchair but getting her up from the floor would be a good distance from the bed to where she was. Staff H was asked if she had a phone conversation with the Physician to explain that this was an unwitnessed fall and the resident stated she hit her head. Staff H stated she did not and could not give a reason why. An interview via telephone was conducted with Staff I on 07/24/25 at 12:30 PM. Staff I was specifically asked what prompted her to check Resident #58 after the fall on 06/23/25. She stated the resident's daughter came to the desk and asked her if she saw the resident and she said that she did not. Staff I went to the room and saw Resident #58's leg was rotated. She was asked if the resident was in pain at the time of her assessment and she stated the resident was, but she was unaware if anyone gave her pain medication. No one presented her with vital signs or neuro checks. She saw the resident approximately 15 minutes after she was aware of the fall. She stated the primary nurse usually evaluates the resident even though the nurse might be an LPN. A telephone interview was conducted on 07/24/25 at 1:38 PM with Resident #58's Attending Physician. When asked about the fall for Resident #58 on 06/23/25 he stated he did not recall what nurse it was that contacted him but remembered the resident had a history of subdural hemorrhage; and she had fallen and hurt her right leg and was subsequently sent out to the hospital. The Physician stated he basically has a protocol for any significant injury they are supposed to call him, including head injury, hitting their head, or chest pain. If it is not an emergency, they are to just notify him by phone (he clarified he meant by textmessage). Review of the hospital records for Resident #58 dated 06/23/25-07/11/25 revealed the resident was evaluated in the emergency room on [DATE]. A review of the History and Physical, dated 06/23/25 revealed the resident was diagnosed with a traumatic 3-millimeter subdural hematoma, a displaced fracture of the right inferior pubic ramus, and displaced subtrochanteric fracture of the right hip. Further review of the hospital record revealed Resident #58 had an ORIF (open reduction and internal fixation) surgery of the right hip on 06/25/25.		

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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.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 (continued on next page)		

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Staff H stated she called for the charge nurse who assessed the resident. Staff H stated four of us got [Resident #58] up. She was put back to bed and Staff H and a certified nursing assistant (CNA) changed her. Then she complained of pain in one of the legs. They called for an x-ray. They were waiting for an x-ray. The resident had called her daughter, and the daughter arrived at the facility within 30 minutes. The daughter evaluated her mother, called the charge nurse and wanted her mother sent out to the hospital because Resident #58's leg did not look right. 911 was called by a nurse and Resident #58 was transported to the hospital. During an interview on 07/22/25 at 3:20 pm Staff K, CNA, who was assigned to Resident #58, stated that she saw the resident at 3:15 PM and she was in bed with the call light close. The next time she saw her was at 3:45 PM and she was on the floor. Her head was facing the door, and her leg faced the bathroom door. The nurse called for assistance to put her back to bed. Resident #58 said her leg hurt, and after that she left the nurse in the room. The call light was not on. Interview with the Administrator on 07/23/25 at 1:50 PM who stated she was not aware that the resident hit her head. She further stated it was not in the documentation and it was not in any of the witness statements. An interview was conducted with Staff J, a Registered Nurse (RN), on 07/23/25 at 2:05 PM. She stated she was one of the staff who picked her [Resident #58] up. They could not carry her to the bed because it was too far, so they put her in a wheelchair first then transferred her to bed. Staff J stated she did not notice the residents' legs were out of alignment. However, the resident was complaining of leg pain. Staff J did not notify the Physician or assess the resident. An interview was conducted with Staff I, RN, Charge Nurse, at 2:00 PM on 07/23/25. She stated she saw the leg of Resident #58 and one leg was shorter than the other and based on her judgement, she called 911. When asked if she knew that the resident hit her head, she stated she did not. If she did, she would call 911, text the doctor, and send the resident out, especially if they were on blood thinners. She stated she had not assessed Resident #58 until the resident's daughter came to the facility. Staff J made the daughter aware that the resident had a fall and x-rays were ordered, but she had not been to her room to assess her. An additional interview was conducted with Staff H on 07/23/25 at 3:10 PM, with another surveyor present. She was asked if she was aware that Resident #58 was on Heparin. She stated she was aware. She was asked again if she asked the resident if she hit her head. Staff H stated she asked her, and the resident stated she did hit her head. Staff H was asked why did she not tell anyone that Resident #58 hit her head, and she could not give a reason. Staff H was asked what the policy is if a resident falls and hits their head. She stated if someone falls and hits their head, they will call 911. If it is an unwitnessed fall, they do neuro checks. Staff H stated she did neuro checks for Resident #58 but there was no evidence in the medical record. She stated she did vital signs at the time of the fall, but there was no evidence in the medical record. Staff H reported she sent a message via text to the doctor to let him know that the resident fell at 4:00 PM and they were going to do an x-ray. A message was sent to the doctor 45 minutes later that they were sending the resident out for possible dislocated hip. Staff H was asked if the resident was transferred to the wheelchair prior to being transferred to bed and she stated that she was. Staff H was asked why she put the resident into the wheelchair. Staff H stated she did not remember who made the decision to put her into the wheelchair, but getting her up from the floor would be a good distance from the bed to where she was. Staff H was asked if she had a phone conversation with the Physician to explain that this was an (continued on next page)		

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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.	unwitnessed fall and the resident stated she hit her head. Staff H stated she did not and could not give a reason why. A telephone call was placed to the resident's daughter on 07/23/25 at 3:52 PM. She returned the call at 5:40 PM and stated she received a call from her mother the day of the fall stating she fell and hit her head. She arrived at the facility around 4:40 PM. She went into her mother's room, and her mother was shaking, and she was covered with a sheet. She lifted up the sheet and her foot was externally rotated. The daughter left the room and spoke to the nurse in the hallway (doesn't remember the name) who said they called to get an x-ray taken. Then she went to the charge nurse (Staff I) and asked if she called 911. Staff I asked her why, is she injured. Staff I then went to her mother's room and saw the leg externally rotated and called 911. 911 came and took the resident to the hospital. An interview was conducted with the Director of Nursing (DON) and the Administrator on 07/24/25 at 10:43 AM regarding Resident #58's fall on 06/23/25. The Administrator stated she did the fall investigation. It was discussed that record review revealed there was a discrepancy in the documented witness statement from Staff H and the interview that the surveyor had with Staff H on 07/23/25 at 11:01 AM. Staff H did not tell the Administrator that the resident hit her head. The witness statement stated she called the MD (Medical Doctor) when she actually texted him. She did not receive orders for a stat x-ray; she texted the Physician that they were doing an x-ray. The surveyor asked the DON if an LPN can assess a resident. She stated that an LPN can do an evaluation, but an RN will do an assessment. It would be expected that vital signs would be done, and neuro checks, if it were an acute condition. It was discussed with the DON that there were no neuro checks in the Electronic Health Record (EHR) and the only vital signs there were documented at 5:04 PM and 5:05 PM on 06/23/25, on the transfer form. The DON was asked if she had done any training on falls with the nursing staff after this fall incident. She stated they had training, but not since the fall incident. She was asked if she did any specific training with Staff H post fall incident and she stated that it was not a part of the investigation. The DON was asked why does the staff text the Physician instead of calling him, especially for an unwitnessed fall. She stated that the physician's preferred conversation by text. The facility does not have a policy on communication with the physician. An interview was on 07/24/25 at 11:48 AM with the Director of Rehab, who stated she has worked in the facility for 16 years. When asked about a transfer board she said they have a beasy board. When asked would the nurses use a beasy board, she said they would not use it. They could use the pad from a Hoyer lift and do a 4 person lift to transfer from floor to bed, so the person stays supine. An interview via telephone was conducted with Staff I on 07/24/25 at 12:30 PM. Staff I was specifically asked what prompted her to check Resident #58 after the fall on 06/23/25. She stated the resident's daughter came to the desk and asked her if she saw the resident and she said that she did not. Staff I went to the room and saw Resident #58's leg was rotated. She was asked if the resident was in pain at the time of her assessment and she stated the resident was, but she was unaware if anyone gave her pain medication. No one presented her with vital signs or neuro checks. She saw the resident approximately 15 minutes after she was aware of the fall. She stated the primary nurse usually evaluates the resident even though the nurse might be an LPN. An interview was conducted with Staff H via telephone on 07/24/25 at 1:00 PM. She was asked again why she did not tell the Administrator that the resident hit her head. She stated she did not know why. She was asked what type of evaluation she did at the time she saw the resident on the floor. She stated she completed approximately 2 neuro checks and wrote it on paper and forgot to put it in the computer. A telephone interview was conducted on 07/24/25 at 1:38 PM with Resident #58's Attending Physician. When asked about the fall for Resident #58 on 06/23/25 he stated he did not recall what nurse it was that contacted him but remembered the resident had a history of subdural hemorrhage; and she had fallen and hurt her right leg and was subsequently sent out to the hospital. The Physician stated he basically has a protocol for any significant injury they are supposed to call him, including head injury, hitting their head, or chest pain. If it is not an emergency, they are to just notify him by phone (he clarified he meant by text message). An additional interview was conducted with the DON on (continued on next page)		

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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.	07/24/25 at 2:05 PM regarding education completed for Staff H. She stated she had not done anything yet. She will educate Staff H face to face on falls, before she does any additional shifts. Review of the hospital records for Resident #58 dated 06/23/25-07/11/25 revealed the resident was evaluated in the emergency room on [DATE]. A review of the History and Physical dated 06/23/25 revealed the resident was diagnosed with a traumatic 3-millimeter subdural hematoma, a displaced fracture of the right inferior pubic ramus, and displaced subtrochanteric fracture of the right hip. Further review of the hospital record revealed Resident #58 had an ORIF (open reduction and internal fixation) surgery of the right hip on 06/25/25.(A subdural hematoma is a type of bleeding that occurs inside of the head, most often caused by head injuries. A pubic ramus fracture describes a type of crack or break in a person's pelvis. A displaced subtrochanteric fracture of the right hip typically requires surgical intervention).		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure indwelling urinary catheter care was performed for 2 out of 2 sampled residents reviewed for catheter (Resident #20 and #42). The findings included: Review of the facility's policy titled, Indwelling Catheter Use and Removal with an effective date of 01/06/25 included in part, the following: If an indwelling catheter is in use, the community will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to: Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection preventions and control procedures. Review of the facility policy titled, Charting and Documentation with a revised date of July 2017 included in part, the following: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's electronic medical record. The electronic medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 2) The following information is to be documented in the resident medical record: c) Treatments or services performed. 7) Documentation of procedures and treatments will include care-specific details, including a) The date and time the procedure/treatment was provided; b) The name and title of the individual(s) who provided the care; c) The assessment data and/or any unusual findings obtained during the procedure/treatment; d) How the resident tolerated the procedure/treatment; e) Whether the resident refused the procedure/treatment; f) Notification of family, physician or other staff, if indicated; and g) The signature and title of the individual documenting. 1. Record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses that included, Cognitive Communication Deficit, and Neuromuscular Dysfunction of Bladder. Review of the Minimum Data Set assessment dated [DATE] for Resident #20 documented in Section C a Brief Interview of Mental Status score of 4, indicating severe cognitive impairment. Review of the Physician's orders for Resident #20 revealed no order for indwelling urinary catheter care. Review of the Medication Administration Record/Treatment Administration Record/Certified Nursing Assistant (CNA) Tasks/Progress Notes for Resident #20 from 07/01/25 to 07/07/20/25 revealed no documentation of indwelling urinary catheter care having been provided. Review of the Care Plan for Resident #20 dated 06/17/25 with a focus on Urinary Catheter, documented the resident has a urinary catheter related to Neurogenic Bladder. The Goal was for the resident to be/remain free from catheter-related trauma through review date. The interventions included in part the following: care and treatment per current MD orders. During an interview conducted on 07/22/25 at 3:00 PM with Staff C, Registered Nurse (RN) who was asked about indwelling urinary catheter care, the RN stated the CNAs perform the catheter care and they document the care in POC (point of care). During an interview conducted on 07/23/25 at 10:25 AM with Staff A Certified Nursing Assistant (CNA) who was asked where she documents the urinary catheter care she provides, she said it is in point of care. During an interview conducted on 07/23/25 at 10:32 AM with Staff D, Registered Nurse (RN), who was asked where would staff document urinary catheter care, she said the CNA should document the care in point of care (Tasks). Staff D acknowledged there was no documentation in the point of care and acknowledged there was no order for urinary catheter care. During an interview conducted on 07/03/25 at 10:50 AM with Staff D, RN, and the Director of Nursing (DON), they both acknowledged there was no order for indwelling urinary catheter care and no documentation of indwelling urinary catheter care. 2. Record review for Resident #42 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Displaced Segmental Fracture of Shaft of Humerus, Right Arm Subsequent Encounter for Fracture with Routine Healing, Cognitive Communication Deficit, and Flaccid Neuropathic Bladder. Review of (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Harbours Edge		STREET ADDRESS, CITY, STATE, ZIP CODE 401 E Linton Blvd Delray Beach, FL 33483	
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Minimum Data Set assessment for Resident #42 dated 06/30/25 documented in Section C a Brief Interview of Mental Status score of 6, indicating severe cognitive impairment.Review of the Physician's Orders for Resident #42 from 07/01/25 to 07/20/25 revealed no order for indwelling urinary catheter care.Review of the MAR/TAR/CNA Tasks/Progress Notes from 07/01/25 to 07/20/25 revealed no documentation of indwelling urinary catheter care provided. Review of the Care Plan for Resident #42 dated 07/21/25 with a focus on the resident has urinary catheter Neurogenic Bladder. The goal was for the resident to be/remain free from catheter-related trauma through review date. The interventions included in part the following: care and treatment per current MD orders. On 07/21/2025 at 10:14 AM an observation was made of Resident #42 lying in bed with an indwelling urinary catheter drainage bag hanging from the side of the bed furthest from the door with no privacy cover.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews and record review, the facility failed to prepare food in a manner to preserve the nutritive value of pureed foods with the potential to affect 7 of 7 residents with orders for pureed diets, including Resident #7, 28, 21, 11 and 20. The findings included: The facility's recipe for brussels sprouts instructed staff to prepare in the following manner: 1. Place vegetables not more than 3-4 inches deep in stainless steel insert pans. Cook vegetables in steamer for 10 to 12 to CCP (Critical Control Point) 145 degrees cook to internal temperature and hold for 15 seconds. Cook time 10-12 minutes. The facility's recipe for pureed brussels sprouts instructed staff to prepare in the following manner: 1. Prepare vegetable per separate recipes. Extend standard cooking time for pureed vegetables by 8 minutes. Drain all liquid. 2. Blend vegetables in food processor until smooth. Prepare broth per separate recipe. Gradually add broth and butter in a thin stream to vegetables; blend until completely pureed, no lumps or bits. 3. Remove from processor; place in a bowl twice the volume of the food product. Gradually add thickener, fold until a smooth Mashed Potato consistency is reached. 5. Reheat to >165 degrees Fahrenheit (F) held for 15 seconds. Maintain >140F for no more than 2 hours. Discard unused product. During the initial kitchen tour, on 07/21/25 at 9:08 AM, accompanied by the Culinary Director and the Registered Dietitian (RD), it was noted that there was a 1/6th sized 6 inch deep pan of brussels sprouts. The internal temperature of the product was 170 degrees F. When Staff F, Cook, was asked about the brussels sprouts, Staff F stated that they were being held to be pureed for lunch on this day. When asked about the process for pureed brussels sprouts, Staff F stated that the brussels sprouts would be cooked for 6 minutes to 165 degrees F and then cooled. After being cooled, the sprouts would be placed in the food processor and pureed. After being pureed the [NAME] would add vegetable broth or thickener based on what is needed and then the sprouts would be reheated to 165 degrees F. The sprouts would then be held until being plated for the lunch meal at 11:00 AM and served at 12:00 PM. During the tour, the Culinary Director acknowledged that the sprouts would be held for more than 2.5-3 hours prior to being served and potentially cooked and reheated multiple times prior to being served. Temperatures were taken using the facility's calibrated metal stemmed probe style thermometer.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide food that meets residents' preferences for 3 of 3 sampled residents observed during dining observations (Resident #60, Resident #18, Resident #43).The findings included:1. A record review revealed that Resident #60 was admitted to the facility on [DATE] with diagnoses of injury of head and syncope and collapse. The admission /Medicare - 5 Day Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident's Brief Interview of Mental Status (BIMS) score was 15, which indicates intact cognition.During an observation conducted on 07/21/2025 at 12:40 PM, it was revealed that Resident #60's meal ticket was not circled for selection of choices. The resident expressed he was very unhappy because he did not get what he wanted and explained that the meal ticket was not his, because it was not circled with his choices.2. A record review revealed Resident #18 was admitted to the facility on [DATE] with diagnoses of displaced fracture of base of neck of left femur and syncope and aftercare following joint replacement surgery. The admission /Medicare - 5 Day Minimum Data Set (MDS) assessment dated [DATE] revealed that the residents Brief Interview of Mental Status (BIMS) score was 14, which indicates intact cognition.During an observation conducted on 07/21/2025 at 12:45 PM, it was revealed that Resident #18's meal ticket consisted of Vanilla Ice Cream which was crossed out with a N/A next to it. Resident #18 explained how frustrated she was because she chose 2 vegetables so she can have her ice cream. A tour of the kitchen revealed that there was Vanilla Ice Cream in the kitchen.3. A record review revealed that Resident #43 was admitted to the facility on [DATE] with diagnoses of other seizures and hypotension. The Modification of admission /Medicare - 5 Day Minimum Data Set (MDS) dated [DATE] revealed that the resident's Brief Interview of Mental Status (BIMS) score iwas10, which indicates moderate cognitive impairment.During an observation conducted on 07/21/2025 at 12:50 PM, it was revealed that Resident #43's meal ticket consisted of Monte [NAME], Grilled American Cheese Sandwich on [NAME] and Diced Mango. The tray consisted of Monte [NAME] and diced cantaloupe but no Grilled American Cheese Sandwich.In an interview conducted on 07/23/2025 at 2:30 PM, the Certified Dietary Manager stated that she has been working for this facility for almost 2 years. She explained that they conduct trainings to make sure staff knows how to read meal tickets properly. She also does random weekly tray line audits. She further explained that during the tray line there are usually 2 diet aids; 1 to pull out the tray and call up the meals including the diet and texture. Once the food is filled, they push the tray at the end of the line, the expeditor checks that everything on the meal ticket is also on the tray and puts the tray on the delivery cart with a checklist on top of it (which room trays were in that cart).		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide the correct therapeutic diet as prescribed by the Physician for 1 of 16 sampled residents reviewed (Resident #69). The findings included: A record review revealed Resident #69 was admitted to the facility on [DATE] with diagnoses of Dysphagia, Unspecific Dementia, and Hyperlipemia. The Brief Interview for Mental Status (BIMS) Evaluation completed on 07/16/2025 revealed Resident #69 had a BIMS score of 15, which was cognitively intact. A review of the Physician's orders revealed the following: No Added Salt (NAS) diet, mechanical soft texture, thin liquid consistency dated 07/19/25, and no drinking fluids with straws dated 07/16/2025. A review of the Speech Therapy Treatment Encounter note dated 07/19/2025 revealed that it was recommended to downgrade the diet to mechanical soft and educate nursing regarding the diet change. In an observation conducted on 07/21/25 at 8:50 AM, revealed Resident #69 was in her room. Closer observation revealed a 24-ounce Styrofoam cup of water with a straw inside. An observation was conducted on 07/21/25, at 12:33 PM in the main dining room. Resident #69 was observed receiving her lunch meal, which consisted of a whole, uncut hot dog, a bun, a whole sweet potato, coleslaw, and a broccoli and cheese soup. The meal ticket showed a regular texture diet and thin liquids. Resident #69 picked up the hot dog with her hands and started taking small bites at a time. During this observation, this Surveyor intervened and asked a staff member to check the meal ticket and the accuracy of the diet written on the meal ticket for Resident #69. In an interview conducted on 07/21/25 at 12:49 PM, Resident #69 stated she is on a mechanical soft diet because she has difficulties swallowing her food. In an interview conducted on 07/21/25 at 1:10 PM with the facility's Speech Language Pathologist (SLP), it was stated that Resident #69 has a mild oropharyngeal swallowing disorder, and she tolerates a mechanical soft diet to make it safer and easier for her to manage. Resident #69 takes some time to swallow her food and might have some residue left after swallowing. Resident #69's cognition has gotten worse, and she may not be as aware of the safety issues when eating. According to the SLP, Resident #69 can drink thin liquids but not with straws. The SLP reported changing Resident #69's diet in the electronic system to mechanical soft and placing a written communication slip outside the main kitchen in a designated box labeled Dietary/Nursing Communication. She also spoke to a staff member on the tray line to let them know of the diet change for Resident #69. When asked if she told nursing about the diet change, she said yes, but could not recall which nursing staff she reported to. The SLP stated that it might have been after the lunch meal and before the dinner meal. In an observation conducted on 07/21/25 at 4:00 PM, Resident #69 was in her room. The closer observation showed a 24-ounce Styrofoam cup of water with a straw inside at the bedside. In an observation conducted on 07/22/25 at 8:55 AM, Resident #69 was in her room. The closer observation showed a 24-ounce Styrofoam cup of water with a straw inside. In this observation, Resident #69 said she received the water cup this morning and that she always drinks the water with the straw. In an observation conducted on 07/22/25 at 1:35 PM, Resident #69 was in her room. The closer observation showed a 24-ounce Styrofoam cup of water with a straw inside at the bedside. In this observation, Resident #69 stated that she was not educated or told by staff not to use a straw for drinking fluids. In an interview conducted on 07/23/25 at 9:16 AM with the facility's Certified Dietary Manager (CDM), she stated that the nurses and therapy staff use a dietary communication sheet that they handwrite the change with the name of the resident, room number, the original diet, and the new updated diet. They bring the form and place it into a box outside the main kitchen labeled Dietary/Nursing Communication. The box is checked randomly by any staff member who enters the kitchen. The box is checked every day, before mealtime, and throughout the day. The communication slips are brought into the kitchen above the tray prep counter, and staff go through the tickets and pull the residents' tickets. The communication (continued on next page)		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tickets are also given to the manager on duty. The manager on duty will then enter the updated diet change into their electronic system. The diet communication slip for Resident #69 was given to the kitchen before the lunch tray line started on Saturday, 7/19/2025. She was not here yet, and staff took the meal tickets for Resident #69 and scratched out the regular diet (previous diet) and wrote the updated diet of mechanical soft on the meal tickets. The CDM said she made the diet change in the electronic system when she arrived at work and acknowledged and printed out the new meal tickets. She was under the impression that the changes had been completed and was not sure how this happened. In an interview conducted on July 24, 2025, at 10:30 AM with Staff G, Certified Dietary Assistant, she reported that the 11:00 PM to 7:00 AM shift usually provides water in the rooms. Staff G stated she did not give Resident #69 the Styrofoam cup of water with a straw inside this morning. When asked if she is allowed to receive water with a straw, she did not have an answer.		

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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. 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 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.		