STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105838	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edward J Healey Rehabilitation and Nursing Center	5101 West Blue Heron Blvd Riviera Beach, FL 33418

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care and services to prevent the development of new pressure ulcers, as evidenced by, failure to implement the physician's order for soft boots and to properly document the resident's refusal of them for 1 of 2 sampled residents reviewed for pressure ulcers (Resident #6). The findings included:Review of the facility's policy and procedure titled, Prevention of Pressure Injury, revised on 04/2020 documented, 1. Interventions will be implemented in accordance with practitioner's orders, including the type of devices to be used, and the frequency of performing the tasks. 2. Interventions will be documented in the Care Plan and EMAR, Electronic Medication Administration Record, and will be communicated to all relevant staff, including the Certified Nursing Assistant (CNA) via the Road Map.Review of the record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease, Muscle Weakness and Stage 4 Ulcer of the Sacral region. Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] documented Resident #6 had a Brief Interview for Mental Status (BIMS) score of 11, on a 0-15 scale, indicating the resident had moderate cognitive impairment. This MDS also documented the resident was on Hospice services; the resident's lower extremities were impaired and was dependent on staff for dressing, shower, and personal hygiene. Review of the physician's orders dated 07/11/23 instructed Resident #6 to always wear Soft Boots every shift while in bed.Review of the current care plan dated 04/14/26 indicated Resident #6 was at risk for new skin breakdown due to impaired mobility and a history of deep tissue injury to both heels with an intervention for soft boots to be always worn in bed. This care plan lacked documentation that the resident refused to wear the boots.Review of the progress notes dated from 05/05/26 to 05/19/26 lacked documentation of the resident's refusal of the soft boots.During an observation on 05/18/26 at 10:01 AM, 05/18/26 at 1:01 PM, 5/19/26 at 8:46 AM, 05/19/26 at 10:30AM and on 05/20/26 at 8:58 AM, Resident #6 did not have soft boots on while in bed.During an interview and side by side record review with Staff G, Registered Nurse (RN) on 05/20/26 at 10:25 AM Staff G was asked the interventions in place to prevent further skin breakdown for Resident #6. According to Staff G, soft boots were prescribed for the resident; however, she had refused to wear them. Staff G reviewed the orders and verified they were to be worn always when in bed. She was then asked to provide documentation that Resident #6 had been refusing the soft boots. Staff G reviewed the resident's record from 05/18/26 to 05/20/26, up to the time of the interview, and confirmed there had been no documentation of the resident's refusal. She further provided information that she did not find any documentation of refusal of soft boots since 02/09/26. When asked if each time the resident refused it would be documented, she said, yes.During an interview with Staff F, Dolphin Unit Manager (UM) on 05/20/26 at 11:50 AM, she stated the resident's order should be connected to the task list to ensure the staff documented the intervention; but it was not linked, so it was not done. Staff F was then asked if each time the resident refused, should it be documented elsewhere, she confirmed, yes, it should have been documented.

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, policy review and record review, the facility failed to provide care and services to maintain range of motion for 2 of 4 sampled residents, as evidenced by failure to follow a physician's order for use of self-feeding adaptive equipment for Resident #84, and failure to provide bilateral boots for contracture prevention for Resident #76. The findings included:1) Review of the policy titled, Use of Assistive Devices-Procedure effective date 05/15/20, documented, in part, 1. Assistive devices include: f. Orthotic or prosthetic equipment, g. Eating utensils 3. The facility will provide assistive devise for residents who need them. Nursing, dietary, social services, and therapy departments will work together to ensure availability of devices, such as ordering and/or replacement. 5. Direct care staff will be trained in the use of the devices as needed to carry out their roles and responsibilities regarding the devices. Training will also include when to refer to other departments for changes in condition or problems with the device. 6. A nurse with responsibility for the resident will monitor the consistent use of the device and safely in the use of the device. Refusals of use, or problems with the device, will be documented in the electronic medical record. Modifications to the plan of care will be made as needed. Review of the record revealed that Resident #84 was admitted to the facility on [DATE]. Review of the EJH Transfer to Restorative Nursing form revealed that Resident #84 had a primary diagnosis of Hemiplegia and Hemiparesis affecting right dominant side, and Muscle Weakness, and was being transferred to the Restorative Nursing Program (RNP) on 04/17/26 as Resident #84 completed his therapy program and required restorative staff to maintain present Activities of Daily Living (ADL) functional status. This form also documented that Resident #84 would be in the Restorative Nursing dining program 5 times per week for 1 meal per day for 3 months and the adaptive equipment included in part, bent utensils with left wrist splint with utensil holder with all meals. Further review of the record revealed that the Care Plan with a start date of 04/17/26 for RNP problem: Resident #84 requires training and skill practice in eating/swallowing related to diagnosis of muscle weakness with an approach: Adaptive Equipment-Bent utensils with left wrist splint with utensil holder with all meals. The record also revealed a Physicians order dated 04/14/26 for Adaptive Equipment- bent utensils with left wrist splint with utensil holder with all meals. An initial interview was conducted on 05/18/26 at 9:57 AM with Resident #84 who was positioned in bed and stated that he felt like some of the things he used to be able to do have gotten worse like feeding himself. The resident moved his left arm in the motion from down at his side to imitating the movement of bringing his hand to his mouth. Resident #84 stated that he used to use a hand splint to feed himself with the therapist, but he does not get therapy anymore. An observation on 05/18/26 at 12:10 AM was made in the dining room where Resident #84 was positioned in his wheelchair and Staff B, Certified Nursing Assistant (CNA) was sitting next to him and feeding him with a curved spoon. Resident #84 was not participating in self-feeding and was not wearing a hand splint. On 05/20/26 at 12:15 PM, observations revealed Resident #84 was being fed by Staff B, and his left hand was under his clothing protector. Staff B was asked what type of skill Resident #84 was working on as part of the RNP. Staff B stated, mostly drinking from the Kennedy cup. She assisted Resident #84 with placement of his left hand around the handle of the cup, assisted with bringing it to (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his mouth and then he was able to hold it and drink from the cup himself. Staff B was asked if there was any other adaptive equipment that Resident #84 used during meals and she stated, yes, the bent spoon. Staff B agreed that she was feeding the resident with the bent spoon and he was not working on that skill. Staff B was then asked if Resident #84 had a left wrist splint for use during meals. She stated that they did use the left wrist splint with him during Occupational Therapy (OT) but when Resident #84 started on the RNP he was refusing to use the splint and was getting upset and refused to use it. Staff B was asked if the Occupational Therapist (OT) knew that Resident #84 had refused to use the left wrist splint and she stated, yes, the OT knows. An interview was conducted on 05/21/2026 at 9:57AM with Staff C, Occupational Therapist who has worked at the facility for 7.5 years. Staff C was asked what type of adaptive equipment Resident #84 uses for self-feeding during the RNP. She stated that he uses a universal splint on his left hand that you can put a utensil in and he can assist with feeding himself. The OT went on to say that Resident #84 has orders to use a bent spoon but can use any utensil he likes with the left wrist splint. Staff C was asked if she has received any update from the RNP regarding Resident #84 and she stated, no, not that I remember. Staff C was then asked if a resident refused to use an adaptive device that was ordered, would the RNP document that refusal. She stated yes, it would be in a progress note written by a Restorative Nurse or if they told the OT department they would have written a progress note. Review of the progress notes under the discipline heading of Restorative Nursing revealed an initial note dated 04/17/26 about Resident #84 beginning in the RNP with the focused area of eating and dining and that staff will assist him in using adaptive equipment including bent utensils, a left wrist splint with a utensil holder, a Kennedy cup with a lid for liquids, and a scoop plate for meals to promote safer and more effective self-feeding. Further review of the progress notes revealed that on 05/12/26 Resident #84 required extensive assistance with the use of adaptive equipment including the left wrist splint with utensil holder. The progress notes did not state that Resident #84 had refused to use the left wrist splint. A second interview was conducted on 05/21/26 at 11:34 AM with Staff C, OT who was asked if she was aware that Resident #84 had refused to use the left wrist splint with utensil holder and she stated she was not aware of that and that when she worked with Resident #84 he liked to use the left wrist splint with utensil holder. The OT was also unable to find any documentation about Resident #84 refusing to use the left wrist splint. Staff C agreed to observe Resident #84 during lunch with the surveyor. An observation was conducted on 05/21/26 at 12:00 PM when Resident #84 was brought into the dining room by Staff B, CNA, and he was not wearing and did not have his left wrist splint with him. Staff C also observed Resident #84 sitting at the table in the dining room without his left wrist splint. She then went to his room and located the left wrist splint in his drawer. The OT brought the left wrist splint out to the dining room and asked Resident #84 if he would like to use it during lunch with the Restorative Nurse. Resident #84 told the OT that he liked the other white splint better and the OT reminded him that the white splint is a palm protector with a finger spreader and is not the splint that is used for meals. Resident #84 appeared to understand and agreed to use the left wrist splint with utensil holder. Staff B, CNA came to the table and the OT showed her the splint and asked the CNA if Resident #84 has been using it. Staff B, CNA, stated that they used to use it with him but that he told the therapist he refused to use it and the OT stated she was not told that Resident #84 refused to the left wrist splint. The CNA was asked who she told or if she documented that Resident #84 had refused to use the left wrist splint and she stated, why would I need to tell anyone if Resident #84 had already told the therapist. The CNA walked away and started to assist another resident with their meal. The OT then assisted (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #84 with donning the left wrist splint and using a smaller bent spoon. Resident #84 needed hand over hand assistance to scoop food on the spoon but then was able to bring the spoon to his mouth and eat without physical assistance at least 5 times during the observation. The OT asked the surveyor if she could leave and the surveyor asked the OT if she thought she should show the CNA how she assisted Resident #84 with use of the left wrist splint to make sure the CNA could recreate the same assistance. The OT then went over to the CNA and they came back to the table and the OT demonstrated the technique and the CNA was then able to assist Resident #84 with his self-feeding goal. 2) Review of the record revealed Resident #76 was admitted to the facility on [DATE] with diagnoses to include Spinal Cord Injury and Paraplegia. Review of the current Quarterly MDS documented the resident had a BIMS score of 3, on a 0 to 15 scale, indicating severe cognitive impairment. This MDS also documented impairment to bilateral lower extremities and that he was dependent upon staff for lower body dressing. Review of the current orders documented as of 06/15/22 the resident was to wear bilateral ankle boots for contracture management. A contracture is defined as a permanent tightening or shortening of muscles, tendons, skin, or other soft tissue that causes joints to become stiff. Review of the care plan initiated on 06/17/16 documented that the resident was dependent upon staff for most of his ADLs (activities of daily living). An added intervention dated 06/15/22 documented the use of the bilateral ankle boots for contracture management. Review of the documentation by the Certified Nursing Assistants (CNAs) lacked any evidence of the provision of the ankle boots. Review of progress notes from 03/01/26 to the date of survey lacked any documentation related to the ankle boots. Observations on 05/18/26 at 12:43 PM and on 05/20/26 at 12:45 PM revealed Resident #76 in the main dining room for lunch in the company of his private aide. On both occasions the resident was sitting in his wheelchair with his feet resting in a blue foot wedge attached to the wheelchair, with the resident wearing regular shoes. During an interview on 05/20/26 at 12:50 PM, when asked about the care of Resident #76, Staff G, Registered Nurse (RN), stated the resident had recently transferred from a different unit and had a history of aggressive behavior towards other residents, therefore a private aid was required every day. When asked about the use of bilateral boots, the RN first questioned, boots? and then confirmed the order in the electronic medical record. The RN stated that application of the bilateral boots was the responsibility of the CNAs. She continued to explain that if the resident refused them, the CNAs would report the refusal to the nurse for documentation in the progress notes. During an interview on 05/20/26 at 12:55 PM, when asked if she applied the ankle boots for Resident #76 that morning, Staff H, Certified Nursing Assistant (CNA) did not answer. When asked if she was aware of the order for the bilateral ankle boots, CNA would not answer yes or no. The CNA was then asked how she would know what care was needed for each resident. The CNA stated she would look at the road map. When asked how she was provided with the road map, the CAN stated it was a paper document that she could get each day. The CNA did not confirm if she had the road map for the day or not. During an interview on 05/20/26 at 1:00 PM, when asked about the physician order for the bilateral (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ankle boots for Resident #76, Staff I, Physical Therapist (PT), confirmed she placed the order in the record in 2022, but it was still active, and should be carried out by the nursing staff, specifically the CNAs. The PT explained that a resident with paralysis lacks the ability to flex their ankles to a normal position, and the ankle boots keep the feet from contracting to a downward (foot drop) position. When asked about the blue foot wedge noted on the resident's wheelchair, the PT explained the boots were for contracture maintenance and the stop drop leg rest was to keep the resident's feet from dropping off the wheelchair and keeps the feet in an upright position. During an observation and interview on 05/20/26 at 1:34 PM, when asked to observe the ankle boots for Resident #76, the private aide obtained them from the bottom of the resident's closet, under some clothing and other items. When asked if the resident was refusing the boots, the private aide stated she was not sure as the resident was usually up in his wheelchair before she arrived at 11:00 AM each day. During an interview on 05/21/26 at 11:33 AM, Staff E, Starfish Unit Manager/ADON (Assistant Director of Nursing) confirmed the CNAs have never been able to document the provision of the ankle boots, as the order was put into the computer incorrectly in 2022, and had no explanation as to how it did not get corrected.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to properly complete quarterly assessments for bed rails/assist bars for 3 of 4 sampled residents reviewed for accidents (Resident #20, Resident #57 and Resident #81). The findings included:Review of the State Operations Manual (SOM) revealed the definition of Bed Rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. Examples of bed rails include, but are not limited to: Side rails, bed side rails, safety rails; Grab bars and assist bars. Resident Assessment: The facility must assess the resident for the risks of entrapment and review possible risks and benefits of bed rails prior to installation or use.A review of the facility's policy titled, Bed Rails, dated 08/22/23 documents that part of the bed rail comprehensive assessment, the following components will be considered when determining the resident's needs. The medical diagnosis, conditions, symptoms and or behavioral symptoms, size and weight, sleep habits, medications, acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, cognition, communication, mobility in and out of bed and risks of falling. Monitoring and supervision of ongoing assessments to ensure that the bed rail is used to meet the residents' needs. A nurse assigned to the resident will complete reassessments not less than quarterly, upon a significant change in status or a change in the type of bed/mattress/rail.A review of the User-Service Manual for the Deluxe Assist Handle documents that the assist device is intended for use as an aid in entering or exiting the bed sleep area, as well as a stable handhold during self-positioning within the bed sleep area.1. Observation on 05/19/26 at 8:58 AM revealed that Resident #20's had an assist handle in place, on the upper left side of his bed.A review of Resident #20's medical records revealed the resident was admitted to the facility on [DATE] with diagnoses to include Cerebral Infarction, Hemiplegia affecting Right Dominant Side, Aphasia, Dysphagia, Essential Hypertension, Muscle Spasm, Peripheral Vascular Disease, Obstructive and Reflux Uropathy, Neuromuscular Dysfunction of Bladder, and Muscle Weakness.A review of the residents quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed that his BIMS (Brief Interview for Mental Status) did not have a number score, which means the resident refused to answer the questions. A physician's order dated 08/22/25 documented a left side upper transfer assist bar. An Occupational Assessment that is done quarterly, dated 01/21/26 and 04/20/26 documented N/A (not applicable) under bed rails with no assessment being completed. It does document the resident uses a left side upper transfer assist bar for mobility. Resident #20 care plan for ADLs (Activities of Daily Living) documented that he is set-up, to dependent with his ADLs. One of the interventions is that the resident had a left side upper transfer bar for mobility.2. Observations on 05/21/26 at 8:30 AM revealed that Resident #57 had an assist handle in place, on the right side of his bed.A review of Resident #57's medical records revealed that Resident #57 was admitted to the facility on [DATE] with diagnoses to include Hemiplegia and Hemiparesis following Cerebral Infarction, affecting Left non-Dominant Side; Essential Hypertension, Spinal Stenosis, Vascular Leukoencephalopathy, Muscle Weakness, Chronic Kidney Disease, Anxiety Disorder, Unspecified Psychosis, Vascular Dementia Severe with Behavioral Disturbances, Peripheral Vascular Disease, Benign Prostatic Hyperplasia, Acute Kidney Failure, Cognitive Communication Deficit, Hallucinations, Auditory Hallucinations, and Depression. A review of the quarterly MDS dated [DATE] documented his BIMS score as a 4, which indicates his cognition is severely impaired. A physician's order dated 01/19/23 documented a right-side upper transfer assist bar. Resident #57's ADL care plan documented he needs assistance with most ADLs and is dependent on staff for some (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of his ADLs. One of the interventions documented that he has a right-side upper transfer assist bar for mobility. A review of the Occupational Assessment documented the last two assessments were completed on 01/22/26 and 04/20/26, showing N/A next to bed rails; and No assessment completed. There is a comment documented that he has an upper right assist bar for mobility. 3. Observations were made on 05/19/26 at 10:58 AM of Resident #81 having an assist handle in place attached to the upper right side of his bed.Review of Resident #81's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses to include Heart Failure, Vascular Dementia with Mood Disturbances, Dysphagia, Depression, Hemiplegia Left non-dominate, Hypertension, Chronic Kidney Disease, Muscle Weakness, and Reduced Mobility. Resident #81's quarterly MDS dated [DATE] documented he has a BIMS score of a 6, which indicates his cognition is severely impaired. A physician's order dated 12/19/25 documented a right side of bed upper transfer assist bar. Resident #81's care plan for ADLs documented that Resident #81 is dependent on staff for most of his ADLs and mobility. One of the interventions included right-side upper transfer assist bar for mobility. A review of an assessment dated [DATE] documented bed rails are not necessary at this time. The Occupational assessment dated [DATE] and 05/21/26 documented N/A next to bed rails, but has a statement that the resident has a right upper transfer assist bar.During an interview on 05/21/26 at 10:23 AM with Staff J, RN (Registered Nurse), she was asked who completes the bed rail assessments. She stated PT (Physical Therapy) does them, we just follow the orders.During an interview on 05/21/26 at 10:35 AM with the Rehab Director, he was asked who completes the bed rail assessments. He stated we do, the physical therapy department completes them quarterly. He looked up Resident #20's electronic medical chart and stated, Oh he doesn't have a bed rail, he has an assist bar; those are not considered bed rails. We do quarterly assessments on everyone, but we don't classify the assist bars as bed rails. He stated that the assessment falls under the Occupational Therapy Assessments.During an interview on 05/21/26 at 10:45 AM with the Administrator, she stated that the assist bars are not considered bed rails although when asked for a policy for assist bars, she stated we only have a policy on bed rails. When the surveyor went back into her office and showed her the definition of bed rails from the State Operations Manual (SOM), she acknowledged that the devices do fall under bed rails.During a secondary interview on 05/21/26 at 12:30 PM, with the Administrator, she stated the assist bars are actually called assist handles and are not considered a bed rail, cannot cause entrapment, and that is one of the reasons why they went with those. She said the physician put assist bars instead of assist handles in the orders. The surveyor requested a copy of the user manual for the assist handles.During an interview on 05/21/26 at 12:50 PM with the Maintenance Director, he stated, We do weekly checks of the bed rails. We do one unit a week.

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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 policy review, observation, interview and record review, the facility failed to ensure staff maintained sterile technique during tracheostomy care and suctioning as evidenced by improper handling of sterile supplies, failure to prevent contamination of the sterile field, failure to change gloves after contact with potentially contaminated surfaces and equipment. This deficient practice had the potential for increased risk for infection for 1 of 1 sampled resident (Resident #52); and failed to change gloves during wound care for 1 of 1 sampled resident (Resident #28).The findings included:The facility policy titled Tracheostomy Care and Suction Policy and Procedure, dated 05/04/26, indicated the purpose of the policy was to establish standardized, evidence based best practices for the care and maintenance of tracheostomy tubes in the skilled nursing center setting. The policy stated proper tracheostomy care and suctioning minimizes the risk of infection, maintains airway patency, and promotes resident safety and comfort. The procedure for respiratory therapy trach care #3 directed staff to maintain sterile technique throughout the procedure. Clinical record review revealed Resident #52 was admitted to the facility on [DATE] with diagnoses including Anoxic Brain Damage, Quadriplegia, and Respiratory Failure. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had severe cognitive impairment and was rarely understood. The assessment further revealed the resident received oxygen therapy, suctioning, and tracheostomy care. The care plan dated 03/26/26 revealed Resident #52 had altered respirations related to respiratory failure evidenced by the presence of a tracheostomy. Review of physician orders revealed: 09/06/23 – Suction three times daily for secretions. 09/11/25 – Change trach collar daily and as needed. 09/23/25 – Trach #4 Shiley cuffless for respiratory failure. On 05/20/26 at 8:48 AM, tracheostomy care was observed with Staff A, Registered Nurse. Staff A donned clean gloves and disinfected the bedside table. She then removed the gloves, washed her hands, opened the treatment cart, and gathered sterile utility drapes. Staff A opened the sterile drapes and placed two sterile drapes on the bedside table using bare hands without gloves, which had the potential to contaminate the sterile field prior to use. Staff A then sanitized her hands and donned a gown, mask, face shield, and clean gloves. She returned to the treatment cart and obtained supplies including a suction kit, trach care kit, trach mask, split sponge, hydrogen peroxide, and normal saline (NS). She touched all items with clean gloves and placed them next to the sterile drapes. Staff A increased the oxygen to 10 liters and placed a pulse oximeter on the resident's finger with oxygen saturation noted at 99 percent. She then removed the gloves, sanitized her hands, and donned new clean gloves. Staff A retrieved suction tubing attached to the wall above the bed and placed the tubing directly on the resident's bed next to Resident #52, creating a contamination risk. While wearing the same pair of clean gloves, Staff A used the bed remote to raise the bed, closed the privacy curtain, repositioned (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105838	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edward J Healey Rehabilitation and Nursing Center	5101 West Blue Heron Blvd Riviera Beach, FL 33418

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the trash can, and immediately proceeded to remove the tubing/mask from the resident's neck and tracheostomy area without changing gloves after touching environmental surfaces and equipment. Staff A then lowered the oxygen to 5 liters. She removed the gloves, sanitized her hands, and donned a new pair of clean gloves. Using clean gloves, Staff A opened supplies and placed the trach mask, size 4 inner cannula, NS, split sponge, and gauze onto the sterile utility drapes after touching the items with clean gloves, potentially contaminating supplies intended for the sterile field. The only item not touched prior to placement on the sterile drape was the size 4 inner cannula, which was allowed to drop onto the field. Staff A opened the NS and poured it into a container, removed the clean gloves, sanitized her hands, and donned sterile gloves. She attached sterile suction tubing to the suction tubing previously placed on the resident's bed and suctioned the tracheostomy twice. These practices failed to maintain a sterile field throughout the tracheostomy care and suctioning procedure. On 05/20/26 at 12:52 PM, an interview was conducted with the [NAME] Unit Manager. After reviewing the observation findings with her, she acknowledged concerns related to tracheostomy care and infection control and stated Staff A would review the tracheostomy care policy. On 05/20/26 at 1:00 PM, an interview was conducted with Staff A. She agreed with the findings. On 05/20/26 at 1:07 PM, a subsequent interview with the [NAME] Unit Manager revealed the sterile drapes should not have been touched with bare hands and Staff A should have changed gloves before removing the oxygen tubing/mask from the resident. On 05/21/26 at 10:28 AM, an interview with the Nursing Home Administrator revealed Staff A was provided competency training and an instructor observed her performing tracheostomy care on a resident following the surveyor's observation. During the competency review, the instructor identified concerns with Staff A's tracheostomy care technique and had to stop and re-educate her during the procedure. 2) Review of the policy Wound Care (EJH-NUR-074A) reviewed 04/27/21, documented in part, Procedure: . 5. Perform hand hygiene, don gloves and any PPE needed. 6. Set up area for supplies. 7. Place resident in a comfortable position. 8. Remove old dressing, pull glove over old dressing and discard in red bag. 9. Perform hand hygiene and don gloves. This policy then instructed staff to provide the wound care. Review of the record revealed Resident #28 was admitted to the facility on [DATE] with diagnoses to include Paraplegia. Review of the current Annual MDS assessment documented that the resident had a BIMS score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. Further review of this MDS documented the resident did not have a current pressure injury. Review of the wound assessments for Resident #28 revealed a new pressure injury to the resident's coccyx as of 03/18/26. Review of the physician orders documented the current wound care as of 04/27/26 was to cleanse the wound with normal saline, apply a dampened Hydrofera Blue dressing (an antibacterial foam dressing), and cover with gauze and a border dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/20/26 at approximately 10:00 AM, Staff A, Registered Nurse (RN)/Wound Care Nurse, obtained the wound care supplies for Resident #28 and placed them on a clean barrier. The RN donned PPE to include gloves and gown, repositioned the resident, then removed the gloves and donned sterile gloves. The RN removed the old dressing with the sterile gloves, dropped the dressing into the red bag trash, and continued the wound care with the now contaminated gloves from the old dressing. During an interview on 05/21/26 at 11:16 AM, the Infection Preventionist was made aware of the observation made on 05/20/26 with the Wound Care Nurse. When told of the failure to change gloves, the Infection Preventionist stated she should have taken the dressing off with the non-sterile gloves and then provide the care with the sterile gloves.