4/5/21

	or Health Care Adminis				FORM): 03/29/2021 1 APPROVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDING: 0	JS - MAIN LIC		
		55229	B. WING		03/0	4/2021
				75 70 000F	1 03/0	4/2021
NAME OF PI	ROVIDER OR SUPPLIER	4250 66TH	DRESS, CITY, STA	ITE, ZIP CODE		
BALANCE	D HEALTHCARE		ERSBURG, FL	∟ 33709		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
K 000	INITIAL COMMENTS		K 000			
	A re-licensure survey	was conducted from				
		2021 at Balanced Health				
		in St. Petersburg, Florida in				
	accordance with Natio	onal Fire Protection				
		and 101 (2018 edition) and				
		nts of Florida State Fire				
	Marshal's Rules and I					
		(F.A.C.) 69A-3, F.A.C. I, and Florida Statutes (F.S.)				
		333.0215, adopting National				
		iation (NFPA) 1 and 101				
	(2018 edition) known					
	Prevention Code and					
	standards and require	ements adopted per NFPA				
	101, Chapter 2.					
	Date Opened: 1975 Bldg. Type: II (000)					
	Square Footage: 175.	000				
	Smoke Compartment					
	Floor Levels: 2					
	Generator: 450 kW					
	Licensed Bed: 299					
	Census: 215					
	Fully Sprinklered: Yes					
	Fire Alarm: Yes, moni	itored				
	The following is deser	ription of the deficiencies.				
	found at the time of th			1		

K 222 SS=D NFPA 101 Egress Doors

Egress Doors

arrangements:

Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking

(X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Electronically Signed 03/26/21

K 222

Agency for Health Care Adminis	tration				: 03/29/2021 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: 0	CONSTRUCTION 5 - MAIN LIC	(X3) DATE SURVEY COMPLETED	
	55229	B. WING		03/0	4/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BALANCED HEALTHCARE	4250 66TH				
		ERSBURG, FL			
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 222 Continued From page	1	K 222			
LOCKING Where special locking clinical security needs only one locking device each door and provisi rapid removal of occu- locks; keying of all loc at all times; or other s available to the staff s 18.2.2.2.5.1, 18.2.2.2 SPECIAL NEEDS LO Where special locking safety needs of the p Clinical or Security Lo being met. In addition electrical locks that fa upon loss of power to protected by a super system and the locke complete smoke dete constantly monitored within the locked spac and detection system doors upon activation 18.2.2.2.5.2, 19.2.2.2 DELAYED-EGRESS I ARRANGEMENTS Approved, listed delay installed in accordance	is of the patient are used, is shall be permitted on one shall be made for the parts by: remote control of ks or keys carried by staff uch reliable means t at all times. 6, 19.2.2.2.5.1, 19.2.2.2.6 CKING ARRANGEMENTS a transperse for the stient are used, all of the cking requirements are the locking requirements are it be locked by the building is ised automatic sprinkler of space is protected by a ction system (or is at an attended location per); and both the sprinkler sa are arranged to unlock the 1.5.2, TIA 12-4				

ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised

automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4

STATE FORM 598 SG8N21 If continuation sheet 2 of 14

Agency fi	or Health Care Adminis	tration				: 03/29/2021 I APPROVEE
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S COMPLI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBERS	A. BUILDING: I	95 - MAIN LIC	COMPLI	EIED
					l	
		55229	B. WING		03/0	4/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
		4250 66TH	STN			
BALANCE	ED HEALTHCARE	SAINT PET	ERSBURG, FI	L 33709		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 222	Continued From page	2	K 222			
	ACCECC CONTROLL	LED EGRESS LOCKING				
	ARRANGEMENTS	LED EGRESS LOCKING				
		ress Door assemblies				
	installed in accordance	e with 7.2.1.6.2 shall be				
	permitted.					
	18.2.2.2.4, 19.2.2.2.4					
	ELEVATOR LOBBY E	EXIT ACCESS LOCKING				
	ARRANGEMENTS					
	Elevator lobby exit ac					
		1.6.3 shall be permitted on				
	door assemblies in bu					
	fire detection system	roved, supervised automatic				
	supervised automatic					
	18.2.2.2.4, 19.2.2.2.4					
	This Statute or Rule i	is not met as evidenced by:				
		and interview with the		A. On 3/10/21 delayed egress doors		
	Maintenance Director	, the facility failed to		were identified, and delayed egress		
	maintain delayed egre	ess doors.		signage placed on doors.		
				B. Maintenance Director/designee		
	Findings included:			conducted a quality monitor of egress doors for signage on 3/10/21 and		
	During the facility tour	with the Regional		identified doors were provided delaye		
		and the Maintenance		egress signage.		
		03/2021 and 03/04/2021,		C. On 03/15/21 Administrator		
		m. and 3:30 p.m., the facility		re-educated maintenance department	on	
		tify the delayed egress		delayed egress signage for egress do		
	doors with required si	gnage on the doors		D. Maintenance Director/designee to	,	

the findings.

Class III

7.2.1.6.1.1(4)(a)

throughout the facility. An interview was

conducted with the Maintenance Director

per NFPA 101 (2018 Edition) 19.2.2.2.1,

concurrent with the observations and confirmed

conduct quality monitors for delayed

egress signage on egress doors weekly

for 4 weeks, then monthly for 2 months.

schedule modified based on findings and

trends to ensure compliance is achieved

and maintained.

Findings and trends will be brought to QAPI for review. Quality Monitoring and

		1): 03/29/2021 1 APPROVED
STATEMENT	or Health Care Adminis FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: 0	E CONSTRUCTION D5 - MAIN LIC	(X3) DATE SURVEY COMPLETED	
		55229	B. WING		03/0	14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
DALANCE	ED HEALTHCARE	4250 66T	H ST N			
BALANCE	DILALITICARE	SAINT PE	TERSBURG, FI	L 33709		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 223 SS=D	or horizontal exit, sma area enclosure are se closed position, unles	ng Devices ageway, stairway enclosure, oke barrier, or hazardous aff-closing and kept in the as held open by a release	K 223			4/5/21
	closes all such doors compartment or entire * Required manual fir * Local smoke detect smoke passing throug smoke detection syst	ors designed to detect gh the opening or a required				
	This Statute or Rule Based on observation Regional Maintenance Maintenance Director maintain doors with s Findings included: During the facility tou Maintenance Director Director from 03/03/2	, the facility failed to elf closing devices. r with the Regional and the Maintenance 021 to 03/04/2021 between		A. Self-closing doors on Lifestyle so utility room exit door scheduled to be replaced on 4/28/21, private office dor Lifestyle 1 dining room was repaired of 03/08/21, men's restroom door by ele door closure removed on 3/5/21, Lifes dining room statinvell exit door replakey pad latch on 03/11/21, housekeer door in Lifestyle 2 repaired 03/05/21 leasts of the 2nd floor dining room entr	or on vator style ced bing door y	
		m., it was observed that the doors failed to close and		doors adjusted 03/09/21, and 2 west of door from stairwell at ground level new door closure installed 03/25/21.		real contraction of the contract

entry doors

1) Exit door from Lifestyle soiled utility room

4) Lifestyle 1 dining room stairwell exit door

3) Men's restroom door by elevator

5) Housekeeping door in Lifestyle 2

2) Private office door in Lifestyle 1 dining room

6) 1 of 2 door leafs of the 2nd floor dining room

7) 2-West exit door from stairwell at ground level

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B. On 3/24/21 Maintenance Director

doors for closing and latching. Any

identified concerns were repaired on

maintenance staff on preventative

maintenance of self-closing doors for

3/24/21.

conducted quality monitor of self-closing

C. On 3/15/21 Administrator re-educated

Agency fr	or Health Care Adminis	tration): 03/29/2021 1 APPROVE
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC		(X3) DATE SURVEY COMPLETED	
		55229	B. WING		03/0	14/2021
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ATE, ZIP CODE		
BALANCE	D HEALTHCARE	4250 66TH SAINT PE	I ST N TERSBURG, FI	L 33709		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES * MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 223 K 291 SS=D	Maintenance Director Concurrent we confirmed the findings on firmed the Findings Per NFPA 101 (2018 8.5.4.1 Per NFPA 80 (2016 E Class III NFPA 101 Emergency Emergency Lighting Emergency Lighting of is provided automatic 18.2.9.1, 19.2.9.1 This Statute or Rule Based on observation interview with the Regiment of the Period P	ducted with the Regional and the Maintenance (the Maintenance (the Maintenance) (the observations and section) 19.7.6, 4.6.12, dition) 6.1.3.2.1 / Lighting at least 1-1/2-hour duration ally in accordance with 7.9. Is not met as evidenced by:	K 223	proper closing and latching. D. Maintenance Director/designee to conduct quality monitors for proper cle and latching of self-closing doors two times a week for 4 weeks, then week 12 weeks. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified bat on findings and trends to ensure compliance is achieved and maintains of the complex of t	y for sed	4/5/21
	Findings included:	ord review with the Regional		conducted quality monitor on emerger back up lighting for function. There we no other emergency back-up lights identified.		

Maintenance Director on 03/03/2021 between

9:30 a.m. and 12:00 p.m., the facility failed to

During the facility tour with the Regional Maintenance Director on 03/03/2021 between

provide evidence of monthly and annual testing of

emergency lights equipped with battery backups.

12:50 p.m. and 3:00 p.m., the emergency lights

located in the generator room failed to operate

when tested. An interview was conducted with

the Regional Maintenance Director concurrent

with the observations and confirmed the findings.

STATE FORM caso SG8N21 If continuation sheet 5 of 14

C. On 03/15/21 Administrator

re-educated maintenance staff on

preventative maintenance monitoring of

emergency back-up lighting monthly and

D. Maintenance Director/designee will

conduct quality monitors of operation of

emergency back-up lighting weekly for 4

weeks, then monthly for 2 months, with

follow-up initiated as needed to ensure

substantial compliance with K291.

PRINTED: 03/29/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 05 - MAIN LIC B MING 55229 03/04/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4250 66TH ST N BALANCED HEALTHCARE SAINT PETERSBURG, FL 33709 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 291 Continued From page 5 K 201 Findings and trends will be brought to per NFPA 101 (2018 Edition) 19.2.9.1. 7.9.2.6. QAPI for review. Quality Monitoring and 7.9.2.7, 7.9.3.1.1(1)(3)(5) schedule modified based on findings and trends to ensure compliance is achieved Class III and maintained K 325 K 325 NFPA 101 Alcohol Based Hand Rub Dispenser 4/5/21 SS=D (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1. unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet. excluding one individual dispenser per room

* Storage in a single smoke compartment greater than 5 gations complies with NFPA 30 * Dispensers are not installed within 1 inch of an

This Statute or Rule is not met as evidenced by: Based on observation and interview with the

Regional Maintenance Director, the facility failed

to maintain the maximum storage limits of alcohol

* Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6. 19.3.2.6. 42 CFR Parts 403, 418, 460.

ignition source

482, 483, and 485

STATE FORM SG8N21 If continuation sheet 6 of 14

A. On 03/04/21 alcohol based hand rub

was removed and stored to not exceed

number of gallons per storage area.

Agency for Health Care Administration						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC	(X3) DATE SURVEY COMPLETED			
	55229	B. WING	03/04/2021			

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BALANCE	D HEALTHCARE	1250 66TH ST N SAINT PETERSBURG, FI	⊥ 33709	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
K 325	Continued From page 6	K 325		in the second
	based hand rub (ABHR) per compartment. Findings included: During the facility tour with the Regional Maintenance Director between 03/03/2021 to 03/04/2021, and between 9:00 a.m. and 3:30 p.m., it was observed that the facility had 40 gallons of ABHR stored in Room 107. An interview was conducted with the Regional Maintenance Director concurrent with the observations and confirmed the findings. per NFPA 101 (2018 edition) 19.4.3(7) Class III		B. On 3/5/21 Housekeeping Director/designee completed quality monitor of alcohol-based hand rub for required storage amounts. No other issues identified. C. Housekeeping Director/designee will re-educate housekeeping staff on storage of alcohol-based hand rub by 04/01/21. D. Housekeeping Director/designee to conduct quality monitors of storage of alcohol-based hand rub 3 times a week for dichol-based hand rub 3 times a week for dichol-based hand rub 3 times a week for for weeks, fine meekly for 8 weeks, then monthly to ensure substantial compliance of K325. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained.	
K 541 SS=D	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2015 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that ope directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All nex-chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protectic in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and	e w		4/5/21

AHCA Form 3020-0001

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Agency fo	or Health Care Adminis	tration				: 03/29/2021 APPROVED
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: (CONSTRUCTION 15 - MAIN LIC	(X3) DATE S COMPLE	
		55229	B. WING		03/0	4/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ITE, ZIP CODE		
BALANCE	ED HEALTHCARE	4250 66TH				
			FERSBURG, FI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 541	Continued From page	7	K 541			
	room are protected by accordance with 19.3 (4) Existing fuel-fed in by fire resistive constitute. 19.5 4, 9.5 8.4. 2015 NEW Rubbish chutes, incin shall comply with the unless otherwise speed "The fire resistance room shall not be requal to the shall comply with automa in accordance with Sc "Chutes shall disch."	ted to discharge into same / automate sprinklers in // 3.9 or 19.3.5.7.) cinerators shall be sealed vuction to prevent further NFPA 82 erators, and laundry chutes provisions of Section 9.5, // 2.16ed in 18.5.4.2. rating of chute charging // 2.16ed in 18.5.4.2. reting of chute shall be tic extinguishing protection // 2.17ed in 18.5.4.2. retion 9.7. // 3rge into a trash collection for purpose and shall be ce with 8.7.				
	Based on observation Maintenance Director maintain the laundry of Findings included: During the facility tour			A. On 3/6/21 latches were removed laundry chutes to ensure closing. B. On 3/6/21 Maintenance Director completed quality monitor of laundry chutes for proper closing and no othe concerns identified. C. On 03/15/21.Administrator re-educated maintenance staff on		

9:00 a.m. and 3:30 p.m., it was observed that 4 of

4 laundry chute fire rated intake doors failed to be

position secured by non-approved methods. An

interview was conducted with the Maintenance

Director concurrent with the observations and

confirmed the findings.

self-closing, as they were found in the open

STATE FORM SG8N21 If continuation sheet 8 of 14

maintaining laundry chutes closure.

complete quality monitors for proper

closing of laundry chutes daily for 2

then monthly to ensure substantial

D. Maintenance Director/designee to

weeks, then 3 times a week for 10 weeks.

compliance of K541. Findings and trends will be brought to QAPI for review. Quality

PRINTED: 03/29/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 05 - MAIN LIC B MING 55229 03/04/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4250 66TH ST N BALANCED HEALTHCARE SAINT PETERSBURG, FL 33709 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 541 Continued From page 8 K 541 (Photographic evidence obtained) Monitoring and schedule modified based on findings and trends to ensure per NFPA 101 (2018 edition) 19.3.1, 8.6.1, 8.6.2, compliance is achieved and maintained. per NFPA 82 (2014 edition) 6.2.3.3.1.1. 6.2.3.3.2.1 Class III K 712 K 712 NEPA 101 Fire Drills 4/5/21 SS=D Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire

conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms 18.7.1. 19.7.1. 4.7 This Statute or Rule is not met as evidenced by:

conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and

Based on record review and interview with the Regional Maintenance Director and the Maintenance Director, the facility failed to conduct fire drills as required by NFPA 101.

Findings included:

During the facility record review with the Regional Maintenance Director between 03/03/2021 and 03/04/2021, and between 9:30 a.m. and 3:30 p.m., the facility failed to conduct fire drills for: 1) 2nd and 3rd shifts for Q2 2020

- A. On 3/26/21 fire drills were conducted for each shift.
- B. Current residents had the potential to he affected
- C. On 3/24/21 Administrator re-educated Maintenance Director on conducting fire drills once a shift per quarter and maintaining documentation of such drills. On 3/25/21 Maintenance Director created yearly calendar of fire drills to ensure fire drills to be conducted once a shift per quarter.

	or Health Care Adminis		1		FORM): 03/29/2021 1 APPROVE
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ECONSTRUCTION D5 - MAIN LIC	(X3) DATE SURVEY COMPLETED	
		55229	B. WING		03/0	4/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
BALANCE	D HEALTHCARE	4250 66TH	I ST N TERSBURG, F	. 22700		
			EKSBUKG, F	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 712	Continued From page	9	K 712	none and a second		distribution of the state of th
	Maintenance Director Director concurrent w confirmed the findings	20 ducted with the Regional and the Maintenance ith the observations and		D. Administrator/designee to conduquality monitors of fire drills conducted and documented monthly for 3 month ensure substantial compliance of K71 Findings and trends will be brought to QAPI for review. Quality Monitoring a schedule modified based on findings it trends to ensure compliance is achieved and maintained.	d s, to 2. and and	
K 741 SS≃D	Smoking Regulations Smoking regulations include not less than (1) Smoking shall be ward, or compartmen combustible gases, o and in any other haze area shall be posted SMOKING or shall be international symbol f (2) In health care occ prohibited and signs major entrances, seci	shall be adopted and shall he following provisions: prohibited in any room, twhere flammable liquids, coygen is used or stored rdous location, and such with signs that read NO posted with the	K 741			4/5/21

(3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where

(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is

smoking is permitted.

permitted.

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		L. F.				: 03/29/2021 APPROVED
STATEMENT	or Health Care Adminis r of DEFICIENCIES OF CORRECTION	tration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION D5 - MAIN LIC	(X3) DATE SURVEY COMPLETED	
		55229	B. WING		03/0	4/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
BALANCE	D HEALTHCARE	4250 66T	H ST N ETERSBURG, F	1 23700		
	0.111.07.07	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
K 741	Continued From page	10	K 741			
	18.7.4, 19.7.4 (Note smoking tower not ashtrays)	er disposal receptacles are				
	Based on observation Regional Maintenanc to maintain the requir and employee smokli Findings included: During the facility tou Maintenance Director 03/04/2021, and betw p.m., it was found in smoking areas that: 1) The facility failed te non-combustible maintenance Director on the smoking areas that: 2) The facility failed the equipped with self-circle ashtrays into 3) Cigarette butts were combustible trash care	r with the Regional between 03/03/2021 to treen 9:00 a.m. and 3:30 he resident and employee o provide ashtrays of arial and of safe design provide metal containers using cover devices to empty e also observed in as in both smoking areas ducted with the Regional concurrent with the firmed the findings.		A, 1. On 3/22/21 non-combustible material self-closing ashtrays were purchased and provided for resident a staff smoking areas. Z. Self-closing no containers clearly marked for cigarett butts only to empty ashtrays into will brovided for resident and staff smokin areas by 4/2/21. 3. On 3/25/21 combustible trash cans were clearly marked for trash only in resident and smoking areas. B. Current smoking residents and si have the potential to be affected. C. SDC/designee will re-educate st 04/01/21 on use of proper self-closing metal containers to empty ashtrays in and combustible arbatrays, self-closing metal containers to empty ashtrays in and combustible trash cans to be use trash only. D. Maintenance Director/designee to complete quality monitors for noncombustible material self-closing ashtrays, self-closing metal container cigarette butts, and combustible trash container cigarette butts, and combustible trash only daily Monday – Fit	netal e g g staff taff by l J to, d for	
	Class III			for 2 weeks, then weekly for 10 weeks then monthly to ensure substantial compliance of K741. Findings and tre	в,	

6550

will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained.

STATEMENT	or Health Care Adminis FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION 105 - MAIN LIC	FORM (X3) DATE S COMPL	ETED
		55229			03/0	04/2021
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ATE, ZIP CODE		
BALANCE	D HEALTHCARE	4250 661 SAINT P	IH SI N ETERSBURG, F	L 33709		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 761	Continued From page	11	K 761			
K 761 SS=D	NFPA 101 Maintenan Doors	ce Inspection & Testing -	K 761			4/5/21
	annually in accordance for Fire Doors and Ot Non-rated doors, inclupatient rooms and sm routinely inspected as maintenance program Individuals performing testing possess know experience that demo), the door inspections and ledge, training or mstrates ability, pection and testing are vailable for review.				
	Based on observation Maintenance Director and the facility tour, it	is not met as evidenced by: a and interview with the during document review was observed that the ain the fire rated attic access		A. On 03/25/21 the fire rated attic at doors were inspected and documented. B. Current residents had the potential be affected. C. On 03/24/21 Administrator re-educated Maintenance Director on requirement for annual inspection of fixed at the capes doors.	d. al to	

During the facility record review, and interview

Maintenance Director between 03/03/2021 to

evidence for the annual inspection of the fire

total of 30 doors in the building.

per NFPA 1 (2018 edition) 12.4.6.8.4.1, 12.4.6.8.4.2, 12.4.6.8.4.3

03/04/2021, and between 09:00 a.m. and 3:30

p.m., it was observed that the facility provided no

rated attic access doors. In an interview with the

Maintenance Director, they had said there were a

with the Regional Maintenance Director and the

D. Maintenance Director/designee to

of inspection of fire rated attic access

doors monthly for 3 months to ensure

and trends will be brought to QAPI for

ensure compliance is achieved and

maintained

conduct quality monitor of documentation

substantial compliance of L761. Findings

review. Quality Monitoring and schedule

modified based on findings and trends to

STATEMENT	or Health Care Adminis r of DEFICIENCIES OF CORRECTION	tration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: 0	5 - MAIN LIC	COMPL	ETED
		55229	B. WING		03/0	04/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4250 66TF	STN			
BALANCE	D HEALTHCARE	SAINT PE	TERSBURG, FI	. 33709		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPS DEFICIENCY)	BE	(X5) COMPLETE DATE
K 761	Continued From page	12	K 761			
K 914 SS=D	Class III NFPA 99 Electrical Sy Testing	stems - Maintenance and	K 914			4/5/21
	Hospital-grade recept locations and where canesthesia is adminis installation, replacem testing is performed a documented performs diseased at intervals not isolation monitors (LII intervals of less than actuating the LIM test which activates both For LIM circuits with manual test is performed at 15 months. Li G. 3.3.3.2 after any rejelectric distribution sy maintained of require	seep sedation or general tered, are tested after initial ent or servicing. Additional It intervals defined by a consideration of the time the second of the time the time the time the time the time the time time the time time time time time time time tim				

This Statute or Rule is not met as evidenced by: Based on record review and interview with the

Regional Maintenance Director, the facility failed

During the facility record review with the Regional

to test receptacles and or provide documented performance data for receptacles located in

patient care rooms and bed locations.

Findings included:

STATE FORM caso SG8N21 If continuation sheet 13 of 14

A. On 3/25/21 annual receptacle testing

C. On 3/24/21 Administrator re-educated

Maintenance Director on requirement for

electric receptacles to be tested annually

D. Maintenance Director to conduct

completed and documented. B. Current residents had the potential to

be affected.

and documented.

Agency f	or Health Care Adminis	tration				: 03/29/2021 I APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: 0	CONSTRUCTION D5 - MAIN LIC	(X3) DATE SURVEY COMPLETED	
		55229	B. WING		03/0	4/2021
NAME OF F	ROVIDER OR SUPPLIER		RESS, CITY, STA	ITE, ZIP CODE		
BALANCI	ED HEALTHCARE	4250 66TH SAINT PET	ST N ERSBURG, FI	∟ 33709		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 914	03/04/2021, and betw p.m., the facility failed annual no evidence o inspection and testing was conducted with it Director concurrent w confirmed the findings	between 03/03/2021 to reen 09:30 a.m. and 3:30 to provide evidence of f annual receptacle was provided. An interview ne ground Maintenance tith the observations and	K 914	quality monitoring of annual testing of electric receptacle and documentation monthly for 3 months to ensure substacompliance of K914. Findings and tre will be brought to QAPI for review. Q Monitoring and schedule modified bas on findings and trends to ensure compliance is achieved and maintained.	n antial nds uality sed	

		ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVED IO: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		105390	B. WING			3/04/2021
	ROVIDER OR SUPPLIER		4250	EET ADDRESS, CITY, STATE, ZIP CO 166TH ST N NT PETERSBURG, FL 33709		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
E 004 \$\$=D	0.3/03/2021 to 0.3/04/2021 conversing home was reviewed. Balan compliance with Erne Code of Federal Reg 483.73, Requirement Facilities. The following is a des noncompliance. Develop EP Plan, Re CFR(s): 483.73(a) The [facility] must cor Federal, State and lo preparedness require	ocription of the view and Update Annually mply with all applicable cal emergency ments. The [facility] must	E 004			4/5/21
	emergency prepared requirements of this s	d maintain a comprehensive ness program that meets the section.				
	include, but not be lin elements:					
	and maintain an eme	The [facility] must develop rgency preparedness plan d], and updated at least lan must do all of the				***************************************
		ency Plan. The [hospital or ith all applicable Federal, gency preparedness lospital or CAH] must				***************************************

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 03/26/2021 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & I	MEDICAID SERVICES		OMB NO. 0938-039			
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED			
	105390	B. WING	03/04/2021			

THE STATE OF THE PROPERTY OF T	OTTAL THEOREGO, OTT, OTTAL, ET GOOD
DALANOED WEATHOADE	4250 66TH ST N
BALANCED HEALTHCARE	SAINT PETERSBURG, FL 33709

		105390	B. WING _			03/	04/2021
NAME OF P	ROVIDER OR SUPPLIER		_	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			1	43	250 66TH ST N		
BALANCE	D HEALTHCARE			s	AINT PETERSBURG, FL 33709		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
E 004 4	emergency prepared requirements of this s all-hazards approach. * [For LTC Facilities a Plan. The LTC facilities a Plan. The LTC facilities an emergency prepar reviewed and updated. * [For ESRD Facilities Plan. The ESRD Land Individual Plan. The	less program that meets the action, utilizing an a state of the control of the co	Ef	0004	A. The Emergency Preparedness Program will be updated and reviewed is 04/05/21. B. No other concerns identified. C. On 03/15/21 Administrator re-educated Maintenance Director on policy to update and review Emergency Preparedness Program annually. D. Administrator/designee will conduct quality monitors for the update and review of the Emergency Preparedness Program monthly for three months to ensure compliance with E004. Findings and trends will be brought to QAPI for review Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained	t ew im w.	

					PRINTED: 03/29/2021 FORM APPROVED OMB NO: 0938-0391
TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		105390	B. WING		03/04/2021
NAME OF PROVIDER OR SUPPLIER 105390 S. WING STREET ADDRESS, CITY, STATE 4250 66TH ST N SAINT PETERSBURG, FL PROVIDERS PI PREDIX RECOLLING FOR THE PRECIDENCY FILE RECOLLING	STREET ADDRESS, CITY, STATE, ZIP CODE				
BALANCE	D HEALTHCARE			4250 66TH ST N SAINT PETERSBURG, FL 33709	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
K 000	INITIAL COMMENTS		K 00	o	
	0.3/03-04/2021 at Baia nursing home in St. P Balanced Health Card 42 CFR 483.90(a) an Association (NFPA) 1 requirements for nurs Initial Plan Review: 15 Existing NFPA 220 Construction Number of beduz 299 Census: 215 The following is a des noncompliance. Egress Doors CFR(s): NFPA 101 Egress Doors CFR(s): NFPA 101 Egress Doors in a required mequipped with a latch use of a tool or key fin using one of the following one of the following of the following one locking device only one locking device only one locking device in provision of a following pid removal of occus locks; keying of all loc	anced Health Care, a reteteraburg, Florida. e is not in compliance with d National Fire Protection 01(2012 edition) sing homes. 975 on Type: II (111) scription of the earns of egress shall not be or a lock that requires the on the egress side unless wing special locking	K 22	2	4/5/21

SPECIAL NEEDS LOCKING ARRANGEMENTS

LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6

Electronically Signed 03/26/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other asfeguards provide sufficient protection to the patients. (See instructions.) Except for running homes, the findings stated above are disclossable 80 days, to following the data of survey whether or on a plan of correction is provided. For running homes, the above findings and piles of correction are disclossable 14 days following the date these occurrents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	M APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION D1 - MAIN FED	(X3) DATE	
		105390	B. WING	_		03/	04/2021
NAME OF PR	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
BALANCE	D HEALTHCARE			1	1250 66TH ST N SAINT PETERSBURG, FL 33709		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 222	safety needs of the p ² Clinical or Security Lobeing met. In addition electrical locks that fa upon loss of power to protected by a supersystem and the locked complete smoke date constantly monitored within the locked spar and detection system and testection system and consumer activation 18.2.2.2.5.2, 19.2.2.2. DELAYED-EGRESS I ARRANGEMENTS Approved, listed delay installed in accordance permitted on door assortinary hazard content throughout by an app fire detection system automatic sprinkler system automatic sprinkler system automatic sprinkler system access-Controlled Eginstalled in accordance mermitted. 18.2.2.4.19.2.2.4 ACCESS-CONTROLI ARRANGEMENTS ELEVATOR LOBBY E ARRANGEMENTS	g arrangements for the attent are used, all of the ocking requirements are to, the locks must be ill safely so as to release the device; the building is issed automatic sprinkler of space is protected by a cition system (or is at an attended location ce); and both the sprinkler as are arranged to unlock the	к	222			

by an approved, supervised automatic fire detection system and an approved, supervised

automatic sprinkler system.

DEPARTM	VENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTERS	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	SURVEY LETED
461040	obtatedion	ISENT TOTAL OF TOTAL OF	A. BUILDI	NG 0	t - MAIN FED	COM	
		105390	B. WING _			03/	04/2021
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BALANCE	D HEALTHCARE				250 66TH ST N		
					AINT PETERSBURG, FL 33709		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFD TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 222	Continued From page		K 2	222			
1	18.2.2.2.4, 19.2.2.2.4						
	by:	is not met as evidenced					
		n and interview with the	İ		A. On 3/10/21 delayed egress doors		
	Maintenance Director	, the facility failed to			were identified, and delayed egress		
	maintain delayed egre	ess doors.			signage placed on doors.		
	Cindings included:				B. Maintenance Director/designee		
	Findings included:				conducted a quality monitor of egress doors for signage on 3/10/21 and		
	During the facility tour	with the Regional			identified doors were provided delayed		
	Maintenance Director	and the Maintenance			egress signage.		
		03/2021 and 03/04/2021,			C. On 03/15/21 Administrator		
		m. and 3:30 p.m., the facility			re-educated maintenance department of		
		itify the delayed egress			delayed egress signage for egress doo	rs.	
	doors with required si throughout the facility				 D. Maintenance Director/designee to conduct quality monitors for delayed 		
	conducted with the M				egress signage on egress doors weekl	u.	
		bservations and confirmed			for 4 weeks, then monthly for 2 months		
	the findings.				Findings and trends will be brought to		
					QAPI for review. Quality Monitoring an		
	per NFPA 101 (2012 e	edition) 19.2.2.2.1,			schedule modified based on findings at		
	7.2.1.6.1.1(4)				trends to ensure compliance is achieve and maintained.	d	
K 223	Doors with Self-Closin	na Devices	k:	223	and mankaned.		4/5/21
	CFR(s): NFPA 101	19 5011000					., .
	D	Devices					
	Doors in an exit page	ng Devices ageway, stairway enclosure,					
		oke barrier, or hazardous					
		elf-closing and kept in the					
		is held open by a release					
		7.2.1.8.2 that automatically					
	closes all such doors	throughout the smoke					
		e facility upon activation of:					
	* Required manual fire	e alarm system; and					

* Local smoke detectors designed to detect smoke passing through the opening or a required

smoke detection system; and

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2021 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
AND DI AN OF CODDECTION DEPT TO STATE OF THE PERSON NAMED OF THE P		1	E CONSTRUCTION D1 - MAIN FED	(X3) DATE SURVEY COMPLETED	
		105390	B. WING		03/04/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BALANCE	D HEALTHCARE		- 1	1250 66TH ST N SAINT PETERSBURG, FL 33709	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
K 223	* Automatic sprinkler * Loss of power. 18.22.2.7, 18.2.2.2.8 This REQUIREMENT by: Based on observatio Regional Maintenance Director maintain doors with the second of the	system, if installed; and , 19.2.2.2.7, 19.2.2.2.8 is not met as evidenced is not met as evidenced in and interview with the e Director and the ; the facility failed to elf closing devices. r with the Regional and the Maintenance 021 to 03/04/2021 between m., it was observed that the doors failed to close and style solled utility room in Lifestyle 1 dining room or by elevator oom stainwell exit door ir to Lifestyle 2 the 2nd floor dining room om stainwell exit door or the Lifestyle 2 the Pad floor dining room om stainwell at ground level ducted with the Regional and the Maintenance ith the observations and s. Edition) 19.7.6, 4.6.12,	K 223	A. Self-closing doors on Lifestyle st utility room exit door scheduled to be replaced on 4/28/21, private office dc Lifestyle 1 dining room was repaired 03/08/21, men's restroom door by elevator door closure removed on 3/5 Lifestyle 1 dining room stairwell exit or replaced key pad latch on 03/11/21, housekeeping door in Lifestyle 2 reps 03/05/21, door leafs of the 2nd floor room entry doors adjusted 03/09/21, 2 west exit door from stairwell at grout level new door closure installed 03/22 and the conducted quality monitor of self-closing and latching. Any identified ooncerns were repaired on 3/24/21. C. On 3/15/21 Administrator re-edu maintenance of self-closing doors for proper closing and latching. D. Maintenance Director/designee to conduct quality monitors for proper closing and latching of self-closing dc two times a week for 4 weeks, then weekly for 12 weeks. Findings and trival to ensure of findings and trends to ensure	sor on 5/21, foor silining and and silining and ining cated
K 291		uluutij 6. 1.4.2. l	K 291	compliance is achieved and maintain	ed. 4/5/21

		D HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - MAIN FED	(X3) DATE COMP	SURVEY
		105390	B. WING_			03/	04/2021
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
			- 1	42	50 66TH ST N		
BALANCE	D HEALTHCARE			S	AINT PETERSBURG, FL 33709		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES A MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 291	Continued From page	. 4	к	291			
	is provided automatic 18.2.9.1, 19.2.9.1 This REQUIREMENT by: Based on observatio interview with the Rey the facility failed to mbackup lighting. Findings included: During the facility rec Maintenance Director 9.30 a.m. and 12.90 provide evidence of n emergency lights equ During the facility tou Maintenance Director 12.50 p.m. and 3.90 plocated in the general when tested. An inte the Regional Mainten with the observations	ord review with the Regional on 03/03/2021 between .m., the facility failed to contriby and annual testing of ipped with battery backups. with the Regional on 03/03/2021 between .m., the emergency lights or room failed to operate view was conducted with ance Director concurrent and confirmed the findings.			A. On 3/8/21 The emergency lights located in the generator room were replaced. B. On 3/3/21 Maintenance Director conducted quality monitor on emergen back up lighting for function. There we no other emergency back-up lights identified. C. On 03/15/21 Administrator re-educated maintenance staff on preventative maintenance staff on preventative maintenance monitoring cemergency back-up lighting monthly at annually. D. Maintenance Director/designee with conduct quality monitors of operation of emergency back-up lighting weekly for weeks, then monthly for 2 months, with follow-up initiated as needed to ensure substantial compliance with K291. Findings and trends will be brought to QAPI for review. Quality Monitoring stackedule modified based on findings a trends to ensure compliance is achieve and maintained.	of find fill of 4	
K 325 SS≖D	Alcohol Based Hand CFR(s): NFPA 101	Rub Dispenser (ABHR)	K	325			4/5/21
		Rub Dispenser (ABHR) in accordance with 8.7.3.1,					

unless all conditions are met: * Corridor is at least 6 feet wide

		ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVED IO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G 01 - MAIN FED	(X3) DAT	TE SURVEY MPLETED
		105390	B. WING		0:	3/04/2021
NAME OF P	ROVIDER OR SUPPLIER		' T	STREET ADDRESS, CITY, STATE, ZIP CODE		
BALANCE	D HEALTHCARE			4250 66TH ST N SAINT PETERSBURG, FL 33709		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 325	gallons (0.53 gallons ounces of Level 1 aer * Dispensers shall ha horizontal spacing * Not more than an at fluid or 135 ounces at smoke compartment excluding one individual * Storage in a single sithan 5 gallons compli * Dispensers are not ignition source * Dispensers over car sprindered smoke co * ABHR does not exo C Operation of the dis Section 18.3.2.6.(11) * ABHR is protected at 18.3.2.6. 19.3.2.6. 42 * ABB, and 485 This REQUIREMENT by: Based on observatio Regional Maintenanc on maintain the maxin based hand rub (ABH Findings included: During the facility tou Maintenance Director O3/04/2021, and betw.	dispenser capacity is 0.32 in suites) of fluid and 18 osols we a minimum of 4-foot gareage of 10 gallons of arcsol are used in a single outside a storage cabinet, all dispenser per room smoke compartment greater es with NFPA 30 installed within 1 inch of an opeted floors are in mpartments eed 95 percent alcohol penser shall comply with or 19.32.6(11) gaginst inappropriate access CFR Parts 403, 418, 460, is not met as evidenced in and interview with the eDirector, the facility failed num storage limits of alcohol (R) per compartment.	К3	A. On 03/04/21 alcohol based ha was removed and stored to not ext number of gallons per storage ares. B. On 3/5/21 Housekeeping Director/designee completed qualithmonitor of alcohol-based hand rub required storage amounts. No oth issues identified. C. Housekeeping Director/design re-educate housekeeping staff on a fol alcohol-based hand rub by 04/0 D. Housekeeping Director/design conduct quality monitors of storage	y for er ee will storage 1/21. ee to	

Maintenance Director concurrent with the

observations and confirmed the findings.

		ID HUMAN SERVICES				FOR	M APPROVED
		MEDICAID SERVICES	_				D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		ITRUCTION IN FED		SURVEY PLETED
		105390	B. WING _			03	/04/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STREET	ADDRESS, CITY, STATE, ZIP CODE		
BALANCE	D HEALTHCARE				TH ST N PETERSBURG, FL 33709		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 325		e 6 edition) 19.3.2.6, 8.7.3.1	КЗ	cor will Mo on	npliance of K325. Findings and tr be brought to QAPI for review. Q nitoring and schedule modified ba findings and trends to ensure npliance is achieved and maintain	uality sed	
K 541 SS=D	Rubbish Chutes, Incir CFR(s): NFPA 101	nerators, and Laundry Chu	K 5	41			4/5/21
	Chutes 2012 EXISTING (1) Any existing linen pneumatic rubbish an aniferctly onto any corri resistive construction shall be provided with a fire protection rating shall comply with 9.5. (2) Any rubbish and provided with automa in accordance with 3.3 Any trash chute st collection room used protected in accordan protected by accordance with 19.3. (4) Existing fuel-fed ir by fire resistive construse. 19.5.4, 9.5, 8.4, NFP. This REQUIREMENT by:	or linen chute, including the linen systems, shall be the extinguishing protection 7. All discharge into a trash for no other purpose and noe with 8.4. (Existing teed to discharge into same y automatic sprinklers in 5.9 or 19.3.5.7.) Incinerators shall be sealed ruction to prevent further		A	On 3/5/21 latches were removed	I from	
	Based on observatio Maintenance Director				On 3/5/21 latches were removed ndry chutes to ensure closing.	from	

maintain the laundry chute intake doors.

		ID HUMAN SERVICES				RM APPROVED IO. 0938-0391	
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED		(X3) DA	(X3) DATE SURVEY COMPLETED	
		105390	B. WING _		0	3/04/2021	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
BALANCE	D HEALTHCARE			4250 66TH ST N SAINT PETERSBURG, FL 33709			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 541	Director from 03/03/2 9:00 a.m. and 3:30 p. 4 laundry chutle fire re self-closing, as they v position secured by n interview was conduc Director concurrent w confirmed the finding (Photographic eviden per NFPA 101 (2012 9.5.2 9.5.2 p. P. P. P. P. P. P. S. (2009 e 5.2.3.3.2.1	r with the Maintenance 021 - 03/04/2021 between m., it was observed that 4 of sted intake doors failed to be were found in the open on-approved methods. An ted with the Maintenance rith the observations and s. ce obtained) edition) 19.3.1, 8.6.1, 8.6.2,	K 5	chutes for proper closing and no other concerns identified. C. On 03/15/21. Administrator re-educated maintenance staff on maintaining laundry chutes closure. D. Maintenance Director/designee to complete quality monitors for proper closing of laundry chutes daily for 2 weeks, then 3 times a week for 10 weeks, then monthly to ensure substantial compliance of K541. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained.		4/5/21	
SS=D	CFR(s): NFPA 101 Fire Drills Fire drills include the signal and simulation conditions. Fire drills inexpected times un least quarterly on each with procedures and established routine. between 9:00 PM an announcement may be alarms. 19,7,1.4 through 19.7 This REQUIREMENT by:	are held at expected and der varying conditions, at it h shift. The staff is familiar is aware that drills are part of Where drills are conducted 16:00 AM, a coded be used instead of audible	N/	A. On 3/25/21 fire drills were co	anducted	4021	

Regional Maintenance Director and the

Maintenance Director, the facility failed to conduct

for each shift.

Facility ID: 55229

B. Current residents had the potential to

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND REAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A BUILDING 01 - MAIN FED 105390 R MING 03/04/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4250 66TH ST N BALANCED HEALTHCARE SAINT PETERSBURG, FL 33709 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY K 712 Continued From page 8 K 712 fire drills as required by NFPA 101 or provide he affected. evidence of documented orientation training C. On 3/24/21 Administrator re-educated related to the current fire plan in lieu of Maintenance Director on conducting fire conducting fire drills as per CMS QSO-20-31-All. drills once a shift per quarter and maintaining documentation of such drills. Findings included: On 3/25/21 Maintenance Director created vearly calendar of fire drills to ensure fire During the facility record review with the Regional drills to be conducted once a shift per Maintenance Director between 03/03/2021 and quarter. 03/04/2021, and between 9:00 a.m. and 3:30 D. Administrator/designee to conduct p.m., the facility failed to conduct fire drills or quality monitors of fire drills conducted orientation training for: and documented monthly for 3 months, to 1) 2nd and 3rd shifts for O2 2020 ensure substantial compliance of K712. 2) 1st and 3rd shifts for Q3 2020 Findings and trends will be brought to 3) All shifts for Q4 2020 QAPI for review. Quality Monitoring and schedule modified based on findings and An interview was conducted with the Regional trends to ensure compliance is achieved Maintenance Director and the Maintenance and maintained. Director concurrent with the observations and confirmed the findings. per NFPA 101 (2012 Edition) 19.7.1.6, 19.7.1.7 CMS OSO-20-31-All K 741 Smoking Regulations K 741 4/5/21 SS=D CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids. combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO

SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all

		ID HUMAN SERVICES					M APPROVED
CENTERS FOR MI	EDICARE &	MEDICAID SERVICES	_				0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED			(X3) DATE SURVEY COMPLETED	
		105390	B. WING			03/	04/2021
NAME OF PROVIDER OR	SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		
DAL ANOED (1544 71)				4	250 66TH ST N		
BALANCED HEALTH	CARE			s	AINT PETERSBURG, FL 33709		·
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE	
major en that prohi of the that prohi of the sponsis (4) The r where the (5) Ashth design si smoking (6) Metal devices is the readility permitted the sponsis of the sponsi	ibits smokin- ting by paties bite shall be pequirement of e patient is a ups of nonco- hall be provided in the patient is a ups of nonco- hall be provided is permitted, containers or no which as y available to 1. 9.7.4 QUIREMENT on observatio Maintenanch in the requir loyee smoki included: the facility totu area bite to unce Director are facility totu area that: citility failed to the with self-cic into the facility failed to the with self-cic into the self-cic into the trash call the trash ca	ondary signs with language shall not be required, this classified as not rorbibited. If 18.7 4(3) shall not apply inder direct supervision, mibustible material and safe ted in all areas where with self-closing cover httays can be emptied shall o all areas where smoking is is not met as evidenced in and interview with the e Director, the facility failed ed equipment in the resident	к	741	A. 1. On 3/22/21 non-combustible material self-closing ashtrays were purchased and provided for resident a staff smoking areas. 2. Self-closing montainers clearly marked for cigarette butts only to empty ashtrays into will b provided for resident and staff smoking areas by 4/2/21. 3. On 3/25/21 combustible trash cans were clearly marked for trash only in resident and stanked for trash only in resident and stanked the potential to be affected. C. SDC/designee will re-educate star 04/01/21 on use of proper self-closing metal containers to empty ashtrays int and combustible trash cans to be usect trash only. D. Maintenance Director/designee to complete quality monitors for	etal e g ttaff aff ff by o,	

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED			(X3) DATE SURVEY COMPLETED	
		105390	B. WING		03/	04/2021	
NAME OF PE	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
BALANCE	D HEALTHCARE		- 1	250 66TH ST N AINT PETERSBURG, FL 33709			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE REGULATORY OR LSC (DENTIFYING INFORMATION) TA			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
K 741	Continued From page observations and con per NFPA 101 (2012	firmed the findings.	K 741	ashtrays, self-closing metal containers cigarette butts, and combustible trash cans for trash only daily Monday – Fri for 2 weeks, then weekly for 10 weeks then monthly to ensure substantial compliance of K741. Findings and trew will be brought to CAPI for review. Q Monitoring and schedule modified bas on findings and trends to ensure	day i, nds uality ed		
K 761 SS=D	Maintenance, Inspect CFR(s): NFPA 101	tion & Testing - Doors	K 761	compliance is achieved and maintaine	id.	4/5/21	
	annually in accordance for Fire Doors and Ot Non-rated doors, includation from and smouthly inspected as maintenance program Individuals performing testing possess know that demonstrates ab Written records of insmaintained and are a 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFP. This REQUIREMENT by:	a are inspected and tested ce with NFPA 80, Standard ther Opening Protectives. uding corridor doors to noke barrier doors, are s part of the facility to the door inspections and ledge, training or experience litty. pection and testing are valiable for review.		A. On 03/25/21 the fire rated attic ac	cess		
	Maintenance Director and the facility tour, it	during document review was observed that the ain the fire rated attic access		doors were inspected and documente B. Current residents had the potenti- be affected. C. on 03/24/21 Administrator re-educated Maintenance Director on	d.		

Findings included:

requirement for annual inspection of fire rated attic access doors.

		ID HUMAN SERVICES			FOR	M APPROVED	
		MEDICAID SERVICES	_			D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN FED		(X3) DATE SURVEY COMPLETED	
		105390	B. WING		03	/04/2021	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
			1	4250 66TH ST N			
BALANCE	D HEALTHCARE			SAINT PETERSBURG, FL 33709			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
K 761	Continued From page	e 11 ord review, and interview	K 70	D. Maintenance Director/d	lesignee to		
	with the Regional Mai Maintenance Director	intenance Director and the between 03/03/2021 to yeen 09:00 a.m. and 3:30		conduct quality monitor of do of inspection of fire rated att doors monthly for 3 months	ocumentation ic access		
	p.m., it was observed evidence for the annu	that the facility provided no ual inspection of the fire		substantial compliance of L7 and trends will be brought to	761. Findings O QAPI for		
		ors. In an interview with the		review. Quality Monitoring a			
	total of 30 doors in the	they had said there were a		modified based on findings a ensure compliance is achiev			
	total of 30 doors in the	e bullding.		maintained.	red and		
	per NFPA 1 (2012 edi	ition) 12.4.6.6, 12.4.6.9					
K 914	Electrical Systems - N	Maintenance and Testing	K 9	14		4/5/21	
SS=D	CFR(s): NFPA 101						
	Electrical Systems - N	Maintenance and Testing					
	Hospital-grade recept						
		deep sedation or general					
		tered, are tested after initial					
		ent or servicing. Additional					
	testing is performed a	ance data. Receptacles not					
		de at these locations are					
		exceeding 12 months. Line					
		M), if installed, are tested at					
	intervals of less than	or equal to 1 month by					
		t switch per 6.3.2.6.3.6,					
		visual and audible alarm. For					
		mated self-testing, this					
		ned at intervals less than or					
		.IM circuits are tested per pair or renovation to the					
	electric distribution sy						
		d tests and associated					
		ns, containing date, room or					
	area tested, and resu						
	6.3.4 (NFPA 99)						

by:

This REQUIREMENT is not met as evidenced

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND REAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 01 - MAIN FED 105390 R MING 03/04/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4250 66TH ST N BALANCED HEALTHCARE SAINT PETERSBURG, FL 33709 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 914 Continued From page 12 K 914 Based on record review and interview with the A. On 3/25/21 annual receptacle testing Regional Maintenance Director, the facility failed completed and documented. B. Current residents had the potential to to test receptacles and or provide documented performance data for receptacles located in be affected. patient care rooms and bed locations. C. On 3/24/21 Administrator re-educated Maintenance Director on requirement for Findings included: electric receptacles to be tested annually and documented. During the facility record review with the Regional D. Maintenance Director to conduct Maintenance Director between 03/03/2021 to quality monitoring of annual testing of 03/04/2021, and between 09:30 a.m. and 3:30 electric receptacle and documentation p.m., the facility failed to provide evidence of the monthly for 3 months to ensure annual receptacle inspection and testing. An substantial compliance of K914. Findings interview was conducted with the Regional and trends will be brought to QAPI for Maintenance Director concurrent with the review. Quality Monitoring and schedule observations and confirmed the findings. modified based on findings and trends to ensure compliance is achieved and per NFPA 99 (2012 edition) 6.3,3.2, 6.3.4,1,3 maintained.