STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105390	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Balanced Healthcare	4250 66th St N Saint Petersburg, FL 33709

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews the facility failed to provide adequate supervision to two (#4 and #5) of two residents which resulted in an physical altercation perpetrated by one resident (#4).Findings included:Review of the facility's reported incident log showed a resident - resident physical abuse incident had occurred on 3/8/26 between Resident #4 and Resident #5.On 3/26/26 at 10:37 a.m. Resident #5 was observed in room lying on bed with eyes closed.Review of Resident #5s progress notes showed a note dated 3/8/26 at 10:11 p.m. The note referred to a linked incident: Resident to Resident 3/8/26 at 4:20 p.m. go to incident. The note revealed Staff C, Licensed Practical Nurse (LPN) was sitting at desk charting with staff members then writer looked up and see (Resident #5) get hit on the right side of the face by another resident. CNA and writer got up and redirected resident to room, (Resident #5) stayed in his chair till we came to check on him, (Resident #5) has no complaints of pain or discomfort.Review of a psychiatry provider note dated 3/9/26 showed during the last visit Resident #5 was stable and was recently in a physical altercation with another patient where (Resident #5) was the victim. The resident denied pain and did not know why he was hit, doesn't worry this will happen again, (and) appeared to be at psychosocial baseline. Review of Resident #5s admission Record showed the resident was admitted on [DATE] and 5/28/25. The record revealed diagnoses not limited to psychotic disorder with hallucinations due to known physiological condition, generalized anxiety disorder, paranoid schizophrenia, recurrent moderate major depressive disorder, and pseudobulbar affect. Review of Resident #5s comprehensive assessment revealed a Brief Interview of Mental Status (BIMS) score of 9 out of 15, indicative of a moderate cognitive impairment.Review of Resident #5s care plan revealed the following focuses and interventions:Has the following behavior problem(s): rights on wall with pens or markers, places pictures on wall with toothpaste, howls and makes disruptive noises at times, will sit down in various places in the halls, scratches walls, floors, and ceilings with fork or spoon, hear's things, resident to resident non-aggressor, will take foods from meal trays and discard in room trash at times, continues to be non-compliant with fluid restriction, continuously clapping hands/ screaming, calling 911 stating (pronoun) drink soap, (and) throwing stuff on floor. The focus was revised on 3/23/26.Has a communication problem due to impaired cognition, revised on 10/01/24.2.Review of Resident #4s progress notes showed on 3/8/26 at 4:30 p.m. Resident remains in room, 1: 1 supervision in progress, no further aggression nor combative Behavior noted. Resident whom affected by Behavior denied any pain nor discomforts.Review of Resident #4s progress notes showed on 3/8/26 the psych provider returned call and was updated on the resident's behavioral status as well as follow up (f/u) interventions a well as 1:1 supervision and the facility was notified of psych intent to follow up with a telehealth visit tomorrow.Review of psychiatry note on 3/9/26 showed the reason for the encounter was it had been reported Resident #4 was unstable requiring psychiatric assessment, as per collected information patient was recently in a physical altercation where he was the aggressor. Patient stated the other patient had rattle snakes who were trying to hurt him. The note revealed per collected information and interview it appears that patient is unstable.On 3/26/26 at 10:34 a.m. Resident #4 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was observed in room lying on bed. The resident stated the facility took good care of him and no behaviors were observed. The resident's roommate was lying in bed and there was no observed interaction between the two residents.Review of Resident #4s admission Record showed the resident was admitted on [DATE] and 3/14/26. The record included diagnoses not limited to unspecified dementia unspecified severity with other behavioral disturbances, reoccurring mild major depressive disorder, other specified persistent mood disorders, and generalized anxiety disorder.Review of Resident #4s quarterly Minimum Data Set (MDS) on 2/17/26 showed the resident's Brief Interview of Mental Status (BIMS) score was 11 of 15 indicating a moderate cognitive impairment. The comprehensive assessment revealed the resident did not exhibit any behaviors during the assessment period. The facility was requested to provide the BIMS section C of MDS dated [DATE]. The facility provided an incomplete BIMS assessment dated [DATE].Review of Resident #4s care plan included the following focuses with related interventions:Has impaired cognitive function/ impaired thought processes related to (r/t) dementia.Is/has Potential to be physically aggressive related to (r/t) dementia and poor impulse control - punched mirror in bathroom breaking glass. The focus was initiated in revised on 5/12/25.Has potential for psychosocial well-being problem related to (r/t) anxiety (and) depression.Has the following behaviors: wandering/exit-seeking, attempting to take television (TV) down on smoke patio, Risk for harm to others/ physically aggressive, lying in shower letting water run over him, striking peer with wet floor sign, pulling fire alarm, wandering about taking cups (and) drinks from rooms of peers, takes personal clothing from rooms and places on clothing in other places, ambulates about without a shirt, pulling call light out of wall, broke mirror in bathroom and attempted to break mirror in room over a dresser, slapped peer, and grabbed peer by wrist. The focus was revised on 1/26/26. The interventions revealed the following: Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, in situations. Document behavior and potential causes. An interview was conducted on 3/266/26 at 11:23 a.m. with Staff D, Certified Nursing Assistant (CNA). The staff member stated Resident #4s behaviors were walking around and stealing food, staff have to constantly tell resident to get out of other rooms. The staff member stated Resident #5 has the behaviors as walking up and down hallways, yelling and screaming. The staff member was not in attendance for the incident involving Resident #4 and #5.An interview was conducted on 3/26/26 at 12:20 p.m. with Staff A, Licensed Practical Nurse/Unit Manager (LPN/UM). The staff member reported nurses document every shift if a resident was on 1:1 or on a 15-minute form if on 15 minute checks. During a continued interview on 3/26/26 at 1:13 p.m. the staff member reported not being at facility during the altercation between Resident #4 and #5 but had heard Resident #5 had rolled up (to nursing station) in wheelchair, Resident #4 had been seen walking in hallway and hit Resident #5, saying he did not like Resident #5. Staff A stated there had never been a problem between the two residents before, were roommates.An interview was conducted on 3/26/26 at 1:48 p.m. with the Risk Manager (RM), Regulatory Compliance Consultant (RCC) , Director of Nursing (DON) and the assistant DON (ADON). The RM reviewed the incident between Residents #4 and #5. The RM reported the assigned CNA (Staff B) and Staff C, LPN, on Sunday 3/8/26, were at nursing station and Resident #5 was sitting near nursing station in wheelchair trying to talk with the staff members. Resident #4 was seen walking down hallway from conference room area, saw Resident #5, stopped to say something to the resident and punched Resident #5 to the right side of face. The RM stated Staff B didn't know if it was closed fist or open handed. Staff C had reported seeing the hit and following the incident asked why, Resident #4 had responded I don't like him. The RM stated Resident #4 does not have a lot of language; one or two words. The RM stated the psych Nurse Practitioner (NP) had been rounding on 3/8/26 and when asked about the incident Resident #4 had reported rattlesnakes were trying to get Resident #5. The RM reported speaking with Resident #4 on 3/8/25 and couldn't get any information was babbling. The RM clarified the assistant administrator had reported the incident and the RM interviewed Resident #4 on Monday morning (3/9/26) and the resident didn't remember the incident. The day after the event (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the RM reported interviewing Staff B and Staff C. Staff C had reported sitting at desk charting and saw Resident #5 get hit on right side by Resident #4, the staff member jumped up, separated the residents and placed Resident #4 on 1:1 supervision. The RM did not know who had done the 1:1 supervision for Resident #4 immediately following the incident. The RM stated the nurse documents on 1:1 every shift and if a resident had behaviors the aide would notify the nurse. The RM stated Resident #4 was on 1:1 supervision until the next day, 3/9/26. The RM stated Staff B reported Resident #5 was at the nursing station, Resident #4 was walking in the hallway and hit Resident #5 on the right side of face, Staff B and C separated the residents and Resident #4 was placed on 1:1. The RM reported no one else had witnessed the incident and had not interviewed any other staff as Staff B had witnessed it. The RM allowed this writer to review Staff B's written statement, Resident #4 (statement identified resident by room number) was walking in hallway, walked toward Resident #5 and punched him, resident back turned so couldn't see if it was open or closed fist but Resident #5 hat came off after the punch. The nurse asked Resident #4 why and the resident said he didn't like (Resident #5). The RM did not have a written statement from Staff C who also witnessed the incident. The RM stated the incident had been refuted and being schizophrenic they can be very impulsive. The RM stated the incident was refuted based on policy Resident #4 did not have intent, no harm to Resident #5, and Resident #5 had told psychiatry (the next day) he had seen rattlesnakes.A request for the staff schedule on 3/8/26 was made during the RM interview, the facility failed to provide it.Review of policy - Abuse, Neglect and Exploitation, revised 11/29/22, revealed It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policy and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The policy defined Abuse as The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse in certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.VI. Protection of ResidentThe facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: C. Increased supervision of the alleged victim and residents.