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	11/07/2024

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50570 Based on observations and interviews, the facility did not ensure a clean, sanitary, and homelike environment for three (1 [NAME] [also known as the secured unit], 1East, and Lifestyle 2) out of six Wings. Findings included: On 11/4/24 at 10:13 a.m., a tour of the 1 East wing was conducted. Observations of room [ROOM NUMBER] revealed the privacy curtains between bed A and B with stains and dirty. Further observations of room [ROOM NUMBER] revealed paint was peeled from the ceiling above the window. An observation of the bathroom shared by rooms [ROOM NUMBERS] revealed a detached shower head, white washcloth, and a light cover fixture on the shower seat. Further observations of the floor of the shower revealed multiple unknown particles and debris that were black and white colored. Further observations of the bathroom revealed multiple brown stains on the seat of the toilet. On 11/4/24 at 10:27 a.m., an observation of room [ROOM NUMBER] revealed two dresser knobs were separated from the drawer. An observation of the window revealed multiple, individual blinds were broken and/or missing. Observations of the ceiling, above the window, revealed paint was peeled from the ceiling and pieces of plaster were separated from where the wall meets the ceiling. An observation of the bathroom revealed the border trim was separated from the wall. Further observation of the bathroom revealed a brown and yellow substance on the front of the sink. A blue-colored cleaning rag was observed on one of the residents' bedside table. On 11/4/24 at 10:37 a.m., an observation of room [ROOM NUMBER] revealed one of the dresser knobs was separated from the drawer. An observation of the area above the window revealed the paint was separated from the ceiling in multiple areas. An observation of the floor and the leg of the bedside table, by the B Bed, revealed brown substances in multiple areas. An observation of the bathroom shared by room [ROOM NUMBER] and 103 revealed multiple unknown black particles on the shower floor. An observation of the shower curtain revealed it was dirty and stained. Further observations of the bathroom revealed multiple black particles to the left of the toilet. Another observation of the bathroom revealed a used paper towel on the floor and toilet paper between the tank and seat. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/4/24 at 10:46 a.m., an observation of room [ROOM NUMBER], to include the window, revealed two blind panels were missing. Further observation of room [ROOM NUMBER] revealed the paint surrounding the air conditioning unit was separated and peeled from the wall. Multiple holes were observed in the wall by the air conditioning unit. On 11/4/24 at 10:52 a.m., an observation of the bathroom, shared by room [ROOM NUMBER] and 101 revealed a hole in the ceiling surrounded by a black colored ring. Further observation of the bathroom revealed the bottom of the shower curtain appeared dirty with a dark brown and black color. An observation of the bathroom floor revealed multiple black, white and grey colored debris and unknown particles. On 11/4/24 at 11:16 a.m., an observation of room [ROOM NUMBER] revealed the ceiling closest to the bathroom, had stains that were dark brown and black colored. Further observation of that area revealed a crack/small opening where the wall and ceiling met. The same wall observed had cracks towards the top of the ceiling. An observation of the bathroom revealed a shower curtain stained with a dark brown substance. Observations of the ceiling, above the window in the bathroom, revealed an open area with exposed metal pieces. The windowsill in the bathroom had a piece of knotted hair that was observed. Further observation of the bathroom ceiling revealed a hole around the water sprinkler where the paint was separated from the ceiling. On 11/4/24 at 11:19 a.m., an observation of room [ROOM NUMBER] revealed the wall on the left on the B bed side had multiple scratches which caused the paint to separate from the wall. An observation of the bathroom revealed the sink was full of liquid that contained chunks of a white and yellow colored substance. An interview with the residents in room [ROOM NUMBER] revealed the sink had not been functional for weeks. They stated the maintenance team was made aware, but the sink was not fixed. On 11/4/24 at 11:25 a.m., an observation of room [ROOM NUMBER] revealed the bottom dresser drawer was not there. Further observations of room [ROOM NUMBER] revealed the wall behind the head of the bed, on the B side, had multiple scratches which caused the paint to separate from the wall. On 11/4/24 at 11:44 a.m., an observation of the floor in room [ROOM NUMBER] revealed a dead cockroach, food wrappers and other unidentified items. Further observation of room [ROOM NUMBER] revealed missing and broken window blinds in the A bed area. Observations by the window, on the B bed side, revealed black spots and paint separated from the ceiling. On 11/4/24 at 12:00 p.m., an observation of room [ROOM NUMBER] revealed a hole in the wall, to the right of the outlet by the air conditioning unit. Further observation of that area revealed cracks and paint separated from the wall by the door frame of the bathroom. An observation of D bed revealed wood laminate and plaster was missing from the bottom of the foot of the bed. Further observation of room [ROOM NUMBER] revealed a dark brown substance on the floor, towards the bathroom door. Observations in the bathroom revealed the border trim had holes and started to separate from the wall. Small cracks and holes were observed by blue and white colored tile on the bathroom wall. A screw on the right side of the toilet was observed on its side, laying on the bottom part of the toilet. An observation of the ceiling, in the bathroom of room [ROOM NUMBER], revealed a small hole and black spots surrounding the water sprinkler. On 11/4/24 at 12:16 p.m., an observation of the 1 East hallway, between rooms [ROOM NUMBERS], revealed caution tape and wet floor signs on top of missing tiles on the floor and wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/4/24 at 12:54 p.m., an observation of room [ROOM NUMBER] revealed a brown substance on the blinds closest to the bathroom door. Further observation of room [ROOM NUMBER] revealed a hole above the outlet, to the right of the air conditioning unit. Another hole was observed to the right of the air conditioning, between the unit and the outlet. Observations of the air conditioning revealed the paint around the unit and the outlet was separated from the wall. On 11/4/24 at 1:02 p.m., an observation of the assisted dining area on the first floor revealed multiple ceiling tiles with small to large water stains. The ceiling tile above table 10 was observed with a large water stain that covered the majority of the tile and appeared warped/bubbled. An observation of the ceiling above the exit sign/door revealed a large ceiling tile was missing. On 11/4/24 at 1:47 p.m., an observation of the end of the 1 East hallway, in front of room [ROOM NUMBER], revealed a dead cockroach, [Vendor name] individual packet, and other unidentified items/debris. On 11/5/24 at 10:18 a.m., an observation of room [ROOM NUMBER] revealed the area above the window had paint that was separated from the ceiling. Observations of multiple areas in the ceiling above the window were cracked and had chipped paint/plaster. On 11/5/24 at 3:20 p.m., an observation was made in room [ROOM NUMBER], Lifestyle 2 unit. An observation of the Air Conditioner (AC) revealed two wet towels underneath the unit. The towels observed were slightly discolored with a tan to light brown color, and saturated with water. The residents in room [ROOM NUMBER], Lifestyle 2 stated the AC unit had been repaired twice, but continued to leak water. The residents stated the staff knew about this and explained they [staff] are the ones who placed the towels under the AC unit. During the interview and observation, a staff member entered the room. The unidentified staff member observed the AC unit and when asked about it she said, Have you seen this place. She stated she would tell the nurse about the AC unit that leaked water. On 11/6/24 at 9:45 a.m., an observation of room [ROOM NUMBER] revealed the sink was fixed and did not have the same concerns that were identified on 11/4/24. The residents in the room stated it was fixed after the observation made on 11/4/24. Further observations of the bathroom revealed the toilet was off center and shifted to the right side. Observations of the call light system in the bathroom revealed it did not have a cord, and it appeared to be separated from the wall. A box of gloves, with a few gloves coming out from the top, were observed on the bathroom floor next to the toilet. On 11/6/24 at 11:39 a.m., an observation of the secured unit in 1 [NAME] revealed the nourishment room ceiling had paint separated from it, and plaster exposed. Patches of exposed plaster and concrete were observed in the ceiling of the nourishment room. On 11/6/24 at 12:00 p.m., an interview was conducted with Staff F, Registered Nurse (RN). He stated room [ROOM NUMBER], in the Lifestyle 2 wing, has a trash can in the room to catch water that comes from the roof when it rains. Staff F, RN stated the ceiling keeps getting patched, but the actual problem has not been fixed. He stated, The room has been that way for a long time. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/6/24 at 12:50 p.m., a tour and interview with the Director of Maintenance Director (DOM) was conducted related to rooms in the secured unit and1 West. An observation in room [ROOM NUMBER] in 1 [NAME] revealed the shower area was not clean and when he turned on the water in the shower, there was low water pressure. An observation of room [ROOM NUMBER] in 1 [NAME] revealed the bathroom tiles were separated from the ceiling and yellow-colored spots were observed throughout the ceiling. An observation of room [ROOM NUMBER] in 1 [NAME] revealed the call light was pulled out of the wall. An observation of room [ROOM NUMBER] in 1 [NAME] revealed the bathroom door was not able to close. An observation of room [ROOM NUMBER], in the unit known as Lifestyle 2, was observed with a large, commercial size trash can in the left corner of the room. The ceiling of room [ROOM NUMBER], specifically in the left corner over the trash can, was observed with water damage and paint separated from the ceiling. An interview was conducted with the DOM, who stated his process for identifying concerns is staff putting in a work order in the [Vendor name] system. He stated when a work order is submitted, he will receive an alert to his phone. The DOM stated he was not aware of the concerns observed in the secured unit and in room [ROOM NUMBER], in the Lifestyle 2 unit. He stated he had not been to the secured unit in 3 months, and he was not aware of the issues. The DOM stated, If staff don't put a work order in the system, then I'm not aware that things need to be repaired in the building. On 11/6/24 at 1:29 p.m., room [ROOM NUMBER] had the same concerns observed on 11/4/24. On 11/6/2024 at 2:20 p.m., an interview was conducted with the DOM, in room [ROOM NUMBER] on the Lifestyle 2 unit. The DOM observed the towels under the AC unit. The DOM stated he had not received a work order for this AC unit. The DOM stated anyone in the facility can place a work request for maintenance through the facility's electronic software. The DOM stated he would immediately address the AC unit leaking water. On 11/7/24 at 11:52 a.m., a tour of the assisted dining room on the first floor was conducted with the DOM. An interview with the DOM at 11:54 a.m. regarding the concerns in the assisted dining room revealed the maintenance team who was assisted by the housekeeping staff members, had worked on replacing the ceiling tiles. He stated he thought the staff members were done with the project. The DOM stated he did not follow up to confirm the project was completed. During the observation and interview, 6 ceiling tiles were identified as needing to be replaced. The DOM stated the ceiling tiles were previously wet and needed to be replaced. An observation of the ceiling by the exit sign, in the assisted dining room, revealed there was water dripping into a large, commercial sized garbage can. There was a white towel observed next to the trash can. The DOM stated, I had no idea about the leak in the dining room. He stated the leak could be coming from an air conditioning unit on the 2nd floor. The DOM stated it was not the maintenance team who put the trash can and towel under the missing tile that was leaking water. On 11/7/24 at 12:06 p.m., a tour of the 1 East unit was conducted with the DOM, Area Manager for Housekeeping, and Staff E, Housekeeping. The following rooms/areas, to include bathrooms and hallways, were toured: 101, 102, 104, 106, 107, 108, 110, 112, 113, 117, 118, and 1 East hallway by room [ROOM NUMBER]. Staff E, Housekeeping stated the housekeeping staff work from 7 a.m. to 3:30 p.m. He stated housekeeping staff don't clean while the residents are in their rooms. At 12:09 p.m., the Area Manager for Housekeeping stated they recently had an issue with staffing, specifically in 1 East. She stated a staff member in housekeeping who was previously a, Floater, is now permanently in 1 East as of Monday, 11/4/24. During the tour, a dead cockroach was observed in the bathroom shared by room [ROOM NUMBER] and 103. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:11 p.m., the Area Manager for Housekeeping stated two days ago new shower curtains were ordered for the facility. She stated over 40 new privacy curtains arrived this week, however, they are currently in the laundry area. At 12:22 p.m., the DOM stated he was not aware of most of the concerns observed in 1 East, except for the hallway by room [ROOM NUMBER]. He stated the maintenance team is in progress with laying down the tiles in that area. Regarding the concern with the sink in room [ROOM NUMBER], the DOM stated he does not know who repaired it and could not provide a completed work order because he does not have one. The DOM stated he expected Certified Nursing Assistant's (CNA's) and Nursing staff to put in work orders in the [Vendor name] system. He stated all staff members have access to the [Vendor name] system to put in work orders, except for housekeeping and dietary staff. He stated he does not conduct room audits. He stated, Angel rounds would be better. On 11/7/24 at 12:26 p.m., an observation of room [ROOM NUMBER], in the Lifestyle 2 unit, and interview with the DOM revealed the ceiling that is leaking water has been scraped and repatched multiple times. He stated the ceiling will be scraped and repatched again until the roof is repaired. The DOM stated they are currently in a cost comparison/bidding process with two roofing companies. He confirmed the roofing company came to the facility in September and October of this year to assess the roof. On 11/7/2024 at 12:45 p.m., an observation and interview was conducted in room [ROOM NUMBER], Lifestyle 2 unit. The AC unit continued to leak water, with a puddle of water observed close to the electrical cable for the unit. One of the residents, who was in the room during the observation, stated an individual came yesterday to repair the AC unit. An interview was conducted with Staff K, CNA and Staff F, RN. Staff K, CNA stated a work order was placed in the computer. Staff F, RN stated he assisted Staff K, CNA and showed her how to place a work request for room [ROOM NUMBER]'s leaking AC unit. On 11/7/2024 at 1:21 p.m., an interview was conducted with the DOM. The DOM was observed looking at his phone and confirmed he did not see a work order for room [ROOM NUMBER], in the Lifestyle 2 unit. The DOM confirmed he was aware of the leak, as discussed on 11/6/24, and stated he would have the leak immediately addressed. A review of the facility policy titled, Safe and Homelike Environment, with a revised date of 4/11/23, revealed the following, Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safety and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Further review of the policy under, Policy Explanation and Compliance Guidelines, revealed the following, 1. The facility will create and maintain, to the extent possible, a homelike environment that de-emphasizes the institutional character of the setting. 3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. 9. General Considerations: . e. Report any furniture in disrepair to Maintenance promptly. f. Report any unresolved environmental concerns to the Administrator. Photographic Evidence Obtained.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on observation, record review and interview the facility did not implement a comprehensive person-centered care plan consistent with resident rights for one resident (#51) out of eight residents sampled. Findings included: On 11/04/2024 at 10:30 a.m., an observation and interview were conducted with Resident #51 in her room. Resident #51 stated she did not consistently get her bath twice a week and had not had her hair washed in over two months. Resident #51 stated she would like to have a bath consistently at least twice a week and would like to have her hair washed. Resident #51 stated she had asked for this but stated she did not get this offered to her. Resident #51 preferred to stay in bed and have a bed bath and stated she did not know how they would wash her hair. A review of Resident #51's Admission Record showed diagnoses: Bipolar disorder Type 2 diabetes mellitus Depression Essential hypertension Post-traumatic stress disorder, chronic Paranoid schizophrenia Muscle weakness, general Morbid obesity A review of Resident #51's care plan showed a Focus area of Behavior problem related to false allegations, Androphobia (extreme fear of men), declines care and declines getting out of bed. Interventions include but are not limited to: Two staff persons for all care No Male CNAs (Certified Nursing Assistants) A review of the Minimal Data Set (MDS) dated [DATE] Category C- Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. In Section GG-Functional Abilities and Goals, item GG0130- Self Care, showed Resident #51 dependent for toileting hygiene, shower/bathe, lower body dressing and putting on and off footwear. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #51's past 30-day BB-Bowel and Bladder Elimination task showed Resident #51 had been provided incontinence care by male CNAs. Photographic evidence obtained. On 11/07/24 9:50 a.m., an interview was conducted with Staff O, Minimum Data Set Coordinator/Licensed Practical Nurse (MDS coordinator/LPN). Staff O, MDS/LPN stated Resident #51 was care planned for no male CNAs. Staff O, MDS/LPN reviewed the toileting task documentation and agreed male CNAs had provided incontinence care. Staff O, MDS/LPN stated during the last care plan meeting she recalled Resident #51 stated she was ok with male CNAs but the plan of care decision amongst the facility was to continue with no male CNAs. On 11/07/24 at 12:50 p.m., an interview was conducted with Staff K, CNA. Staff K, CNA stated she did not know of Resident #51 requiring no male CNAs. On 11/07/2024 at 12:53 p.m., an interview was conducted with Staff J, Licensed Practical Nurse (LPN). Staff J, LPN stated Resident #51 was not to have male CNAs but the resident had not stated any concerns to her. On 11/07/2024 at 12:55 p.m., an interview was conducted with Staff L, CNA. Staff L, CNA stated Resident #51 was not to have male CNAs and stated the resident had not voiced any concerns to her. On 11/07/2024 at 12:57 p.m., an interview was conducted with Staff M. CNA. Staff M, CNA stated she was not aware of Resident #51's concerns for no male CNAs. On 11/07/2024 at 1:25 p.m., an interview was conducted with Staff N, CNA. Staff N, CNA stated Resident #51 had to have no male CNAs in the past but stated she thought not anymore. A review of Resident #51's (Brand name of a nursing worksheet that summarizes patient information) under Special Considerations showed the following: Two persons present for all care No male CNAs 11/07/2024 at 4:00 p.m., an interview was conducted the Director of Nursing (DON). A review of the past 30-day BB-Bowel and Bladder Elimination task was reviewed. The DON agreed male staff members had provided incontinence care but stated the resident had stated she agreed with all staff providing care and would have psychiatry come see the resident for an evaluation on this subject matter. A review of the facility's policy titled, Comprehensive Care Plans revised 7/27/2022, showed a policy statement: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment. The Comprehensive Care Plan showed the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally- competent and trauma -informed. 2. 3. The comprehensive care plan will describe at a minimum the following: a. The services that are to be furnished to attain or maintain their resident's highest practicable physical, mental and psychosocial well-being. b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment. c. g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger- specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re- traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. 4. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MSDS assessment. 6. The comprehensive care plan will include measurable objective and time frames to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. 7. 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on record review and interview, the facility did not honor the wishes for Activities of Daily Living (ADL) related to bathing of body and hair for two residents (#51 and #100) out of eight residents sampled. Findings included: 1. On 11/04/2024 at 9:30 a.m., observations and interviews were conducted with Resident #51 and #100. Resident #51 stated she had not consistently received her baths in weeks and her hair had not been washed in over a month. Resident #51 stated she preferred bed baths and stated baths were scheduled three times a week but could not state the days. Resident #100 stated she did not get her baths three times a week and her hair had not been washed in over a month. Resident #100 stated she preferred to have bed baths. A review of the facility's 30-day bathing task showed Resident #51 had three baths in 30 days. Resident #51's bathing schedule on the bathing task showed shower/bath every Monday, Wednesday and Friday during the 3-11 shift. A review of Resident #51's Minimum Data Set (MDS) dated [DATE], under Section C-Cognition, showed a Brief Interview for Mental Status (BIMS) of 15 which indicated intact cognition. Section GG-Functional Abilities, area GG0130- Self -Care showed Resident #51 was dependent for shower/bathe self. A review of Resident #51's care plan dated 9/02/2024 showed a Focus Area of ADL-Care Deficits related to decreased ability to perform ADLs in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion and toileting due to impaired physical functioning related to weakness and morbid obesity. Resident #51 requires substantial assist with most ADLs. Interventions/Tasks include but are not limited to: Bathing/Showers: dependent on staff for bathing/showering on Tuesday, Thursdays and Saturdays 7-3 shift. 2. A review of the facility's 30-day bathing task showed Resident #100 had three baths in 30 days. Resident #100's bathing schedule on the bathing task showed shower/bath every Tuesday, Thursday and Saturday during the 3-11 shift. A review of Resident #100's Minimum Data Set (MDS) dated [DATE], under Section C-Cognition, a Brief Interview for Mental Status (BIMS) showed a 13 which indicated intact cognition. Section GG-Functional Abilities, area GG0130- Self -Care showed Resident #100 dependent for shower/bathe self. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #100's care plan dated 9/27/2024 showed a focus area of dependent on staff for meeting emotional, intellectual, physical and social needs related to immobility, enjoys animals, crochet, visits from staff, outdoors as tolerated, TV, enjoys attending beauty shop as needed/visits. The goal for this focus area: resident will participate in 1:1 visit of choice as tolerated two times a month through next review date. Interventions/Tasks include: all staff to converse with resident while providing care, invite the resident to scheduled activities, provide 1:1 opportunity in room resident enjoys crocheting, and outdoors as tolerated. A focus area of ADL self-care performance deficit related to dementia, chronic pain and fibromyalgia. Interventions include but are not limited to: Bathing/Showering: The resident is dependent on staff for bathing/showers. Scheduled shower days are Monday- Wednesday and Friday on 7-3 shift. Resident's preference is bed bath. On 11/07/2024 at 4:00 p.m., an interview was conducted with the Director of Nursing (DON). A review of the documented shower/bath tasks were reviewed for Residents #51 and #100. The DON agreed of the limited baths provided but stated it could be a documentation concern by the Certified Nursing Assistants. A review of the facility's policy titled, Activities of Daily Living (ADLs), revised on 11/22/2021 showed the following policy statement: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care 2. Transfer and ambulation 3. Toileting 4. Eating to include meals and snacks, and 5. Using speech, language or other functional communication systems. A review of the facility's policy showed the following policy explanation and compliance guidelines: 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. . 5-The facility will maintain individual objectives of the care plan and periodic review and evaluation.

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Balanced Healthcare	4250 66th St N Saint Petersburg, FL 33709

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 39866 Based on observations, interviews, and record reviews, the facility failed to provide quality care and services related to wound care management and treatment for two (#377 and #378) out of three sampled residents. Findings included: 1. Review of Resident #378's Admission Record revealed he was admitted to the facility with medical diagnoses of congestive heart failure, dementia with behavioral disturbances, unsteadiness on feet, cellulitis of other sites, mood affective disorder, and anxiety disorder. An observation was conducted on 11/04/24 at 10:30 AM. Resident #378 was observed sitting in the hallway in a recliner chair. He was observed to have bandages on his bilateral upper arms. He said he got the injuries from slipping and falling at home. He said he was not sure how often they changed the bandages. His left upper arm bandage was dated 11/4 and was clean and intact. The right upper arm bandage was intact and clean but dated 10-31. An observation was conducted on 11/4/24 at 3:39 PM. Resident #378 was observed self-propelling in his wheelchair down the hallway. His right upper arm bandage was intact dated 10-31. His left upper arm bandage was intact, clean, and dated 11/4. There was no bandage on his right elbow. An observation was made on 11/5/24 at 10:00 AM. Resident #378 was observed in bed, eyes closed. His right upper arm bandage was observed intact dated 10/31. His left upper arm bandage was soiled with red drainage dated 11/4. There was no bandage on his right elbow. An observation was made on 11/6/24 at 8:58 AM. Resident #378 was observed sitting up in bed eating his breakfast. He was observed with a bandage on his right upper arm that was not intact and dated 10-31. His left elbow was observed with scabs on it. He also had a bandage on his left upper arm, not intact and soiled with red drainage near the elbow dated 11/4. The dressing was observed below his wound on his upper right arm and the wound was exposed. The wound was circular with a moist, pink, wound bed. He said the bandages on his arms need to come off. Review of Resident #378's physician order with a start date of 10/22/24 revealed right elbow skin tear cleanse with normal saline, apply xeroform and bordered gauze. One time a day. There were no other physician orders for skin treatment. Review of Resident #378's October and November medication administration record (MAR) and treatment administration record (TAR) revealed a physician order with a start date of 10/22/2024 for right elbow skin tear cleanse with normal saline, apply xeroform and bordered gauze. One time a day. The physician order was signed off as completed every day except 10/25/24 including November 5th and 6th. There was no other skin care documentation on the October and November MAR or TAR for the right or left upper arm. Review of Resident #378's progress notes revealed a note dated 10/25/24 at 6:18 AM, .Bandages to right and left arms intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an incident note dated 10/22/24 at 10:19 PM revealed Resident found on the floor of his room, lying on his back with his legs stretched out in front of him. resident [sic] last seen in bed about an hour prior to him being found. resident [sic] assessed for injury then assisted from the floor by 3 staff members and placed in a recliner chair. resident [sic] has skin tear to right upper arm. Area cleansed with normal saline, tao [triple antibiotic ointment], and dry dressing applied. POA [Power of Attorney] and MD [Medical Doctor] notified. Review of Resident #378's Weekly Skin Evaluation dated 10/26/24 revealed Skin Condition: Skin Tear(s), left arm. Review of Resident #378's Weekly Skin Evaluation dated 11/5/24 revealed Skin Condition: Skin Intact An interview was conducted on 11/6/24 at 9:10 AM with Staff A, Registered Nurse (RN). She said she was taking care of Resident #378, and she reviewed Resident #378's medical record and said the resident came in on 10/16/24 and there were bandages noted on his left and right upper arm from the hospital because of skin tears. Staff A, RN reviewed Resident #378's physician orders and said there was only an order to apply a dressing to his right elbow daily. Staff A, RN went into Resident #378's room and confirmed the residents' right upper arm had a bandage on it and it was not intact and dated 10-31. She removed the bandage halfway and said it was a skin tear. She also said there was no bandage on his right elbow, and he had a scab there. She looked at his left upper arm bandage, confirmed it was dated 11/4 and not intact with red drainage on it. The wound was exposed, and she said that it was also a skin tear. She said normally the nurse would put in a wound care consult and the wound care nurse would come and assess the resident and treat the wounds daily. 2. Review of Resident #377's Admission Record revealed she was admitted to the facility with medical diagnoses of repeated falls, hepatic encephalopathy, dementia without behavioral disturbances, and extrapyramidal and movement disorder. An observation was conducted on 11/04/24 at 10:41 AM. Resident #377 was observed self-propelling down the hallway in her wheelchair. She was observed to have an undated bandage on her right eyebrow and reddish, green, black, discoloration around her right eye. The resident said she fell off a table. An observation was conducted on 11/5/24 at 10:06 AM. Resident #377 was observed in her wheelchair self-propelling out of her room. She was observed to have a reddish, black, and green bruise to her right eye with an undated bandage on her right eyebrow with dark drainage on it. An observation was conducted on 11/6/24 at 9:05 AM Resident #377 was observed in her wheelchair in the hallway near the nurse's station. She was observed to have an undated bandage on her right eyebrow. The bandage was intact but soiled with dark drainage. Review of Resident #377's physician orders did not reveal an order to change the right eyebrow bandage. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #377's incident note dated 10/28/2024 at 6:18 PM showed Approximately 6.05 pm [sic], the writer hear [sic] res [resident] screaming. when [sic] the writer entry [sic] to her room found her on the floor. Res report to the writer she was traying [sic] to get hair brush[sic] on the floor. Upon skin examination res has skin tear on right eyebrow. VS [vital signs] WNL [within normal limits]. No complaint of pain or discomfort. No SOB [shortness of breath]. Supervisor notified. order given and noted. We continue to monitor. Review of Resident #377's progress notes dated 10/30/2024 at 6:40 AM showed . Bandage intact over right eyebrow. No bleeding noted at this time. Review of Resident #377's progress notes 10/30/2024 at 9:50 PM showed .Bandage changed over right eyebrow. No bleeding noted at this time. We [sic] continue to monitor. Review of Resident #377's Weekly Skin Evaluation dated 10/28/24 showed skin tear to the right eyebrow. Review of Resident #377's Weekly Skin Evaluation dated 10/29/24 showed .skin abrasion above right eye from fall. An interview was conducted on 11/6/24 at 9:45 AM with Staff A, RN, she confirmed she was taking care of Resident #377. She reviewed Resident #377's medical record and confirmed there was not a physician order to change the bandage to her right eye and there should have been. She also confirmed the residents bandage was not dated and it should have been. An interview was conducted on 11/6/24 at 9:54 AM with Staff B, Licensed Practical Nurse (LPN), Wound Care Nurse. She said there was a wound care nurse seven days a week. The expectation was whenever there was a wound the nurses should put in a wound care consult so they could be notified to perform the treatment and management of wounds. Staff B said she was not aware Resident #378 had any wounds or skin tears. She also said she was not aware Resident #377 had any wounds. She said all bandages and dressings should have physician orders to change them and the bandages and dressings should be labeled with a date, time, and signature. An interview was conducted on 11/6/24 at 2:57 AM with the Director of Nursing (DON). She said if there were any wounds there should be a wound care consult put in so the wound care nurse could be informed, and the wounds could be treated. The DON said the facility had a wound care nurse seven days a week. Review of the facility's Wound Treatment Management policy, with a revised date of 11/23/2022 revealed the following. Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse. 3. Dressing changes may be provided outside the frequency parameters in certain situations: a. Feces has seeped underneath the dressing. b. The dressing has dislodged. c. The dressing is soiled otherwise or is wet. 4. Dressings will be applied in accordance with manufacturer recommendations. 5. Treatment decisions will be based on: .iii. Incidental (i.e. skin tear, medical adhesive related skin injury). .6. Guidelines for dressing selection may be utilized in obtaining physician orders . a. The guidelines are to be used to assist in treatment decision making. b. Due to unique needs and situations of individuals, the guidelines may not be appropriate for use in all circumstances. c. The facility will follow specific physician orders for providing wound care. 7. Treatments will be documented on the Treatment Administration Record or in the electronic health record. 8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. Lack of progression towards healing. b. Changes in the characteristics of the wound (see above). c. Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights.

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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** 46498 Based on observations, record review and interviews the facility failed to ensure smoking adaptive equipment was provided for one (#42) of 11 residents sampled. Findings included: During an observation made on 11/4/2024 at 10:15 a.m. and 11/6/2024 at 2:20 p.m., Resident #42 was observed outside smoking without using a smoking adaptor. Resident #42 said he did not use smoking adaptive equipment while smoking. Review of an Admission Record dated 11/ 7/2024, showed Resident #42 was admitted to the facility on [DATE] with diagnoses to include but not limited to Parkinsonism, unspecified, Type 2 Diabetes, Aute Respiratory Failure, and Paranoid Schizophrenia. Review of a Quarterly Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. Review of Resident # 42's care plan revised on 9/13/2024, showed the resident was at risk for smoking injuries to self - related to use of cigarettes. The care plan goals showed Resident #42 will continue to smoke safely in a designated area at scheduled times per facility smoking policy through the next review. The interventions included adaptor to be used while smoking, [Resident #42] requires a smoking apron while smoking. On 11/6/2024 at 10:20 am., an interview was conducted with Staff G, Certified Nursing Assistant (CNA) . Staff G stated Resident #42 was supposed to use a smoking adaptor while smoking because he smoked his cigarettes down to his fingertips. Staff G said, He has not used his adaptor in a while because he lost it and was not given another adaptor. On 11/6/2024 at 10: 20 am., an interview was conducted with Staff H, CNA. She stated she was familiar with Resident #42. She stated Resident #42 had not used a smoking adaptor in a long time because he lost it. On 11/6/2024 at 11:00 am., an interview was conducted with Staff I, Licensed Practical Nurse (LPN). She stated Resident #42 used a smoking adaptor while smoking because he smoked his cigarettes down to his fingertips. She stated her expectations were for staff to provide residents with the items they needed to ensure safe smoking. On 11/6/2024 at 1:00 pm., an interview was conducted with Staff C, LPN/UM (Unit Manager). She stated Resident #42 used a smoking adaptor because he smoked his cigarettes down to his fingertips. Staff C stated she had to educate herself and her staff to ensure the resident's care plan interventions were followed while they were outside smoking. She stated her expectation was for staff to notify the nurse if a resident did not have a smoking adaptor before taking the resident outside to smoke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Resident Smoking, Revised on 8/26/2024, showed it is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non- smoking residents. Under Policy Explanation and Compliance Guidelines: 10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan. 12. If a resident or family does not abide by the smoking policy or care plan (e.g. does not wear protective gear), the plan of care may be revised to include additional safety measures. 13. Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50570 Based on observation, interview, and record review, the facility failed to provide enteral nutrition according to standards of practice related to expired nutritional formula for one resident (#246) out of one resident sampled. Findings included: On [DATE] at 12:11 p.m., an observation of Resident #246 revealed he was laying down in bed, with a family member at the bedside. On the left side of the bed, there was a pole and enteral feeding pump observed. An observation of the pole and enteral feeding pump revealed there was no tube feeding bag or container hanging. Further observation revealed the pump was off. An observation of the small dresser, to the left of Resident #246's bed, revealed three, 8-ounce bottles of TwoCal HN [high nutrient] 2.0 formula with a date observed at the top which indicated the following, 1 SEP 2024. A review of Resident #246's Admission Record revealed an original admitted [DATE] and a re-admitted [DATE]. Further review of the Admission Record revealed diagnoses to include but not limited to dysphagia, oropharyngeal phase, unspecified protein-calorie malnutrition, and unspecified, and encounter for attention to gastrostomy. A review of Resident #246's Active Orders revealed the following, Enteral Feed Order one time a day provide two cal enteral feeding 55 ml/hr [milliliters/hour] from 7 pm to 7 am. for a total of 550 ml a day, with an order and start date of [DATE]. Further review of enteral feed orders revealed the following, Enteral Feed Order one time a day provide two cal enteral feeding 55 ml/hr from 7 pm to 7 am. for a total of 550 ml a day; Provide Nutren 2.0 if two cal is out of stock, with an order and start date of [DATE]. Further review of Resident #246's enteral feed orders revealed the following, Enteral Feed Order one time a day Stop eternal feed 7 am daily, with an order date of [DATE], and a start date of [DATE]. A review of Resident #246's Medication Administration Record (MAR) for [DATE] included the following: Enteral Feed Order one time a day provide two cal enteral feeding 55 ml/hr from 7 pm to 7 am. for a total of 550 ml a day, Start Date [DATE], D/C [discontinue] Date [DATE]. A review of the documentation in the MAR revealed it was administered daily as ordered. Dietitian consult one time a day, Start Date [DATE]. A review of the documentation in the MAR revealed it was completed daily as ordered. Enteral Feed Order every shift Enteral 4b - Observe for signs of intolerance, i.e. diarrhea, N&V [nausea and vomiting], constipation, abdominal distention/cramping, fluid overload, aspiration, hypo/hyper-glycemia every shift, Start Date [DATE]. A review of the documentation in the MAR revealed it was completed daily as ordered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:40 a.m., an observation of the 1 East nourishment room, where the enteral feeding formula was stored, revealed multiple 8-ounce bottles and one case of TwoCal HN 2.0 with a use by date of [DATE]. A review of a manual found through an Internet search titled, Best Practices for Managing Tube Feeding, published [DATE] from [Vendor name] revealed the following, .3. Maintain proper storage and handling of formula: . G. Do not use after expiration date on container. The manual was viewed using the following link, https://static.abbottnutrition.com/cms-prod/abbottnutrition-2016.com/img/M4619.005%20Tube%20Feeding%20manual_tcm,d+[DATE].pdf, on [DATE]. TwoCal HN 2.0 is a product of [Vendor name]. On [DATE] at 9:45 a.m., an interview with Staff C, Unit Manager (UM)/Licensed Practical Nurse (LPN) revealed Central Supply staff put the enteral nutrition formula in the nourishment room. She stated Central Supply and the nursing staff reviewed the formula upon putting it into the nourishment room. Staff C stated the nursing staff reviewed the formula every time they used a bottle for the resident. An observation of the 1 East nourishment room was conducted with Staff C and she confirmed the TwoCal HN 2.0 was expired as of [DATE]. Staff C, UM/LPN stated she reviewed the pantry on Monday, [DATE] or Tuesday, [DATE] and didn't see the expired formula. She was observed removing the formula and stated she would provide education to Central Supply staff and all staff members. On [DATE] at 11:00 a.m., an interview with Staff D, Central Supply revealed he received the enteral nutrition formula and put it in the nourishment rooms. He stated his process consisted of comparing the formula received to the invoice. Staff D stated he checked the expiration date, ensured it was the right product, and verified the amount. He stated if the formula was expired, he would toss it. Staff D, Central Supply stated he was the primary staff member who received the enteral nutrition formula. He stated he received shipments on Tuesday and Thursday, and expected one today. On [DATE] at 1:36 p.m., an interview with the Director of Nursing (DON) revealed the nurse received the product that was brought from Central Supply. She stated the nurse put the enteral nutrition formula in the room, or Central Supply stocked the room. The DON stated she expected staff to make sure it was the right product they were receiving and providing to residents. She confirmed it was an issue that the resident was being provided formula that was expired. On [DATE] at 3:01 p.m., the Regional Nursing Home Administrator (NHA) stated the facility had no policy related to enteral nutrition or receiving formula from Central Supply. Photographic Evidence Obtained.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on observation, record review and interview, the facility did not ensure Enhanced Barrier Precautions (EBP) were initiated for three (#163, #138, and #237) of four residents sampled. Findings included: 1. On 11/04/2024 at 9:25 a.m., an observation was made of Residents #237. Resident #237 was in his room with a 1:1 sitter. Resident #237's room had a sign on his door for EBP. The signage was unclear on which resident was on EBP. Staff F, Registered Nurse, stated Resident in bed A was on EBP secondary to a wound. Resident #237 did not have an order for Enhanced Barrier Precautions. A review of Resident #237's physician orders showed the following: Sacrum: Cleanse with normal saline, apply collagen with calcium alginate to wound bed, cover with border foam gauze daily every day shift for pressure ulcer, dated 10/31/2024. 2. On 11/04/2024 at 10:00 a.m., an observation was made of Resident #163. Resident #163 had an intravenous (IV) medication infusion into a venous access catheter to his left arm. Outside Resident #163's room there was no signage for EBP or any personal protective equipment (PPE). A review of Resident #163 Admission Record showed a readmitted [DATE]. Review of the Admission Record showed Resident #163 with diagnoses of but not limited to: Pressure ulcer of right hip, stage two, dated 10/14/2024 Pressure ulcer of the left buttock, stage two, dated 10/14/2024 Pressure ulcer of the left ankle, unstageable, dated 10/14/2024 Pressure-induced deep tissue damage of the right heel, dated 10/14/2024 Pressure-induced deep tissue damage of the left heel, dated 10/14/2024 Pressure ulcer of other site, stage two, dated 10/14/2024 Pressure-induced deep tissue damage of other site, dated 10/14/2024 a review of resident A review of resident #163 physician orders showed the following: Change midline dressing to LUA (left upper arm) weekly, every evening shifts every seven days, dated 11/03/2024. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Change needleless access device as needed for midline catheter, dated 11/05/2024. Change administration set for midline catheter every 24 hours intermittent. Label with date/time/initials, dated 11/05/2024. Right hip: Cleanse with normal saline, pat dry, apply Santyl and xeroform, apply bordered gauze daily/as needed every day shift for pressure ulcer dated 10/31/2024. Resident #163 did not have an order for Enhanced Barrier Precautions. On 11/05/2024 at 9:50 a.m., an observation was made of Resident #163. Resident #163 had an IV pole with an empty bag hanging from an IV pole. Outside Resident #163's room there was no signage for EBP or any personal protective equipment (PPE). On 11/06/2024 at 5:00 p.m., an observation was made of Resident #163 with IV medication hanging from an IV pole. Outside Resident #163's room there was no signage for EBP or any personal protective equipment (PPE). 3. 11/06/2024 at 4:45 p.m., an observation was conducted of the Lifestyle One wing. Resident # 138 was observed with EBP signage on the room door. Resident #138 was observed with nursing staff and emergency medics without wearing PPE. An unknown nursing staff member stated Resident #138 will be transferred to the hospital. A review of Resident #138's Admission Record showed an admitted [DATE]. A review of Resident #138's physician orders showed the following: Cleanse left buttocks with normal saline pat dry apply collagen powder apply border gauze dressing every day shift, dated 8/24/2024. Resident #138 did not have an order for Enhanced Barrier Precautions. On 11/07/2024 at 11:10 a.m., an interview was conducted with the Infection Control Preventionist/Assistant Director of Nursing (ICP/ADON). The ICP/ADON said residents would be discussed daily during the facility's clinical morning meetings. Residents newly admitted , new orders for wound care, antibiotics, catheters were reviewed on an ongoing basis. The ICP/ADON stated she would add the residents to her list for EBP and from there would walk to the residents' room to ensure a sign was posted and PPE was provided. The ICP/ADON provided a list of residents on her list with EBP orders. The list provided was a written list of residents on a notepad in the ICP/ADON's handwriting. Residents #163, 237,106, and 138 were not on her list. On 11/07/2024 at 4:00 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated she was aware of the findings of missed opportunities to identify current residents requiring EBP isolation. A review of the facility's policy titled, Enhanced Barrier Precautions, implemented on 10/22/2023 showed a policy statement: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The policy explanation and compliance guidelines include the following: (continued on next page)

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	11/07/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Prompt recognition of need: . c. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high contact resident care activities that require the use of gown and gloves. 2. Initiation of Enhanced Barrier Precautions- a. Nursing staff may place residents with certain conditions or devices on enhanced barrier precautions empirically while awaiting physician orders. b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds for example chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers and/or indwelling medical devices such as central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes even if a resident is not known to be infected or colonized with a MDRO (multidrug resistant organism). ii. Infection or colonization with any resistant organisms targeted by the CDC (Centers for Disease Control and Prevention) and epidemiologically important MDRO when contact precautions do not apply. . 7. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device is removed.