

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2025
NAME OF PROVIDER OR SUPPLIER The Pavilion at Ocean Point		STREET ADDRESS, CITY, STATE, ZIP CODE 3202 Duke Street San Diego, CA 92110	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on interview and record review the facility failed to provide care in a respectful and dignified manner when an employee showed a soiled linen wipe with bowel movement to Resident 1's face.</p> <p>As a result, Resident 1 was disrespected and had the potential to decrease resident's self-worth.</p> <p>Findings:</p> <p>On 6/3/25 at 10:16 A.M. an interview and record with Licensed Nurse (LN) 1 were conducted. LN 1 stated he received a report from the nocturnal shift nurse that Certified Nurse Assistant (CNA) 1 had put the soiled linen wipes with bowel movement to Resident 1's face while CNA 1 was providing care to Resident 1. According to LN 1's progress notes on 5/25/25 at 11:56 A.M., CNA 1 was taking excessive amount of time to clean up urine and so Resident 1 asked CNA 1 what was going on. CNA 1 placed the soiled wet wipe 2 inches from my face and told Resident 1 had bowel movement.</p> <p>On 6/3/25 at 10:45 A.M. an interview was conducted with Resident 1. Resident 1 stated CNA 1 was providing care when CNA 1 placed the soiled wipes with bowel movement about one to two (1 to 2) inches to Resident 1's face. Resident 1 stated he was so upset and had not experienced this with other CNAs. Resident 1 stated he felt violated as a man, he was not expecting anything like this and he wanted respect because the CNA was helping him.</p> <p>On 6/3/25 at 1:18 P.M., a phone interview with CNA 1 was conducted with the Assistant Director of Nursing (ADON) and Director of Staff Development (DSD) present. CNA 1 stated she was providing care to Resident 1, CNA 1 stated she showed the soiled wipe with bowel movement to Resident 1's face because Resident 1 did not believe her. CNA 1 stated she did not think showing the soiled wipe with bowel movement to Resident 1's face was inappropriate when Resident 1 did not believe her.</p> <p>On 6/3/25 at 1:54 P.M., an interview was conducted with the DSD. The DSD stated it was inappropriate for CNA 1 to show the soiled wipes with bowel movement to Resident 1.</p> <p>On 6/24/25 at 9:57 A.M., an interview and record review were conducted with the ADON.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the Interdisciplinary team (IDT- a group of healthcare workers from different fields to who work together to address a resident's physical, psychological and social needs) notes indicated .On 05/25/2025 at approximately 0415, the patient requested a different CNA, stating the previously assigned CNA 1 made him feel disrespected, humiliated, and uncomfortable during perineal care. The patient reported requesting a brief change due to urination. During the perineal care, he stated CNA 1 excessively wiped his buttocks for a prolonged period while he was turned on his side. When he questioned her actions, he alleged CNA 1 held soiled wipes close to his face and stated he had pooped. The patient reported becoming upset and asking CNA 1 to stop .</p> <p>During this interview and record review, the ADON stated it was not appropriate to show the soiled linen or wipes with bowel movement to Resident 1 because it could be seen as a demeaning practice.</p> <p>According to the facility policy entitled Resident Rights Quality of Life, revised date March 2027, indicated . Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being . XI. Demeaning practices and standards of care that compromise dignity are prohibited. Facility Staff</p> <p>promote dignity and assist residents as needed by: .B. Promptly responding to the resident's request for toileting assistance .</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observation, interview and record review the facility did not ensure a TV (television) remote control was provided for 1 of 3 resident's (Resident 1) in a shared room.</p> <p>As a result, Resident 1 was upset and an altercation with another resident occurred/transpired.</p> <p>Findings:</p> <p>On 6/3/25 the Department received a facility reported incident about a resident-to-resident altercation on 6/1/25.</p> <p>On 6/3/25 at 11:27 A.M., an observation and interview with Resident 2 were conducted. Resident 2 was observed sitting in a wheelchair. Resident 2's room was observed to have three beds and each bed had TV. There was two TV remote control. Resident 2 stated about two days ago after dinner, he was upset because he could find the TV remote control. Resident 2 asked his roommate where the TV remote control was. Resident 2 stated his roommate hit him once in the chest. Resident 2 stated there was only one TV remote control at that time.</p> <p>On 6/3/25 at 11:55 A.M. an interview was conducted with Certified Nurse Assistant (CNA) 2. CNA 2 stated Resident was asking for his TV remote control.</p> <p>A review of the Interdisciplinary team (IDT- team (IDT- a group of healthcare workers from different fields to who work together to address a resident's physical, psychological and social needs) notes on 6/4/25 at 1:25 P.M. indicated .On June 1, 2025, the resident was involved in a physical altercation with another resident (resident #5435527), in which the resident was reportedly hit by the roommate. This incident led to a reported physical abuse case to CDPH via SOC 341. The resident reported that the incident occurred when he asked the other resident for the TV remote control .</p> <p>On 6/24/25 at 9:23 A.M., an interview and record review were conducted with the Maintenance Director. The Maintenance Director stated staff should notify the maintenance team and write a work order request in the work order binder. According to the facility binder for work order there was no written request for a TV remote control for Resident 2. The Maintenance Director stated he was not aware Resident 1's room only had one TV remote control. The Maintenance Director stated each resident should have provided their own TV remote control.</p> <p>On 6/24/5 at 9:33 A.M., an interview the Director of Nursing (DON) and Assistant Director of Nursing (ADON) was conducted. The ADON stated Resident 2 went outside the hallway asking for his TV remote control and no one assisted Resident 2. The ADON stated Resident 2 went back to his room and a resident-to-resident altercation occurred. The ADON stated the staff at that time should d have assisted Resident 2 to avoid the altercation. The ADON stated the staff should have help locate the missing TV remote control. The ADON stated each resident should a TV remote control. The DON stated staff should have assisted Resident 2 in looking for the TV remote control.</p> <p>According to the facility policy entitled Resident Rights- Accommodation of Needs, revised date 1/1/12, indicated .The Facility's environment is designed to assist the resident in achieving independent functioning and</p> <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>maintaining the resident's dignity and well-being. Facility Staff will assist residents in achieving these goals . V. In order to accommodate residents' individual needs and preferences, Facility Staff attitude and behavior are directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible according to residents' wishes. VI. Facility Staff interacts with the residents in a way that accommodates the physical or sensory limitations of the residents, promotes communication, and maintains each resident's dignity .</p>		