STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055322	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Ocean Point	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)
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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a care plan was implemented related to falls for one of two residents reviewed for falls (Resident 1).As a result, Resident 1 was at risk for additional falls. Findings:Resident 1 was admitted to the facility on [DATE] with diagnoses to include muscle weakness and dementia (a loss of thinking, remembering, and reasoning that interferes with daily living and activities), per the admission Record.An interview was conducted with the Administrator (ADM) on 7/31/25 at 10:30 A.M. The ADM stated Resident 1 had fallen from his wheelchair on 7/21/25, and this was the first time Resident 1 had sustained an injury. Per the ADM, Resident 1 had been in his room, seated in a wheelchair with no staff present when the fall occurred. The ADM stated Resident 1 had hit his head and was bleeding from his forehead, so he was sent to the hospital to be assessed.On 7/31/25 at 10:45 A.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated Resident 1 was often in her office, and enjoyed watching football on television and getting snacks. The DSD stated if Resident 1 wasn't in his bed, he was usually seated in his wheelchair at the nurses station. Per the DSD, Resident 1 enjoyed watching people walking by, and watching the nurses work. The DSD stated placing Resident 1 at the nurses station was also an intervention to prevent falls, since he could be seen by many staff members and assisted in the event he slid from his chair, or attempted to get up independently.On 7/31/25 at 1 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated she was familiar with Resident 1, and provided care to him often. CNA 1 stated Resident 1 liked to sit by the nurses station and watch people, and this kept him safe from falls because staff could easily see him there. CNA 1 stated Resident 1 was only in his room when he wanted to take a nap or go to sleep for the night, otherwise he was at the nurses station or at an activity. CNA 1 stated Resident 1 was unable to use the call light to get assistance, and was unable to explain what he needed to staff. CNA 1 stated Resident 1 answered most questions with a Yes or No.On 7/31/25 at 1:15 P.M., an interview was conducted with CNA 2. CNA 2 stated she was aware of which residents were fall risk because the nursing station kept a binder with a list of resident names as a resource. CNA 2 stated Resident 1 was listed as a fall risk, but the binder did not advise staff on ways to prevent him from falling. CNA 2 stated she was aware a care plan was available for staff to use, and the care plan included interventions for fall prevention, but she had not used care plans to identify ways to keep Resident 1 from falling.A record review was conducted.On 5/28/25, Resident 1's Brief Interview for Mental Status (BIMS, an assessment of thinking and memory) score was six, indicating severe cognitive impairment.Resident 1's Fall Risk Assessment (a evaluation of risk factors for falls, including diagnoses, medications, and fall history) score at the time of the fall was 17, indicating high risk for falls.Resident 1's care plan indicated he was at risk for falls due to his diagnosis of dementia, and others. Interventions to prevent falls were to anticipate his needs, ensure his call light was within reach, and encourage/assist the resident promptly. On 7/31/25 at 1:30 P.M. an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated a Fall Risk score of 10 or higher indicated the resident was at high risk for falls, and the facility should implement strategies to prevent the falls from continuing. The ADON stated Resident 1 had care plan interventions for fall prevention, including anticipating his needs, and ensuring the call light was within reach. The ADON stated those interventions may not be effective as Resident 1 was unable to use the call light or communicate his needs. The ADON stated the care plan should have included not leaving the resident in a wheelchair unattended, but it did not. Per the ADON, the care plan did not address the specific care needs of Resident 1. The ADON stated, Care plans are for problems being addressed, and interventions and goals. Our care plan for (Resident 1) was not specific to his needs. The ADON stated a binder at the nurses station included a list of residents who were at risk for falls, but it did not include individualized interventions. Per a facility policy, revised 8/24/23 and titled Comprehensive Person-Centered Care Planning, Policy: The Facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being.

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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** Based on interview and record review, the facility failed to implement strategies to prevent a resident from falling (Resident 1).As a result, Resident 1 sustained a fall with injury.Findings:Resident 1 was admitted to the facility on [DATE] with diagnoses to include muscle weakness and dementia (a loss of thinking, remembering, and reasoning that interferes with daily living and activities), per the admission Record.An interview was conducted with the Administrator (ADM) on 7/31/25 at 10:30 A.M. The ADM stated Resident 1 had fallen from his wheelchair on 7/21/25, and this was the first time Resident 1 had sustained an injury. Per the ADM, Resident 1 had been in his room, seated in a wheelchair with no staff present when the fall occurred. The ADM stated Resident 1 had hit his head and was bleeding from his forehead, so he was sent to the hospital to be assessed.On 7/31/25 at 10:45 A.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated Resident 1 was often in her office, and enjoyed watching football on television and getting snacks. The DSD stated if Resident 1 wasn't in his bed, he was usually seated in his wheelchair at the nurses station. Per the DSD, Resident 1 enjoyed watching people walking by, and watching the nurses work/ The DSD stated placing Resident 1 at the nurses station was also an intervention to prevent falls, since he could be seen by many staff members and assisted in the event he slid from his chair, or attempted to get up independently.On 7/31/25 at 1 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated she was familiar with Resident 1, and provided care to him often. CNA 1 stated Resident 1 liked to sit by the nurses station and watch people, and this kept him safe from falls because staff could easily see him there. CNA 1 stated Resident 1 was only in his room when he wanted to take a nap or go to sleep for the night, otherwise he was at the nurses station or at an activity. CNA 1 stated Resident 1 was unable to use the call light to get assistance, and was unable to explain what he needed to staff. CNA 1 stated Resident 1 answered most questions with a Yes or No.A record review was conducted. On 5/28/25, Resident 1's Brief Interview for Mental Status (BIMS, an assessment of thinking and memory) score was six, indicating severe cognitive impairment.Resident 1's care plan indicated he was at risk for falls. Interventions to prevent falls were to anticipate his needs, ensure his call light was within reach, and encourage/assist the resident as needed.Resident 1's Fall Risk Assessment (a evaluation of risk factors for falls, including diagnoses, medications, and fall history) score at the time of the fall was 17, indicating high risk for falls. On 7/31/25 at 1:30 P.M. an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated a Fall Risk score of 10 or higher indicated the resident was at high risk for falls, and the facility should implement strategies to prevent the falls from continuing. The ADON stated Resident 1 had many interventions for fall prevention, including anticipating his needs, and ensuring the call light was within reach. The ADON stated those interventions may not be effective as Resident 1 was unable to use the call light or communicate his needs. The ADON stated when Resident 1 was in his wheelchair, he was usually left at the nurses station so staff could monitor him for safety. Per the ADON, the fall occurred in Resident 1's room, and no staff had been present. The ADON stated, Staff should have left him where he could be monitored, instead of in his room.Per a facility policy, revised 8/24/23 and titled Fall Management Program, Purpose: To provide residents a sfe environment that minimizes complications associated with falls. the licensed nurse will develop a care plan according to the identified risk factors.will initiate, review and update the Resident's.care plan.The licensed nurse will evaluate the Resident's response to the interventions. and update.as necessary.