

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 08/13/2025
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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure four of seven residents were provided care in a manner that promoted dignity and respect when: 1. Staff did not answer Resident 1's call bell for seven hours;2. Resident 2 waited one hour to have his brief changed; 3. Resident 3 waited all night to have his brief changed; 4. Resident 4 waited one and a half hours for call light to be answered;5. Call light response was an issue verbalized by residents at the Resident Council meetings for three consecutive months. These failures resulted in not ensuring residents' rights to be treated with respect and dignity, with the potential to cause psychosocial harm to the involved residents. In addition, this failure had the potential for residents who remained wet for an extended period to develop or worsening of bedsores and infection.</p> <p>Findings:1. Resident 1 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (disrupted blood flow to the brain) due to thrombosis (blood clot) according to the facility's admission Record. During a review of Resident 2's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 7/9/25, section C0500 indicated Resident 1's Brief Interview for Mental Status (BIMS- evaluates cognition, the ability to remember and think clearly) score was 13, intact cognition. During an observation and interview on 8/13/25 at 9:11 A.M. with Resident 1, Resident 1 was in bed and stated there was a power outage at the facility last week on 8/6/25. Resident 1 stated the electrical power was off from 10 P.M. until 6 A.M. Resident 1 stated he was provided with a call bell similar to the ones used at hotels. Resident 1 stated he pressed the call bell around 10 PM and staff did not come to his room until 5:30 A.M. Resident 1 stated he felt bad because his roommate needed assistance. Resident 1 stated he also waited two hours last week at night before anyone came to check on him. Resident 1 stated he felt frustrated having to wait so long for staff to assist him. 2. Resident 2 was admitted to facility on 8/7/25 with diagnoses including neurogenic bowel (nerve damage affecting signals between the brain and the bowel, leading to difficulties with bowel control and emptying) and pressure ulcer (bedsore) of sacral (the triangular shaped bone at the base of the back) region according to the facility's admission Record. An observation and interview was conducted on 8/13/25 at 9:39 A.M. with Resident 2. Resident 2 was in bed and stated he had been at the facility for almost one week and the call light response was too long. Resident 2 stated he needed his brief to be changed yesterday evening (8/12/25), but waited for one hour. Resident 2 stated he had no control of his bowels and had to call for assistance to be changed or repositioned. 3. Resident 3 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side according to the facility's admission Record. During a review of Resident 2's MDS dated [DATE], indicated BIMS score of 14, intact cognition. An observation and interview on 8/13/25 at 9:42 A.M. was conducted with Resident 3. Resident 3 was in a wheelchair in his room. Resident 3 had no right arm and Resident 3's left arm was on his lap. Resident 3 stated there was a facility power outage on 8/6/25. Resident 3 stated he was provided with a call bell, but he could not use it because he was not able to raise or reach using his left arm. Resident 3 stated he stayed wet until the electrical power turned on at 5:45 A.M. Resident 3 further stated he waited one hour yesterday (8/12/25) afternoon for someone to assist with the use of the urinal. Resident 3 stated he ended up being wet which made him angry and uncomfortable. During an interview on 8/13/25 at 10:10 A.M. with Certified Nurse Assistant (CNA) 1, CNA 1 stated residents' call lights should be answered immediately. CNA 1 stated residents have complained about the call light response and has been reported to the charge nurse. CNA 1 further stated if residents were left wet, they could develop rashes and bedsores. 4. Resident 4 was admitted to the facility on [DATE] with diagnoses including muscle weakness and acquired absence of right upper limb (arm) according to the facility's admission Record. During a review of Resident 2's MDS dated [DATE], indicated BIMS score of 14, intact cognition. An observation and interview on 8/13/25 at 10:27 A.M. was conducted with Resident 4. Resident 4 was in bed and stated she waited an hour and a half for brief change. Resident 4 stated she could not recall the date and time but felt helpless having to wait too long. An interview was conducted on 8/13/25 at 10:31 A.M. with Licensed Nurse (LN) 1. LN 1 stated call light response should be as soon as possible. During an interview on 8/13/25 at 19:39 A.M. with CNA 2, CNA 2 stated call lights should be answered as soon as possible, at least between 10 to 20 minutes. CNA 2 stated residents could develop a rash and skin redness if left wet too long. 5. A review of the facility's minutes for the Resident Council meeting titled, Quality of Life Questions (QOL)</p>		