STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056105	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Balboa Nursing & Rehabilitation Center	3520 Fourth Avenue San Diego, CA 92103

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on interviews and record review, the facility failed to communicate and develop a baseline care plan (detailed plan with information about a patient's treatment, goal, and interventions) related to a resident ' s (Resident 1) suicidal ideation (SI, when you think about, consider or feel preoccupied with the idea of death and suicide) tendency for one of one sampled resident. As a result, the lack of communication among facility staff related to Resident 1 ' s SI and a resident centered care plan with specific interventions to monitor Resident 1 from harming herself with overdosing of medications and cutting herself with a butter knife on 1/20/25. Findings: A record review was conducted of Resident 1. Resident 1 was readmitted to the facility on [DATE], with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body), per the facility ' s Admission Record. A record review was conducted of Resident 1. Resident 1's History and Physical (H & P), dated 10/17/24, indicated the attending physician (AP) documented Resident 1 was admitted to the facility for rehabilitation and Resident 1 had the capacity to make medical decisions. Per the H & P, Resident 1 was right handed and had left sided weakness. A review of Resident 1 ' s psychiatric assessment completed by Nurse Practitioners (NPs 1 and 2) was conducted. The NPs documented Resident 1 was assessed for suicidal risk on the following dates: 11/29/24, 12/5/24, 12/26/24, 1/2/25, and 1/16/25 - for the question Have you wished you were dead or wished you could go to sleep and not wake up? Resident 1 answered Yes. For the question Have you actually had any thoughts of killing yourself? Resident 1 answered Yes. For the question Have you been thinking about how you might do this? Yes - patient reports thinking about overdosing on medication. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	For 11/29/24 notes, NP 1 documented Resident 1 was at moderate risk for SI and recommended monitoring of Resident 1. NP 1 documented Resident 1 had Major Depressive Disorder (MDD, a mood disorder that causes a persistent feeling of sadness and loss of interest) and was placed on trazodone (anti-depressant) medication for Resident 1. For 12/5/24 notes, NP 1 documented Resident 1 had suicide attempt one month ago by overdosing herself on pills. The NP documented Resident 1 was at high risk for SI written in bold letters. The NP recommended monitoring of Resident 1. The NP added sertraline (anti-depressant) medication for Resident 1. For 12/26/24 notes, NP 2 documented Resident 1 required closely monitoring. Per the NP note, NP 2 saw Resident 1 on 12/12/24 and 12/19/25 with the same recommendation to monitor Resident 1. For 1/2/25 notes, NP 2 documented Resident 1 required closely monitoring. For 1/16/25 notes, NP 2 documented Resident 1 required closely monitoring. A review of Licensed Nurse (LN) progress notes dated 1/20/25 at 12:29 P.M. was conducted. LN 1 documented At 1000, the resident was seen in her room attempting self-harm by cutting her wrist with a butter knife and reporting she had ingested approximately 90 metformin pills that she had in her possession from her daughter bringing them to her from the [name of pharmacy]. She also reported taking a ziplock bag with other unidentified pills. Empty metformin bottle and an empty ziplock found in residents' possession .The butter knife was removed from the patient's possession and secured. Laceration and bleeding noted on resident's left wrist with a scant amount of bleeding noted at the time of intervention . On 1/23/25 at 2:21 P.M., an interview with Certified Nursing Assistant (CNA) 1 was conducted. CNA 1 stated Resident 1 was alert and knew what was going on. CNA 1 stated Resident 1 did not seem to be depressed. CNA 1 stated there was no communication reported related to monitoring Resident 1. CNA 1 stated the staff did not know Resident 1 had pills on her belongings. On 1/23/25 at 1:27 P.M., an interview with LN 1 and a joint review of Resident 1 ' s clinical record was conducted. LN 1 stated on 1/20/25, LN 4 called him to check Resident 1 in her room because she was cutting her wrist. Per LN 1, Resident 1 was actively cutting herself with a metal butter knife. Per LN 1, while taking the metal butterknife from Resident 1, Resident 1 was bleeding and LN 1 noticed an empty bottle of home medication containing metformin pills (antidiabetic medication). Per LN 1, he asked Resident 1 what she did, and Resident 1 told him she ingested 90 pills of metformin (antidiabetic medication) and some pills from a plastic bag. LN 1 stated he did not know what other medications Resident 1 ingested. LN 1 stated Resident 1 did not verbalize her depression. LN 1 stated the psychiatrist NP placed Resident 1 on anti-depressant medications. LN 1 stated he was not aware there was a note from the provider indicating Resident 1 needed monitoring. LN 1 stated they (staff) were not aware Resident 1 had suicidal ideation. LN 1 stated NP 1 saw Resident 1 on 11/29/24. LN 1 stated, I see the notes from the psychiatrist, I don ' t know about this note, this is the first time I saw the notes. We don ' t monitor [name of resident 1]. LN 1 stated he was not sure if the other LN knew about Resident 1 ' s SI. LN 1 stated there was no communication related to Resident 1 ' s SI and monitoring. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 3:27 P.M., an interview with LN 2 and a joint review of Resident 1 ' s clinical record was conducted. LN 2 stated she would sometimes worked as a charge nurse and one responsibility of the charge nurses was to check the laboratory results from the fax machine and relay the results to the attending physician. LN 2 stated she did not receive a report related to Resident 1 ' s SI and monitoring. LN 2 stated she was not aware of the psychiatrist notes and recommendations. LN 2 stated, With nursing standpoint, gets order for medication. LN 2 stated she was not aware Resident 1 had SI. LN 2 stated the facility ' s protocol was to monitor residents with SI. LN 2 stated they (staff) were not aware Resident 1 had history of overdosing herself with medications. LN 2 was shaking her head when she was reading NP 1 ' s notes indicating Resident 1 had a SI and the plan was to overdose herself with medications, LN 1 stated This is the first time I am reading this. LN 2 stated the protocol was when a resident was assessed with SI, the staff would have to closely monitor the resident. LN 2 stated there was no care plan developed related to monitoring Resident 1 of any behavior and or safety. On 1/23/25 at 5:11 P.M., an interview with LN 3 and a joint review of Resident 1 ' s clinical record was conducted. LN 3 stated NP 1 saw Resident 1 on 11/29/24 and she gave an order of trazodone for Resident 1. LN 3 stated, I have not seen the psych notes that she had passive SI. This is my 1st time seeing this note. On 3/6/25, a telephone interview with CNA 2 was conducted. CNA 2 stated she had Resident 1 on 1/20/25. CNA 2 stated Resident 1 did not eat all her meals which she usually did. CNA 2 stated there was no communication of monitoring Resident 1 related to her SI. CNA 2 stated for resident inventories, the staff did not go to the nightstand of the residents who were continent. CNA 2 stated, We did not know she had some medications there, we don ' t check. On 3/6/25 at 2:28 P.M., a telephone interview with NP 1 was conducted. NP 1 stated she saw Resident 1 on 11/29/24 and alerted the charge nurse that Resident 1 was moderate to high risk on suicide risk assessment and needed close monitoring. NP 1 stated the facility staff should be communicating with each other since Resident 1 was at moderate to high risk of suicidal ideation. NP 1 stated Resident 1 should have been closely monitored meaning for residents with SI, they should be placed on one-on-one monitoring. NP 1 stated the other biggest factors was Resident 1 had access to medications and butterknife and no one knew she had those. NP 1 stated Resident 1 had a diagnosis of MDD because she met the criteria of having a recurrent thought of death or trying harm herself. NP 1 stated she did not communicate to the social services but informed the charge nurse of the facility. A review of the message of NP 1 to the facility was conducted. The message dated 12/5/24 at 9:46 P.M. indicated, NP 1 informed the facility that Resident 1 was at moderate to high risk of suicide, to ensure there were not medications or weapons in the resident ' s room and that the staff would have to checked Resident 1 more often. A review of hospital records was conducted. The psychiatry (psych) consults notes dated 1/20/25 at 1:19 P. M., indicated the interview with Resident 1 was limited due to lethargy (decrease in consciousness), nausea and vomiting. Per psych notes, Resident 1 endorses a month of worsening depressed mood and SI. Per the psych notes, Resident 1 had symptoms of depressed mood, insomnia, hopelessness, decreased energy, and worsening suicidal ideation. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of hospital records was conducted. The emergency department (ED) physician notes dated 1/21/25 at 2:06 P.M., indicated Resident 1 had worsening SI over the past month and planned to end her life. The ED notes indicated that while Resident 1 was in the ED, Resident 1 ' s vital signs were significant with tachycardia (heart rate over 100 beats per minute) in addition to tachypnea (rapid, shallow breathing). The ED notes indicated Resident 1 ' s lab results were abnormal, and Resident 1 became more agitated, somnolent (a state of strong desire for sleep, or sleeping for unusually long periods) and altered mental status. The ED notes indicated Resident 1 was admitted to the ICU in critical condition and to proceed forward with hemodialysis. On 3/20/25 at 12:28 P.M., a telephone interview with the Director of Nursing (DON) was conducted. The DON stated no one alerted her on the message from NP 1. The DON stated the message should have been communicated and a care plan developed to ensure resident safety. A review of the facility ' s policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident .

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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 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on interviews and record review, the facility failed to protect a resident (Resident 1) with suicidal ideation (SI, when you think about, consider or feel preoccupied with the idea of death and suicide) tendency from harm, when staff did not: 1. Supervise Resident 1 with known SI tendencies to harm herself with overdosing on medications and cut herself with a butter knife, 2. Follow through on a provider ' s recommendations (five opportunities) for SI safe monitoring of Resident 1, 3. Developed of interdisciplinary and core staff communication for the planning, monitoring and evaluating Resident 1 ' s plan of care related to overdosing self, to ensure Resident 1 did not have access to medications for her safety and well-being, and, 4. Fully account for Resident 1 ' s belongings including medications from home. As a result, these failures provided Resident 1 an opportunity to harm herself by overdosing on her medications from home and cutting herself with a metal butterknife on 1/20/25. Resident 1 was transported from the facility to a GACH (General Acute Care Hospital). Resident 1 was admitted to the ICU (Intensive Care Unit), was placed on life support and underwent hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) for treatment and recovery. Findings: A record review was conducted of Resident 1. Resident 1 was readmitted to the facility on [DATE], with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body), per the facility ' s Admission Record. A record review was conducted of Resident 1. Resident 1's History and Physical (H & P), dated 10/17/24, indicated the attending physician (AP) documented Resident 1 was admitted to the facility for rehabilitation and Resident 1 had the capacity to make medical decisions. Per the H & P, Resident 1 was right-handed and had left sided weakness. A record review was conducted of Resident 1. Resident 1's minimum data set (MDS - a federally mandated resident assessment tool), dated 10/17/24, indicated Resident 1's brief interview for mental status (BIMS, ability to recall) score was 15/15 (a score of 13 to 15 suggests the patient is cognitively [process of acquiring knowledge and understanding] intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). A review of Resident 1 ' s psychiatric assessment completed by Nurse Practitioners (NPs 1 and 2) was conducted. The NPs documented Resident 1 was assessed for suicidal risk on the following dates: (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 0740 Level of Harm - Actual harm Residents Affected - Few	11/29/24, 12/5/24, 12/26/24, 1/2/25, and 1/16/25 - for the question Have you wished you were dead or wished you could go to sleep and not wake up? Resident 1 answered Yes. For the question Have you actually had any thoughts of killing yourself? Resident 1 answered Yes. For the question Have you been thinking about how you might do this? Yes - patient reports thinking about overdosing on medication. For 11/29/24 notes, NP 1 documented Resident 1 was at moderate risk for SI and recommended monitoring of Resident 1. NP 1 documented Resident 1 had Major Depressive Disorder (MDD, a mood disorder that causes a persistent feeling of sadness and loss of interest) and was placed on trazodone (anti-depressant) medication for Resident 1. For 12/5/24 notes, NP 1 documented Resident 1 had suicide attempt one month ago by overdosing herself on pills. The NP documented Resident 1 was at high risk for SI written in bold letters. The NP recommended monitoring of Resident 1. The NP added sertraline (anti-depressant) medication for Resident 1. For 12/26/24 notes, NP 2 documented Resident 1 required closely monitoring. Per the NP note, NP 2 saw Resident 1 on 12/12/24 and 12/19/25 with the same recommendation to monitor Resident 1. For 1/2/25 notes, NP 2 documented Resident 1 required closely monitoring. For 1/16/25 notes, NP 2 documented Resident 1 required closely monitoring. A review of Licensed Nurse (LN) progress notes dated 1/20/25 at 12:29 P.M. was conducted. LN 1 documented At 1000, the resident was seen in her room attempting self-harm by cutting her wrist with a butter knife and reporting she had ingested approximately 90 metformin pills that she had in her possession from her daughter bringing them to her from the [name of pharmacy]. She also reported taking a ziplock bag with other unidentified pills. Empty metformin bottle and an empty ziplock found in residents' possession .The butter knife was removed from the patient's possession and secured. Laceration and bleeding noted on resident's left wrist with a scant amount of bleeding noted at the time of intervention . On 1/23/25 at 2:21 P.M., an interview with Certified Nursing Assistant (CNA) 1 was conducted. CNA 1 stated Resident 1 was alert and knew what was going on. CNA 1 stated Resident 1 did not seem to be depressed. CNA 1 stated there was no communication reported related to monitoring Resident 1. CNA 1 stated the staff did not know Resident 1 had pills on her belongings. (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 0740 Level of Harm - Actual harm Residents Affected - Few	On 1/23/25 at 1:27 P.M., an interview with LN 1 and a joint review of Resident 1 ' s clinical record was conducted. LN 1 stated on 1/20/25, LN 4 called him to check Resident 1 in her room because she was cutting her wrist. Per LN 1, Resident 1 was actively cutting herself with a metal butter knife. Per LN 1, while taking the metal butterknife from Resident 1, Resident 1 was bleeding and LN 1 noticed an empty bottle of home medication containing metformin pills (antidiabetic medication). Per LN 1, he asked Resident 1 what she did, and Resident 1 told him she ingested 90 pills of metformin and some pills from a plastic bag. LN 1 stated he did not know what other medications Resident 1 ingested. LN 1 stated Resident 1 did not verbalize her depression. LN 1 stated the psychiatrist NP placed Resident 1 on anti-depressant medications. LN 1 stated he was not aware there was a note from the provider indicating Resident 1 needed monitoring. LN 1 stated they (staff) were not aware Resident 1 had suicidal ideation. LN 1 stated NP 1 saw Resident 1 on 11/29/24. LN 1 stated, I see the notes from the psychiatrist, I don ' t know about this note, this is the first time I saw the notes. We don ' t monitor [name of resident 1]. LN 1 stated he was not sure if the other LN knew about Resident 1 ' s SI. LN 1 stated there was no communication related to Resident 1 ' s SI and monitoring. On 1/23/25 at 3:27 P.M., an interview with LN 2 and a joint review of Resident 1 ' s clinical record was conducted. LN 2 stated she would sometimes worked as a charge nurse and one responsibility of the charge nurses was to check the laboratory results from the fax machine and relay the results to the attending physician. LN 2 stated she did not receive a report related to Resident 1 ' s SI and monitoring. LN 2 stated she was not aware of the psychiatrist notes and recommendations. LN 2 stated, With nursing standpoint, gets order for medication. LN 2 stated she was not aware Resident 1 had SI. LN 2 stated the facility ' s protocol was to monitor residents with SI. LN 2 stated they (staff) were not aware Resident 1 had history of overdosing herself with medications. LN 2 was shaking her head when she was reading NP 1 ' s notes indicating Resident 1 had a SI and the plan was to overdose herself with medications, LN 1 stated This is the first time I am reading this. LN 2 stated the protocol was when a resident was assessed with SI, the staff would have to closely monitor the resident. LN 2 stated there was no care plan developed related to monitoring Resident 1 of any behavior and or safety. On 1/23/25 at 5:11 P.M., an interview with LN 3 and a joint review of Resident 1 ' s clinical record was conducted. LN 3 stated NP 1 saw Resident 1 on 11/29/24 and she gave an order of trazodone for Resident 1. LN 3 stated, I have not seen the psych notes that she had passive SI. This is my 1st time seeing this note. On 3/6/25, a telephone interview with CNA 2 was conducted. CNA 2 stated she had Resident 1 on 1/20/25. CNA 2 stated Resident 1 did not eat all her meals which she usually did. CNA 2 stated there was no communication of monitoring Resident 1 related to her SI. CNA 2 stated for resident inventories, the staff did not go to the nightstand of the residents who were continent. CNA 2 stated, We did not know she had some medications there, we don ' t check. (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 0740 Level of Harm - Actual harm Residents Affected - Few	On 3/6/25 at 2:28 P.M., a telephone interview with NP 1 was conducted. NP 1 stated she saw Resident 1 on 11/29/24 and alerted the charge nurse that Resident 1 was moderate to high risk on suicide risk assessment and needed close monitoring. NP 1 stated the facility staff should be communicating with each other since Resident 1 was at moderate to high risk of suicidal ideation. NP 1 stated Resident 1 should have been closely monitored meaning for residents with SI, they should be placed on one-on-one monitoring. NP 1 stated the other biggest factors was Resident 1 had access to medications and butterknife and no one knew she had those. NP 1 stated Resident 1 had a diagnosis of MDD because she met the criteria of having a recurrent thought of death or trying to harm herself. NP 1 stated she did not communicate to the social services but informed the charge nurse of the facility. A review of the message of NP 1 to the facility was conducted. The message dated 12/5/24 at 9:46 P.M. indicated, NP 1 informed the facility that Resident 1 was at moderate to high risk of suicide, to ensure there were not medications or weapons in the resident ' s room and that the staff would have to checked Resident 1 more often. A review of hospital records was conducted. The psychiatry (psych) consults notes dated 1/20/25 at 1:19 P. M., indicated the interview with Resident 1 was limited due to lethargy (decrease in consciousness), nausea and vomiting. Per psych notes, Resident 1 endorses a month of worsening depressed mood and SI. Per the psych notes, Resident 1 had symptoms of depressed mood, insomnia, hopelessness, decreased energy, and worsening suicidal ideation. A review of hospital records was conducted. The emergency department (ED) physician notes dated 1/21/25 at 2:06 P.M., indicated Resident 1 had worsening SI over the past month and planned to end her life. The ED notes indicated that while Resident 1 was in the ED, Resident 1 ' s vital signs were significant with tachycardia (heart rate over 100 beats per minute) in addition to tachypnea (rapid, shallow breathing). The ED notes indicated Resident 1 ' s lab results were abnormal, and Resident 1 became more agitated, somnolent (a state of strong desire for sleep, or sleeping for unusually long periods) and altered mental status. The ED notes indicated Resident 1 was admitted to the ICU in critical condition and to proceed forward with hemodialysis. On 3/20/25 at 12:28 P.M., a telephone interview with the Director of Nursing (DON) was conducted. The DON stated no one alerted her on the message from NP 1. The DON stated the LNs should have informed her about the message to ensure she knew what was happening in the facility and ensure resident safety. The DON stated the expectation was to make sure there would be no repeated incident. A review of the facility ' s policy titled Safety and Supervision of Residents, revised July 2017, indicated, . Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes .Individualized Resident centered Approach to Safety .2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents, 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision . (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 0740 Level of Harm - Actual harm Residents Affected - Few	A review of the facility ' s policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident .