

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER Balboa Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate supervision for one resident, Resident 1, who eloped (a patient leaving a healthcare facility without proper authorization or staff awareness) from the facility late at night, was unlocatable by the facility for nearly 14 hours, and sustained a fall while away from the facility.</p> <p>This failure had the potential for Resident 1 to suffer serious injury.</p> <p>Findings:</p> <p>According to a report filed to the Department by Adult Protective Services (APS):</p> <p>On 6/2/25, the police department Psychiatric Emergency Response Team ([NAME]) unit responded to a call for a missing person at risk. During investigation, a clinician learned that Licensed Nurse (LN) 1 knew that Resident 1 left the facility at approximately 1:30 AM and never returned. LN 1 did not report this until shift change at 7:30 AM. A phone call was made to the police at 8:17 AM. The police department filed a missing person at risk report.</p> <p>An unannounced visit was conducted at the facility on 6/3/25 at 12:15 PM. The Director of Nursing (DON) stated Resident 1 returned to the facility on 6/2/25 after 4 PM. The total time Resident 1's whereabouts were unknown was approximately 14 hours.</p> <p>A review of Resident 1's admission Record indicated he was admitted to the facility on [DATE] with diagnoses that included unsteadiness on feet. A review of Resident 1's admission orders indicated that there were no orders for Resident 1 to go out of the facility without supervision.</p> <p>On 6/3/25 at 12:50 PM an interview with the DON and concurrent record review of Resident 1's fall risk assessment dated [DATE] indicated a score of 14 which was moderate risk for fall. The evaluation did not include the antihypertensive medication Resident 1 took for seven days prior to the date of the evaluation. A review of Resident 1's fall risk assessment dated [DATE] after return to the facility indicated a score of 16 which was high risk for falls. The evaluation did not include the antihypertensive medication Resident took for seven days prior to the date of the evaluation. The DON stated the Medication Administration Record (MAR) indicated Resident 1 received the ordered antihypertensive medication for seven days preceding both fall risk evaluations, the evaluations were not accurate and the risk level should have been higher.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's care plans indicated, substance abuse. This care plan was initiated on 5/8/25. Interventions included, Assess for the risk of leaving the facility without notification.</p> <p>On 6/3/25 at 1250 an interview with the DON and concurrent review of Resident 1's care plans indicated, Resident is a smoker. This care plan was initiated on 5/10/25. Interventions included, supervision provided while resident is smoking. The DON stated, The care plan is a template. Accompanying the resident outside to smoke safely is in the care plan but no one accompanied him.</p> <p>On 6/3/25 at 1:57 PM a telephone interview was conducted with Licensed Nurse (LN) 1 who stated, It's not the first time he got out like that. He goes down at night to smoke. I got busy, I was preoccupied and didn't notice he didn't return. I didn't notice until around 4 AM because he was not in bed. I did ask a senior nurse because I'm a new nurse, I wasn't sure what to do. He told me I could call the DON when she's awake. He said we don't want to wake someone for that. He said we could call the police and the DON after 7 AM. (Resident 1) didn't return during my shift.</p> <p>A review of a physician progress note dated 6/3/25 at 3:52 PM indicated, The patient returned the same day, at (3:17 PM), with an abrasion (an injury caused by scraping resulting in wearing away the surface of the skin) noted on the left side of his face.the patient would need . an x-ray of his face, and his wound cleaned and dressed.</p> <p>A review of Resident 1's x-ray report dated 6/3/25 indicated, There is a moderate suprapatellar effusion (excess fluid above the knee joint).</p> <p>A review of Resident 1's physician progress note dated 6/4/25 indicated, .patient was found many blocks away. He reported that he got lost. Noted with abrasions over face and left knee.Patient reported falling off his wheelchair.</p> <p>On 6/4/25 at 3:56 a telephone interview was conducted with LN 2 who stated he was the nursing supervisor of the third floor. LN 2 stated, I told (LN 1) to let Security (look for Resident 1), they come in later at about 5:30 AM. A patient who is a fall risk or with any level of cognitive impairment should not go outside the facility without staff. We would notify our supervisor about an issue, but we don't have a floor supervisor at night. I said you can wait and notify (the DON) at the beginning of the shift. I didn't look at his chart to see if the information the other nurse gave me was accurate because I was too busy doing my own work. If I don't know what to do in a situation I would talk to the DON.</p> <p>On 6/3/25 at 12:44 PM an observation and interview were conducted with Resident 1 who was noted to have a triangle shaped gauze dressing loosely taped over the left side of his face with ability to visualize scrapes and skin breaks from above his left temple to below his left cheekbone. There was a small amount of bright red blood noted. Resident 1's upper lip was noted with broken skin and a small amount of bright red blood and moderate swelling. Resident 1 stated, I went over a curb and fell out of the wheelchair. Resident 1 did not recall the time he went outside but stated, It was dark out. My knee is very painful when I walk, it's swollen and scraped up. Someone called the building for me because I don't know what I'm doing (Resident 1 held up a cell phone in his right hand). I couldn't find my way back, I was lost.</p> <p>(continued on next page)</p>

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