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	08/19/2025

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 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. Based on observation, interview and record review, the facility failed to provide resident safety when a resident (Resident 1) eloped form the facility without staff being aware. As a result, Resident 1 had successful elopement and was found on 8/19/25. Findings: On 8/18/25 the Department of Public Health received a report of elopement for Resident 1 at 8/16/25 and facility search done at 10 P.M. per the report. During a review of Resident 1's facility record on 8/17/25 at 1:23 P.M. indicated .Resident left facility without MDs [doctor's] order, not informing staffs or signing out.received a report that Resident left the unit around lunch time. Resident does walk throughout building on a daily basis. Resident has not back yet, unknow location at this time. Staff has searched the building and surrounding neighborhood.Observed that established history of walking throughout the premises and able to go back to his room, ambulate around with no assistance. A building-wide search was promptly initiated.but the he could not be located. On 8/19/25 at 12 P.M., an observation of the facility was conducted. The facility building has three entrances/exit. The entrance/exit included the front lobby, the side entrance/exit by the parking area and at the back. On 8/19/25 at 12:10 P.M. an interview with the Quality Assurance Nurse (QA). The QA stated Resident 1 was last seen on 8/16/25 around lunch time. QA stated Resident 1 was last seen around 12:18 P.M. using the elevator. On 8/19/2025 at 12:53 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated Resident 1 was independent. CNA 1 stated Resident 1 roam around and used elevator. On 8/19/25 at 2:03 P. M., an interview with Receptionist 1 was conducted. Receptionist 1 stated facility front entrance/exit opened from 8 A.M. to 8 P.M. Receptionist 1 stated some residents could be in the front lobby by the front entrance/exit. Receptionist 1 stated licensed nurse would inform me when residents would need supervision or could be by themselves. Receptionist 1 stated there were two elopements last week. On 8/19/25 at 4:10 P. M., an interview with the Administrator (ADM) and QA was conducted. The ADM stated there were three elopements in the last six (6) months and the two elopements occurred this month. ADM stated there three were entrances/exits in the building. QA stated the back entrance/exit was locked. ADM stated the facility would increase surveillance. ADM stated Resident 1's elopement happened on the weekend when there were less staff. QA stated nobody saw Resident 1 leaving the building. QA stated her expectation was to make sure elopement would not occur again for resident safety.

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