

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 09/09/2025
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to administer pain medication for one of two residents (Resident 1) in a timely manner. This failure placed Resident 1 at risk of unnecessary pain. Findings: Resident 1 was admitted to the facility on [DATE]and 8/21/25 with diagnoses to include right trochanteric bursitis (inflammation of the hip joint), type 2 diabetes, chronic pain syndrome according to the facility's admission Record. According to the physician History and Physical Examination (H&P) dated 8/22/25, indicated Resident 1 has the capacity to understand and make decisions. On 9/9/25 at 2:22 P.M., concurrent observation and interview was conducted with Resident 1. Resident 1 stated on 9/5/25 around 2 A. M., she was in severe pain and asked for pain pill multiple times. Resident 1 stated she was not given pain medication at that time. Resident 1 stated there was a lack of communication between the employees. On 9/9/25 at 3:08 P.M., a concurrent interview and record review was conducted with Licensed Nurse (LN) 1. According to the physician orders, Resident 1 received Hydrocodone-acetaminophen 10-325 milligrams (mg), give two tablets by mouth every 8 hours as needed for moderate pain (pain scale 4 to 6 out of a possible 10 as the worst pain) and Oxycodone 10 mg, give 1 tablet by mouth every 4 hours as needed for sever pain (pain scale 7 to10 and 10 as the worst pain). According to the electronic Medication Administration Record (eMAR), Hydrocodone-acetaminophen 10-325 mg was last administered on 9/4/25 at 6:01 P.M. and 9/5/25 at 4:40 A.M. According to the electronic Medication Administration Record (eMAR), Oxycodone 10 mg was last administered on 9/4/25 at 8:50 P.M. and 9/5/25 at 8:27 A.M. During this interview and record review, LN 2 acknowledged there was an opportunity to provide pain medication around 9/5/25 12AM to 2 AM window. There was no pain medication at around 2 A.M. On 9/9/25 at 4:26 P.M. an interview with LN 2 was conducted with the Quality Assurance Nurse (QA) present. LN 2 stated around 2 AM, Resident 1 was asking for pain medications, but the medication nurse assigned to Resident 1 was on break and did not endorse her medication cart keys. LN 2 stated there was no pain medication given to Resident 1 at that time. LN 2 stated around 3 A.M., the medication nurse assigned to Resident 1 returned, but LN 2 forgot to inform the medication nurse assigned to Resident 1 that Resident 1 was asking for pain medications. LN 2 stated there was no pain medication given to Resident 1 at that time. LN 2 stated around 4 A.M., Resident 1 awakened and was asking for pain medication. The medication nurse assigned to Resident 1 was not available for interview. On 9/9/25 at 4:45 P.M., a concurrent interview and record review was conducted with QA Nurse.The QA Nurse stated LN 2 did not have the medication cart keys and LN 2 forgot to endorse Resident 1's request for pain medication to the assigned LN to Resident 1. QA Nurse stated the expectation when Resident 1 complained of pain and requested a pain medication, LNs should check the physician orders and offer what was available in the emergency kit. The QA nurse stated Resident 1's pain should be addressed in a timely manner for patient comfort.During this interview and record review, QA Nurse acknowledged there was an opportunity to provide pain medication around 9/5/25 12AM to 2 AM window.</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
---	-------	-----------