

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 12/12/2025
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 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</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 0740</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 identify a resident's behavior of hitting and yelling at staff and residents for one of two residents reviewed for behavioral disturbances. (Resident 1) This failure had the potential for Resident 1 to have further altercations with other residents of the facility and a potential safety risk for Resident 1. Findings: On 11/26/25 at 8:23 A.M. and on 12/12/25 at 8:25 A.M., an unannounced onsite visit at the facility was conducted related to a reported resident to resident altercations. A review of the facility's five-day (5-day) summary investigation dated 11/17/25 was conducted. The 5-day summary indicated Resident 1 entered another resident's room and grabbed the other resident's walker on 11/14/25. The 5-day summary indicated the other resident initiated physical contact with Resident 1's left inner arm to protect his space. A review of the facility's five-day (5-day) summary investigation dated 12/1/25 was conducted. The 5-day summary indicated Resident 1 struck another resident on the head with her cane. Resident 1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory, thinking skills and eventually the ability to carry out simple tasks) with late onset and cerebral infarction (disrupted blood flow to the brain, a stroke) according to the facility's admission Record. During an observation and interview on 11/26/25 at 8:36 A.M. with Resident 1, Resident 1 was sitting at the edge of her bed with Certified Nurse Assistant (CNA) 1 at bedside. Resident 1 was smiling and stated she had no problems with any of the other residents in the facility. Resident 1 stated she did not get upset with anyone in the facility and had not hit anyone. An interview on 11/26/25 at 8:38 A.M. was conducted with CNA 1. CNA 1 stated Resident 1 had behavioral problems. CNA 1 stated Resident 1 got up from bed frequently, walked down the hall, told staff or other residents what to do and yelled at others which made other residents angry. During an interview on 11/26/25 at 8:44 A.M. with Licensed Nurse (LN) 2, LN 2 stated Resident 1 used her cane to try to hit others and yelled at other residents. LN 2 stated Resident 1 needed close monitoring even prior to the resident-to-resident altercation on 11/14/25. A review of Resident 1's care plans (CP) were conducted. CP dated 11/14/25 indicated, Resident is at risk for alteration/psychosocial distress r/t [related to] alleged victim of abuse .Resident exhibits episodes of wandering in hallways and entering rooms.at risk for behavioral symptoms such as combative, verbally or physically abusive to due diagnosis of Dementia [a condition characterized by loss of memory, language, problem solving and other thinking abilities] There was no care plan regarding Resident 1's behaviors prior to 11/14/25. During a review of the Order Summary Report for Resident 1, the Order Summary Report indicated, Monitor episodes of behavior AEB [as evidenced by] physical aggression every shift for 3 Days. Order Date 11/15/25.End Date 11/18/25. There were no other behavior monitoring prior to Resident 1's altercation on 11/14/25. During a review of Resident 1's Minimum Data Set (MDS- a clinical assessment tool) dated 11/7/25, the MDS indicated zeros (no behaviors) in section E0200A physical behavioral symptom and E0200B verbal behavioral symptoms. An interview on 11/26/25 at 11:19 A.M. with the social service assistant (SSA) was conducted. The SSA stated she completed Resident 1's MDS but did not interview staff and was not aware of Resident 1's behavior. An interview was conducted on 11/26/25 at 11:31 A.M. with the Quality Assurance (QA-) nurse. The QA nurse stated Resident 1's behaviors should have been identified and care planned to determine how to care for the resident. A review of the facility's policy and procedure (P&P) titled, Behavioral Assessment, Intervention, and Monitoring, dated February 2025 was conducted. The P&P indicated, As part of the comprehensive assessment, staff evaluate [based on input from the resident, family and caregivers, review of the medical record, and general observations].the resident's usual patterns of cognition, mood, and behavior.The IDT [Interdisciplinary Team-team members with various areas of expertise who work together toward the goals of their residents] evaluates behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develops a plan of care accordingly.</p>		