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	01/27/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect and keep private residents' Protected Health Information (PHI- refers to any individual identifiable health information that is created, received, stored or transmitted by a healthcare provider which includes demographic data, medical history, test results, and payment information and this information is protected under HIPPA-the Health Insurance Portability and Accountability Act of 1996) for 59 of 194 residents when it posted lists of residents' Enhanced Barrier Precautions (EBP) in the 2nd, 3rd, and 4th floor shower rooms.This failure did not protect the residents' medical privacy and had the potential to allow residents' PHI to be seen by anyone going into the shower room. Findings:On 1/9/26 at 10:35 A.M., a concurrent observation of the 3rd floor shower room and interview with Certified Nursing Assistant 5 (CNA) was conducted. A document titled 3rd Floor EBP was posted on the shower mirror when entering the room. This document contained 23 resident names with room numbers and reason for EBP. CNA 5 stated that the list was a list for EBP patients to remind the staff about needed personal protective equipment (PPE-gowns, gloves, mask, face shield) when residents were showered. CNA 5 stated she thought the Infection Preventionist (IP) hung the lists. CNA 5 stated that residents' private information should not be posted in public areas because anyone could come in and read the information. CNA 5 stated that residents' private information should be protected.On 1/9/26 at 10:45 A.M., a concurrent observation of 2nd floor shower room and interview with CNA 6 was conducted. A document titled 2nd Floor EBP was posted on the shower mirror when entering the room. This document contained 16 resident names with room numbers and the reason for EBP. CNA 6 stated that the list was a list for EBP patients to remind them who needed PPE when being showered. CNA 6 stated that residents' private information should not be posted in public areas because anyone could come in and read the information. CNA 6 stated that residents' private information should be protected for their privacy and respect.On 1/9/26 at 10:55 A.M., a concurrent observation of the 4th floor shower room and interview with CNA 7 was conducted. A document titled 4th Floor EBP was posted on the shower mirror when entering the room. This document contained 20 resident names with room numbers and reason for EBP. CNA 7 stated that the list was a list for EBP residents. CNA stated that residents' private information should not be posted in public areas because anyone could come in and read the information. CNA stated that residents' private information should be protected for their privacy.On 1/9/26 at 11:05 A.M., a concurrent observation of 4th floor shower room and interview with Quality Assurance Nurse (QAN) was conducted. QAN stated that the list was for EBP patients to remind the staff about needed PPE when residents were showered. QAN stated that residents' private information should not be posted in public area because anyone could come in and read the information. QAN stated that residents' private information should be protected for their privacy.On 1/9/26 at 11:20 A.M., an interview with Licensed Nurse (LN) 2 about the EBP list in shower room [ROOM NUMBER] was conducted. LN 2 stated that residents' private information should not be posted in public (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	areas because anyone could come in and read the information. LN 2 stated that residents' private information should be protected for their privacy.On 1/9/26 at 11:35 A.M., an interview with LN 3 about the EBP list in shower room [ROOM NUMBER] was conducted. LN 3 stated that residents' private information should not be posted in public areas because anyone could come in and read the information. LN 3 stated that residents' private information should be protected for their privacy.On 1/9/26 at 12:05 P.M., an interview with RN 3 about the EBP list in shower room [ROOM NUMBER] was conducted. RN 3 stated that residents' private information should not be posted in public areas because anyone could come in and read the information. RN 3 stated that residents' private information should be protected for their privacy.On 1/9/26 at 12:20 P.M., an interview with RN 4 was conducted about the EBP list in shower room [ROOM NUMBER]. RN 4 stated that residents' private information should not be posted in public areas because anyone could come in and read the information. RN 4 stated that residents' private information should be protected for their privacy.On 1/9/26 at 12:45 P.M., an interview with RN 5 about the EBP list in shower room [ROOM NUMBER], was conducted. RN 5 stated that residents' private information should not be posted in public areas because anyone could come in and read the information. RN 5 stated that residents' private information should be protected for their privacy.On 1/9/26 at 1:10 P.M., an interview with LN 4 about the EBP list in shower room [ROOM NUMBER] was conducted. LN 4 stated that residents' private information should not be posted in public area because anyone could come in and read the information. LN 4 stated that residents' private information should be protected for their privacy.On 1/9/26 at 1:15 P.M., an interview with the IP about the list in shower room [ROOM NUMBER], was conducted. The IP stated that residents' private information should not be posted in a public area because anyone could come in and read the information. The IP stated that residents' private information should be protected for their privacy.On 1/13/26 at 1:36 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation is that PHI should not be posted in a public area like a shower room. The DON stated the importance of keeping PHI private was to keep it in a secured area to protect the residents' private information from being disclosed to the public.RR of facility policy titled Residents Rights, dated 2001, indicated Federal and stated laws guarantee certain basic rights to all residents of this facility. These include the resident's right to: .3. The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. All inquiries concerning the release of resident information should be directed to the HIPPA compliance officer.RR of facility policy titled Protected Health Information (PHI), Management and Protection of, dated 2001, indicated .1. It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure.4. When using or disclosing PHI.reasonable efforts must be made to limit the PHI used or disclosed to the minimum necessary to accomplish the purpose of the use or disclosure of such information.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to maintain a homelike environment for four of nine residents (3,4,5,16) when it did not fix leaking ceilings and windows in resident rooms 417,421, and 425.This failure created hazardous non-homelike environment for the affected residents when it rained.Findings:On 1/2/26 between 2 P.M and 4:10 P.M, a concurrent interview with the Director of Maintenance (DOM) and tour of the facility's kitchen, the 2nd, 3rd, and 4th floor residents' room was conducted. All resident rooms on each floor were observed and alert residents were interviewed. The DOM stated that they (the facility) just got a new roof, and the only leak that staff had told him about was the leak in the 3rd floor dining room, and it was fixed by resealing the sliding glass door with caulk. A tour of the fourth floor was conducted and three rooms (417, 421, 425) had severe leaks from the ceiling when it rained on 12/31/25 per the residents interviewed (Resident 3, 4, 5, 16).Record review of admission Record for Resident 3 indicated she was admitted on [DATE] for diagnoses which included: Fracture of right femur (broken large leg bone), Fall, Atrial Fibrillation (a common heart condition where the heart's upper chambers beat irregularly, rapidly, and out of sync with the lower chambers), and Chronic Kidney Disease (a long-term condition where the kidneys become damaged and lose the ability to filter waste and excess fluid from the blood effectively).Record review of Brief Interview For Mental Status (BIMS-Test used to test thinking), dated 11/1/25, for Resident 3 indicated a score of 11, which indicated moderate cognitive impairment.On 1/2/26, at 2:20 P.M., a concurrent interview with Resident 3 and observation of room [ROOM NUMBER] 's bathroom was conducted. Resident 3 was alert, oriented, and lying in bed. Resident 3 stated that she had been at the facility for four months and this is the first time that they had problems with flooding in the bathroom. Resident 3 stated The floor was very wet last night, and staff had to put down lots of towels to absorb the water. Water damage was observed on bathroom ceiling with wet spots and some towels on floor. Resident 3 stated that the flooding and water damage were not homelike. The DOM stated he was not aware of damage in observed area.Record review of admission Record for Resident 4 indicated she was admitted on [DATE] for diagnoses which included: Neuropathy(damage or dysfunction of one or more nerves), Rheumatoid Arthritis (a chronic, systemic autoimmune disease where the immune system mistakenly attacks the lining of joints, causing inflammation, pain, swelling, and stiffness), and Fibromyalgia (a chronic disorder causing widespread musculoskeletal pain, fatigue, sleep disturbances, and cognitive(thinking) issues, stemming from altered pain processing in the central nervous system).Record review of BIMS for Resident 4, dated 10/14/25, indicated a score of 12, which indicated moderate cognitive impairment.On 1/2/26 at 2:25 P.M., a concurrent interview with Resident 4 and observation of room [ROOM NUMBER]'s bathroom was conducted. Resident 4 was alert, oriented, and lying in bed. Resident 4 stated that the bathroom was flooded last night and staff had to place lots of towels down to soak up the water. Resident 4 stated that the water on the floor last night was dangerous and not homelike. Resident 4's bathroom showed signs of water damage and paint bubbling to the ceiling.Record review of admission Record for Resident 5 indicated she admitted on [DATE] for diagnoses which included: Acute Kidney Failure (the sudden loss of kidney function, usually over hours to days), Rheumatoid Arthritis, and Depression (a serious mood disorder causing persistent sadness and loss of interest, affecting thoughts, feelings, and daily functioning for at least two weeks).Record review of BIMS for Resident 5, dated 10/14/25, indicated a score of 15, which indicated intact cognition.On 1/2/26 at 2:30 P.M., a concurrent interview with Resident 5 and observation of room [ROOM NUMBER]'s outer wall was conducted. Resident (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5 was alert, oriented, and sitting in her wheelchair next to her bed. Resident 5 stated that her roommate in bed C, by the wall was complaining of the wall leaking water a lot last night. Resident 5 stated staff had to put down lots of towels to absorb the water that had leaked down on the floor. No standing water was observed in room at time of observation. Resident 5 stated that the leaking wall was not homelike and could have been dangerous if someone slipped on it.On 1/2/26 at 3:20 P.M., an observation of the 3rd floor dining and interview with the DOM was conducted. The DOM stated that there was a complaint of a leak at the sliding door that led to outdoor patio, as water had leaked through the sliding glass door, the DOM stated that they applied new sealant that day that stopped the leak. Large fans were observed blowing in the room.On 1/2/26 at 4:20 P.M., a concurrent interview with the Director of Maintenance (DOM) and record review of maintenance binder for 4th floor was conducted. The DOM stated that his Maintenance Workers (MW) round daily, but they did not detect the water damage for rooms [ROOM NUMBERS], but room [ROOM NUMBER] was reported on 12/31/25 by a Certified Nursing Assistant (CNA). Review of the 4th floor maintenance binder indicated no maintenance entries about the leaks. The DOM stated that the areas with leaks should have been reported to him and documented in the log.On 1/2/26 at 4:45 P.M. an interview with Registered Nurse (RN) 1 was conducted. RN 1 stated that if he saw the leaking ceiling, he would first try to control the water to prevent slipping with towels. RN 1 stated that that process for reporting leaking ceilings to maintenance and repair is to contact maintenance by phone or Teams app, then write in the maintenance binder. RN 1 stated that leaking ceilings were not homelike and could be a slipping hazard for residents.On 1/2/26 at 4:55 P.M. an interview with RN 2 was conducted. RN 2 stated that if she saw there was a leak, she would first try and move residents from the area affected then control water with towels. RN 2 stated that that process for reporting problems to maintenance was to contact maintenance by phone or Teams app, then write in the maintenance binder. RN 2 stated that leaking ceilings and water damaged walls were not homelike.On 1/2/26 at 5:05 P.M., an interview was conducted with CNA 2. CNA 2 stated that if the ceiling was leaking, she would attempt to soak up the water with towel, make her charge nurse aware then call maintenance then document in maintenance binder. CNA 2 stated leaking ceilings and flooding were not homelike.On 1/2/26 at 5:15 P.M., an interview with CNA 3 was conducted. CNA 3 stated that if she saw a leaking ceiling she would move the residents from the are that was flooded, then try and mop up the water with towels, then call maintenance and document in the maintenance binder. CNA 3 stated that leaking ceilings were not homelike or safe.On 1/2/26 at 5:30 P.M., an interview with RN 1 was conducted. RN 1 stated that if she saw a leaking ceiling she would first move affected residents and then try to control the water by putting down towels, RN 1 stated she would contact maintenance via Teams app or by phone to let them know there was a leak, then write in the maintenance binder. RN 1 stated that leaking ceilings and flooded bathrooms are not homelike.On 1/2/26 at 5:45 P.M., an interview with CNA 4 was conducted. CNA 4 stated that if the ceiling was leaking water she would first move affected residents, then try to soak up the water with towels, then call maintenance, and document in maintenance binder. CNA 4 stated that the expectation was to keep the floor dry and non-slippery. CNA 4 stated leaking ceilings were not homelike.On 1/6/26 at 3:50 P.M., an interview with CNA 1 was conducted. CNA 1 stated that if she saw a leaking ceiling she would move the residents from the are that was flooded, then try and mop up the water with towels, then call maintenance, and then document in maintenance binder. CNA 1 stated that leaking ceilings were not homelike or safe.Record review of admission record for Resident 16 indicated she was admitted on [DATE] with diagnoses which included: Fall, Chronic Obstructive Pulmonary Disease (is a progressive lung disease causing airflow limitation, characterized by persistent breathing difficulties), Congestive (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Heart Failure a chronic condition where the heart muscle weakens or stiffens, failing to pump blood efficiently enough to meet the body's needs, causing a backup of blood and fluid).Record review of BIMS dated 10/22/25, for Resident 16 indicated a score of 11, which indicated moderate cognitive impairment.On 1/9/26 at 10:10 A.M., an observation of room [ROOM NUMBER]'s bathroom and interview with Resident 16 was conducted. Resident 16 was alert, oriented, and agreeable to interview. Resident 16 was in bed. Resident 16 stated . there was a lot water on the floor last week, they had to put down big towels, and no one could go in the bathroom, staff put towels from the wall to the toilet to the door, but it didn't come out of the bathroom. Resident 16 stated the leaking ceilings and flood were not homelike.On 1/9/26 at 11:50 A.M., a concurrent interview with Maintenance Worker (MW) 1 and record review of maintenance binder for 4th floor was conducted. MW 1 stated I check the maintenance book every day. Staff should write in the book the problems and type of maintenance or repair done, and I sign off when it's completed. MW 1 stated that could not find any entries in the 4th floor maintenance binder about the leaking ceilings or flooded resident bathrooms in 417, 421, or 425. MW stated .the DOM sends him texts about what he needed to fix. MW 1 stated the repairs should also be documented in the maintenance binder because there would be no way to know if a repair was made. MW 1 stated the expectation is staff should report the needed repair by call or teams and write in the maintenance binder, and the DOM will text him what needed to be repaired. MW stated the importance of clear communication between maintenance workers is to keep the residents safe and maintain a homelike environment.On 1/9/26 at 1:50 P.M., an interview was conducted with the DOM. The DOM stated that leaking ceilings are not homelike and can be dangerous. The DOM stated the expectation is for staff to call him about any flooding or free water or leaks via Teams app and to document it on the maintenance binder. The DOM stated the importance of reporting required maintenance and documenting it in maintenance binder is to make sure repairs are done in a timely manner. The DOM stated the importance of clear communication between maintenance workers is to keep the residents safe and maintain a homelike environment.On 1/9/26 at 2 P.M., an interview with the Administrator (ADM) was conducted. The ADM stated the leaking ceilings and water damage walls are not homelike. The ADM stated that the facility should be aware of any leaks in the ceiling and they should be repaired immediately. The ADM stated that the DOM should be aware of all repairs that should need immediate attention. The ADM stated the importance of timely repair of leaking ceilings is to prevent slip hazards for the safety of residents and staff.Record review of facility policy Homelike Environment dated 2001 indicated Residents are provided with a safe, clean, homelike environment.2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary, and orderly environment.