

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 05/15/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>52274</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure a dignified dining experience for 1 (Resident #92) of 6 sampled residents reviewed for nutrition.</p> <p>Findings included:</p> <p>A facility policy titled, Dignity revised 02/2021, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The policy specified, 5. When assisting with care, residents are supported in exercising their rights. For example, residents are: a. groomed as they wish to be groomed; b. encouraged to attend activities of their choice, including religious, political, civic, recreational, or social activities; c. encouraged to dress in clothing that they prefer; d. allowed to choose when to sleep, eat and conduct activities of daily living; and e. provided with a dignified dining experience.</p> <p>A facility policy titled, Assistance with Meals revised 03/2022, indicated, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident.</p> <p>An Admission Record revealed the facility admitted Resident #92 on 10/07/2023. According to the Admission Record, the resident had a medical history that included diagnoses of amyotrophic lateral sclerosis (ALS, a nervous system disease that weakened muscles and impacted physical function), dysphagia (difficulty swallowing), contracture, muscle wasting and atrophy, and need for assistance with personal care.</p> <p>A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/02/2025, revealed Resident #92 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident was dependent on staff for eating.</p> <p>Resident #92's Care Plan Report included a focus area initiated 10/09/2023, that indicated the resident was at risk for an activity of daily living/mobility decline and required assistance related to diagnoses that included ALS. Interventions directed staff to provide substantial/maximal assistance with eating (initiated 10/09/2023).</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and observation on 05/13/2025 at 8:26 AM, Resident #92 was observed lying in bed. It was noted that the resident's breakfast meal tray was on an overbed table near the bottom of their bed and out of the resident's reach. Resident #92 stated their breakfast meal tray was delivered to their room at 8:15 AM. At 8:48 AM, Certified Nursing Assistant (CNA) #5 entered Resident #92's room and fed the resident's roommate their breakfast meal.</p> <p>During an interview on 05/13/2025 at 9:05 AM, CNA #5 stated that she was assigned to Resident #92; however, the resident was usually their breakfast and lunch meal by a restorative nursing assistant (RNA).</p> <p>During a concurrent interview and observation on 05/13/2025 at 9:07 AM, RNA #6 entered Resident #92's room and spoke with the resident. At 9:17 AM, RNA #6 brought another breakfast meal tray to the resident's room and received assistance from another staff member to reposition Resident #92 in their bed. At 9:21 AM, RNA #6 placed Resident #92's dentures in their mouth and then proceeded to feed the resident at 9:21 AM. RNA #6 stated Resident #92 was in the restorative dining program and he usually fed the resident around 9:00 AM.</p> <p>During a concurrent interview and observation on 05/14/2025 at 8:22 AM, , Resident #92 was observed lying in bed. It was noted that the resident's breakfast meal tray was on an overbed table near the bottom of their bed and out of the resident's reach. Resident #92 stated their meal tray was delivered to their room at 8:15 AM. According to Resident #92, staff always brought their meal tray early, laid it down out of their reach and no one came back for a long time to feed them. Resident #92 stated they did not like having to wait to be fed, while they watched their meal tray and their roommate being fed.</p> <p>During a concurrent interview and observation on 05/14/2025 at 8:22 AM, Resident #92 was being fed their breakfast meal by RNA #6. RNA #6 stated he started to fed the resident at 9:00 AM. RNA #6 stated Resident #92 saw when their meal was placed in their room and they knew when it was there, but having the meal sit was not typical.</p> <p>During an interview on 05/15/2025 at 9:42 AM, Licensed Vocational Nurse #7 stated Resident #92 required total assistance from staff and was fed breakfast and lunch by an RNA.</p> <p>During an interview on 05/15/2025 at 9:50 AM, the Infection Control Nurse (ICN) stated she supervised the restorative program. The ICN stated meal carts came at different times to unit based on who was assigned to the program. According to the ICN, Resident #92 was on the feeding program, an RNA was scheduled to feed the resident their meal dependent on when the tray arrived, and that the resident was to be fed immediately.</p> <p>During an interview with the Administrator and Director of Nursing (DON) on 05/15/2025 at 10:40 AM, the DON stated the expectation was that the RNA who was assigned to feed each resident should feed the resident at the time that the tray was distributed. The Administrator stated his expectations were the same expectation as the DON, that once all trays were delivered then the RNAs were to come back and deliver the assigned tray and feed the resident at that time so that the food did not get cold. The Administrator stated residents should never be able to see someone else eat and not have their food. The DON stated both residents in a room should be fed at the same time for a dignified meal experience.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>45849</p> <p>Based on interview, record review, and facility policy review, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 2 (Resident #77 and Resident #185) of 38 residents whose MDSs were reviewed.</p> <p>Findings included:</p> <p>A facility policy titled, Resident Assessments, revised 10/2023, revealed the section titled, Policy Interpretation and Implementation, included, 11. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. 12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews.</p> <p>1. An Admission Record indicated the facility admitted Resident #185 on 01/21/2025. According to the Admission Record, the resident had a medical history that included diagnoses of multiple rib fractures, a history of falling, and dementia.</p> <p>A discharge MDS, with an Assessment Reference Date (ARD) of 02/12/2025, revealed Resident #185 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #185 had been discharged to a short-term general hospital.</p> <p>Resident #185's Care Plan Report, included a focus area initiated 01/22/2025, that indicated the resident had a need for assistance with discharge planning. Interventions directed staff to assess the resident for the appropriate level of care and make recommendations, coordinate referrals to outside resources, and educate the resident and family regarding home care needs.</p> <p>Resident #185's Order Summary Report, with active orders as of 02/12/2025, included an order dated 02/11/2025 to discharge the resident home per request with home health.</p> <p>During an interview on 05/15/2025 at 10:28 AM, MDS Coordinator #14 stated he obtained information for the MDS assessment from visiting with residents to make observations, reviewing hospital records, obtaining information from nursing, and reviewing progress notes. MDS Coordinator #14 stated a resident's discharge location was documented on the MDS assessment. He stated that the Social Services Director (SSD) had completed the discharge section of the MDS for Resident #185. MDS Coordinator #14 confirmed that according to Resident #185's progress notes, the resident had discharged with their personal belongings to home, but the SSD had coded on the MDS assessment that the resident went to the hospital. He stated the SSD should have documented that Resident #185 was discharged home.</p> <p>During an interview on 05/15/2025 at 10:52 AM, the SSD confirmed that the discharge summary for Resident #185 indicated the resident had discharged home with their family member. The SSD stated the MDS revealed Resident #185 was discharged to a short-term hospital but should have shown that the resident went home. The SSD stated she must have gotten confused with where the resident was admitted from.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/15/2025 at 11:06 AM, the Administrator stated he expected the MDS, including the discharge destination, to be accurate. During a concurrent interview, the Director of Nursing (DON) stated the MDS should be correct.</p> <p>46258</p> <p>2. An Admission Record revealed the facility admitted Resident #77 on 09/19/2018. According to the Admission Record, the resident had a medical history that included diagnoses of major depressive disorder, psychotic disorder, bipolar disorder, and generalized anxiety disorder.</p> <p>An annual MDS, with an Assessment Reference Date (ARD) of 09/06/2024, revealed Resident #77 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated Resident #77 did not have a Preadmission Screening and Resident Review (PASRR).</p> <p>Resident #77's Care Plan Report, included a focus area revised 06/23/2023, that indicated Resident #77 had episodes of bipolar disorder exhibited by angry outbursts. The Care Plan Report included a focus area initiated 03/21/2025 that indicated the resident was at risk for psychosocial well-being and adjustment issues, emotions distress and ineffective coping skills, poor impulse control, and adverse effects on function, mental, physical, social, or spiritual wellbeing related to a diagnosis of depression.</p> <p>A letter from the State of California Health and Human Services Agency Department of Health Care Services, dated 06/05/2023, revealed Resident #77's PASRR Level II evaluation was completed on 06/04/2023.</p> <p>During an interview on 05/15/2025 at 10:28 AM, MDS Coordinator #14 confirmed that the PASRR was not coded correctly. He further stated the person that was signing off on the section of the MDS for PASRRs did not ensure accuracy, just that it was completed. He also stated that the Social Services Director (SSD) was responsible for the section for the PASRR.</p> <p>During an interview on 05/15/2025 at 10:53 AM, the SSD revealed she did not know Resident #77 had a PASRR Level II. She further confirmed that the MDS was not accurate.</p> <p>During an interview on 05/15/2025 at 11:06 AM, the Administrator revealed that the MDS should have been accurate. During a concurrent interview, the Director of Nursing (DON) stated the MDS should have been coded right.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>46258</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure a care plan was followed for 1 (Resident #30) of 7 residents reviewed for nutrition.</p> <p>Findings included:</p> <p>A facility policy titled, Assistance with Meals, revised 03/2022, specified, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident.</p> <p>An Admission Record revealed the facility admitted Resident #30 on 02/25/2013. According to the Admission Record, the resident had a medical history that included hemiplegia and hemiparesis (partial weakness on one side of the body) following a cerebral infarction (stroke), dysphagia (difficulty swallowing), and functional quadriplegia.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/06/2024, revealed Resident #30 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #30 required supervision or touching assistance with eating.</p> <p>Resident #30's Care Plan Report, included a focus area initiated 03/31/2025, that revealed Resident #30 had moderate oropharyngeal dysphagia, which impeded safe swallowing. The Care Plan Report included a focus area revised on 03/31/2025, that revealed Resident #30 had a self-care deficit and required assistance with activities of daily living (ADLs), and they needed to be supervised while eating.</p> <p>An observation of meal service on 05/14/2025 at 9:01 AM revealed Resident #30 received their breakfast tray. At 9:13 AM, Resident #30 was observed in their bed consuming their breakfast. No staff were in the room supervising Resident #30. Resident #30 continued to consume their breakfast until they were done with their meal.</p> <p>An observation of meal services on 05/14/2025 at 1:52 PM revealed Certified Nursing Assistant (CNA) #12 delivered Resident #30 their lunch tray, set up the tray (uncovered food and drinks) for Resident #30 to eat, and exited the room. Resident #30 was observed eating their meal and drinking their milk and juice. There were no staff in the room supervising Resident #30.</p> <p>During an interview on 05/14/2025 at 2:03 PM, CNA #12 stated he did not know that Resident #30 needed to be supervised while eating. He stated he would get the information (related to the resident's required assistance with meals) from a coworker and if they did not provide the information he needed, he would look in the Kardex or look in the resident's health record. CNA #12 stated that not supervising someone that needed to be observed while eating could lead to that resident choking or aspirating.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation of meal services on 05/15/2025 at 9:01 AM, Resident #30 was observed in their bed, eating their breakfast. There was no staff supervising Resident #30. During a concurrent interview with Resident #30, they stated that no one had been in their room during the meal.</p> <p>During an interview on 05/15/2025 at 9:08 AM, CNA #13 stated she did know Resident #30 needed to be supervised during meal service. She stated she left Resident #30 while they were eating to answer a call light. CNA #13 acknowledged that when a resident needed to be supervised during meals, the staff member needed to stay during the entire meal.</p> <p>During an interview on 05/15/2025 at 9:53 AM, the Speech Language Pathologist (SLP) stated Resident #30 needed to be supervised while eating to remind them to take a bite and to take small bites. She added Resident #30 needed to be supervised for the entire meal, every meal.</p> <p>During an interview on 05/15/2025 at 11:06 AM, the Administrator stated that if there was a clinical recommendation, it needed to be followed. The Administrator stated that if the recommendation was not followed it could have led to choking.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46258</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff followed a physician's order for supervision during meals for 1 (Resident #30) of 7 residents reviewed for nutrition.</p> <p>Findings included:</p> <p>A facility policy titled, Assistance with Meals, revised 03/2022, specified, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. The policy revealed the section titled, Policy Interpretation and Implementation, included, 2. Facility staff will serve resident trays and will help residents who require assistance with eating.</p> <p>An Admission Record revealed the facility admitted Resident #30 on 02/25/2013. According to the Admission Record, the resident had a medical history that included hemiplegia and hemiparesis (partial weakness on one side of the body) following a cerebral infarction (stroke), dysphagia (difficulty swallowing), and functional quadriplegia.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/06/2024, revealed Resident #30 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #30 required supervision or touching assistance with eating.</p> <p>Resident #30's Order Summary Report, with active orders as of 05/14/2025, included an order dated 03/10/2025, for a regular diet with pureed texture and thin liquids consistency, and that specified one-on-one supervision with meals.</p> <p>Resident #30's Care Plan Report, included a focus area initiated 03/31/2025, that revealed Resident #30 had moderate oropharyngeal dysphagia, which impeded safe swallowing. The Care Plan Report included a focus area revised on 03/31/2025, that revealed Resident #30 had a self-care deficit and required assistance with activities of daily living (ADLs), and they needed to be supervised while eating.</p> <p>Resident #30's Visual/Bedside Kardex Report, dated 05/14/2025, revealed Resident #30 required supervision during meals.</p> <p>Resident #30's Wednesday Breakfast and Wednesday Lunch tray ticket revealed Resident #30 required one-on-one supervision during meals.</p> <p>An observation of meal service on 05/14/2025 at 9:01 AM revealed Resident #30 received their breakfast tray. At 9:13 AM, Resident #30 was observed in their bed consuming their breakfast. No staff were in the room supervising Resident #30. Resident #30 continued to consume their breakfast until they were done with their meal.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation of meal services on 05/14/2025 at 1:52 PM revealed Certified Nursing Assistant (CNA) #12 delivered Resident #30 their lunch tray, set up the tray (uncovered food and drinks) for Resident #30 to eat, and exited the room. Resident #30 was observed eating their meal and drinking their milk and juice. There were no staff in the room supervising Resident #30.</p> <p>During an interview on 05/14/2025 at 2:03 PM, CNA #12 stated he did not know that Resident #30 needed to be supervised while eating. He stated he would get the information (related to the resident's required assistance with meals) from a coworker and if they did not provide the information he needed, he would look in the Kardex or look in the resident's health record. CNA #12 stated that not supervising someone that needed to be observed while eating could lead to that resident choking or aspirating.</p> <p>During an observation of meal services on 05/15/2025 at 9:01 AM, Resident #30 was observed in their bed, eating their breakfast. There was no staff supervising Resident #30. During a concurrent interview with Resident #30, they stated that no one had been in their room during the meal.</p> <p>During an interview on 05/15/2025 at 9:08 AM, CNA #13 stated she did know Resident #30 needed to be supervised during meal service. She stated she left Resident #30 while they were eating to answer a call light. CNA #13 acknowledged that when a resident needed to be supervised during meals, the staff member needed to stay during the entire meal.</p> <p>During an interview on 05/15/2025 at 9:53 AM, the Speech Language Pathologist (SLP) stated Resident #30 needed to be supervised while eating to remind them to take a bite and to take small bites. She added Resident #30 needed to be supervised for the entire meal, every meal.</p> <p>During an interview on 05/15/2025 at 11:06 AM, the Administrator stated that if there was a clinical recommendation, it needed to be followed. The Administrator stated that if the recommendation was not followed it could have led to choking. During a concurrent interview, the Director of Nursing (DON) stated that staff needed to do what was ordered.</p>

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52274</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to provide timely podiatry services for 1 (Resident #388) of 3 sampled residents reviewed for activities of daily living.</p> <p>Findings included:</p> <p>A facility policy titled, Podiatry Services revised 02/2023, indicated, It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. The policy specified, 5. The social worker or designer will assist residents in making appointments and arranging transportation to obtain needed services.</p> <p>An Admission Record revealed the facility admitted Resident #388 on 04/14/2025. According to the Admission Record, the resident had a medical history that included diagnoses of muscle weakness and dorsalgia (back pain).</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/21/2025, revealed Resident #388 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required partial/moderate assistance with personal hygiene.</p> <p>Resident #388's Order Summary Report which contained active orders as of 05/14/2025, revealed an order dated 04/14/2025, for podiatry evaluation and treatment as indicated for mycotic toenails every 90 days and as needed.</p> <p>Resident #388's Social Service Note dated 04/16/2025, indicated the resident was referred to podiatry.</p> <p>Resident #388 Nurse's Note written by the Assistant Director of Nursing and dated 04/26/2025, revealed social services was contacted by the ADON to please add the resident to the podiatrist list as soon as possible for an ingrown toenail.</p> <p>During a concurrent observation and interview on 05/12/2025 at 11:40 AM, Resident #388 stated they had an ingrown toenail and had been told that the podiatrist would come in and see them, but it had not been done. Resident #388 stated their toenail hurt and that pain medication did not help. Resident #388 removed the sock from their right foot, and it was noted that the toenail on their big toe on the right foot was about 1 inch long, above the top of the toe, and the nail was thick.</p> <p>During an interview on 05/14/2025 at 8:54 AM, Certified Nursing Assistant (CNA) #8 stated she was assigned to Resident #388, Resident #388 needed to see podiatrists, and was on the list. Per CNA #8, the podiatrist came into the facility on ce per month.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/14/2025 at 8:59 AM, Registered Nurse #9 stated that she was assigned to Resident #388 and the resident made complaints of ingrown toenails and pain for at least one and a half weeks.</p> <p>During an interview on 05/14/2025 at 9:08 AM, Licensed Vocational Nurse (LVN) #10 stated Resident #388 had been asking to be seen by the podiatrist and had pain that was managed by pain medication given for generalized pain. LVN #10 stated that the podiatrist company had come in the facility for urgent matters but had not come in for Resident #388. Per LVN #10, the resident was scheduled to be seen by the podiatrist on 05/15/2025.</p> <p>During an interview on 05/14/2025 at 9:30 AM, the Social Service Director (SSD) stated that residents were referred to podiatry by nursing or a resident would let social services (SS) know that they needed to be seen. The SSD stated the podiatrist came in every 90 days; if there was an emergent need they would do a special visit. Per the SSD, if the podiatrist was unable to come in for an emergent visit then the resident would be sent out for services. The SSD stated that the podiatrist was expected to come to the facility on [DATE] and would stay for three days to do each floor. The SSD stated that Resident #388 was currently on the list; a referral was sent out to the vendor on 05/09/2025 to cut the resident's toenails.</p> <p>During an interview with the Director of Nursing (DON) and the Administrator on 05/15/2025 at 10:40 AM, the DON stated that her expectation was that as soon as the resident had concerns with their toenails, social services would contact the podiatrist right away and make sure that the resident got the care needed. The Administrator stated that his expectation was the same expectation as the DON, and that he expected the floor staff report to appropriate channels and forward to social services.</p>		

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 05/15/2025
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>45849</p> <p>Based on observation, interview, facility document and policy review, the facility failed to follow the prepared menu for residents who received diets with mechanical soft or ground meat for 30 of 183 residents who resided in the facility and failed to follow the prepared menu for residents who received diets with pureed meat for 21 of 183 residents who resided in the facility.</p> <p>Findings included:</p> <p>An undated facility policy titled, Menus, indicated, Menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. The policy revealed the section titled, Policy Interpretation and Implementation, included, 6. Menus must be followed. Deviations from posted menus are recorded (including the reason for the substitution and/or deviation) and archived. Further review revealed, 8. Menus provide a variety of foods from the basic daily food groups and indicate standard portions at each meal.</p> <p>The facility's Spring Cycle Menus, revealed that the planned lunch meal on 05/13/2025 included a 3-ounce (oz) portion of barbeque (BBQ) chicken for regular diets. The menus revealed the mechanical soft diet included a #10 (3.2 oz) scoop of ground moist BBQ chicken, and the pureed diet included a #8 (4 oz) scoop of pureed BBQ chicken.</p> <p>Observations on 05/13/2025 beginning at 10:40 AM revealed [NAME] #3 serving the mechanical soft BBQ chicken with a #12 (2.67 oz) scoop. [NAME] #3 served pureed BBQ chicken with a #12 (2.67 oz) scoop.</p> <p>During an interview on 05/13/2025 at 1:41 PM, [NAME] #3 stated she looked at the menus to know what size portion scoops to use for serving meals. [NAME] #3 confirmed she had used a #12 scoop to serve the mechanical soft and pureed chicken. [NAME] #3 reviewed the menu and confirmed that the portion size should have been a #10 portion scoop for the mechanical soft BBQ chicken and a #8 portion scoop for the pureed BBQ chicken.</p> <p>During an interview on 05/13/2025 at 3:42 PM, Dietary Director (DD) #2, the former Dietary Director who was assisting with training the current Dietary Director, stated her expectation was that the cook should check the menu spreadsheet before starting the meal service. DD #2 stated it was important to serve the correct portion sizes to ensure residents received adequate nutrition.</p> <p>During an interview on 05/13/2025 at 3:45 PM, DD #1, the current Dietary Director, stated her expectation was that they served the correct portion sizes. DD #1 stated it was important to serve the correct portions to ensure residents received the right nutrients.</p> <p>During an interview on 05/14/2025 at 3:16 PM, the Registered Dietitian (RD) stated it was important to serve the correct portion sizes to ensure residents received adequate nutrition and protein.</p> <p>(continued on next page)</p>		

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 05/15/2025
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/15/2025 at 8:45 AM, the Director of Nursing (DON) stated she expected staff to follow the correct portion sizes because that was what the doctor ordered.</p> <p>During an interview on 05/15/2025 at 8:49 AM, the Administrator stated his expectation was that staff should follow the menu and portion sizes.</p>