STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056176	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Heights Transitional Care Center	2707 Pine Street San Francisco, CA 94115

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure three out of three sampled staff employee files, (Unlicensed Staff A, Unlicensed Staff B and Unlicensed Staff C) had annual performance reviews or evaluations (systemic [entire organization], periodic process that assesses an employee's job performance, skills, and accomplishments against established company goals) performed for the year(s) 2025 and 2026.These failures had the likelihood for missed opportunities to provide specific education-based training for unlicensed staff members to capture potential safety concerns and improve outcomes like improving resident care concerns.During an interview on 3/12/26 at 2:29 PM with Director of Staff Development (DSD), DSD stated they had been in the position with the facility for approximately two years and had the responsibility of managing all of the unlicensed staff at the facility who provide care to the residents within the facility. During a concurrent interview and record review on 3/12/26 at 2:55 PM with DSD, the employee file of Unlicensed Staff A (USA) was reviewed. DSD stated USA had been hired in the month of July and the annual performance review or evaluation would not be completed until July of 2026 and it was March, sot it had not been done. Surveyor requested the annual performance review or evaluation for 2025, and DSD stated, they do not do performance reviews but presented a document, Annual Clinical Care Training Checklist dated 7/21/25 was reviewed. The checklist indicated to be comprised of skills which the employee and DSD initialed and there was no indication how the skills were assessed, for example by return demonstration or verbalizing to the DSD how the employee might perform the skill. DSD was asked if the form would capture, for example; an incident where Unlicensed Staff A had an allegation with a resident which had been unsubstantiated, but further training might have been helpful and DSD stated no, the form would not capture those types of instances. DSD looked down and stated, I work very hard and try my best. Surveyor asked for clarification if anyone else in the building was conducting performance reviews or evaluations and DSD stated no one would because they were in charge of all unlicensed staff and it was their responsibility to do anything related to these staff members. During an interview on 3/12/26 at 3:58 PM with Administrator (ADM), ADM was asked who performed the annual performance evaluations for unlicensed staff in the facility and ADM stated it was the DSD. Surveyor asked ADM what would be considered a performance evaluation and ADM presented a copy, titled, Performance Evaluation, reviewed 9/13/2023. Surveyor presented ADM with a copy of Annual Clinical Care Training Checklist and asked if this would be considered a performance evaluation and ADM stated no, the form presented and titled performance evaluation was the approved form. ADM stated the form (Annual Clinical Care Training Checklist) indicated to be a skills type of check list and actually that was why the facility chose the performance evaluations as part of the quality improvement for the year (2026). Surveyor asked why it was chosen and ADM stated because it was identified that it was not being completed with the unlicensed staff. Surveyor asked who the DSD reported to and ADM stated it was the Director of Nursing and the Director of Nursing reported to ADM. ADM stated ultimately, it's their responsibility that the performance evaluations were not getting done, since their were in charge of the building. During a concurrent interview and record review on 3/12/26 at 4:23 PM with DSD, the employee file of Unlicensed Staff B (USB) was reviewed. Surveyor presented the performance evaluation form obtained from Admin to DSD who stated, Yes, I (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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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was supposed to complete all of the unlicensed staff by April 1, 2026, but I have not completed any of them yet. Employee file review for USB was reviewed and DSD presented, Annual Clinical Care Training form dated 1/6/26. Surveyor clarified with DSD regarding the performance evaluation for USB and if there was one for 2025 or 2026 and DSD stated no. During a concurrent interview and record review on 3/12/26 at 4:55 PM with DSD, the employee file for Unlicensed Staff C (USC) was reviewed. DSD stated USC had been hired in January of 2025. Surveyor clarified with DSD if USC had a performance evaluation due in January of 2026 and had one completed to date, DSD stated no. During a review of the facility's, Employee Handbook titled, Performance Evaluations, dated 2023, indicated, Performance feedback should be on-going between supervisors and employees. However, we established annual, documented reviews as a standard to formalize an interactive conversation about what is going well, where there could be improvements, goals for career growth and to set objectives to work towards.You (employee) will be critiqued on the quality and quantity of the work you perform: job knowledge, customer service, professional behavior, attitude and treatment of others, . Included was a copy of the Performance Evaluation, revised 2/4/2026 (5 pages total).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, facility staff failed to ensure their walk-in freezer and walk-in refrigerator were maintained in a sanitary manner and a container of thickening powder was dated and labelled. These failures had the potential for food to be stored in an unsanitary manner and for residents to be exposed to expired food products.Findings:During a concurrent kitchen observation and interview with the Nutritional Service Supervisor (NSS) on 3/9/26 at 9:17 AM, these observations were made with the NSS:A clear plastic container, 1/2 full of a white powder was stored on a shelf next to the cook top. The container had no label and there was no opened date nor expiration date on the container.two blue berries, a clear plastic lid for a disposable cup, a can of ginger ale (8 fluid ounce, fluid ounce is a unit of liquid measurement), and a container of Ensure plus (dietary supplement, 8 fluid ounce) were found on the floor of the walk-in refrigerators (under the shelves).A handful of frozen peas and diced carrots, and four small frozen doughs were found on the floor of the walk-in freezer (under the shelves).During the interview, the NSS stated the white powder was a fluid thickening agent and should have been labelled and dated for a used by date. An observation was made that the walk-in refrigerator was dimly lit and the NSS confirmed this observation. The NSS stated this may have prevented staff from cleaning the area properly and may impede supervisory staff from checking to see if the area was clean in a proper manner.Review of the facility's policy titled GENERAL APPEARANCE OF FOOD & NUTRITION DEPARTMENT, dated 2018, indicated .Floors, floor mats, and walls must be scheduled for routine cleaning and maintained in good condition.1. Floors must be mopped at least once per day. 2. Sweep the floor, pushing all debris forward. Use a dust pan to remove and dispose of debris as it accumulates.Review of the facility's policy titled DRY STORAGE QUICK REFERENCE GUIDE, dated January 2026, indicated .Thickener . Recommended storage time .18-24 months. No other policy was provided by the facility regarding labeling and dating of food items.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, three issues were identified regarding dialysis communication books for Resident 7 and 27, two out of four resident receiving outpatient dialysis.1. Resident 7's dialysis communication book was missing important information. 2. Two medications were administered by dialysis staff to Resident 7. One was not clarified and both were not communicated to the physician and/or dietitian.3. Residents 27's dialysis communication book was left at the dialysis center and information regarding the latest dialysis session was not charted in the nursing notes.These failures had the potential to negatively impact continuity of care for Residents 7 and 27.Findings:Review of Resident 7's medical records titled dialysis communication book on 3/11/26 at 1:29 PM indicated documentations regarding post dialysis pain assessments were left blank on these dialysis dates: 3/10/26, 3/7/26, 3/5/26, 3/3/26, 2/28/26, 2/26/26, 2/24/26, 2/21/26, 2/19/26, 2/17/26, 2/14/26, 2/12/26, 2/10/26, 2/7/26, 2/5/26, and 2/3/26. Additionally, on 3/10/26, dialysis staff documented in the dialysis communication book they administered two medications to Resident 7 during his dialysis session. One medication was calcitriol (a medication that helps with calcium absorption), and the other medication was written in an illegible manner.During a concurrent interview and record review on 3/11/26 at 1:33 PM, the missing pain assessments and the illegible medication within Resident 7's dialysis communication book were reviewed with the Unit Manager. The Unit Manager looked at the medications administered by the dialysis staff on 3/10/26 and stated calcitriol was administered and she was unable to identify the second medication because it was written in an illegible manner. The Unit Manager was asked to search Resident 7's medical records for documentation that:staff clarify what medications were administered by dialysis staff and/or communicated to physicians and/or Registered Dietitian which medications were administered during dialysis.Staff documented they assessed Resident 7 for pain after returning from dialysis (from March to February 2026).The Unit Manager searched Resident 7's medical records and stated she could not find these documentations. During a concurrent interview and record review with the Nurse Manager on 3/11/26 at 1:51 PM, the Nurse Manager stated Resident 27's dialysis communication book was left at the dialysis center. The Unit Manager was asked to search for documentation regarding the missing dialysis communication book and data collected by the dialysis staff such as pre and post dialysis weights, medications administered, and/or other complications during Resident 27's last dialysis session. After searching Resident 27's records, the Unit Manager stated she was unable to find documentation regarding the missing dialysis communication book nor information regarding the last dialysis session. Additionally, the Unit Manager confirmed staff failed to document post dialysis assessments for vital signs, pain assessment and dialysis site condition after Resident 27's last dialysis session.Review of the facility's policy titled Hemodialysis Care and Coordination (hemodialysis = a process to help diseased kidney filter wastes and fluid), revised on October 2025, indicated .The facility shall assure that each resident receives care and services for the provision of . dialysis consistent with professional standards of practice. This shall include: Ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices: and Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices: and Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interviews, and record reviews, the facility failed to ensure the accountability of controlled medications (medication with high potential for abuse and addiction) when the Controlled Drug Record (CDR, accountability records, an inventory sheet that keeps records of the usage of controlled medications) for one of six sampled residents (Resident 66) did not reconcile with the Medication Administration Record (MAR). This failure resulted in inaccurate accountability and the potential for abuse and diversion of controlled medications. Review of Resident 66's Physician's Order, dated 1/20/26, indicated oxycodone (a controlled narcotic medication for pain) 5 mg (milligram, unit of measurement), Give 1 tablet (5 mg) by mouth every 6 hours as needed for breakthrough pain (moderate pain 4-7 [pain scale]). and Give 2 (10 mg) tablet by mouth every 6 hours as needed for breakthrough pain (severe pain 8-10). During a concurrent interview and record review on 3/11/26 at 2:40 PM with License Vocational Nurse (LVN) 2 and Nurse Manager (NM) 2, Resident 66's CDR and MAR were reviewed. The MAR indicated two tablets of oxycodone 5 mg were administered on 1/22/26 at 9:08 AM. However, the CDR did not indicate the medications were signed out on that date and time. LVN2 and NM2 verified the two tablets of Resident 66's oxycodone 5 mg were documented as administered on the MAR on 1/22/26 at 9:08 AM but not signed out of the CDR. During an interview on 3/12/26 at 3:33 PM, the Director of Nursing (DON) stated, she was aware of the concern with the narcotic accountability for Resident 66. The DON stated it is important to ensure medications are properly accounted for to prevent missing medications and possible medication diversion by staff. During a concurrent interview and record review on 3/12/26 at 3:38 PM with the DON. The facility's policy and procedure (P&P) titled, PREPARATION AND GENERAL GUIDELINES, dated in April 2008 was reviewed. The P&P indicated, . Controlled Medications.When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): Date and time of administration .Amount administered .Signature of the nurse administering the dose . The DON stated the information in the CDR and MAR should match.