STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056272	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Francisco Health Care	1477 Grove Street San Francisco, CA 94117

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to inventory and secure personal properties for Residents 1, 2, 3, and 4. These failures resulted in missing properties for Residents 1 and 2 and inaccurate and/or missing inventory lists for Residents 3 and 4.Findings: During a concurrent inventory observation, interview, and record review with the Director of Nursing (DON) on 4/9/26 at 11:00 AM these issues were identified:The DON looked at Resident 3's medical records and stated Resident 3 was admitted on [DATE]. Observation/audit of Resident 3's inventory found one woman's housedress with a woman's name and room number on the inside of the dress under the collar.The DON looked at Resident 4's medical records and stated he was admitted on [DATE]. A search of Resident 4's electronic medical records found no inventory sheet and a search of his physical chart at the nursing station found no inventory sheet. Observation of Resident 4's room revealed he had: a long sleeve t-shirt, one sweatpants, one shirt, one pant, and one donated shirt labeled with Resident 4's room number.During the interview, the DON stated staff should inventory and document resident's belongings immediately upon admission and ensure items not belonging to residents be reported to facilitate return to original owner or donation. Review of Resident 1's medical records titled admission RECORD, printed on 4/10/26, indicated Resident 1 was admitted on [DATE] under hospice for comfort focused treatment (comfort care focused on quality of life rather than curing a terminal illness). Review of an Ambulance transport document (not titled), dated 10/7/25, indicated Resident 1 was transported with .belongings consisting of 1 bag with supplies, one cell phone, a wheelchair and one backpack. Review of Resident 1's medical records titled INVENTORY OF PERSONAL ITEMS, dated 10/7/25, indicated .No Belongings upon arrival I gave her clothes from donation. During an interview on 4/10/26 at 11:09 AM, Resident 1's responsible party (R1RP) stated she was in contact with the Administrator via phone and text regarding Resident 1's missing items such as cell phone, driver license, and debit card. R1RP stated she was quite alarmed regarding an abnormal financial issue going on while Resident 1 was staying at the facility. R1RP stated Resident 1 took $1,200 out of her account to give to a staff member to buy an airline ticket to Zimbabwe (a country in [NAME]). R1RP said Resident 1 has never been to [NAME] and does not know anyone in [NAME]. R1RP stated there were also abnormal issues going on after Resident 1 passed away on 12/17/25. Someone was making long distance calls from her cell phone after she passed away and there were withdrawals from her debit card after Resident 1 passed away. R1RP stated all this information was shared with the Administrator and she asked for help in investigating and retrieving Resident 1's cell phone, driver's license and debit card. R1RP stated to this day, the facility has not taken responsibility for safeguarding Resident 1's belongings. During an interview on 4/10/26 at 12:11PM, the Administrator stated he was aware of R1RP's requests and concerns. The Administrator stated he looked into the issue regarding Resident 1 transferring money to his Certified Nursing Assistant (CNA) 1 to purchase an airline ticket to Zimbabwe. The Administrator stated he has been an Administrator for 20-30 years and admitted these kind of interactions/relationships between resident and staff were highly unusual. The Administrator stated he looked into the matter, and found the money was refunded when Resident 1 was unable to take the trip. The Administrator stated he took (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056272	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Francisco Health Care	1477 Grove Street San Francisco, CA 94117

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no further action as there was nothing in the facility's handbook and/or policy specifically prohibiting this particular kind of interaction. The Administrator stated he was looking at revising policies after this incident. The Administrator stated the facility's admission inventory list for Resident 1 showed no belongings. The Administrator was made aware of ambulance transport documentation showing Resident 1 arrived with a cell phone and some belongings. The Administrator did not comment on this. The Administrator was made aware Resident 1's admission inventory documentation may not be accurate based on data gathered on the facility's current inventory system and safeguarding of belongings. The Administrator did not comment on this. The Administrator was asked if he expanded his sample to look at other residents under CNA 1's care? The Administrator stated No. The Administrator was asked if he documented all his investigation regarding R1RP's allegations? The Administrator stated some of the documentations were in emails but No he did not formally document the allegations and his investigation. Review of Resident 2's medical record titled MDS (Minimum Data Set, a standardized resident assessment tool), dated 1/4/26, indicated her BIMs (a 0-15 point test/assessment tool used to check a resident's memory and thinking abilities) score was 5 out of 15 (a score of 5 indicates severe problems with memory and thinking). Review of Resident 2's hospital discharge record titled D/C planning Ongoing Assessment, dated 9/27/24, indicated .Discharge To: Skilled nursing facility. (social worker) discussed with . (admission staff) at San Francisco Health Care Center regarding .(Resident 2's) valuables. reported .(Resident 2) having $3600 in US dollars, a yellow necklace and bracelet, and two [NAME] pendants . (admission staff at San Francisco Health Care Center) documented and will put in safe place and return upon discharge. During an interview on 04/21/2026 at 1:55 PM, the Social Worker (SW) stated she was made aware of the missing money and jewelry by Resident 2's family member on March 17, 2026. The SW stated she started to investigate the case and based on Resident 2 arriving without any belongings from the hospital, the SW concluded the facility was not responsible for these missing items. The SW was asked if she was aware the hospital documented on 9/27/24 Resident 2 was to be discharged with $3,600 and jewelry. The hospital also documented they spoke with a facility admission staff (Admission) to lock these valuables for safe keeping. The SW said she interviewed the admission staff. The SW stated the admission staff said she did not remember the phone conversation with the hospital and does not remember if money and valuables were discussed with the hospital during Resident 2's discharge. The SW said during her investigation, the ombudsman translated for Resident 2 and Resident 2 stated upon arrival at the facility, she gave her money and jewelry to a Vietnamese man. The SW stated they did not have a Vietnamese man working at the facility during that time frame. The SW stated Resident 2 has never mentioned her money and jewelry since admission and this issue only came up when her family member asked about the money and jewelry. During an interview 4/9/26 at 3:30 PM with the Administrator, DON, and SW, issues with the facility's inventory system and safeguarding of resident's belongings were shared with the facility's management team. The following were discussed: There were issues identified with Residents 3 and 4 regarding their inventories (see above). This may indicate a recent problem or an ongoing systemic problem with the facility's inventory system and/or safeguarding of resident's belongingsThere was evidence CNA 1 was treating monetary transactions between him and Resident 1 as between two consenting adults. By bypassing management oversight, this creates an environment where the facility may not be able to safeguard belongings of vulnerable residents.There was an independent source (hospital staff) documenting Resident 2 was coming to the facility with money and jewelry. There was no documented evidence the facility followed up and investigated when Resident 2 arrived at the facility without her money and jewelry. The facility stated they were not aware of item 3 and will submit their investigation regarding item 3. The facility did not discuss or offered any new documentation regarding items 1 and 2. Review of a facility policy titled Investigating Incidents of Theft and/or Misappropriation of Resident Property, revise April 2017, indicated .Residents have the right to be free from theft and/or misappropriation of personal property. Providing measures to safeguard resident valuables from easy public access.Inventorying resident belongings upon admission .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056272	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Francisco Health Care	1477 Grove Street San Francisco, CA 94117

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report allegations of misappropriation of personal properties for Residents 1 and 2 within 24 hours to the appropriate agencies. This failure did not ensure vulnerable residents were protected from misappropriation of personal properties. Findings: During an interview on 4/10/26 at 11:09 AM, Resident 1's responsible party (R1RP) stated she was in contact with the Administrator via phone and text regarding Resident 1's missing items such as cell phone, driver license, and debit card. R1RP sent evidence that she texted the Administrator on March 17, 2026 regarding these issues. During an interview on 4/10/26 at 12:11PM, the Administrator stated he was aware of R1RP's concerns thru phone calls and text messages but could not remember when he was first made aware of these allegations. When the Administrator was asked does March 17, 2026, sound about right? The Administrator answered sound about right. The Administrator was asked if he called this allegation in within 24 hours of learning about the allegation? The Administrator stated no. During an interview on 4/8/26 at 9:10 AM, the Complainant stated Resident 2 alleged she was missing approximately $3,000 and some jewelry. During an interview on 4/21/2026 at 1:55 PM, the Social Worker (SW) stated she was made aware of the missing money and jewelry by Resident 2's family member on March 17, 2026. Review of California Department of Public Health (CDPH) electronic data for facility reported incidents from March 17 to April 21 found no evidence the facility reported Resident 2's allegation to CDPH. Review of a facility policy titled Investigating Incidents of Theft and/or Misappropriation of Resident Property, revise April 2017, indicated .Residents have the right to be free from theft and/or misappropriation of personal property.Should an alleged or suspected case of staff misappropriation of resident property be reported, the facility Administrator, or his/her designee, will notify the following persons or agencies within twenty-four (24) hours of such incidents, as appropriate .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056272	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Francisco Health Care	1477 Grove Street San Francisco, CA 94117

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate allegations of misappropriation of personal properties for Residents 1 and 2. This failure did not ensure the facility could uncover weaknesses within their system to safeguard personal properties or implement effective measures to prevent misappropriation of personal properties. Findings: Review of Resident 1's medical records titled admission RECORD, printed on 4/10/26, indicated Resident 1 was admitted on [DATE] under hospice for comfort focused treatment (comfort care focused on quality of life rather than curing a terminal illness). Review of an Ambulance transport document (not titled), dated 10/7/25, indicated Resident 1 was transported with .belongings consisting of 1 bag with supplies, one cell phone, a wheelchair and one backpack. Review of Resident 1's medical records titled INVENTORY OF PERSONAL ITEMS, dated 10/7/25, indicated .No Belongings upon arrival I gave her clothes from donation. During an interview on 4/10/26 at 11:09 AM, Resident 1's responsible party (R1RP) stated she was in contact with the Administrator via phone and text regarding Resident 1's missing items such as cell phone, driver license, and debit card. R1RP stated she was quite alarmed regarding an abnormal financial issue going on while Resident 1 was staying at the facility. R1RP stated Resident 1 took $1,200 out of her account to give to a staff member to buy an airline ticket to Zimbabwe (a country in [NAME]). R1RP said Resident 1 has never been to [NAME] and does not know anyone in [NAME]. R1RP stated there were also abnormal issues going on after Resident 1 passed away on 12/17/25. Someone was making long distance calls from her cell phone after she passed away and there were withdrawals from her debit card after Resident 1 passed away. R1RP stated all this information was shared with the Administrator and she asked for help in investigating and retrieving Resident 1's cell phone, driver's license and debit card. R1RP stated to this day, the facility has not taken responsibility for safeguarding Resident 1's belongings. During an interview on 4/10/26 at 12:11PM, the Administrator stated he was aware of R1RP's requests and concerns. The Administrator stated he looked into the issue regarding Resident 1 transferring money to his Certified Nursing Assistant (CNA) 1 to purchase an airline ticket to Zimbabwe. The Administrator stated he has been an Administrator for 20-30 years and admitted this kind of interaction/relationship between resident and staff was highly unusual. The Administrator stated he looked into the matter, and found the money was refunded when Resident 1 was unable to take the trip. The Administrator stated he took no further action as there was nothing in the facility's handbook and/or policy specifically prohibiting this particular kind of interaction. The Administrator stated he was looking at revising policies after this incident. The Administrator stated the facility's admission inventory list for Resident 1 showed no belongings. The Administrator was made aware of ambulance transport documentation showing Resident 1 arrived with a cell phone and some belongings. The Administrator did not comment on this. The Administrator was made aware Resident 1's admission inventory documentation may not be accurate based on data gathered on the facility's current inventory system and safeguarding of belongings. The Administrator did not comment on this. The Administrator was asked if he followed this precise sequence of action upon learning of this allegation. 1. Suspend CNA 1; 2. Report the allegation to the appropriate agencies; 3. Conduct and document a thorough investigation. The Administrator stated No. The Administrator stated he investigated immediately, found no merit to the allegations and closed the case. The Administrator was asked if he expanded his sample to look at other residents under CNA 1's care? The Administrator stated No. The Administrator was asked if he documented all his investigation regarding R1RP's allegations? The Administrator stated some of the documentations were in emails but No he did not formally document the allegations and his investigation. Review of Resident 2's medical record titled MDS (Minimum Data Set, a standardized resident assessment tool), dated 1/4/26, indicated her BIMs (a 0-15 point test/assessment tool used to check a resident's memory and thinking abilities) score was 5 out of 15 (a score of 5 indicates (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056272	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Francisco Health Care	1477 Grove Street San Francisco, CA 94117

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	severe problems with memory and thinking). Review of Resident 2's hospital discharge record titled D/C planning Ongoing Assessment, dated 9/27/24, indicated .Discharge To: Skilled nursing facility. (social worker) discussed with . (admission staff) at San Francisco Health Care Center regarding .(Resident 2's) valuables. reported .(Resident 2) having $3600 in US dollars, a yellow necklace and bracelet, and two [NAME] pendants . (admission staff at San Francisco Health Care Center) documented and will put in safe place and return upon discharge. During an interview on 04/21/2026 at 1:55 PM, the Social Worker (SW) stated she was made aware of the missing money and jewelry by Resident 2's family member on March 17, 2026. The SW stated she started to investigate the case and based on Resident 2 arriving without any belongings from the hospital, the SW concluded the facility was not responsible for these missing items. The SW was asked if she was aware the hospital documented on 9/27/24 Resident 2 was to be discharged with $3,600 and jewelry. The hospital also documented they spoke with a facility admission staff (Admission) to lock these valuables for safe keeping. The SW said she interviewed the admission staff. The SW stated the admission staff said she did not remember the phone conversation with the hospital and does not remember if money and valuables were discussed with the hospital during Resident 2's discharge. The SW said during her investigation, the ombudsman translated for Resident 2 and Resident 2 stated upon arrival at the facility, she gave her money and jewelry to a Vietnamese man. The SW stated they did not have a Vietnamese man working at the facility during that time frame. The SW stated Resident 2 has never mentioned her money and jewelry since admission and this issue only came up when her family member asked about the money and jewelry. During an interview 4/9/26 at 3:30 PM with the Administrator, DON, and SW, issues with the facility's inventory system and safeguarding of resident's belongings were shared with the facility's management team. The following were discussed: There was evidence CNA 1 was treating monetary transactions between him and Resident 1 as between two consenting adults. There was no documentation the investigation expanded the sample to look at residents under CNA 1's care. There was no documented evidence the investigation looked into what type of relationship CNA 1 had with Resident 1.There was an independent source (hospital staff) documenting Resident 2 was coming to the facility with money and jewelry. There was no documented evidence the facility followed up and investigated when Resident 2 arrived at the facility without her money and jewelry. After discussing these issues, the facility offered no other documents regarding these issues. Except to say they will be submitting their investigation and conclusion regarding Resident 2's issues. On 4/22/26, at 10:03 AM, the SW was asked to submit all raw data and her investigations and conclusions regarding Resident 2's allegations. Review of the untitled and undated documents sent by SW regarding Resident 2's allegations found these issues:There was no attempt to contact the transporting company regarding what item(s) Resident 2 brought from the hospital.The facility's conclusion was weighted heavily on Resident 2's statement she handed over her money and jewelry to a Vietnamese man upon admission. The investigator accepted this statement was from a resident with an assessed severe memory problem. Expansion of the sample may be necessary in this case instead of concluding all elements of Resident 2's statements were false. There was no evidence the facility expanded their sample to look at other residents' belongings surrounding the admission staff identified in Resident 2's allegation. Review of a facility policy titled Investigating Incidents of Theft and/or Misappropriation of Resident Property, revise April 2017, indicated .Residents have the right to be free from theft and/or misappropriation of personal property. Providing measures to safeguard resident valuables from easy public access. The investigation shall consist of at least the following:An interview with any witnesses that may have knowledge of the missing items . interviews with staff members (on all shifts) having contact with the resident during the past 48 hours.interview with the resident's roommate, family members, and visitors.