

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER San Francisco Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview, and record review, the facility failed to ensure Resident 2 was free from physical restraints when Certified Nursing Assistant (CNA) 1 used a sheet to restrict Resident 2's movement. This failure had the likelihood to result in physical harm, pain, fear, and loss of autonomy for Resident 2. Additionally, this incident was not documented in Resident 2's electronic medical records. There was no documented evidence Resident 2's emergency contacts or her physician were notified of the incident. There was no documented evidence Resident was monitored and provided psychosocial care after the incident. Findings: During a review of Resident 2's medical records, dated 12/31/2025, Resident 2's Minimum Data Set (MDS= a standardized resident assessment tool) indicated Resident 2 was dependent on staff for toileting, required maximal assistance with personal hygiene, and required moderate assistance with transfers. Additionally Resident 2 was identified as having fallen since admission. During a review of Resident 2's medical records, dated 02/31/2026, Resident 2's Care Plan (care plan= a treatment plan to manage a resident's health) indicated Resident 2 was a fall risk and Resident 2 .needs 1:1 sitter. During a review of a facility document, dated 01/31/2026, titled REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE it indicated the Administrator .discovered that someone had used a folded sheet and wrapped it around the resident and through the back of the wheelchair. It was tied in a fashion around the back of the wheelchair to which the resident could not .(undo) or free herself from the chair. During an interview on 07/23/2026 at 3:32 PM with the Administrator, the Administrator stated the facility does not permit the use of bedsheets or other non`approved materials to restrict a resident's movement. The Administrator stated CNA 1's action was not consistent with the facility's expectations or resident`rights policies. The Administrator stated he substantiated the incident as abuse. During an interview on 07/29/2026 at 11:36 AM with CNA1's Supervisor, the Supervisor stated she interviewed CNA 1 after the incident. The Supervisor stated CNA 1 said it was a hard assignment and she could not keep an eye on Resident 2 while taking care of the other residents. The Supervisor stated CNA 1 said Resident 2 was very impulsive and wanted to self-transfer without assistance and the only way to keep her safe was to tie her up. During a concurrent interview and record review on 07/30/2026 at 11:00 AM with a Medical Record Staff (MRS), Resident 2's electronic medical records were reviewed for the restraint incident. After searching Resident 2's records, the MRS stated there was no evidence staff alerted the physician or Resident 2's emergency contacts regarding the incident. Additionally, there were no documentation from nursing services regarding the incident. There was no documented evidence the incident was addressed in Resident 2's care plans. During a review of the facility's policy titled ABUSE AND PREVENTION POLICIES & PROCEDURES, not dated, indicated . Residents must not be subjected to abuse by anyone, including but not limited to: facility staff. The Administrator is designated as the Abuse Prevention Coordinator for the facility. Such violations shall also be reported immediately to (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	State agencies and other entities or individuals in accordance with or as may be required by existing State and Federal law. During an interview on 07/30/2026 at 11:40 AM the Director of Nursing was asked to provide the facility's policy regarding how nurses should monitor and document follow an unusual event such as an incident of abuse. The facility provided the following policy. The facility provided a policy titled Charting and Documentation, not dated, indicating . All incidents, accidents, or changes in the resident's condition must be recorded . shall include at a minimum: .The assessment; data and/or any unusual findings .Notification of family, physician. The policy failed to provide instructions on when and for how long a resident should be monitored after an unusual occurrence.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to re-admit Resident 1 after sending Resident 1 to a hospital for evaluation. This failure deprived Resident 1 of his right to return to the facility and resume necessary care and services identified in the resident's care plan. Findings: During a concurrent interview and record review on [DATE] at 11:30 AM with a Medical Record Staff (MRS), Resident 1's medical records were reviewed. Upon review, the MRS stated Resident was transferred to a hospital on [DATE] for evaluation due to a change in condition. The MRS stated Resident 1 was not re-admitted to the facility. During an interview on [DATE] at 12:49 PM with an admission Staff (AS), the AS stated Resident 1 was under hospice care prior to transfer to the hospital. When the hospital called to try to re-admit Resident 1, the AS said hospice would not take the resident back. The AS stated Resident 1 was a hospice patient and not a patient of the facility. Therefore, the facility did not re-admit Resident 1. The AS was asked to explain how Resident 1 converted to being a hospice patient and not a patient of the facility. The AS did not answer. The AS was asked if hospice was an ancillary service contracted and provided by the facility to residents under the facility's care and when under hospice, wasn't a hospice resident still contracted with the facility for 24- hour custodial care? The AS provided no explanation to indicate a hospice resident was no longer a resident of the facility. The AS provided no other explanation why Resident 1 was not re-admitted to the facility. The AS was asked if during the request for re-admission, were there appropriate beds available for Resident 1 and if there were none did the facility put Resident 1 on a wait list? The AS did not answer. During a review of Resident 1's medical record titled admission RECORD, RESIDENT INFORMATION, printed on [DATE], indicated there were three family members/emergency contacts for resident 1. During an interview on [DATE] at 3:55 PM with Resident 1's family member (FM 2), FM 1 stated the facility never contacted him regarding re-admission to the facility. During an interview on [DATE] at 3:59 PM with Resident 1's family member (FM 2), FM 2 stated the facility never contacted her regarding re-admission to the facility. During an interview on [DATE] at 4:01 PM with Resident 1's family member (FM 3), FM 3 stated the facility never contacted her regarding re-admission to the facility. Review of the facility's policy titled Bed-Holds and Returns, dated 2001, indicated .All residents/representatives are provided written information regarding the facility and state bed-hold policies, .residents be permitted to return to the facility following hospitalization or therapeutic leave applies to all residents regardless of payer source. Residents who seek to return to the facility within the bed-hold period defined in the state plan are allowed to return to their previous room, if available. Residents who seek to return to the facility after the state bed-hold period has expired (or when state law does not provide for bed-holds) are allowed to return to their previous room if available or immediately to the first available bed in a semi-private room .		