STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555276	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Bruno Skilled Nursing	890 El Camino Real San Bruno, CA 94066

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 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 develop and implement an effective discharge planning process and ensure an orderly discharge for one of three sampled residents (Resident 1).The facility discharged Resident 1 to the emergency department solely due to exhaustion of Medicare benefits, despite no documented change in condition. The facility did not assist Resident 1 and/or their representative in applying for Medical Assistance or offered the option to pay privately to continue residing at the facility. The facility failed to provide and document adequate preparation and orientation prior to Resident 1's discharge.The deficient practice resulted in Resident 1 being transferred to an emergency department unnecessarily, without appropriate discharge planning, financial counseling, or orientation, placing the resident at risk for emotional distress and care disruption.Review of Resident 1's admission record indicated, was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease with (acute) exacerbation (COPD - an ongoing lung condition caused by damage to the lungs), centrilobular emphysema (a type of COPD that affects the upper lobes of the lungs, primarily caused by smoking), other abnormalities of gait and mobility, unsteadiness on feet, difficulty of swallowing, chronic kidney disease (CKD - the long-term, progressive loss of kidney function, where kidneys are damaged and unable to filter blood properly), and retention of urine.Review of Resident 1's Notice of Medicare Non-Coverage (NOMNC - a form given by the facility to all Medicare beneficiaries at least two days before the end of a Medicare covered Part A stay or when all Part B therapies ending) dated 12/2/25 indicated Medicare coverage ended on 12/6/25.Review of Resident 1's discharge care plan initiated on 11/15/25 indicated, Discharge/Transfer Planning Preference: Resident, Resident's Responsible Party/Family Members indicates preference to discharge to: [blank] . The care plan did not address the specific discharge problem(s), goals, and interventions for Resident 1. Additionally, the care plan was not revised/updated with changes in Resident 1 and/or RP's discharge preferences. Review of the Medical Practitioner Narrative Note with a service date of 12/4/25 and electronically signed on 12/7/25 indicated, .Patient was medically stabilized but not strong enough to return home . Reason for consultation is to optimize therapy, pain control and discharge planning . Discharge planning. Pending therapy progress. Will continue discussion with therapy team, family and SW (Social Worker).Review of Resident 1's physician's order dated 12/8/25 indicated, Discharge to home with home health services on 12/8/2025 with RN (Registered Nurse), PT (Physical Therapist), OT (Occupational Therapist), HHA (Home Health Aide), SW (Social Worker).Review of the physician's note titled, Discharge Summary, dated 12/5/25 indicated a discharge date of 12/7/25 for Resident 1. The physician's Discharge Summary indicated, .Limited improvements post SNF (Skilled Nursing Facility) rehab.discharge condition: stable. Discharge disposition: home . Home Health Orders and Physician Certification of Face-To-Face Encounter .12/4/25.3. Medical Necessity: My clinical findings support the need for the following skilled services: PT for (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skilled instruction in falls prevention, safety and mobility, therapeutic exercises .Review of the Notice of Proposed Transfer/Discharge (NOPTD) dated 12/4/25 indicated, .Effective date of discharge: [DATE].Reason for transfer/discharge: The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility . Location which resident is being transferred/discharged : To go to VA [facility location] to check benefits eligibility and assign a Social Worker to work on placement .Review of the Discharge Summary and Post-Care Instructions with an effective date 12/4/25 indicated, Resident 1 was scheduled for discharge on [DATE] 11:00 AM. The Discharge Summary and Post-Care Instructions also indicated, .Discharge Location Name and Address: To Go to VA [facility location] and check benefits eligibility and assign a Social Worker with Placement under VA Program. Mode of transportation: other - [Name of RP]-Friend.Review of the Social Service Note dated 12/5/25 indicated, .I will bring him to VA on Monday (12/8/25) and go to benefits eligibility and he will go to ER (emergency room) and the social worker will attend to him. Approved by the Admin. I arranged transport for pick up at 10:30 AM.During a concurrent interview and record review on 12/30/25 at 12:47 PM, the Director of Nursing (DON) and Assistant DON (ADON) reviewed Resident 1's clinical record for any change in condition before and on the discharge day. The record showed no significant change warranting an emergency transfer. The DON and ADON confirmed that Resident 1 was stable with no change in condition during the discharge day (12/8/25).Review of the Nurse's Note dated 12/8/25 indicated Resident 1 was discharged from the facility via [name of transportation company] at 10:50 AM. The Nurse's Note did not indicate Resident 1's discharge destination and home health information as indicated in the physician's order.Review of the Social Service Note dated 12/8/25 indicated, .I brought him to the ER (emergency room) for them to assign a social worker, a VA PCP and to check how he is doing. He has exhausted days at the SNF from [Name of previous SNF] to [SNF where resident was discharged]. The VA Social Worker will help find a place to stay with VA programs.During an interview on 12/30/25 at 1:07 PM, the Social Worker (SW) stated that the facility's Administrator had approved of taking Resident 1 to the VA [location] on 12/8/25, to verify his benefits eligibility since his Medicare benefits were exhausted and brought Resident 1 to the emergency department so that a case manager, outpatient social worker, and a new primary care physician could be assigned to him. The SW also confirmed that Resident 1 was in stable condition with no changes when he was taken to the emergency department.During a phone interview on 12/30/25 at 5:26 PM, Resident 1's representative (RP) stated they were not informed about applying for MediCal or paying privately. The RP described the discharge as rushed and claimed nothing was prepared in advance. The RP mentioned that the SW knew Resident 1 had no place to stay since his previous apartment was demolished for new construction. However, the SW told her they couldn't keep him due to exhausted Medicare coverage. Additionally, the RP stated that the SW scheduled an appointment for Resident 1 at the VA hospital to check for benefits eligibility and that she was not present when the resident was taken to the emergency department. The RP was informed that the doctor at the emergency department said that Resident 1 was not eligible to stay or be admitted in the hospital.During a phone interview on 1/8/26 at 10:26 AM, the complainant stated that he received a call from the VA [location] that Resident 1 was discharged from a SNF to the emergency department for no apparent medical necessity. The complainant described it as patient dumping for the reason that Resident 1 was brought to the emergency department due to exhausted Medicare benefits.During a phone interview on 1/22/26 at 9:24 AM, VA staff confirmed there was no appointment for Resident 1 on 12/8/25 for benefits eligibility. VA staff stated that Resident 1, his RP, or the SNF SW can call to check veterans' benefits without needing an appointment. During further interview, VA staff stated that the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SNF SW brought Resident 1 straight to the emergency department on 12/8/25 when there was nothing wrong with the resident. Furthermore, SNF SW was told by the [ED] doctor that she cannot just bring the patient in for no reason. VA staff added, It was a messy discharge. Patient ran out of 100 days Medicare and they never filed a MediCal application for him.Review of Resident 1's clinical record revealed a lack of care coordination and discharge planning discussions with the interdisciplinary team, resident, and RP before discharge. Additionally, the discharge summaries from the medical provider, social services, and nursing contained conflicting information. Review of the facility's policy and procedures titled, Transfer or Discharge, Emergency, revised 8/2018, indicated, .1. Residents will not be transferred unless: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot bet in the facility . 4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures.b. Notify the receiving facility that the transfer is being made; c. Prepare the resident for transfer; d. Prepare a transfer form to send with the resident.Review of the facility's undated policy and procedures titled, Transfer or Discharge, revised 8/2018, indicated, .1. When the facility transfers or discharges a resident, the following information is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider: a. basis for the transfer or discharge; b. That an appropriate notice was provided to the resident and/or legal representative; c. The date and time of the transfer or discharge; e. The new location of the resident .3. If the basis for the discharge is that the resident's health has improved sufficiently so that the resident no longer needs the care of the facility, the resident's physician (or provider) documents information about the resident's condition and the appropriateness of the discharge . 2. It is the policy of the facility to notify residents of a change in payment status and ensure the residents have the necessary assistance to submit any third-party paperwork . 5. If the resident continues to need long-term care services, the facility will offer the resident the ability to remain, which may include: a. offering the resident the option to remain in the facility by paying privately for a bed; b. providing the Medicaid-eligible resident with necessary assistance to apply for Medicaid coverage in accordance with S483.10(g)(13), F579, with an explanation that:(1) if denied Medicaid coverage, the resident would be responsible for payment for all days after Medicare payment ended; and (2) if found eligible, and no Medicaid bed became available in the facility or the facility participated only in Medicare (SNF only), the resident would be discharged to another facility with available Medicaid beds if the resident wants to have the stay paid by Medicaid .