

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: 555276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER San Bruno Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	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 interviews and record reviews, the facility failed to follow transfer and discharge requirements related to transfer and discharge for 7 out of 14 residents (Residents 1, 2, 3, 4, 5, 6, and 7). This failure resulted in or had the potential to result in residents experiencing inappropriate or unsafe transfer or discharge decisions, and increased risk of unmet care needs or disruption in continuity of care. During an interview on 07/02/2026 at 10:12 AM with Family Member 1 (FM 1) of Resident 6), FM 1 stated the Social Worker (SW) informed FM 1 that Resident 6 would have to move out because the facility is no longer a long-term care facility and is converting to short-term care only. During an interview on 07/03/2026 at 10:55 AM with FM 2 of Resident 6, FM 2 stated the social worker informed her that FM 2 would need to find an alternative due to the facility's conversion to short-term care only. FM 2 reported that the Nursing Home Administrator (NHA) directed FM 2 to contact the Institute on Aging (IOA) for assistance with transferring Resident 6. During an interview on 07/03/2026 at 12:31 PM with FM 3 of Resident 5, FM 3 stated that Resident 5 is a long-term care resident and the social worker told FM 3 that Resident 5 would have to move because the facility is converting to short-term care only. FM 3 stated the social worker said the transition would be complete by the end of the year and asked FM 3 to contact IOA to help transfer Resident 5. FM 3 reported the facility has been aggressive in trying to push Resident 5 out and has witnessed other residents similarly pressured. FM 3 stated communication from the facility has only been verbal, and no written notice of discharge has been received. During an interview on 07/06/2026 at 1:08 PM with FM 3 of Resident 5, FM 3 stated that FM 3 was told documents for IOA needed to be signed and was asked to provide a departure timeframe. During a concurrent interview and record review on 07/06/2026 at 1:08 PM with FM 3 of Resident 5, correspondence notes between FM 3 and the facility showed a sustained pattern of pressure from the facility regarding IOA enrollment and relocation. Documentation indicated the facility first notified FM 3 of its transition to short-term care on 01/08/2026. Starting 01/09/2026, staff repeatedly urged IOA enrollment, including introducing IOA representatives on 01/15/2026 and again on 01/27/2026, when an IOA assessment was conducted without FM 3's knowledge or presence. FM 3 contacted the Ombudsman on 01/29/2026 and raised concerns with facility leadership on 01/30/2026 about assessments occurring without FM 3's involvement, noting Resident 5 cannot speak or sign documents due to cognitive impairment. Despite these objections, the SW continued approaching FM 3 and Resident 5 about IOA on 02/04/2026, 03/11/2026, 04/02/2026, 04/16/2026, and 04/24/2026. IOA staff also contacted FM 3 on multiple dates, including 04/04/2026 and 06/17/2026, and on 05/22/2026 requested a timeframe for relocating Resident 5 at the NHA's direction. Additional notes showed the NHA discussing IOA involvement on 03/31/2026 and 05/18/2026. During an interview on 07/03/2026 at 12:51 PM with (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: 555276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER San Bruno Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	resident Resident 1, Resident 1 stated Resident 1 is a long-term care resident and the SW informed Resident 1 that Resident 1 would have to move due to the facility converting to short-term care only. Resident 1 reported that in October 2025, SW asked Resident 1 to sign a form that Resident 1 later realized was discharge paperwork, plus a form authorizing IOA to access medical records. Resident 1 sought help from the Ombudsman. Resident 1 stated no additional paperwork has been provided. Resident 1 reported that the SW enrolled Resident 1 with IOA without Resident 1 initiating it. Resident 1 stated the SW had shown photos of alternative facilities and arranged conversations with other facilities to encourage Resident 1 to relocate. Resident 1 reported the facility has been aggressive in attempting to discharge Resident 1 and has made it clear long-term care residents are no longer wanted. During an interview on 07/06/2026 at 10:25 AM with FM 4 of Resident 3, FM 4 stated Resident 3 is a long-term care resident and the facility informed FM 4 that Resident 3 needed to move out because it was converting to short-term care only. FM 4 reported significant pressure from the facility for Resident 3 to leave. During an interview on 07/08/2026 at 9:23 AM with FM 4 of Resident 3, FM 4 stated the facility rushed Resident 3's discharge, causing unnecessary stress. FM 4 stated the facility told FM 4 that Resident 3 had to leave because long-term care residents were no longer accepted. FM 4 reported that at one point, the social worker said the social worker would personally take Resident 3 to Resident 3's parent's home. FM 4 was pressured to sign paperwork while Resident 3 was being transported out of the facility. FM 4 stated Resident 3 was discharged with wounds. During an interview on 07/06/2026 at 10:44 AM with FM 5 of Resident 4, FM 5 stated the facility originally extended Resident 4's life and that the facility later informed the family it was converting to a short-term care facility. FM 5 felt the facility forced Resident 4 out. During an interview on 07/06/2026 at 11:25 AM with FM 6 of Resident 4, FM 6 stated Resident 4 was a long-term care resident and the social worker informed FM 6 that Resident 4 would have to move because the facility was converting to short-term care only. During an interview through email correspondence regarding Resident 4 on 07/09/2026 at 6:34 PM with FM 6, FM 6 stated that FM 6 was contacted by Outreach & Engagement Coordinator (OEC) from IOA on 02/20/2026 and FM 6 and FM 7 were not interested in enrolling Resident 4 in the IOA. After 02/20/2026, each month FM 6 received phone calls from the SW to get the family to agree to move Resident 4. FM 6 also mentioned that the NHA had told FM 6 over a phone conversation they couldn't do anything more for Resident 4 at the facility and that the nearby hospital needed the facility's space for patients that really needed their care. During an interview on 07/10/2026 at 4:25 PM with FM 8, FM 8 stated they been harassed and pressured by the facility to agree to her Resident 7's discharge, including being told that Resident 7 has to go and being threatened with a 30-day discharge notice. FM 8 stated Resident 7 requires skilled nursing care, has complex medical conditions, and needs constant care including frequent blood draws. FM 8 stated the facility repeatedly contacts FM 8 every week by phone or email urging discharge, and that staff have told FM 8 the facility is now a short-term care facility. FM 8 feels the facility discriminates because Resident 7 has Medi-Cal, and FM 8 believes the facility receives more money for short-term Medicare residents. FM 8 stated the facility has offered incentives, including paying for one month of a caregiver, to get FM 8 to agree to discharge. FM 8 stated Resident 7 has no place to go, and fears Resident 7 will die if discharged. FM 8 added that staff tell FM 8 they are not cooperating when FM 8 refuses to agree to a discharge. The resident and family interviews consistently show that the facility pressured long-term care residents and their families to relocate because the facility claimed it was converting to short-term care only. Family members and residents repeatedly reported being told they had to move, being pushed to enroll with IOA, and being urged to agree to discharge even when residents required ongoing skilled nursing care. Several families (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER San Bruno Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	described frequent calls, verbal pressure, rushed or coerced discharge processes, and IOA assessments performed without consent. Some residents were shown alternative facilities, or asked to sign discharge-related paperwork. Multiple interviewees also reported aggressive tactics, inconsistent information, lack of written notices, and fear of harm if residents were forced to leave. Collectively, these accounts show a sustained pattern of inappropriate, pressured discharge efforts driven by facility preference-not resident need. During an interview with Case Worker (CW) from IOA on 07/06/2026 at 12:08 PM, a CW at IOA and CW for Resident 4, the CW stated they heard the facility is trying to discharge long term care residents and they have been kind of aggressive at trying to push long term care residents out of the facility. CW states the IOA has been receiving a high number of referrals from the facility to assist in helping long term care residents find alternative places to live. During an interview on 07/07/2026 at 1:17 PM with SW, SW stated the facility continues to accept long-term care residents and that residents such as Resident 8 and Resident 6 are not stable for discharge. SW stated long-term care residents are being offered IOA as an opportunity to be in the community and that these offers are options, not directives. SW stated short-term residents generally already have housing, and IOA referrals are offered because there is life after this place. SW stated the administrator assists because we are a team and denied receiving any directive to discharge long-term care residents, stating discharges occur only when a resident is fit to go home and agrees. SW stated they have not told residents or families they must move due to conversion to short-term care, and that IOA representatives obtain signatures directly from residents or provide copies for review. SW stated they are unaware of any plan to convert to short-term care and continues to ask residents if they are interested in IOA. SW stated they have offered IOA to approximately 5-6 residents, primarily as an option for placement, but could not identify short-term residents who were offered IOA. SW stated they were not directed by administration to encourage IOA referrals and described their role as suggesting options while IOA obtains consent. SW stated IOA assessments are scheduled with family notification, including for residents unable to consent, and stated IOA provides authorization copies. Regarding the 01/27/2026 IOA visit for Resident 5, SW stated IOA was assessing who might benefit from services, that they introduced IOA staff to residents, and that they apologized to FM 3, stating no assessment occurred without their knowledge. SW stated signed documents are provided only upon request and that residents have expressed differing views about relocating. SW stated leadership becomes involved when families need assistance or communication support, and acknowledged showing pictures of other facilities to Resident 1 and Resident 5 as options. SW stated they are responsible for providing residents with appeal rights information. During an interview on 07/08/2026 at 12:35 PM with NHA, NHA stated the facility has not converted to a short-term only model and continues to accept long-term care residents if they have a clinical need. NHA stated residents are referred to IOA for placement only if they no longer meet skilled nursing criteria, and that no residents or families have been told they must move out due to conversion. NHA stated discharge notices are not issued unless necessary, preferring to work with families first, and that communication is often verbal or via email. NHA stated there is no quota for long-term residents, but there is an incentive to limit them for profitability. NHA stated they directed staff to refer residents to IOA, including Resident 4, Resident 1, Resident 6, and Resident 5, and that some families declined referrals. NHA stated residents have not been given timelines to leave, discharge planning begins on day one, and care conferences are held. NHA stated IOA assessments require family notification and representatives are present for residents unable to consent. NHA stated IOA handles paperwork and residents must request copies if desired. NHA stated FM 2 was asked to contact IOA for Resident 6's transfer. NHA stated compliance with discharge requirements includes proper notice, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER San Bruno Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	physician documentation, interdisciplinary team involvement, and identifying safe placements. NHA stated the facility follows discharge planning policies and aims to avoid patient dumping, and feels IOA helps find homes for residents who no longer need skilled nursing care. During an interview on 07/08/2026 at 2:04 PM with Director of Nursing (DON), the DON stated the facility is not transitioning to short-term care only and aims to serve the community's skilled nursing needs. DON stated there are no specific instructions for nursing staff regarding long-term residents or discharge planning, and nursing staff continue to provide care regardless of resident type. DON stated discharge planning is mainly handled by social services, with nursing focusing on care conferences and wound care. DON stated clinical justification for discharge is determined when residents no longer require skilled care, documented by physicians. DON stated they were not aware of any long-term residents being told to leave without a physician order, nor have they been instructed to inform residents or families about moving due to conversion. DON stated residents are not pressured to relocate, and nursing staff have not communicated that long-term residents are unwanted. DON stated social services provide discharge notices and help families find placements. DON stated they are not aware of residents signing discharge paperwork without understanding or receiving copies, nor have they observed repeated approaches to residents or families about IOA or relocation. DON stated social services have assisted residents in finding alternative placements and with guidance from the NHA. During an interview on 07/07/2026 at 1:17 PM with the SW, the SW stated all communications regarding Resident 1 are conducted through email, confirmed Resident 1 is a long-term care resident, and was unsure if Resident 1 had been asked to sign IOA documents. SW stated [NAME] is handling communications with Resident 1 and the Health Care Agent (HCA) for Resident 1, and that Resident 1 has toured care homes and is happy with one. SW was unsure if an IOA agreement was signed and indicated NHA is managing this process, but confirms stated the Resident 1 was asked if they were interested in IOA options. SW stated NHA is the primary contact for communicating with the family about other placement options. During a concurrent interview and record review on 07/08/2026 at 2:04 PM with the DON, Resident 1's medical record was examined. The record showed that no Notice of Proposed Transfer or Discharge had been issued. The DON confirmed there is no physician documentation indicating that Resident 1 needs to be moved because the facility cannot meet the resident's care needs, nor is there documentation showing that Resident 1's health has improved to the point that the current level of care is no longer required. The DON further confirmed that the facility is preparing to discharge the resident. During a review of admission Record for Resident 1, accessed on 07/09/2026, indicated an admission Date of 08/17/2022 and the resident has not been discharged. During a review of the Minimum Data Set (MDS) - Version 3.0 Resident Assessment and Care Screening for Resident 1, dated 06/23/2026, the MDS indicated Resident 1 has a Brief Interview for Mental Status (BIMS) Summary Score of 14. The Brief Interview for Mental Status (BIMS) is a short test used in nursing homes to check how clearly a resident is thinking and how well the resident remembers information. A score between 13 and 15 means the resident is thinking clearly with little to no memory problems. A score between 8 and 12 shows the resident has some memory or thinking difficulties, while a score between 0 and 7 indicates more serious problems with memory or thinking. During a review of History and Physical (H&P) for Resident 1, dated 08/19/2022, the History and Physical indicated Resident 1 was transferred to the facility on [DATE] following acute hospitalization from 08/11/2022 to 08/17/2022 for altered mental status, sepsis, and a urinary tract infection (UTI). The H&P also indicated that Resident 1 was admitted to the facility to complete intravenous antibiotics and to receive skilled physical and occupational therapy. During a review of a Nurse Practitioner (NP), Physician Assistant (PA) and Medical Doctor (MD) Progress Notes, from (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER San Bruno Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	01/08/2026 to 06/09/2026, the Progress Notes indicated that Resident 1 was identified as a custodial resident. The notes did not indicate that a discharge is necessary for Resident 1's well-being or that the facility is unable to meet Resident 1's care needs. In addition, the NP Progress Note dated 01/08/2026 noted that according to the SW, Resident 1 had been referred to IOA for possible placement. During a review of Medi-Cal Long-Term Care Facility admission and Discharge Notification dated 10/02/2025, the Medi-Cal Long-Term Care Facility admission and Discharge Notification indicates it was signed by Resident 1 and the SW on 10/02/2025. The document noted a reason for discharge as discharged to residence or home of another and a date of discharge as 10/30/2025. The document was not signed by the Resident 1's HCA. During a review of the Social Services Note dated 10/03/2025 at 3:16 PM, the Social Services Note documents a discussion the SW had with Resident 1 about the living conditions of a house. The note does not indicate why the living conditions of a house was discussed. During a review of the Social Services Note dated 10/03/2025 at 3:27 PM, the Social Services Note briefly mentions that the SW will allow the resident choose the home health services. During a review of the Social Services Note dated 10/03/2025 at 5:55 PM (noted as a late entry), the Social Services Note indicated that the SW contacted the Resident 1's HCA to inform them that the resident owed money to San Francisco County and Medi-Cal for Resident 1's stay at the facility. The SW explained that the resident would need to pay more than one thousand dollars to Medi-Cal to continue residing at the facility, as Medi-Cal was covering the cost of his stay. The HCA asked whether the resident could remain until November 2025, and the SW clarified that an additional month would result in further Medi-Cal charges. The note indicated that the HCA agreed to discharge the resident on 10/30/2025. It also stated that the SW would arrange Home Health services and In-Home Supportive Services (IHSS) and had provided the resident with two Home Health agency business cards for selection. During a review of the Social Services Note dated 10/06/2025 at 1:29 PM, the Social Services Note indicated that the Ombudsman had spoken to Resident 1 and Resident 1 did not agree with the discharge on [DATE]. During a review of the Social Services Note dated 10/14/2025 at 11:39 AM, the Social Services Note indicated that the Resident 1 was okay with discharging on 10/31/2025. During a review of the Social Services Note dated 1/6/2026 at 6:32 PM, the Social Services Note indicated the SW documented that the HCA for Resident 1 agreed to IOA. The findings show the facility pursued discharge of Resident 1 without clinical justification, required notices, or proper involvement of the resident and representative. The SW and NHA focused on alternative placement and IOA enrollment despite Resident 1 being a long-term care resident with no physician documentation supporting discharge, no improvement indicating a lower level of care, and no evidence the facility could not meet Resident 1's needs. Collectively, the findings demonstrate a pattern of pressured discharge planning. During an interview on 07/08/2026 at 2:04 PM with the DON, the DON stated, the reason for the Resident 2's discharge was that their condition improved. During a review of admission Record for Resident 2, accessed on 07/06/2026, indicated an admission Date of 07/20/2025 and a discharge date of 10/01/2025. During a review of the MDS - Version 3.0 Resident Assessment and Care Screening for Resident 2, dated 10/01/2025, the MDS indicated Resident 2 has a BIMS Summary Score of 11. During a review of the H&P for Resident 2, dated 12/26/2024, the H&P indicated Resident 2 was transferred to the facility on [DATE] following acute hospitalization from 12/19/2024 to 12/23/2024 for a fall at home. The H&P also indicated that Resident 2 was admitted to the facility for skilled physical and occupational therapy. During a review of Physician Discharge Summary for Resident 2, dated 10/01/2025, the Physician Discharge Summary indicated that the resident was discharged without a formal discharge visit from one of the facility's care providers due to late notification. It also noted that the Discharge (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER San Bruno Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	Summary was completed for documentation purposes only. The Discharge Summary did not indicate a reason for discharge. During a review of a NP, PA, and MD Progress Notes, from 09/08/2025 to 09/29/2025, the Progress Notes did not indicate that a discharge was necessary for the Resident 2's well-being or that the facility was unable to meet the resident's care needs. During a review of the Notice of Medicare Non-Coverage (NOMNC) for Resident 2, dated 09/26/2025, the NOMNC indicated Resident 2's Medicare coverage for current physical and occupational services would end on 09/30/2025. Resident 2 was informed five days before discharge on [DATE]. During a review of Notice of Proposed Transfer or Discharge for Resident 2, with effective date of 10/01/2025 at 11:01 AM, the Notice of Proposed Transfer or Discharge indicated a typed-in date of resident representative notification and verification on 10/01/2026, and an actual signature from Resident 2 dated 10/01/2025 (a typed-in date). The Notice of Proposed Transfer or Discharge was faxed to the Ombudsman on 10/01/2026 at 12:45 PM. The Notice also included Appeal Rights and Contact Information, stating that residents have the right to appeal and were provided contact details for the Long-Term Care Ombudsman, Office of Hearings and Appeals, and Developmental Disability (DD)/Mental Illness (MI) advocacy agencies. These appeal rights were not provided to Resident 2 until the discharge date of 10/01/2025. During a review of Discharge Summary and Post-Care Instructions for Resident 2, with effective date of 10/01/2025 at 10:49 AM, the Discharge Summary and Post-Care Instructions listed a discharge date and time of 10/01/2025 at 11:00. It stated Resident 2 was discharged to another skilled nursing facility because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility. During a review of Change in Condition Evaluation for Resident 2, with effective date of 09/30/2025 at 9:00, the Change in Condition (COC) Evaluation indicated the resident had a functional decline that had started that morning. The COC Evaluation that the resident had demonstrated a noticeable increase in generalized weakness during activities of daily living (ADLs) compared to Resident 2's usual baseline function. The findings show Resident 2 was discharged without clinical justification and without proper notice. Although the DON stated the discharge occurred because the resident's condition improved, clinical records-including provider notes, the H&P, and the MDS-did not support that Resident 2 no longer required skilled care. A functional decline was documented the day before discharge, further contradicting the stated reason. Required discharge procedures were not followed: the physician did not complete a formal discharge visit, and appeal rights were given only on the day of discharge. Notice documents were issued too late for meaningful review or appeal. Resident 2 was discharged despite documented need for continued care. During a 07/07/2026 interview at 1:17 PM, the SW provided multiple reasons for Resident 3's discharge, including: a change in condition related to a cerebrovascular accident (stroke); the family agreeing to transfer Resident 3 to hospice; the family preferring a skilled nursing facility or hospice; limited bed availability at the facility; another facility having more bed availability; and the family being unable to care for Resident 3 at home. During an interview on 07/08/2026 at 2:04 PM with DON, DON stated, the reason for Resident 3's discharge was that Resident 3's health had improved. During a review of admission Record for Resident 3, accessed on 07/06/2026, indicated an admission Date of 03/01/2026 and a discharge date of 06/03/2026. During a review of the MDS - Version 3.0 Resident Assessment and Care Screening for Resident 3, dated 03/03/2026, the MDS indicated Resident 3 has a BIMS Summary Score of zero. During a review of H&P for Resident 3, dated 02/13/2026, the H&P indicated Resident 3 was transferred to the facility on [DATE] following acute hospitalization from 01/13/2026 to 02/12/2026 for complications from brain aneurysm. The H&P also indicated that Resident 3 was admitted to the facility for skilled physical, occupational, and speech therapy along with gastrointestinal tube care. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER San Bruno Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	During a review of H&P for Resident 3, dated 03/04/2026), the H&P indicated Resident 3 was transferred to the facility on [DATE], following acute hospitalization from 02/14/2026 to 03/01/2026 for seizures. The H&P also indicated that Resident 3 was admitted to the facility for skilled physical and occupational therapy. During a review of COC Evaluation for Resident 3, with an effective date of 02/14/2026 at 3:01 PM, the COC Evaluation indicated the reason for the evaluation was a fever and a seizure that had started on 02/14/2026. During a review of COC Evaluation for Resident 3, with an effective date of 03/23/2026 at 12:15 PM, the COC Evaluation indicated the reason for the evaluation was a wound on the left heel. During a review of Notice of Proposed Transfer or Discharge for Resident 3, with effective date of 05/22/2026 at 5:02 PM, the Notice of Proposed Transfer or Discharge indicated a typed in date of resident representative notification and verification on 05/27/2026, and an actual signature from FM 4 of Resident 3 dated 06/02/2026. The Notice of Proposed Transfer or Discharge was faxed to the Ombudsman on 06/03/2026 at 12:00 PM. Although the form lists an effective date of 05/22/2026, the resident representative did not sign until 06/02/2026-one day before the effective date of transfer/discharge date of 06/03/2026. The Notice also included Appeal Rights and Contact Information, stating that residents have the right to appeal and were provided contact details for the Long-Term Care Ombudsman, Office of Hearings and Appeals, and DD/MI advocacy agencies. These appeal rights were not provided to FM 4 until one day before the discharge date of 06/03/2026. During a review of Discharge Summary and Post-Care Instructions for Resident 3, with effective date of 05/22/2026 at 5:02 PM, the Discharge Summary and Post-Care Instructions listed a discharge date of 06/03/2026, with no discharge time noted. It stated [NAME] was discharged to another skilled nursing facility because the facility could not meet the resident's needs, citing unstable medical or behavioral conditions requiring a higher level of care. Under Special Treatments, Devices, and Procedures, the form showed checked boxes for tube feeding, wound care, and Enhanced Barrier Precautions. The document was signed by FM 4 of Resident 3 on 06/02/2026. During a review of a NP, PA, and MD Progress Notes, from 04/24/2026 to 05/28/2026, the Progress Notes did not indicate that a discharge was necessary for the Resident 3's well-being or that the facility was unable to meet the resident's care needs. There was no Physician Discharge Summary in the resident's medical chart. The findings show Resident 3 was discharged without meeting the regulatory criteria for transfer or discharge. Staff provided conflicting and unsupported reasons for discharge. Resident 3 had significant medical needs, including seizures, tube feeding, wound care, and a BIMS score of zero, indicating severe cognitive impairment. Provider notes did not document an inability to meet Resident 3's needs or a requirement for higher level care, and there was no physician discharge summary. Required discharge notices and appeal rights were issued only one day before the effective discharge date, preventing meaningful review or appeal. Collectively, the inconsistent explanations, lack of clinical justification, late notification, and absence of required documentation demonstrate an improper and pressured discharge. During an interview on 07/07/2026 at 1:17 PM with the SW, the SW stated Resident 4 was discharged to a care home on [DATE] so the resident could be closer to family, as requested by the sister FM 6, and that this was coordinated with IOA. SW stated Resident 4 had a stroke, was stable, and the family agreed to work with IOA and signed transfer documents. During an interview on 07/08/2026 at 12:35 PM with the NHA, the NHA stated, confirmed Resident 4 had been referred to IOA. During an interview on 07/08/2026 at 2:04 PM with DON, the DON stated Resident 4 had been discharged because his health improved and no longer needed the services provided by the facility. During a review of admission Record for Resident 4, accessed on 07/06/2026, indicated an admission Date of 04/05/2017 and a discharge date of 06/11/2026. During a review of the MDS - Version 3.0 Resident Assessment and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER San Bruno Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	Care Screening for Resident 4, dated 06/11/2026, the MDS indicated Resident 4 has a BIMS Summary Score of that was not completed. During a review of the MDS - Version 3.0 Resident Assessment and Care Screening for Resident 4, dated 03/18/2026, the MDS indicated Resident 4 has a BIMS Summary Score of zero. During a review of Notice of Proposed Transfer or Discharge for Resident 4, with effective date of 06/04/2026 at 5:18 PM, the Notice of Proposed Transfer or Discharge indicated a typed in date of resident representative notification and verification on 06/05/2026, and an actual signature from FM 7 dated 06/08/2026. The Notice of Proposed Transfer or Discharge was faxed to the Ombudsman on 06/11/2026 at 4:22 PM. Although the form lists an effective date of 06/04/2026, the resident representative did not sign until 06/08/2026--three days before the effective date of transfer/discharge date of 06/11/2026. The Notice also included Appeal Rights and Contact Information. During a review of Discharge Summary and Post-Care Instructions for Resident 4, with effective date of 06/04/2026 at 6:18 PM, the Discharge Summary and Post-Care Instructions listed a discharge date and time of 06/11/2026 at 11:00. It stated Resident 4 was discharged to another skilled nursing facility because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility. During a review of all of MD Progress Notes for Resident 4, from 11/02/2025 to 02/01/2026, the MD Progress Notes do not indicate that a discharge was necessary for the Resident 4's well-being or that the facility was unable to meet the resident's care needs. There was also no Physician Discharge Summary in the resident's medical chart and the MD Progress Note dated 02/01/2026 was the last MD Progress Note in the chart. During a review of Physician Order for Resident 4, dated 05/31/2026 at 5:51 PM (marked as a late entry), the Physician Order indicated occupational therapy order clarification for skilled occupational therapy two times per week for eight weeks (07/26/2026). The resident was discharged on 06/11/2026. During a review of Physician Order Resident 4, dated 05/29/2026, the Physician Order indicated discharge to the Residential Care Facility for the Elderly (RCFE) with home health on 06/11/2026. During a review of the Notice of Medicare Non-Coverage (NOMNC) for Resident 4, dated 06/05/2026, the NOMNC indicated his Medicare coverage for current physical and occupational services would end on 06/10/2026. Resident 4 was informed six days before discharge on [DATE]. During a review of the IOA Authorization for Use and Disclosure of Protected Health Information, signed on 04/09/2026 by FM 7, the document indicates that Resident 4's protected health information (PHI) is used to determine his eligibility for the IOA, for their care management, and for their health or psychosocial assessments, and for administra		