

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

Printed: 07/18/2026
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 12/05/2025
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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview, and record review the facility failed to ensure residents were provided a private space to participate in resident council meetings (regular gatherings where residents meet to discuss concerns or suggest improvements for their living environment). This failure resulted in residents not receiving adequate privacy during their group meetings. Findings: During a group interview on 12/03/2025 at 3:00 PM with Residents (58, 24, 26, 27, 43), Resident 24 stated, Resident Council meetings are often held in a hallway due to limited private spaces within the facility. Resident 24 stated, The only space is the old dining room, but that is being used for the gym now. When asked if a private space to participate in resident council meetings was requested by the participating residents. Resident 24 stated, Yes! But they told us there was no room available. Resident's 26 and 27 also verified group meetings were held in facility hallways as well. During an interview on 12/5/2025 at 10:18 AM with the Activity Director (AD- a professional responsible for planning, organizing, and leading programming), AD stated, Sometimes we hold the resident council meeting in the hallway if the gym is busy. A small group in the corner of the hallway. During a review of several Resident Council Minutes dated 9/26/2025, 10/24/2025, and 11/28/2025, the resident council minutes indicated 22 residents attended resident council meetings with no specified location documented. During a review of the facility's policy and procedure titled, Resident Council undated, the policy and procedure indicated 3. The resident council group is provided with space, privacy, and support to conduct meetings.		

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review the facility failed to provide adequate monitoring for antipsychotic medications (a class of psychiatric drugs that helps manage severe mental health symptoms) for two out of five sampled residents (Residents 2 and 5) and PRN (as needed) medications were ordered beyond 14 days for three out of five sampled residents (Residents 7,8,18). This failure had the potential to result in adverse consequences ranging from functional decline, hospitalization, permanent injury, or death. Findings: During a concurrent interview and record review on 12/04/2025 at 5:37 PM with Licensed Vocational Nurse 1 (LVN1), Resident 2's blood pressure values on 11/07/2025 was reviewed. The blood pressure values indicated, Resident 2's blood pressure was documented as 156/77 on 11/07/2025 at 11:51 AM, 136/83 on 11/07/2025 at 4:17PM, and 135/77 on 11/08/2025 at 02:38 AM. LVN1 verified no additional blood pressure values were documented on 11/7/2025. Review of Resident 2's Medication Administration Record (MAR) dated 11/1/2025- 11/30/2025, indicated, Orthostatic BP (blood pressure) r/t (related to) antipsychotics every day shift every Fri (Friday) laying, sitting, and standing with an order start date of 11/07/2025. LVN1 defined Orthostatic blood pressure as Take BP (blood pressure) in sitting, lying, and standing position, wait at least 5 mins in each position before taking new bp (blood pressure). It should be documented in the vitals tab, the tab that we just reviewed. LVN1 verified Resident 2's November 2025 MAR, orthostatic blood pressure values on 11/7/25, 11/14/2025, 11/21/2025, and 11/28/2025 were All same blood pressures with no documentation on time BP was taken. LVN1 stated, This is not right. I don't think she would have same BP each time. During a concurrent interview and record review on 12/04/2025 at 5:57 PM with the Assistant Director of Nursing (ADON), Resident 2's November 2025 MAR was reviewed. The MAR indicated, duplicate blood pressure readings were documented for each orthostatic blood pressure order. ADON stated side effects of antipsychotic drug use are monitored to assess orthostatic blood pressure changes and potential fall hazards. ADON and LVN1 confirmed only one blood pressure was documented per shift. ADON validated documentation does not accurately reflect orthostatic blood pressure monitoring and increases risk for Resident 2 Becoming hypotensive and falling. During a concurrent interview and record review on 12/05/2025 at 12:20 PM with ADON, Resident 7 and 8's Note to Attending Physician/Prescriber, dated 11/06/2025 were reviewed. The Note to Attending Physician/Prescriber indicated, CURRENT ORDER: Lorazepam 2 mg/mL, give 0.5 mL q (every) 4h PRN Anxiety or Agitation, missing stop date.RECCOMENDATION: Please clarify the order.1) If the order is to be continued beyond 14 days, please update to include a specific duration of use and provide clinical rationale to support use beyond the CMS 14 day limit.OR 2) add a 14 day stop to the order. ADON confirmed, Resident 7 and Resident 8 both have current Lorazepam 2 mg/mL, give 0.5 mL q4h PRN Anxiety or Agitation orders with no stop date documented. ADON was unable to locate clinical rationales to support use beyond 14-day limit. During a record review of Resident 18's, admission Record, dated 8/6/25, indicated Resident 18 was admitted to the facility 8/6/25 with a history of schizophrenia (a chronic brain disorder that disrupts how a person thinks, feels and behaves, causing them to lose touch with reality through symptoms like hallucinations (hearing/seeing things) and delusions (false beliefs), leading to disorganized thinking, difficulty with emotion and problems with focus), weakness and low blood pressure. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 18's, Order Summary Report, dated October 2025, November 2025 and December 2025, indicated Resident 18 was prescribed olanzapine (antipsychotic medication for the treatment of schizophrenia), oral tablet 5 milligrams, give one tablet by mouth every 24 hours as needed for agitation/psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with external reality) which was started on 10/20/25 and did not have an end date, meaning the medication would have had a stop date for taking the medication. During a review of Resident 18's, Medication Regime Review dated 8/7/ 2025 conducted by the pharmacist indicated the medications the Resident 18 had been admitted to the facility were reviewed and no other pharmacist review had been conducted through to 12/4/2025 at the time of the survey. During concurrent interview and record review on 12/4/25 at 12:21 PM with Licensed Nurse A (LNA), Resident 18's, Order Summary Report, dated December 2025 and Resident 18's, Medication Administration Record (MAR) dated December 2025 were reviewed. Resident 18's order for Olanzapine, 5 milligrams, one tablet by mouth every 24 as needed for agitation/psychosis. was reviewed and LNA stated the medication was prescribed or started on 10/20/25 and confirmed the facility policy for as needed medications was usually for doctors to only prescribe medications for 14 days at a time and then either renew the medication or discontinue. LSA stated the reason why this medication does not have a stop date was that it was not prescribed by the usual doctors at the facility and this resident really needed the medication as it was written. The MAR was reviewed for November 2025, and it appeared that Resident 18 did not use or need the medication once that month, LSA stated she did not know anything about that, but Resident 18 had needed it in the past. LSA stated if this medication had been prescribed by the doctors at the facility, then it would have had a stop date at 14 days, so LSA stated they did not know why the medication did not have an end date. During a concurrent interview and record on 12/4/25 at 2:12 PM with Director of Nursing (DON), Resident 18's, Order Summary Report dated December 2025 was reviewed with the DON. [NAME] confirmed the olanzapine order as needed and start date of 10/20/25 and asked what the facility policy was regarding as needed medications. DON stated, as needed medication usually has a stop date of 14 days and DON stated they thought the order could be placed indefinitely if the behaviors were still in place and the resident needed the medication as ad needed bases than it would be acceptable. DON stated, as in this case, this medication does not need a stop date and can continue as needed indefinitely. During a review of the facility's policy and procedure titled, Medication Regime Review, dated 2001, indicated, 1. A licensed consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication.g. other medication errors, included related to documentation.1. Medication regimens are done upon admission (or as close to admission as possible and at lease monthly thereafter, or more frequently if indicated depending on a resident's condition.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview and record review the facility did not provide adequate medication review for five out of five sampled residents (Residents 2,5,7,8,18) when: 1) One out of five sampled residents (Resident 18)'s as needed antipsychotic orders, did not include end dates or rationales were not addressed in the medical record. 2) One out of five sampled residents (Resident 18)'s medication profile was not reviewed monthly after admission. 3) Four out of five sampled residents (Resident 2,5,7,8)'s recommendations made by the pharmacist were not followed up, implemented, or addressed. 4) One out of five sampled residents (Resident 5)'s is on multiple antipsychotic medications for same diagnosis of MDD. These failures had the potential to cause harm from adverse consequences related to medication therapy, due to lack of timely implementation of pharmacy recommendations. 1. During a record review of Resident 18's, admission Record, dated 8/6/25, indicated Resident 18 was admitted to the facility 8/6/25 with a history of schizophrenia (a chronic brain disorder that disrupts how a person thinks, feels and behaves, causing them to lose touch with reality through symptoms like hallucinations (hearing/seeing things) and delusions (false beliefs), leading to disorganized thinking, difficulty with emotion and problems with focus) and low blood pressure. During a review of Resident 18's, Order Summary Report, dated October 2025, November 2025 and December 2025, indicated Resident 18 was prescribed olanzapine (antipsychotic medication for the treatment of schizophrenia), oral tablet 5 milligrams, give one tablet by mouth every 24 hours as needed for agitation/psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with external reality) which was started on 10/20/25 and did not have an end date, meaning the medication would have had a stop date for taking the medication. During concurrent interview and record review on 12/4/25 at 12:21 PM with Licensed Nurse A (LNA), Resident 18's, Order Summary Report, dated December 2025 and Resident 18's, Medication Administration Record (MAR) dated December 2025 were reviewed. Resident 18's order for Olanzapine, 5 milligrams, one tablet by mouth every 24 as needed for agitation/psychosis. was reviewed and LNA stated the medication was prescribed or started on 10/20/25 and confirmed the facility policy for as needed medications was usually for doctors to only prescribe medications for 14 days at a time and then either renew the medication or discontinue. LSA stated the reason why this medication does not have a stop date was that it was not prescribed by the usual doctors at the facility and this resident really needed the medication as it was written. The MAR was reviewed for November 2025, and it appeared that Resident 18 was not administered or need the medication once that month, LSA stated she did not know anything about that, but Resident 18 had needed it in the past. LSA stated if this medication had been prescribed by one of the doctors at the facility, then it would have had a stop date at 14 days, and so LSA stated they did not know why the medication did not have an end date. During a concurrent interview and record review on 12/4/25 at 2:12 PM with Director of Nursing (DON), Resident 18's, Order Summary Report dated December 2025 was reviewed with the DON. [NAME] confirmed the olanzapine was prescribed as needed and the start date of 10/20/25 was confirmed. DON confirmed the facility policy was regarding as needed medications was to prescribe the medication for 14 days only. DON stated in this case with Resident 18, they continued to have the same behaviors necessitating the prescribed medication so it would then be acceptable to prescribe the medication as needed but indefinitely without a stop date. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent interview and record review on 12/4/25 at 2:12 PM with DON, Resident 18's Medication Regime Review, dated 8/7/25 (conducted by the pharmacist) at the time of admission was reviewed. DON was asked if there were any other reviews by the pharmacist and DON stated no, the pharmacist reviews were done on admission and then every quarter so Resident 18 would not have been due until later that month (December). DON stated that would have been the facility policy to have the resident medication reviews done every quarter after the initial admission. DON stated in the case of Resident 18 for example, there would have been no need to review their as needed medications stop dates since the application for a stop date did not apply to this particular resident for the olanzapine medication prescription. During a review of the facility's policy and procedure titled, Medication Regime Review, dated 2001, indicated, 1. A licensed consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication.g. other medication errors, included related to documentation.1. Medication regimens are done upon admission (or as close to admission as possible and at lease monthly thereafter, or more frequently if indicated depending on a resident's condition. 3. During a concurrent interview and record review on 12/05/2025 at 12:20 PM with the Assistant Director of Nursing (ADON), Resident 7 and 8's Note to Attending Physician/Prescriber, dated 11/06/2025 was reviewed. The Note to Attending Physician/Prescriber indicated, CURRENT ORDER: Lorazepam 2 mg/mL, give 0.5 mL q (every) 4h PRN Anxiety or Agitation, missing stop date.RECCOMENDATION: Please clarify the order.1) If the order is to be continued beyond 14 days, please update to include a specific duration of use and provide clinical rationale to support use beyond the CMS 14 day limit.OR 2) add a 14 day stop to the order. ADON stated, Resident 7 and 8's current orders listed above were active on Resident 7 and 8's medication administration record with no stop dated noted. ADON also confirmed no physician/ prescriber response was documented on Note to Attending Physician/Prescriber received on 11/06/2025. A concurrent interview and record review on 12/05/2025 at 12:42 PM with the Director of Nursing (DON), Resident 2's Note to Attending Physician/Prescriber, dated 11/06/2025 was reviewed. The Note to Attending Physician/Prescriber indicated CURRENT ORDER: Heparin 5,000 units BID (twice a day) for post DVT (deep vein thrombus) PPX (prophylaxis).The patient is on the above medication with no stop date indicated. RECCOMENDATION: Please consider adding a stop date to this order if clinically appropriate. DON stated, the above recommendation was provided to Resident 2's physician on 12/03/2025 and a telephone order was provided to discontinue the medication on 12/03/2025, although the pharmacist recommendation was originally made on 11/06/2025. DON stated, physician/prescriber response to pharmacist recommendations noted on the Note to Attending Physician/Prescriber should be uploaded in chart timely. DON later confirmed no attending physician/prescriber response was provided for Resident 7 and 8's recommendations. I will get it signed now. Review of Resident 5's admission Record, indicated admitted on [DATE] with diagnoses including: Pneumonia, (a lung infection), Dementia (a brain disorder that causes decline in memory and thinking), Anxiety Disorder (a mental condition like persistent worry, fear and nervousness), Major Depression(condition with persistent sadness, hopelessness and loss of interest). During a record review, Order Summary Report, dated 10-25-12-5-25, indicated, Seroquel Oral Tablet 25 mg (Quetiapine Fumarate) give one tablet by mouth three times a day for Delusions. Target Behavior: Delusion at the end of each shift. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Medication Administration Record (MAR) dated 10/25/-12/4/25, indicated, Seroquel 25 mg for MDD (Major Depressive Disorder). Review of facility document, Medication Regimen Review (MRR) with Recommendation to Physician, dated 11/6/25. Indicated Seroquel 25 mg, please review for appropriate diagnosis. During an interview on 12/5/25/ at 10:53 AM with facility pharmacist, per Pharmacist, MRR review was done on 11/6/25 and he recommended to physician, to use the appropriate diagnosis for Seroquel. The pharmacist next visit will be on 12/8th. Per pharmacist, if there is no response from the physician, he will re- recommend again. As of 12/5/25 during this interview the recommendation was not acted upon. During an interview on and concurrent record review on 12/5/25 at 11:30 A, with Director of Nursing (DON), per DON, the process is to leave a copy of the pharmacist recommendation for the physician, in a folder and physician will review and sign the recommendation if he agrees or disagrees. Then the page is checked by medical records and entered in EMR if there is order or any changes. Review of the medical records, no order or change in the diagnosis for Seroquel. DON confirmed. 4. Review of Resident 5's admission Record, indicated admitted on [DATE] with diagnoses including: Pneumonia, (a lung infection), Dementia (a brain disorder that causes decline in memory and thinking), anxiety disorder (a mental condition like persistent worry, fear and nervousness), Major Depression(condition with persistent sadness, hopelessness and loss of interest). Review of Order Summary Report dated 10/25-12/4/25, indicated, Clonazepam Oral Tablet 0.5 mg, give 1 tablet orally three times a day for (Major Depressive Disorder) MDD, start date 11/25/25. Mirtazapine Oral Tablet 15 MG Give 1 tablet by mouth for MDD start date 10/25/25.Paroxetine HCl Oral Tablet 40 mg Give 1 tablet by mouth one time a day for MDD. Seroquel Oral (Quetiapine Fumarate) Give 1 Tablet by mouth three times a date for MDD, start date 10/25/25. Review of facility document, Consultant Pharmacist's Medication Regimen Review, dated 10/27/2, indicated Current Orders: Clonazepam, Mirtazapine, Paroxetine and Quetiapine. Recommendation: Please enter orders in PCC to monitor target behavior and SE for the medications listed above. No indication that these four antipsychotic drugs can be given together. During an interview on 12/5/25/ at 10:53 AM with facility pharmacist, per Pharmacist, another pharmacist came on 10/27/25. Pharmacist recommendation to enter orders in the PCC to monitor target behavior.Pharmacist aware resident is on four different antidepressant /antipsychotic medications. No Notes		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed maintain sanitary (hygienic and clean) durable medical equipment (medical equipment prescribed by a doctor for home use) used for the completion of activities of daily living (fundamental self-care tasks done daily) for one out of three sampled residents (Resident 2).This failure had the potential to result in the spread of disease-causing organisms due to ineffective cleaning and sanitation.Findings:During an observation 12/2/2025 at 10:06 AM, a white metal commode riser (a mobility aid attached to a standard toilet to increase its height) with affixed handrails and toilet seat was placed over the toilet in the shared bathroom of rooms [ROOM NUMBERS]. One dime sized area of chipped paint and red/brown discolorations were present on the middle of the horizontal metal back bar and multiple locations on the right posterior (back) leg post.During a concurrent interview and record review on 12/3/2025 at 11:06 AM with the Maintenance Director (Mnt), Monthly equipment checklist, dated [DATE] was reviewed. The monthly equipment checklist indicated, Resident Recliners/Chairs condition were inspected. Mnt stated, All areas on sheet are checked. It takes longer than 1 day, so we just put November.The equipment titled Recliners/Chair includes all our toilet bedside commodes and risers.During a concurrent observation and interview on 12/3/2025 at 11:18 AM with Mnt in the shared bathroom of rooms [ROOM NUMBERS], Mnt verified chipped paint and red/brown discolorations in multiple locations on the equipment. Mnt stated, That should be replaced. Yes. That is rust (a reddish- or yellowish-brown flaky coating of iron oxide that is formed on iron or steel by oxidation). I will replace it right now. When asked why the durable medical equipment should be replaced, Mnt stated Because it is not safe, it's not clean and it's not sanitary. It's not safe for the residents, before we used to paint, but now we replace them.During a review of the facility's policy and procedure titled, Annual Inspections, last revised on 11/18/2009, indicated, .Patient Care and Other Equipment.The maintenance manager is ultimately responsible for maintaining other equipment such as, but not limited to,.oxygen concentrators, scales, lifts, and the like.and proof retained that such equipment is maintained per manufactures specifications.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 2Number of residents cited: 1Based on observation, interview and record review, the facility did not ensure, one resident, (Resident 40) of 2 residents, have his Preadmission Screening and Resident Review(PASARR) re-evaluated on the 30th day.This failure has potential for further screening and referrals for needed services will not be provided. Review of admission Record, dated, 12/5/25, indicated, admitted on [DATE], with diagnoses including: Cerebral Palsy (a neurologic disorder caused by abnormal development or damage to the developing brain), Bipolar Disorder (a serious mental illness causing extreme mood swings), Depression (condition with persistent sadness, hopelessness and loss of interest), Autistic Disorder (a complex neurodevelopmental condition that affects communication and social interaction). Review of PASARR Level 1 Screening submitted on 10/30/25. Result: Negative.Reason: Exempted Hospital Discharge.During an interview on 12/2/25 at 3 PM, with DON, asking her who completes the PASARR. Per DON the Marketing director completes and submits the PASARR on all new admits. Asked for a copy of PASARR. During an interview on 12/3/25 at 10 AM, with Marketing Director, per MD she completes and submits PASARR for all new admits. Per MD she completed and submitted for this resident on 12/3/25, copy was provided.Review of the new level 1 Screening submitted by nursing facility, dated 12/3/25.Result: Negative Reason: Exempted Hospital DischargeLevel II Mental Health Evaluation. Referral : Not required.If the individual remains in the NF longer than 30 days, the facility must resubmit a new Level 1 Screening as a Resident Review on the 31st day.Review of California Department of Health Care Service (DHCS), Preadmission Screening and Resident Review (PASARR) Level 1 Screening Assessment Guide, dated 10/2024, indicated; Definition1: Status Change: For current SNF residents.exceed the number of days allowed for their Categorical Determination or Exempted Hospital Discharge.Review of facility's document, Tool Tip Legend, undated, indicated, 2. The Screening type Resident Review (RR) is selected for an individual who: 3) Is identified as an Exempted Hospital Discharge who exceeds a stay of thirty (30) calendar days.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review the facility failed to provide services that maintained professional standards of quality for one out of three residents (Resident 8), when a certified nursing assistance administered a medication. This failure resulted in Resident 8 being administered medication by non-licensed staff that had the potential for clinically significant adverse consequences. Findings: During an interview on 12/04/2025 at 3:01 PM in Resident 8's room, with a certified nursing assistant (CNA 2), CNA 2 stated, Resident 8 has her own eye wipes due to eye buildup. CNA 2 stated, We put this on the eyes. I do not use towels. CNA 2 reached in Resident 8's top drawer in bedside cabinet and removed an individually wrapped pre- moistened packet of OCuSOFT LID SCRUB eyelid cleanser. During a phone interview on 12/05/2025 at 10:23 AM with the consulting pharmacist (PharmD), PharmD stated, due to the active ingredients in OCuSOFT LID SCRUB eyelid cleanser it is a medication that must have an active physician order, administered by a licensed nurse, and stored in a locked location. During a concurrent observation and interview on 12/05/2025 at 12:54 PM with the Assistant Director of Nursing (ADON) in Resident 8's room, a blue box containing the OCuSOFT LID SCRUB eyelid cleanser wipes were found in Resident 8's bedside cabinet. ADON stated, Yes. This I have definitely seen this in the medication cart given by nurses. I will remove, get MD order, and have LN administer it. ADON stated he was unaware of medication being administered by certified nursing assistants and it is the facility expectation that only licensed nurses administer medications. During a review of the facility's policy and procedure titled, Administering Medications, dated 04/2019, indicated, 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. 4. Medications are administered in accordance with prescriber orders, including any required time frame.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review the facility failed to provide the necessary services to maintain good grooming, personal, and oral hygiene for one out of three residents (Resident 8). This failure resulted in Resident 8 having difficulty opening both eyes due to white greasy build up on her bilateral (left and right) upper and lower lash line and thick white build up on the base of her lower gums and bottom row of her natural teeth. Findings: Review of Resident 8's medical records titled MINIMUM DATA SET (MDS, a standardized resident assessment tool), dated 09/23/2025, indicated Resident 8: Had limited function range of motion and impairments on both upper and lower extremities that interfered with daily functions. Was dependent on staff for oral hygiene needs (the ability to use suitable items to clean teeth). Was dependent on staff for personal hygiene needs (the ability to maintain personal hygiene, including washing/drying face). During an observation on 12/02/2025 at 10:23 AM, Resident 8 was observed lying flat in bed with television on, placed in front of her. Resident 8 was observed having difficulty opening both eyes due to white greasy build up on bilateral upper and lower lash line and thick white build up on the base of her lower gums and bottom row of her natural teeth. During an interview on 12/02/2025 at 10:25 AM with a Certified Nursing Assistant (CNA1), when asked what were Resident 8's care needs, CNA1 stated, We keep her clean and dry. We turn her every 2 hours, so she does not get pressure sores. But sometimes she is soaking wet and we change her more often. She is nonverbal. During a concurrent observation and interview on 12/04/2025 at 3:01 PM with Certified Nursing Assistant 2 (CNA 2) in Resident 8's bedside, Resident 8 was laying in bed with white greasy buildup on outer bilateral outer corners and inner corners of eye. CNA 2 stated, Resident 8's eyes were Dirty. I will clean after I get finished with another resident. CNA 2 reported resident has own eye wipes due to eye buildup. We put this on her eyes. I do not use towels. CNA 2 opened Resident 8's top drawer in the wooden bedside chest of drawers and removed a blue plastic box that contained individually packaged pre-moistened pads, labeled OCUSOFT LID SCRUB eyelid Cleaner. During a review of Job Description: Certified Nursing Assistant, dated 02/2024, the job description indicated General Purpose- The primary purpose of your job position is to provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan. Assist residents with daily functions (dental and mouth care, bath functions, combing of hair, dressing and undressing as necessary). During a review of Resident 8's Care Plan Report initiated on 10/08/2024 was reviewed. The Care Plan Report indicated, interventions provided to Resident 8 included Assist with maintaining good personal hygiene Q (every) shift and as needed. Provide assistance with care and ADL. During a review of the facility's policy and procedure titled, Activities of Daily Living (ADL), Supporting, (undated), indicated .5. Appropriate care and services are provided for residents who are unable to carry out ADL's independently, with the consent of the resident, and in accordance with the plan of care, including assistance with: a. hygiene (bathing, dressing, grooming, and oral care).		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review the facility failed to provide received individualized and ongoing activities and stimulation for one of three residents (Resident 7). This failure resulted in Resident 7 not receiving individualized activities designed to meet her interests and support psychosocial well-being. Findings: During an observation on 12/02/2025 at 09:43 AM, Resident 7 was observed lying in bed arousable (able to be easily woken up) to voice, with no music or television playing at Resident 7's bedside. On multiple subsequent observations, on 12/04/2025 at 9:23 AM, 12/04/2025 at 5:31 PM, 12/05/2025 at 10:34 AM and 10:50 AM Resident 7 was lying in bed with no individualized activities or stimulation observed. During an interview on 12/05/2025 at 10:18 AM with the Activities Director (AD- a professional responsible for planning, organizing, and leading programming), AD stated, We just go by room to room and do room visits. There is no set schedule. If they're (residents) bedbound they have the TV (television) and music should be on continuously. We play music for them (residents) because it is soothing for them. AD stated each room visit lasts approximately 10 minutes each offered 2-3 times a week. During a record review of Activity Assessment dated 12/05/2025, the Activity assessment indicated Resident 7 likes music and it was somewhat important for Resident 7 to do her favorite activities and to do things with groups of people. During a review of the facility's policy and procedure titled Activity Programs dated 06/2018, indicated, Activity programs are designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. 12. Individualized and group activities are provided that: reflect the cultural and religious interests, hobbies, life experiences and personal preferences of the residents.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed identify an environmental hazard for one out of four residents (Resident 2), when the hot water temperature in a shared resident bathroom was greater than 120 degrees Fahrenheit. This failure resulted in Resident 2 having increased risk for burns caused by scalding. Findings: During an observation on 12/02/2025 at 10:07 AM in the shared resident bathroom for rooms [ROOM NUMBERS], the hot water in the resident's face bowl was recorded at 121.5 degrees Fahrenheit on a calibrated (correlated with those of a standard) thermometer. During a concurrent observation and interview on 12/03/2025 at 11:47 AM with the Maintenance Director (Mnt) and the Director of Staff Development/Infection Preventionist (DSD/IP), the hot water in the shared resident room for rooms [ROOM NUMBERS] was intolerable to touch after five minutes of continuous running of the water. The hot water was tested by Mnt with the facility calibrated thermometer, water temperature was recorded as Between 124-26 (degrees Fahrenheit) per DSD/IP and Mnt stated, Its around 125 degrees. We check the hot water every week. I will go lower the boiler now. I will check the remaining facility bathrooms to verify temps (hot water temperatures) DSD/IP stated, I will inform residents not to use the bathroom faucet until hot water is verified within safe temps (temperatures). DSD/IP confirmed Resident 2 is the only resident that utilizes the resident bathroom independently (without staff assistance). During a review of the facility's policy and procedure titled, Water Temperatures, Safety of, dated 12/2009, indicated, Tap water in the facility shall be kept within a temperature range to prevent scalding of residents.3. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:2Number of residents cited:1Based on observation, interview and record review, the facility did not ensure one of two residents, (Resident 5) is receiving the correct amount of oxygen according to physician's order, when order indicates 1L/min. Resident observed to have 2 L/min for three consecutive days.This failure has potential for resident to have oxygen toxicity (lung damage that happens from breathing in too much extra supplemental oxygen. Review of Resident 5's admission Record, indicated admitted on [DATE] with diagnoses including: Chronic Obstructive Pulmonary Disease (COPD)(chronic lung condition causing shortness of breath), Pneumonia, (a lung infection),Shortness of Breath, Anxiety Disorder (a mental condition like persistent worry, fear and nervousness), Major Depression(condition with persistent sadness, hopelessness and loss of interest). Review of Order Summary Report, dated 10/25-12/5/25, indicated, Continuous oxygen via NC @1L/min Goal sat of 88%. Begin weaning from oxygen as tolerated every shift. Start date 11/5/25.Review of Medication Administration Record, dated 10/25-12/5/25, Oxygen saturation recorded every shift indicated, readings from 94 % to 97 %. No recorded weaning of oxygen done.During an observation of resident on 12/1/25 at 2 PM, resident in bed, awake, alert and responsive, on oxygen via nasal cannula at 2 L/min. Asked if she goes to activities, she said no, she does not know, and no one told her about it. asked if she knows how much oxygen they are giving her, per resident, I dont know no one tells me During an observation and interview of Resident 5 on 12/2/25 at 12 noon, resident in bed, sleeping on and off, responds to questions. Observed to be on oxygen via nasal cannula at 2 L/min. DON around the hallway, asked to confirm the oxygen level. Per DON that is a 2 L/min. Asked resident if nurses ever try to take her off oxygen as trial, resident said no, I always have this on pointing to her nasal cannula.During an observation on 12/3/25 at 9:49 AM, resident is in the room sitting up by side of the bed. Has oxygen via nasal cannula at 2L/min. Asked resident why she is on oxygen, per patient, her oxygen level was low that is why she was sent to the hospital. Will have oxygen when i go home.During a concurrent interview and record review on 12/3/25 at 11 AM, with Licensed Vocational Nurse 2, (LVN) 2, per LVN2, the resident has always been on oxygen. The order is at 1 L/min, oxygen saturation ranges from 92-97%, it is given continuously. There is an order to wean off when sat is over 90%. Per LVN, in review of her progress notes, she had weaned her off one time 12/3/25 at 9 am. Review of care plan, for oxygen use initiated 12/3/25 physician's ordered oxygen on 11/5/25. Review of facility Policy and Procedure, Oxygen Administration, undated, indicated: Purpose: The purpose of the procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure one out of two sampled residents (Resident 11) had adequate monitoring of their dialysis (a life sustaining medical treatment that filters waste products, excess fluid, and salt from the blood when kidneys fail, performing the kidneys job of cleaning the blood and balancing minerals) access site (a surgically created connected to the bloods stream that allows blood to be removed, cleaned by a dialysis machine); when it had been surgically changed from one site of the body to another. This failure in inadequate nursing assessment and documentation of Resident 11's current dialysis access stie had the potential for missed bleeding or other untoward side effects a dialysis resident could experience without adequate monitoring of the access site resulting in harm and even death. During a review of Resident 11's, admission Record, dated 6/19/24 indicated Resident 11 had been admitted to the facility on [DATE] with a history of diabetes and chronic kidney disease requiring dialysis treatment. During a review of Resident 1's, Order Summary Report dated December 2025, November 2025, October 2025 and September 2025, indicated Resident 11 had a physician order to Check A.V. (atrio-venous fistula, a surgically created connection between an artery and a vein, typically in the arm for hemodialysis) site to right upper chest dressing QS (every shift) leave intact for 4-6 hours following dialysis, change (dressing or bandage) if soiled or fallen off. If bleeding is noted from dialysis access site, immediately apply pressure to site to stop bleeding., also included the order for dialysis treatment to occur routinely on Tuesday, Thursday and Saturday at a specified offsite location The orders were written on 6/19/2024 and had not been discontinued when the surveyor had reviewed Resident 11's medical record on 12/3/25. During an observation and interview on 12/3/25 at 9:30 AM with Resident 11, Resident 11 was asked where the access for dialysis was located, and Resident 11 had pointed to the left upper arm bandage. Resident 11 was asked if there was anything on his chest and Resident 11 stated that there was nothing on his chest. Resident 11 was wearing a white t-shirt, and the surveyor was unable to observe anything underneath the shirt and no indication Resident 11 was unable to provide an accurate history. During a concurrent interview and medical record on 12/3/25 at 1:25 PM. with Director of Nursing (DON), DON, Resident 11's, Order Summary Report dated December 2025 and November 2025 was reviewed with the corresponding, Medication Administration Record (MAR) for December 2025 and November 2025 where the order to Check A.V. site to right upper chest dressing QS, leave intact for 4-6 hours following dialysis. was indicated for the nurses to document on the MAR each shift for each day of the month. DON stated when reviewing the physician order on the Order Summery Report for November and December 2025, that Resident 11 did not have an access sit on his right upper chest and that had been changed (surgically) in November 2025 and Resident 11's current access site for dialysis was on his left upper arm. All physicians' orders were reviewed, and no other access site physician orders were found. DON stated that it was strange, since the site had been changed back in November and Resident 11 no longer had an access site on his chest. DON was asked where the nurses would document Resident 11's access site and the MAR was reviewed for November and December 2025; where the same physician order of checking Resident 11's right upper chest order was found. The months of November 2025 and December 2025 indicated the nurses documented each day of the month that Resident 11's access site for dialysis was located on the chest compared to the current site of the left upper arm. DON stated they were aware of Resident 11's current left upper arm access site and was asked if documenting on the wrong site was a problem, DON stated it could be a problem if the nurses had no other place to document that the dialysis access site was clean, dry and intact but could not explain why the physician order had not been updated. DON was asked if there was a new nurse who did not know Resident 11 and viewed the physician orders, wouldn't they assess and document the old access site and not assess the current access site? DON stated Resident 11 would alert the nurse as to the current access site since he was (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	very knowledgeable and would make sure the nurse assessed the correct access site. DON was asked since there was documentation that an audit was done every month to check the physician orders for accuracy for situations such as this why wasn't this update in Resident 11's current dialysis access caught, DON stated I do not know again I would have to look into this situation. During a concurrent interview and record review on 12/3/25 at 2:25 PM with Licensed Staff A (LSA), Resident 11's, Medication Administration Record (MAR) for November 2025 and December 2025 was reviewed. LSA reviewed the current date of 12/3/25 and reviewed the physician order of Check AV site to right upper chest. LSA reviewed the MAR with surveyor and stated that was the only place where the nursing would be able to document Resident 11's dialysis access site, even though LSA stated Resident 11 no longer had that as the current access site for dialysis. LSA stated as an example most dialysis days when Resident 11 was having dialysis, they would not see Resident 11 on day shift and would document not at the facility but on the days when Resident 11 was not having dialysis, then that's the only place to document that Resident 11's dialysis site was okay (not bleeding and the bandage were clean and dry). During a review of the facility's policy and procedure titled, Hemodialysis Catheters-Access and Care of dated 2001, indicated, Documentation The nurse should document in the resident's medical record every shift as follows: 1. Location of catheter (a flexible tube acting as an access point to the bloodstream for filtering waste and excess fluid). 2. Condition of dressing (bandage) (interventions if needed). 3. If dialysis was done during shift. 4. Any part of report dialysis nurse post - dialysis being given. 5. Observation post- dialysis. During a review of the facility's policy and procedure titled, Charting Documentation, dated 7/2017, indicated, 3. Documentation in the medical cord will be objective (not opinionated or speculative), completed, and accurate.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to secure medications for one out of three residents (Resident 8) in a locked storage area and to limit access to non- authorized personnel. This failure resulted in Resident 8's medication being stored in unsecured and unsafe storage location, accessible to non-authorized personnel and other residents. Findings: During a concurrent current observation and interview on 12/04/2025 at 3:01 PM in Resident 8's room, with a certified nursing assistant (CNA2), CNA 2 reached in Resident 8's top drawer in the bedside cabinet and removed an individually wrapped pre- moistened packet of OCuSOFT LID SCRUB eyelid cleanser from a blue box. During a phone interview on 12/05/2025 at 10:23 AM with the consulting pharmacist (PharmD), PharmD stated, due to the active ingredients in OCuSOFT LID SCRUB eyelid cleanser it is a medication that must have an active physician order, administered by a licensed nurse, and stored in a locked location. During a concurrent observation and interview on 12/05/2025 at 12:54 PM with the Assistant Director of Nursing (ADON) in Resident 8's room, a blue box containing the OCuSOFT LID SCRUB eyelid cleanser wipes were found in Resident 8's bedside cabinet. ADON confirmed that all medications should be stored in medication room (storage). During a review of the facility's policy and procedure titled, Medication Labeling and Storage (undated), indicated The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and implement infection prevention measures when; Enhanced barrier precautions were not implemented for one of three sampled residents (Resident 7) during high contact care. One out of four sampled residents (Resident 15), had flecks of debris and crust in their oxygen tubing (delivers supplemental oxygen from a source like a machine or oxygen tank, to a resident usually through tube through the nose also called a nasal cannula). This failure had the potential to result in Resident 7 and 15 developing a transmission based communicable disease or infection. Findings: 1. During a concurrent observation and interview on 12/04/2025 at 2:22 PM with Certified Nursing Assistant 2 (CNA 2) in Resident 7's room, Resident 7 received wound care for a stage three pressure injury (a deep wound where skin is lost, revealing the yellow, fatty tissue underneath) on her sacrum (a triangular bone in the lower back). CNA 2 stated, I'm going to get the nurse to change her (Resident 7) dressing because it is dirty. When asked how frequently wound care was provided, CNA 2 stated A lot. Whenever it is dirty. The Assistant Director of Nursing (ADON) provided wound care for Resident 7 at 2:24 PM. No enhanced barrier precautions were observed by ADON or CNA 2 during the high contact wound care for Resident 7. During a review of Resident 7's Care Plan Report, initiated on 07/22/2025, the care plan indicated interventions to Utilize Enhanced Barrier Precautions (EBP) during high-contact resident care activated were to be implemented. During a concurrent interview and record review on 12/05/2025 at 10:34 AM with a Licensed Vocational Nurse (LVN 3), LVN 3 stated, Resident 7's wound dressing is changed by the treatment nurse and floor nurses with the certified nursing assistants (CNAs). LVN 3 reviewed current wound care orders on Resident 7's medical record. When asked if enhanced barrier precautions are utilized when wound care is provided, LVN 3 stated No, she (resident 7) is not on EBP. During an interview on 12/05/2025 at 12:10 PM with ADON, ADON stated Resident 7 was not currently on EBP. ADON confirmed no EBP was utilized during Resident 7's observed wound care provided on 12/04/2025. During a concurrent interview and record review on 12/05/2025 at 12:58 PM with the Director of Staff Development/Infection Preventionist (DSD/IP), Resident 7's Care Plan Report initiated on 07/22/2025 was reviewed. The care plan indicated interventions to Utilize Enhanced Barrier Precautions (EBP) during high-contact resident care activated were to be implemented. DSD/IP stated, Yes. I see that now. EBP should be in place for infection control measures to protect the resident from infections in her (Resident 7's) wounds and for her safety. 2. During a review of Resident 15's, admission Record, dated 12/23/24, indicated Resident 15 had been admitted to the facility to the facility on [DATE] with a history of stroke (when blood flow to part of the brain is blocked or a blood vessel burst cutting off blood flow, causing brain cells to die and leading to damage) and pulmonary edema (fluid buildup in the lungs making it hard to breathe by blocking oxygen from entering the blood). During a concurrent observation and interview on 12/1/25 at 1:04 PM, with Licensed Staff A (LSA), LSA was asked to observe Resident'15 oxygen tubing. LSA observed the tubing from a machine (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(oxygen concentrator) going up to the pillow on the bed and then exiting through two small holes into each nostril of Resident 15's nose. LSA was asked when the oxygen tubing was usually changed, and they stated it was usually changed every day and on the night shift. The surveyor asked when it was last changed since there was no label or indication of when the tubing had been changed. LSA stated they did not know since there usually would be a label to indicate the date, time and initials of the licensed staff who provided the new tubing. LSA was asked to inspect the tubing closer since the room was dark and then noticed the brown, crusty beige area on the tubing and LSA stated the tubing looked dirty and proceeded to flick it off with their gloved fingers. LSA confirmed the oxygen tubing did not look clean, it was dirty and could cause an infection if it was not changed, since the tubing was going through Resident 15's nose. During a review of the facility's policy and procedure titled, Departmental (Respiratory Therapy)-Prevention of Infection dated 2001, indicated, 7. Change the oxygen cannula and tubing every seven (7) days or as needed.		