STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555933	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chinese Hospital D/P Snf	845 Jackson Street San Francisco, CA 94133

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three of six sampled residents (Residents 26, 14, and 15) were free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) when:1. For Resident 26, there was no specific target behavior monitoring for the use of Lorazepam (medication used to treat anxiety) and2. For Residents 14 and 15, there was no diagnosis and/or specific condition for the use of antipsychotic medication.These deficient practices had the potential for residents to receive unnecessary psychotropic medication, be exposed to adverse health consequences from the medication, which could negatively impact the resident's mental, physical, and psychosocial well-being.1. Resident 26 was admitted on [DATE] with diagnoses including sepsis (a life-threatening emergency caused by the body's extreme, harmful response to infection, often leading to rapid organ failure and death), hypertension (high blood pressure), and malnutrition. Review of Resident 26's Order Summary Report (OSR) for the month of February 2026 indicated, .Lorazepam Oral Tablet 1 mg (milligram) Give 1 tablet by mouth every 24 hours as needed for insomnia. Order Start Date 2/13/26. Review of Resident 26's Medication Administration Record (MAR), dated 2/1/26 to 2/28/26 indicated, .Monitor for the following behaviors: restlessness, clinical worsening, suicidality, unusual changes in behavior or serotonin syndrome (hallucinations, seizures, abnormal heartbeat, confusion, agitation). The behavior monitoring did not specify the medication it was monitoring for. Review of Resident 26's MAR dated 2/1/26 to 2/28/26 indicated, .Lorazepam Oral Tablet 1 mg (milligram) Give 1 tablet by mouth every 24 hours as needed for insomnia. was administered on 2/13/26. During a concurrent interview and record review on 2/25/26 at 2:57 PM with Consultant Pharmacist (CP), Resident 26's MAR was reviewed. CP confirmed that there was no specific target behavior monitoring for the use of Lorazepam for Resident 26. CP stated, It's not specific for Lorazepam. 2. A concurrent interview and review of Resident 15's medical records was conducted on 2/24/26 at 1:59 PM with the Director of Staff Development (DSD). Review of Resident 15's medical records titled Order Summary Report, for February 2026, indicated Resident 15 had a physician order for .Paliperidone Palmitate. for schizoaffective (once a month injection to be administered at a clinic). Paliperidone palmitate is a medication used to treat the symptoms of mental disorders, including schizophrenia. Schizophrenia is a mental health condition presenting with hallucinations (seeing or hearing things that are not there), delusions (false belief not based in reality), or disorganized thinking. Schizoaffective disorder is a chronic mental health condition that combines symptoms of (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	schizophrenia with a mood disorder (like severe depression-profound hopelessness and loss of interest in activities, bipolar-elevated mood followed by severe depression). Review of Resident 15's medical records titled Diagnosis Report, for February 2026, found no diagnosis to support the use of paliperidone palmitate. The DSD was asked to search Resident 15's records for any documentation supporting the use of paliperidone palmitate. After searching, the DSD stated she could not find any clinical rationale(s) supporting the use of paliperidone palmitate. A concurrent interview and review of Resident 14's medical records was conducted on 2/24/26 at 2:19 PM with the DSD. Review of Resident 14's medical records titled Order Summary Report, for February 2026, indicated Resident 14 had a physician order for Quetiapine Fumarate . 25 mg (milligram a unit of weight measurement).two times a day for.mood disturbances/visual hallucination. Quetiapine is used to treat schizophrenia (a mental illness that affects how a person thinks, feels and behaves), bipolar disorder (a disease that causes depression, mania, and other abnormal moods) and major depressive disorder. Review of Resident 14's medical records titled Diagnosis Report, for February 2026, found no diagnosis to support the use of quetiapine. The DSD was asked to search Resident 14's records for any documentations supporting the use of quetiapine. After searching, the DSD stated she could not find any clinical rationale(s) supporting the use of quetiapine. On 2/25/26 at 12:20 PM, the [NAME] President of Quality (VPQ) was asked to provide documented evidence to support the use of paliperidone palmitate for Resident 15 and the use of quetiapine for Resident 14. Specifically, the requested documents included but was not limited to: admission summary from prior facility documenting diagnosis, conditions, specific behaviors that would support the use of these psychoactive medications. Physician assessment addressing diagnosis, conditions, behaviors regarding the use of these psychoactive medications Psychiatric assessment addressing diagnosis, conditions, behaviors regarding the use of these psychoactive medications Non-pharmacological interventions to address schizoaffective type behaviors for Resident 15 and mood disturbances/visual hallucinations type behaviors for Resident 14. Review of the documents sent by the VPQ found no supporting documentation for the use of paliperidone palmitate for Resident 15 and the use of quetiapine for Resident 14. Review of the facility's policy titled PSYCHOTROPIC MEDICATION USE POLICY – Skilled Nursing Facility (SNF) Unit, revised on 12/25, indicated . Indication for use: psychotropic medication will be determined to be necessary to treat a specific condition with diagnosis or indication documented in the medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop care plans for Residents 1, 14, 15, and 26, four residents out of a total sample of 8 residents. These were the areas the facility failed to care plan:Resident 15- antipsychotic medicationResident 1- anti-anxiety medication Resident 26- anti-anxiety medicationResident 14- bed railsThese failures had the potential to negatively impact these residents' health and safety.1. A concurrent interview and review of Resident 15's medical records was conducted on 2/24/26 at 1:59 PM with the Director of Staff Development (DSD). Review of Resident 15's medical records titled Order Summary Report, for February 2026, indicated Resident 15 had a physician order for .Paliperidone Palmitate. for schizoaffective (once a month injection to be administered at a clinic). Paliperidone palmitate is a medication used to treat the symptoms of mental disorders, including schizophrenia. Schizophrenia is a mental health condition presenting with hallucinations (seeing or hearing things that are not there), delusions (false belief not based in reality), or disorganized thinking. Schizoaffective disorder is a chronic mental health condition that combines symptoms of schizophrenia with a mood disorder (like severe depression-profound hopelessness and loss of interest in activities, bipolar-elevated mood followed by severe depression). Review of Resident 15's medical records titled Care Plan Report, dated admission date 02/04/2026, found no care plans addressing the use of paliperidone palmitate or schizoaffective disorder. 2. Review of Resident 1's face sheet indicated Resident 1 was admitted and placed in hospice (medical care for people who are expected to live six months or less) on11/28/25 for severe protein-calorie malnutrition (refers to various degrees of nutritional disorders caused by inadequate quantities of protein and energy in the diet). Review of Resident 1's physician orders for February 2026 indicated a prescription for Lorazepam (medication used to treat anxiety [a feeling of intense nervousness]) oral tablet 0.5 mg (milligram). Give 1 (one) tablet by mouth every 4 (four) hours as needed for anxiety manifested by agitation/ restless [sic], with a start date of 2/16/26 and an end date of 3/01/26. During a concurrent interview and record review on 2/25/26 at 1:40 PM, Registered Nurse (RN) 1 confirmed Resident 1's order for Lorazepam and stated, It's a psychotropic medication (any drug that affects behavior, mood, thoughts, or perception) .If he (Resident 1) has agitation, we can give it. RN 1 further stated, If it's (Lorazepam) ordered.supposed to have a care plan. During further review of Resident 1's electronic and paper-based care plan provided by the hospice agency, RN 1 was unable to find a care plan addressing anxiety or the use of Lorazepam. RN 1 stated, I can't find it. I don't know if he has it. I'm just per diem here. Better to ask a regular nurse. During a concurrent interview and record review on 2/25/26 at 2:24 PM, RN 2 reviewed Resident 1's care plan. RN 2 confirmed there was no care plan for anxiety or the use of Lorazepam. During a concurrent interview and record review on 2/25/26 at 3:20 PM, the Nurse Manager (NM) confirmed Resident 1 had an order for Lorazepam but could not find a care plan addressing anxiety or the medication. The NM stated, He should have it. Whenever there's an order for psychotropic medication, there should be a care plan for it. 3. Resident 26 was admitted on [DATE] with diagnoses including sepsis (a life-threatening emergency caused by the body's extreme, harmful response to infection, often leading to rapid organ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	failure and death), hypertension (high blood pressure), and malnutrition. Review of Resident 26's Order Summary Report (OSR) for the month of February 2026 indicated, .Lorazepam Oral Tablet 1 mg Give 1 tablet by mouth every 24 hours as needed for insomnia. Order Start Date 2/13/26. Review of Resident 26's Medication Administration Record (MAR), dated 2/1/26 to 2/28/26 indicated, .Lorazepam Oral Tablet 1 mg Give 1 tablet by mouth every 24 hours as needed for insomnia. was administered on 2/13/26. During a concurrent interview and record review on 2/25/26 at 2:41 PM with Registered Nurse (RN) 2, Resident 26's orders and care plans were reviewed. RN 2 acknowledged that Resident 26 had an order for Lorazepam. RN 2 confirmed that there was no care plan for the use of Lorazepam. RN 2 stated, I don't see it. No care plan for the use of Lorazepam. RN 2 also said to use non-pharmacological interventions first and the use of Lorazepam is the last recourse. 4. Resident 14 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD - a long-term lung disease that makes it hard to breathe) and pulmonary fibrosis (lung disease that occurs when lung tissue becomes damaged and scarred). During an observation on 2/25/2026 9:38 AM, Resident 14 was asleep in bed, with both upper bed rails up. During a concurrent interview and record review on 2/25/26 at 10:12 AM with RN 2, Resident 14's care plans were reviewed. RN 2 said Resident 14 used the bed rails as enabler for turning and repositioning. RN 2 confirmed there was no care plan for the use of bed rails, and stated, No care plan for the use of bed rails. I will put it in. RN 2 further stated, It could be considered as a restraint so it is important to make sure it's for mobility. Review of facility policy and procedure titled, Development and Implementation of Baseline and Comprehensive Care Plan, dated 9/23, indicated, Purpose: It is our purpose to ensure that each resident is provided with individualized, goal-directed care, which is reasonable, measurable and based on resident needs.Procedure: 1. Every resident will have an Interdisciplinary Care Plan.Developing the Care Plan.2. The care plan will include measurable objectives and timeframes to meet the resident's medical, nursing, pharmaceutical, mental and psychosocial needs that are identified in the comprehensive assessment.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to send notification to Ombudsman for one of two residents (Resident 24) when Resident 24 was discharged from the facility against medical advice (AMA).This failure had the potential for resident not having the right to appeal when necessary.Resident 24 was admitted on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction caused by underlying condition), anemia (when you have low levels of healthy red blood cells to carry oxygen throughout your body) and congestive heart failure (a chronic condition where the heart cannot pump blood efficiently, causing fluid buildup, fatigue, and shortness of breath).Review of facility document titled, Notice of Transfer or Discharge, dated 12/16/25, indicated, Resident 24 was discharged AMA on 12/16/25. There was no documentation that notice of discharge was sent to Ombudsman.During a concurrent interview and record review on 2/25/26 at 2:01 PM with Social Worker (SW), Resident 24's Notice of Transfer or Discharge dated 12/16/25 was reviewed. The notice indicated Resident 24 was discharged AMA on 12/16/25. According to the SW, Resident 24 left AMA as he wanted to go back home. SW said the notice was faxed to the Ombudsman. There was no documentation that notice of discharge was sent to Ombudsman. SW stated, I couldn't find it (proof of fax transmittal).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a physician's (MD) order and develop a comprehensive care plan for the use of external catheter for one of one sampled resident (Resident 26).These deficient practices had the potential for resident not to receive appropriate treatment and services.Resident 26 was admitted on [DATE] with diagnoses including sepsis (a life-threatening emergency caused by the body's extreme, harmful response to infection, often leading to rapid organ failure and death), hypertension (high blood pressure), and malnutrition.During an observation on 2/23/26 at 10:56 AM, Resident 26 was asleep in bed, with a catheter (a flexible tube used to deliver fluids into or withdraw fluids from the body) draining with yellowish urine to a drainage bag.During a concurrent interview and record review on 2/26/26 at 9:58 AM, with Licensed Vocational Nurse (LVN) 1, Resident 26's orders and care plans were reviewed. LVN 1 said Resident 26 had the catheter the on admission to help keep the skin dry and prevent skin breakdown. LVN 1 said they ask the MD for an order for the use of catheter, and stated, Yes, we ask the MD. LVN 1 confirmed there was no order for the use of external catheter for Resident 26 and stated, Should have an order for it. I don't see it. Additionally, LVN 1 acknowledged there was no care plan for the use of external catheter and stated, I don't see it. Furthermore, LVN 1 stated the importance of the care plan was to know what the interventions are to take care of the resident with external catheter.The facility was unable to provide a policy and procedure for the use of external male catheter. The facility provided a policy and procedure for the use of external female catheter. On 3/26/26 at 3:32 PM, the [NAME] President for Quality, Medical Staff and Compliance (VPQ) confirmed that the policy and procedure for external female catheter was used for external male catheter as well.Review of facility's policy and procedure (P&P) titled, External Female Catheter, dated 8/24, the P&P indicated, .Procedure: 1. Obtain a physician's order.

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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** Based on observation, interview, and record review, the facility failed to obtain a physician's (MD) order for oral suctioning for one of one sampled resident (Resident 14).This failure had the potential for Resident 14 not to receive appropriate treatment and services.Resident 14 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD - a long-term lung disease that makes it hard to breathe) and pulmonary fibrosis (lung disease that occurs when lung tissue becomes damaged and scarred).During an observation on 2/23/26 at 10:22 AM, Resident 14 was asleep in bed, oral suctioning equipment was at resident's bedside table. The canister contained light yellowish secretions.During an interview on 2/25/26 at 10:44 AM, Hospital Aide (HA) 1 said that the oral suctioning equipment was used to suction secretions of Resident 14. HA 1 stated, I do the suctioning when needed.Review of Resident 14's care plan indicated, .Focus: Resident 14 has altered respiratory status and difficulty breathing.Interventions/Tasks.Maintain a clear airway.If secretions cannot be cleared, suction as ordered/required to clear secretions.Review of Resident 14's clinical record, the Order Summary Report (OSR), active orders as of 1/1/126, the OSR did not indicate an order for oral suctioning.During a concurrent interview and record review on 2/26/26 at 11:02 AM with Nurse Manager (NM), Resident 14's orders were reviewed. NM acknowledged that there was no MD order for oral suctioning, and stated, I don't see one for oral suctioning. Furthermore, NM stated, There's a reason MD writes an order. We can't do anything without a doctor's order.Review of facility's policy and procedure (P&P) titled, Suction Policy and Procedure - SNF, dated 8/27/24, the P&P indicated, .routine suctioning does require a provider order.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review facility staff failed to accurately measure a controlled drug to enable exact reconciliations. Certain medications/chemical substances are subject to strict government control/oversight due to their potential for misuse and harm. For example: Morphine to treat moderate to severe pain.Staff failed to accurately measure the amount of Morphine within a bottle upon receipt and during shift-to-shift verification. This failure had the potential for drug diversion and medication error. Findings: During a concurrent observation, interview, and record review with Registered Nurse (RN 1) on 2/23/26 at 11:03 AM, a bottle of morphine was in the locked controlled substance cabinet of medication cart 3. Observation of the amount of morphine within the bottle indicated it was above the 30 ml (millimeter = a unit of liquid measurement) mark. This observation was confirmed with RN 1 and she agreed there was more than 30 ml of morphine inside the bottle. However, review of a facility document titled Controlled Drug Record, dated 11/20/2025, indicated 30 ml of morphine was initially delivered to the facility and on 2/23/2026, staff documented there should be 29.875 ml remaining. RN 1 attempted to explain why the current observed amount of morphine did not match what was recorded. RN 1 stated pharmacy sometimes overfill liquid medication, and this overfill was not accounted for in their documentation. RN 1 confirmed currently, the amount morphine in the bottle does not match what was documented in their shift-to-shift reconciliation document. RN 1 was asked why staff did not accurately document the overfill upon receipt. RN 1 offered no explanation. During an interview on 2/24/26 at 11:02 AM the Associate Director, Integrated Pharmacy Services (ADIPS) stated she was aware of the over fill issue and had discussed the issue with her team, but they have not implemented any way for staff to accurately account for the over fill. The ADIPS stated she was not aware of any pharmacy policies addressing the overfill issue. The facility was asked to provide their pharmacy policies regarding this overfill issue. Review of the facility's pharmacy policies provided below found no language addressing this overfill issue:Titled MEDICATION ADMINISTRATION POLICY- Skilled Nursing Facility (SNF) Unit, approved on 8/2025.Titled MEDICATION STORAGE POLICY - Skilled Nursing Facility Unit (SNF D/P), approved on 12/2025.

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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 facility staff failed to ensure a pharmacy printed label for a medication was legible. This failure had the potential for medication error. Findings: During a concurrent observation and interview on 2/23/26 at 11:19 AM with Registered Nurse (RN 1), the following was observed in medication cart 2. There was a bottle of nystatin powder (used to treat skin fungal and/or rashes) with an illegible pharmacy printed label. RN1 inspected the label, agreed the label exhibited water damage/ spreading of the ink and confirmed she could not read the resident's name on the label. RN1 stated staff should have called pharmacy and requested a new label for the nystatin powder. During an interview on 2/24/26 at 11:02 AM the Associate Director, Integrated Pharmacy Services (ADIPS) stated she expected staff to call pharmacy to print out a new label if a label becomes illegible. The ADIPS stated as a result of the above findings, staff did an audit and found and replaced another illegible medication label. Review of the facility's policy titled MEDICATION STORAGE POLICY - Skilled Nursing Facility Unit (SNF D/P), approved on 12/2025, indicated To ensure all medications in the Skilled Nursing Facility (SNF) are stored securely, properly labeled.

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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 maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for one of two sampled residents (Resident 14) when the Yankauer suction tip (a bulb-tipped instrument used to remove saliva, blood, and mucus from the oral cavity to maintain a clear airway and prevent aspiration) was not covered while not in use.This deficient practice had the potential to transmit microorganisms and increase the risk of infection for Resident 14.Resident 14 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD - a long-term lung disease that makes it hard to breathe) and pulmonary fibrosis (lung disease that occurs when lung tissue becomes damaged and scarred).During an observation on 2/23/26 at 10:22 AM, Resident 14 was asleep in bed, oral suctioning equipment was at resident's bedside table. The canister contained light yellowish secretions. The Yankauer suction tip was not covered.During a concurrent observation and interview on 2/25/26 at 9:34 AM with Registered Nurse (RN) 2 in Resident 14's room, Resident 14 had oral suctioning equipment at bedside with the Yankauer suction tip not covered. RN 2 stated, The tip is not covered. It should be covered. RN 2 further stated that it was a hygiene issue because the suction tip goes to the mouth, as well as infection control and patient care issues.During a concurrent observation and interview on 2/25/26 aty 10:37 AM with Infection Preventionist (IP) in Resident 14's room, Resident 14 had oral suctioning equipment at bedside with the Yankauer suction tip not covered. IP stated, The tip should not be showing, should be covered to prevent contamination. It should be changed because it's potentially contaminated.Review of facility provided Instructions for Use for Covered Yankauer with Suction Handle indicated, .Put sleeve over Yankauer tip to cover.