STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056272	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Francisco Health Care	1477 Grove Street San Francisco, CA 94117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Medication Error rate- 25.9% Based on observation, interviews and record review, the facility had a medication error rate of 25.9% when seven medication errors occurred out of 27 opportunities during the medication administration for four of seven residents (Residents 256, 72, 63 and 17). The failure had the potential to result in residents not receiving full therapeutic effects or causing side effects for the residents. FINDINGS: 1. During the medication administration observation on 2/24/25 at 8:03 AM, for Resident 17, Registered Nurse (RN) 3 was observed preparing and administering four oral medications. RN 3 crushed all 4 tablets, poured them in a medication cup, mixed with applesauce and administered to patient. Patient took the medication with applesauce. Per RN 3, patient takes medications with no problem. Review of Resident 17's admission Record, admitted 0n 3/15/24 with diagnoses including: Dementia (memory loss) and Failure to Thrive (a decline characterized by weight loss, decreased appetite, poor nutrition, and inactivity). Review of Order Summary Report, dated 2/27/25, indicated, May crush medications or open capsules as indicated per pharmacy protocol. 2. Review of Resident 256's admission Record, admitted on [DATE] with diagnoses including: Cerebral Infarction (a condition where blood flow to the brain is interrupted causing brain tissue to die), Dysphagia(difficulty swallowing), Gastrostomy Status(where a thin flexible tube is inserted through the abdominal wall and into the stomach for feeding). Review of Order Summary Report for Resident 256, dated 2/28/25, indicated, Enteral Feed order every shift Diabetic Source feeding @ 90 ml/hr start at 1 pm stop at 9 am. May crush medications and open capsules as indicated per pharmacy protocol to give via GT. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the medication administration observation on 2/24/25 at 8:30 AM, for Resident 256, RN 3 was observed preparing 6 tablets for Gastrostomy administration. RN 3 crushed all 6 tablets and poured them into a cup of water. After GT placement check, RN 3, poured the mixed tablets with water into the syringe. RN 3 then flushed the tube with a cup of water. RN3 proceeded with giving a liquid antibiotic per GT. RN3 stated it takes a while to dilute the tablets, needs a little push at times. 3. During the medication administration observation on 2/25/25 at 11:30 AM for Resident 63, RN 3 stated, the PCC (Point Click Care - an electronic health record program) is down but I know his medication, will check the MAR(medication administration record) later. RN 3 was observed getting the eyedrop, Artificial Tears and 2 tissues, prepared and explained to the patient, dropped one dop to right eye, then wiped with tissue. Then dropped one drop to left eye and wiped the left eye. Review of Order Summary Report for Resident 63, dated 2/28/25, indicated, Artificial Tears, Instill 2 drops to left eye every 4 hours for dry eyes. Review of facility Policy and Procedure, Medication Administration-Preparation and General Guidelines, dated 6/15, indicated, B. Administration, 2. Medications are administered in accordance with written orders of the prescriber. A. Preparation, 5. The medication administration record (MAR) is always employed during medication administration. Prior to administration of any medications, the medication and dosage schedule on the resident's MAR are compared with the medication label. 4. A review of Resident 72's admission Record, indicated, admitted on [DATE] with diagnoses including: Organ-Limited Amyloidosis (abnormal protein deposits that can build up in organs and tissues causing damage and disease), Paroxysmal Atrial Fibrillation (a kind of irregular heartbeat that occurs intermittently and stops on its own.) During a concurrent observation and interview on 2/24/25 at 9:00 AM, with RN 3, for medication administration for resident 72, RN 3 stated, Resident 72 has an order for Vyndaquel (a medication to delay nerve damage caused by abnormal protein deposits in organs and tissues) 20 mg 4 capsules every day. RN 3 pulled out the box and stated, medication is not available, has been reordered. Last given on 2/19/25. This medication is not available in our Automatic Dispensing Unit (ADU - a computerized system used in healthcare settings to store, dispense, and track medications). During an initial interview on 2/24/25 at 7:00 AM, with Resident 72, Resident 72 stated he has not been given his cardiac medication, Vyndaquel 20 mg since last week. During an interview on 2/24/25 at 9:00 AM, with RN 3, RN 3 stated the medication was reordered; the pharmacy was notified but needed the Attending physician to order. MD gave order and was faxed to pharmacy but the pharmacy stated [the medication was] not available. No progress notes found on this issue. Review of Order Summary Report dated, 2/26/25, indicated, Tafamidis Meglumine (Cardiac - a medication used to treat cardiac amyloidosis - a rare condition caused by abnormal protein deposits in the heart) oral capsule 20 mg. Give 4 capsules by mouth one time a day for cardiac amyloidosis, start date 1/7/25. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of MAR for February 2025, indicated, Tafamidis Meglumine Cardiac, on 2/20/25 to 2/25/25, code 9 = Other/see progress notes initialed by nurses. A review of progress notes did not indicated what code 9 meant. On 2/25/25, indicated Tamafidis is not available . Review of facility progress notes, by MD, dated 2/17/25,Follow ups: if additional 30 days supply of Tafamidis not delivered on 1/8/25, call [Hospital] Specialty Pharmacy at XXX-XXX-XXXX. Review of facility Policy and Procedure, medication Administration- General Guidelines, dated 6/15, indicates: D. Documentation (including electronic) 6.If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time .the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on reverse side of record. If a vital medication is not available, the physician is notified. Nursing documents the notification and physician response.