

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056457	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Greenridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2150 Pyramid Drive El Sobrante, CA 94803	
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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management 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 failed to ensure pain was controlled, for one of three sampled residents (Resident 1), when the facility failed to timely administer pain relief medication to Resident 1. A review of Resident 1's admission record (AR), dated 4/11/26, indicated Resident 1 was admitted for HB-SS with acute chest syndrome (sickle cell disease with sickle-shaped red blood cells blocking blood flow in the lungs, leading to inflammation, low oxygen levels and pain, including severe pain). During a record review of Resident 1's minimum data set (MDS, an assessment tool to guide resident care), dated 4/1/26, the MDS indicated Resident 1 had a Brief Interview for Mental Status score of 14 (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) During a record review of Resident 1's physicians' orders set titled, Order Summary Report, (OSR) dated 03/26/26, OSR indicated Resident 1 had an order for Hydromorphone HCL (a strong synthetic narcotic medication used to treat moderate to severe pain) 2 mg tablet give 1 tablet every 12 hours as needed for severe pain, an order for Hydromorphone HCL 2 mg tablet give 1 tablet by mouth every 4 hours as needed for moderate pain and an order for Hydromorphone HCL 2 mg tablet give 1 tablet by mouth every 4 hours as needed for pain. During a concurrent observation and interview on 6/18/26 at 10:55 a.m. with Registered Nurse 1 (RN 1), at medication cart, RN 1 unlocked the medication cart, then unlocked the controlled medication drawer and removed the emergency medication kit (E-kit). The E-kit was a plastic box, secured with two zip ties. The E-kit contained hydromorphone 2 mg tablets. RN 1 stated, the facility had two medication carts and each cart had an identical E-kit. RN 1 stated, the E-kits contained hydromorphone 2 mg tablets, the pain medication ordered for Resident 1. RN 1 stated, the facility had a procedure for giving a resident medication on an emergency basis. RN 1 stated, Resident 1 had recently been admitted and had not yet received his supply of medications from the pharmacy. The facility's procedure was as follows: when a resident had an order for a medication that the resident needed on an emergency basis and the facility did not have that medication in the resident's medications, the licensed nurse called the pharmacy to obtain a code and after obtaining the code, the licensed nurse removed the medication from the E-kit and gave the medication to the resident. RN 1 stated, the pharmacy must be able to see the doctor's order for the medication to give out the code. During a concurrent interview and record review on 6/18/26 at 11:05 a.m. with RN 1, Resident 1's Progress Notes Type: Nurses Notes (PN NN), dated 3/26/26 at 16:54, PN NN indicated, Resident 1 was admitted to the facility from another facility, the doctor was aware of the admission and all orders had been entered in the electronic chart. RN 1 stated, Resident 1 was admitted on [DATE] at 16:54. During a concurrent interview and record review on 06/18/26, at 11:15 a.m., with RN 1, Resident 1's Progress Notes, Nursing Advanced Skilled Evaluation (PN [NAME]), dated 03/26/26, was reviewed. The PN [NAME] indicated, Resident 1 had a pain score of 10 at 21:19. RN 1 stated, nurses note indicated Resident 1's pain score was a 10 out of 10 at 21:19. During a record review of Resident 1's Progress Notes Type: MDS Notes (PN MDS), dated [DATE] at 23:50, was reviewed. The PN MDS indicated, pt was complaining of pain, due to rx issues pain medication got delayed. Hospital (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was contacted with no success. NP [NAME] was contacted no response, spherical NP on call was contacted, however there was a problem obtaining an rx for controlled meds. Coordinated with pharmacy to obtain vo order, finally got a code for ekit. But patient was in pain that oral medication wont help him, per patient he needs IV meds for pain and requested to call 911. Before pt's left he took dilaudid oral. Per patient he wants to go to ED for IV pain medication . 911 came and transport the pt. During a record review of Resident 1's Progress Notes Type: MDS Notes (PN MDS), dated [DATE] at 23:56, was reviewed. The PN MDS indicated, contacted spherical on call with no answer. During a record review of Resident 1's Medication Administration Record (MAR), dated 3/1/26 - 3/31/26, the MAR indicated, Resident 1 received Hydromorphone HCL Tablet 2 mg by mouth on 3/26/26 at 2345 for pain. During a concurrent interview and record review on 06/18/26, at 11:28 a.m., with RN 1, Resident 1's OSR was reviewed. OSR indicated, Resident1 had one order for Hydromorphone HCL oral tablet 2 mg give 1 tablet by mouth every 4 hours as needed for pain order date 3/26/26 and start date 3/26/26. OSR also indicated, Resident1 had three orders for Hydromorphone HCL oral tablet 2 mg give 1 tablet by mouth every 12 hours as needed for severed pain order date 3/26/26 and start date 3/26/26 with one order indicated as phone order, another order as prescriber entered and the third order as a verbal order. OSR further indicated, Resident 1 had four orders for Hydromorphone HCL oral tablet 2 mg give 1 tablet by mouth every 4 hours as needed for moderate pain order date 3/26/26 and start date 3/26/26 with two orders indicated as phone orders, another order as prescriber written and the fourth order as prescriber entered. RN 1 stated, the multiple orders for hydromorphone tablet 2 mg for pain showed the nurse's attempts to get an order to be able to get a code from the pharmacy so the licensed nurse could open the E-kit to give hydromorphone to Resident 1 for pain. During an interview on 6/18/26 at 1:00 p.m. with RN 1, RN 1 stated, based on RN 1's review of Resident 1's chart, it appeared the licensed nurse taking care of Resident 1 on 3/26/26, had difficulty getting an order for pain medication necessary to get a code to open the E-kit to get pain medication to give to Resident 1. RN 1 stated, nursing notes indicated Resident 1 complained of pain of 10 at 21:19. RN 1 stated, nursing notes indicated there was a delay in giving pain medication. RN 1 stated, MAR indicated the pain medication, hydromorphone 2 mg, was given by mouth at 23:45. RN 1 also stated, nurses notes indicated Resident 1 asked to be transferred to the acute care hospital emergency department in order to receive intravenous pain medication because Resident 1 felt oral pain medication would not be able to adequately treat his pain. During an interview 6/18/26 at 1:29 p.m. with Director of Nursing (DON), DON stated a resident with serious pain needed to be treated right away. DON stated, it was not acceptable for a resident with a pain score of 10, to be in pain and to wait almost 2 and 1/2 hours for pain medication to become available. During a review of the facility's policy and procedure titled, Pain Assessment and Management, dated Revised March 2015, the P&P indicated, . 1. The pain management program is based on a facility-wide commitment to resident comfort. 2. Pain Management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident . [emphasis in original]During a review of the facility's policy and procedure titled, admission Criteria, dated Revised December 2016, the P&P indicated, Our facility will admit only those residents whose medical and nursing needs can be met . 6. Residents will be admitted to this facility as long as their nursing and medical needs can be met adequately by the facility .		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services to meet the needs of the residents, for one of three sampled residents (Resident 1), when the facility failed to obtain emergency medication to timely administer pain relief medication to Resident 1. A review of Resident 1's admission record (AR), dated 4/11/26, indicated Resident 1 was admitted for HB-SS with acute chest syndrome (sickle cell disease with sickle-shaped red blood cells blocking blood flow in the lungs, leading to inflammation, low oxygen levels and pain, including severe pain). During a record review of Resident 1's minimum data set (MDS, an assessment tool to guide resident care), dated 4/1/26, the MDS indicated Resident 1 had a Brief Interview for Mental Status score of 14 (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) During a record review of Resident 1's physicians' orders set titled, Order Summary Report, (OSR) dated 03/26/26, OSR indicated Resident 1 had an order for Hydromorphone HCL (a strong synthetic narcotic medication used to treat moderate to severe pain) 2 mg tablet give 1 tablet every 12 hours as needed for severe pain, an order for Hydromorphone HCL 2 mg tablet give 1 tablet by mouth every 4 hours as needed for moderate pain and an order for Hydromorphone HCL 2 mg tablet give 1 tablet by mouth every 4 hours as needed for pain. During a concurrent observation and interview on 6/18/26 at 1055 a.m. with Registered Nurse 1 (RN 1) next to the medication cart, RN 1 unlocked the medication cart, then unlocked the controlled medication drawer and removed the emergency medication kit (E-kit). The E-kit was a plastic box, secured with two zip ties. The E-kit contained hydromorphone 2 mg tablets. RN 1 stated, the facility had two medication carts and each cart had an identical E-kit. RN 1 stated, the E-kits contained hydromorphone 2 mg tablets, the pain medication ordered for Resident 1. RN 1 stated, the facility had a procedure for giving a resident medication on an emergency basis. RN 1 stated, Resident 1 had recently been admitted and had not yet received his supply of medications from the pharmacy. The facility's procedure was as follows: when a resident had an order for a medication that the resident needed on an emergency basis and the facility did not have that medication in the resident's medications, the licensed nurse called the pharmacy to obtain a code and after obtaining the code, the licensed nurse removed the medication from the E-kit and gave the medication to the resident. RN 1 stated, the pharmacy must be able to see the doctor's order for the medication to give out the code. During a concurrent interview and record review on 6/18/26 at 1105 a.m. with RN 1, Resident 1's Progress Notes Type: Nurses Notes (PN NN) dated 3/26/26 at 1654, PN NN indicated, Resident 1 was admitted to the facility from another facility, the doctor was aware of the admission and all orders had been entered in the electronic chart. RN 1 stated, Resident 1 was admitted on [DATE] at 1654. During a concurrent interview and record review on 06/18/26, at 11:15 a.m., with RN 1, Resident 1's Progress Notes, Nursing Advanced Skilled Evaluation (PN [NAME]), dated 03/26/26, was reviewed. The PN [NAME] indicated, Resident 1 had a pain score of 10 at 2119. RN 1 stated, nurses note indicated Resident 1's pain score was a 10 out of 10 at 2119. During a record review of Resident 1's Progress Notes Type: MDS Notes (PN MDS), dated [DATE] at 23:50, was reviewed. The PN MDS indicated, pt[patient] was complaining of pain, due to rx[treatment] issues pain medication got delayed. Hospital was contacted with no success. Nurse Practitioner (NP) was contacted, no response, spherical NP on call was contacted, however there was a problem obtaining an rx[order] for controlled meds. Coordinated with pharmacy to obtain vo[voice order], finally got a code for ekit[emergency kit]. But patient was in pain that oral medication wont help him, per patient he needs IV meds for pain and requested to call 911. Before pt[patient] left he took dilaudid (a potent synthetic opioid pain medication roughly 2 to 8 times stronger than morphine)oral. Per patient he wants to go to (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ED for IV pain medication . 911 came and transport the pt. During a record review of Resident 1's Progress Notes Type: MDS Notes (PN MDS) dated [DATE] at 2356, it indicated contacted spherical on call with no answer. During a record review of Resident 1's Medication Administration Record (MAR) dated 3/1/26 - 3/31/26, the MAR indicated: Resident 1 received Hydromorphone HCL Tablet 2 mg by mouth on 3/26/26 at 2345 for pain. During a concurrent interview and record review on 06/18/26, at 11:28 a.m., with RN 1, Resident 1's OSR was reviewed. OSR indicated, Resident1 had one order for Hydromorphone HCL oral tablet 2 mg give 1 tablet by mouth every 4 hours as needed for pain order date 3/26/26 and start date 3/26/26. OSR also indicated, Resident1 had three orders for Hydromorphone HCL oral tablet 2 mg give 1 tablet by mouth every 12 hours as needed for severe pain order date 3/26/26 and start date 3/26/26 with one order indicated as phone order, another order as prescriber entered and the third order as a verbal order. OSR further indicated, Resident 1 had four orders for Hydromorphone HCL oral tablet 2 mg give 1 tablet by mouth every 4 hours as needed for moderate pain order date 3/26/26 and start date 3/26/26 with two orders indicated as phone orders, another order as prescriber written and the fourth order as prescriber entered. RN 1 stated, the multiple orders for hydromorphone tablet 2 mg for pain showed the nurse's attempts to get an order to be able to get a code from the pharmacy so the licensed nurse could open the E-kit to give hydromorphone to Resident 1 for pain. During an interview on 6/18/26 at 1300 with RN 1, RN 1 stated, based on RN 1's review of Resident 1's chart, it appeared the licensed nurse taking care of Resident 1 on 3/26/26, had difficulty getting an order for pain medication necessary to get a code to open the E-kit to get pain medication to give to Resident 1. RN 1 stated nursing notes indicated Resident 1 complained of pain of 10 at 2119. RN 1 stated, nursing notes indicated there was a delay in giving pain medication. RN 1 stated, MAR indicated the pain medication, hydromorphone 2 mg, was given by mouth at 2345. RN 1 also stated, nurses notes indicated Resident 1 asked to be transferred to the acute care hospital emergency department in order to receive intravenous pain medication because Resident 1 felt oral pain medication would not be able to adequately treat his pain. During an interview 6/18/26 at 1329 with Director of Nursing (DON), DON stated a resident with serious pain needed to be treated right away. DON stated it was not acceptable for a resident with a pain score of 10, to be in pain and to wait almost 2 and 1/2 hours for pain medication to become available. During a review of the facility's policy and procedure titled, Pain Assessment and Management, dated Revised March 2015, the P&P indicated, . 1. The pain management program is based on a facility-wide commitment to resident comfort. 2. Pain Management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident . [emphasis in original]During a review of the facility's policy and procedure titled, admission Criteria, dated Revised December 2016, the P&P indicated, Our facility will admit only those residents whose medical and nursing needs can be met . 6. Residents will be admitted to this facility as long as their nursing and medical needs can be met adequately by the facility .		