STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075113	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Manor Nursing and Rehabilitation Center	4 Greentree Drive Waterford, CT 06385

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for five (5) of eight (8) sampled residents (Residents #1, #2, #3, #4, and #5) who were reviewed for allegations of misappropriation of personal property, the facility failed to ensure the residents' medications were not removed from the facility by staff. The findings include:Resident #1's diagnoses included osteomyelitis of the right ankle, diabetes mellitus with polyneuropathy, and left foot amputation. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 made reasonable and consistent decisions regarding tasks of daily living. A physician's order dated 7/8/25 directed to administer the pain medication Oxycodone 5 milligrams (mg) one (1) tablet every six (6) hours as needed for pain. Review of the July and August 2025 Medication Administration Records identified Resident #1 received the Oxycodone as ordered. The Facility Reported Incident form dated 10/27/25 identified the Drug Enforcement Agency (DEA) had entered the facility on 10/7/25 to investigate a complaint filed with them regarding missing narcotics. The DEA concluded their investigation on 10/27/25 and discovered that a total of six (6) blister packs for five (5) residents were not accounted for along with the Control Disposition Records. An interview with the contracted pharmacist, Person #2, on 11/7/25 at 12:50 PM and review of the pharmacy shipment summaries identified the dates and quantities of the Oxycodone 5 mg delivered to the facility for Resident #1 were on 7/9/25 a total of thirty (30) tablets and on 8/7/25 a total of twenty (20) tablets. The facility failed to provide documentation of the Control Disposition Records for the Oxycodone that were delivered on 7/9/25 and 8/7/25 and the blister packs of medication. 2. Resident #2's diagnoses included stage four (4) pressure ulcer to the sacrum, congestive heart failure, and spinal stenosis. A physician's order dated 9/11/25 directed to administer the pain medication Oxycodone 5 milligrams (mg) one (1) tablet every six (6) hours as needed for pain. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 made reasonable and consistent decisions regarding tasks of daily living. Review of the September 2025 Medication Administration Record identified Resident #2 received the Oxycodone as ordered. The Facility Reported Incident form dated 10/27/25 identified the Drug Enforcement Agency (DEA) had entered the facility on 10/7/25 to investigate a complaint filed with them regarding missing narcotics. The DEA concluded their investigation on 10/27/25 and discovered that a total of six (6) blister packs for five (5) residents were not accounted for along with the Control Disposition Records. An interview with Resident #2 on 11/6/25 at 1:10 PM identified he/she was discharged home on 9/30/25 with medications and recalled the Oxycodone was not one (1) of them. Resident #2 indicated the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #1, told him/her that the facility could not release the pain medication for him/her to take home. An interview with Person #2 on 11/7/25 at 12:50 PM and review of the pharmacy shipment summaries identified the dates and quantities of the Oxycodone 5 mg delivered to the facility for Resident #2 were on 9/6/25 a total of twenty-eight (28) tablets and on 9/23/25 a total of thirty (30) tablets. The facility failed to provide documentation of the Control Disposition Records for the Oxycodone that was delivered on 9/23/25 and the blister pack of medication. 3. Resident #3's diagnoses included metabolic encephalopathy, congestive heart failure, and rheumatoid arthritis. A physician's order dated 8/20/25 directed to administer the pain medication Hydromorphone 2 milligrams (mg) every four (4) hours as needed for pain. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 was unable to make reasonable and consistent decisions regarding tasks of daily living. The nurse's note dated 8/23/25 at 2:47 PM identified Resident #3's family member requested Resident #3 be transferred to the hospital for evaluation (due to increased pain), the Advacnced Practice Registered Nurse (APRN) was notified, Resident #3 was transferred to the hospital, and did not return to the facility. Review of the August 2025 Medication Administration Record for identified Resident #3 received the Hydromorphone as ordered. The Facility Reported Incident form dated 10/27/25 identified the Drug Enforcement Agency (DEA) had entered the facility on 10/7/25 to investigate a complaint filed with them regarding missing narcotics. The DEA concluded their investigation on 10/27/25 and discovered that a total of six (6) blister packs for five (5) residents were not accounted for along with the Control Disposition Records. An interview with Person #2 on 11/7/25 at 12:50 PM and review of the pharmacy shipment summaries identified the dates and quantities of the Hydromorphone 2 mg delivered to the facility on 8/20/25 was a total of eighteen (18) tablets. The facility failed to provide documentation of the Control Disposition Record for the Hydromorphone delivered on 8/20/25 and the blister pack of medication. 4. Resident #4's

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for five (5) of eight (8) sampled residents (Residents #1, #2, #3, #4, and #5) who were reviewed for allegations of misappropriation of residents' personal property, the facility failed to establish a system of records of receipt and disposition to account for the administration and destruction of controlled medications. The findings include: Resident #1's diagnoses included osteomyelitis of the right ankle, diabetes mellitus with polyneuropathy, and left foot amputation. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 made reasonable and consistent decisions regarding tasks of daily living. A physician's order dated 7/8/25 directed to administer the pain medication Oxycodone 5 milligrams (mg) one (1) tablet every six (6) hours as needed for pain. Review of the July and August 2025 Medication Administration Records identified Resident #1 received the Oxycodone as ordered. The Facility Reported Incident form dated 10/27/25 identified the Drug Enforcement Agency (DEA) had entered the facility on 10/7/25 to investigate a complaint filed with them regarding missing narcotics. The DEA concluded their investigation on 10/27/25 and discovered that a total of six (6) blister packs for five (5) residents were not accounted for along with the Control Disposition Records. An interview with the contracted pharmacist, Person #2, on 11/7/25 at 12:50 PM and review of the pharmacy shipment summaries identified the dates and quantities of the Oxycodone 5 mg delivered to the facility for Resident #1 were on 7/9/25 a total of thirty (30) tablets and on 8/7/25 a total of twenty (20) tablets. The facility failed to provide documentation of the Control Disposition Records for the Oxycodone that were delivered on 7/9/25 and 8/7/25 and the blister packs of medication. 2. Resident #2's diagnoses included stage four (4) pressure ulcer to the sacrum, congestive heart failure, and spinal stenosis. A physician's order dated 9/11/25 directed to administer the pain medication Oxycodone 5 milligrams (mg) one (1) tablet every six (6) hours as needed for pain. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 made reasonable and consistent decisions regarding tasks of daily living. Review of the September 2025 Medication Administration Record identified Resident #2 received the Oxycodone as ordered. The Facility Reported Incident form dated 10/27/25 identified the Drug Enforcement Agency (DEA) had entered the facility on 10/7/25 to investigate a complaint filed with them regarding missing narcotics. The DEA concluded their investigation on 10/27/25 and discovered that a total of six (6) blister packs for five (5) residents were not accounted for along with the Control Disposition Records. An interview with Resident #2 on 11/6/25 at 1:10 PM identified he/she was discharged home on 9/30/25 with medications and recalled the Oxycodone was not one (1) of them. Resident #2 indicated the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #1, told him/her that the facility could not release the pain medication for him/her to take home. An interview with Person #2 on 11/7/25 at 12:50 PM and review of the pharmacy shipment summaries identified the dates and quantities of the Oxycodone 5 mg delivered to the facility for Resident #2 were on 9/6/25 a total of twenty-eight (28) tablets and on 9/23/25 a total of thirty (30) tablets. The facility failed to provide documentation of the Control Disposition Records for the Oxycodone that was delivered on 9/23/25 and the blister pack of medication. 3. Resident #3's diagnoses included metabolic encephalopathy, congestive heart failure, and rheumatoid arthritis. A physician's order dated 8/20/25 directed to administer the pain medication Hydromorphone 2 milligrams (mg) every four (4) hours as needed for pain. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 was unable to make reasonable and consistent decisions regarding tasks of daily living. The nurse's note dated 8/23/25 at 2:47 PM identified Resident #3's family member requested Resident #3 be transferred to the hospital for evaluation (due to increased pain), the Advacnced Practice Registered Nurse (APRN) was notified, Resident #3 was transferred to the hospital, and did not return to the facility. 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