STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555098	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhaven Healthcare Center	455 Florin Road Sacramento, CA 95831

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 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. 48445 Based on interview, and record review, the facility failed to ensure accurate accountability of controlled medications (those with high potential for abuse or addiction) for three of five sampled residents (Resident 1, Resident 2, and Resident 3) when: 1. Controlled medications delivered by the pharmacy for Resident 1, Resident 2, and Resident 3 were missing and unaccounted for; and, 2. Two doses of Resident 1's Hydrocodone-Acetaminophen (Norco, a medication used to relieve moderate to severe pain) were missing and unaccounted for. These failures resulted in the facility not having accurate accountability of controlled medications, the potential for abuse or misuse of these medications, and the potential for not meeting the residents' therapeutic needs or worsening of their medical conditions. Findings: 1. During a review of a report from the facility submitted to the Department, dated 3/21/23, the report indicated, During our ongoing plan of correction audits .dated March 6, 2023, the following findings were made: On 3/13/23 it was reported that we are missing a medication card and count sheet of Hydrocodone-Acetamin [sic] 5/325 mg [milligrams, a unit of measurement] #28 [number of doses]. This medication was prescribed for [Resident 1]. The card was delivered March 2, 2023, so we are unsure of when the card and count sheet went missing .On 3/14/23 during an audit of all controlled medications it was discovered that we are missing a medication card and count sheet of Hydrocodone-Acetamin [sic] 5/325mg #38. This medication was prescribed for [Resident 2]. This card was delivered on March 6, 2023, so we are unsure of when the card and count sheet went missing .On 3/19/23 during an audit of all controlled medications it was discovered that we are missing a medication card and count sheet of Oxycodone [a medication used to relieve moderate to severe pain] 5mg # 9. This medication was prescribed for [Resident 3]. This card was delivered on March 10, 2023, so we are unsure of when the card and Count sheet went missing. The medication cards and count sheets would have the resident's name and prescription number on them. We are unable to identify where the medication card went or who might have taken it. This has affected 3 residents. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Shipping Manifest, dated 3/2/23, the manifest indicated 28 doses of Hydrocodone Acetaminophen 5-325 mg were delivered on 3/2/23 and signed by the nurse to verify receipt. During a review of Resident 2's Shipping Manifest, dated 3/6/23, the manifest indicated 38 doses of Hydrocodone Acetaminophen 5-325 mg were delivered on 3/6/23 and signed by the nurse to verify receipt. During a review of Resident 3's Shipping Manifest, dated 3/10/23, the manifest indicated 18 doses of oxycodone were delivered on 3/10/23 and signed by the nurse to verify receipt. During a concurrent interview and record review on 2/4/25 at 3:04 p.m. with the Director of Nursing (DON), the DON reviewed the pharmacy delivery receipts for Resident 1, Resident 2, and Resident 3 and verified the delivery sheets were signed by the nurse, which indicated the medications were received by the facility. During a follow-up interview on 2/4/25 at 3:13 p.m. with the DON, the DON stated that upon delivery of narcotics, the nurse and the delivery person both sign the delivery receipt. The DON stated each packet delivered should have a narcotic sheet and the nurse will sign off the narcotic sheet indicating the medication was received and the medication will be stored inside the locked narcotic box in the medication cart. The DON further stated the nurses count the narcotic packet and compare it to the narcotic sheet to check how much is left for each resident with narcotic medication. The DON stated, That's accountability .to avoid discrepancy and possible diversion. During a concurrent interview and record review on 2/4/25 at 3:34 p.m. with the Assistant Director of Nursing (ADON), the ADON stated the sheets and the narcotics are counted every shift by incoming and outgoing shift nurses and once the nurse received delivery, the nurse signs the delivery receipts and the medication goes to the narcotic box in the med cart, and the count sheet goes to the binder. The ADON verified the pharmacy delivery receipts were signed by the nurses indicating the medications were received. The ADON stated, Narcotics are narcotics, make sure they are prescribed for the residents only and not for anyone else. [If there are discrepancies] It might delay the care and who knows who has it. During a telephone interview on 2/5/25 at 11:43 a.m. with the DON, the DON stated they were not able to find the controlled drug sheets for the controlled medications delivered for Resident 1 on 3/10/23, for Resident 2 on 3/6/23, and for Resident 3 on 3/2/23. 2. During a review of Resident 1's Controlled Drug Record [CDR], dated 1/19/23, the CDR indicated, Hydrocodone-Acetamin[sic] 5-325 MG Generic For: NORCO 5-325 TABLET .TAKE 1 TABLET BY MOUTH EVERY SIX HOURS AS NEEDED FOR MODERATE PAIN OR SEVERE PAIN. The CDR indicated the nurse received 28 doses of Norco on 1/19/23. The CDR further indicated Resident 1 last received Norco on 3/15/23 and there were two doses left after Norco was last administered. During an interview on 2/4/25 at 2:48 p.m. with Licensed Nurse 1 (LN 1), the LN 1 stated, We count the cards, we count the med count and make sure it matches with the paper .Because one number missing, it's a huge liability, it's narcotics. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/4/25 at 4:44 p.m. with the DON, the DON verified Resident 1 last received Norco on 3/15/23 and there were two doses left based on the CDR. The DON confirmed there was no date, time, or signature for the last two doses. The DON verified there was no documented evidence that the two missing doses for Resident 1's Norco were given or disposed. During a review of the facility's policy and procedure (P&P) titled, Controlled Substances, revised 4/2019, the P&P indicated, The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications .7. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of the shift. 8. Upon Receipt: a. The nurse receiving the medication and the individual delivering the medication verify the name, dose and quantity of each controlled substance being delivered .c. An individual resident controlled substance record is made for each resident who is receiving a controlled substance.