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	02/26/2026

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, the facility failed to ensure safe and effective medication management, when:1. Two of six randomly selected residents' (Resident 12 and Resident 111) controlled medications (those with high potential for abuse and addiction) were not accurately accounted for on the Medication Administration Record (MAR) and the Controlled Drug Record (CDR, an accountability record); and 2. Automated dispensing cabinet (ADC) medication discrepancies, including those involving controlled substances were not identified, reported and resolved in a timely manner for a census of 144 residents.These failures decreased the facility's potential to prevent misuse, loss, or diversion of controlled substances and resulted in three unresolved ADC discrepancies, including a morphine solution (a controlled medication to treat pain) discrepancy that remained unresolved for 21 days.Findings:1. A review of Resident 111's clinical record indicated the following as needed (PRN) orders, dated 2/3/26: (a) Oxycodone (controlled medication for pain) five milligrams (mg; a unit of measure), give one tablet by mouth every four hours as needed for moderate pain and (b) Oxycodone five mg, give two tablets by mouth every four hours as needed for severe pain.During a concurrent interview and record review on 2/24/26 at 2:04 p.m. with the Director of Nursing (DON), DON confirmed two tablets of oxycodone five mg were signed out from the CDR on the following dates and times: 2/4/26 at 1:41 p.m., 2/4/26 at 6:53 p.m., and 2/13/26 at 3:33 p.m. DON also confirmed Resident 111's February 2026 MAR indicated documentation for only one tablet administered at each of the above times. DON acknowledged Resident 111's CDR did not reconcile with the corresponding MAR and stated three oxycodone tablets were signed out but not documented as administered on the MAR, presenting a risk for diversion or misuse of controlled substances.A review of Resident 12's clinical record indicated the following PRN order, dated 8/25/25: Oxycodone five mg, give half tablet by mouth every six hours as needed for moderate-severe painDuring a concurrent interview and record review on 2/24/26 at 2:12 p.m. with DON, DON confirmed on 10/13/25 at 8:16 p.m., half tablet (2.5 mg) of oxycodone was signed out of the CDR with no corresponding administration documented on October 2025 MAR. DON also confirmed October MAR indicated documented administration of half tablet on 10/14/25 at 8:53 a.m. and on 10/17/25 at 2:32 a.m. with no corresponding CDR removals. DON acknowledged Resident 12's CDR did not reconcile with the corresponding MAR and stated there was a risk for diversion and inaccurate charting.A review of the facility's policy and procedure (P&P) titled, Controlled Substances, revised April 2019, indicated, .7. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. The policy further indicated, The nurse administering the medication is responsible for recording: (1) name of the resident receiving the medication; (2) name, strength and dose of the medication; (3) time of administration; (4) method of administration; (5) quantity of the medication remaining; and (6) signature of nurse administering medication. 2. During a concurrent observation and interview on 2/23/26 at 2:06 p.m. with Licensed Nurse (LN) 2 and the Assistant Director of Nursing (ADON) 1, the ADC in the central medication room was inspected. The ADC displayed three active, unresolved discrepancies: (1) gabapentin (used for nerve pain) 100 mg capsules discrepancy created on 11/19/25 at 12:59 p.m., (2) morphine 100 mg/5 ml solution (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 - Some	discrepancy created on 2/2/26 at 4:48 a.m., and (3) vancomycin (oral antibiotic) 125 mg capsules discrepancy created on 1/28/26 at 1:56 p.m. Both ADON 1 and LN 2 confirmed the discrepancies were still open in the system at the time of the observation. ADON 1 stated each nurse had an individual login and password to access the ADC and medication orders appeared on the screen for removal. ADON 1 further stated she was not aware of any active discrepancies and the Consultant Pharmacy (CP) checked the ADC monthly and handled the discrepancies. ADON 1 expected nursing staff to contact the pharmacy if a discrepancy occurred.During an interview on 2/24/26 at 1:37 p.m. with the DON, DON stated she had not been notified of the ADC discrepancies and added, they [the pharmacy] are supposed to tell me right away. DON confirmed the morphine discrepancy remained unresolved since 2/2/26, for a total of 21 days. DON also stated on 2/23/26, after being informed of the issue, she contacted the CP and performed a physical count when prompted by the ADC. DON opened the bin, counted the morphine, and resolved the discrepancy in the system. DON acknowledged the discrepancy could have been due to a missing medication.During a phone interview on 2/24/26 at 3:46 p.m. with the CP, CP stated he investigated the ADC discrepancies monthly when he was at the facility and could not resolve a discrepancy unless he performed a physical count. CP confirmed he was not notified by the DON of the controlled substance discrepancies. CP further stated he would only notify the DON of what he considered a true discrepancy, which he defined as a missing medication.A review of the facility's Automated Dispensing Cabinet (Nexsys) Medication List titled, Periodic Automatic Replenishment (PAR) Versus Usage Report, dated May 30, 2024, indicated the ADC contained 15 controlled medications, including morphine sulfate 100 mg/5 ml solution.A review of the facility's P&P titled, Policy & Procedures for use of Capsa Healthcare Nexsys ADC Medication Management System, dated August 21, 2024, indicated, All discrepancies create a report that is generated daily to the pharmacist-in charge and the director of nursing . for review. The P&P further indicated, Designated parties at the pharmacy and facility are notified in real time of any discrepancy. i. Pharmacy will contact Director of Nursing to confirm discrepancy at ADC. ii. Logs are generated of all activity involving the discrepancy in question and the pharmacy and facility will conduct an onsite investigation.

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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. Based on observation, interview, and record review, the facility failed to ensure medications were properly stored, labeled, and maintained according to the facility's policy and/or manufacturer's specifications for a census of 144 residents, when:1. A treatment cart containing supplies and medications was left unlocked and unsupervised; 2. Resident 74 and Resident 12 had expired medications stored in two of four medication carts;3. Resident 54 had one opened and undated foil pouch containing levalbuterol (a medication to relieve shortness of breath) stored in one of five medication rooms; and 4. Resident 32 had a compounded intravenous (IV; administered into a vein) medication, daptomycin (a potent antibiotic) stored in one of five medication refrigerators after being discontinued.These failures decreased the facility's potential to prevent unauthorized access to medication carts, misuse of medications, administration of expired, contaminated, reduced potency, and ineffective medications and medication errors for vulnerable residents.Findings: 1. During a concurrent observation and interview on 2/25/26 at 2:35 p.m. with Licensed Nurse (LN) 10, LN 10 confirmed the treatment cart was unlocked and unattended. LN 10 stated there were residents and staff in the hallway who could get the medications inside the cart. During an interview on 2/26/26 at 10:50 a.m. with the Director of Nursing (DON), DON stated the medication and treatment carts should always be locked and secured when nurses are away from it; otherwise residents, visitors, or staff could get medications inside the open cart. A review of the facility's policy titled, Medication Labeling and Storage, dated 2001, indicated, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. 2. During a concurrent observation and interview on 2/23/26 at 9:19 a.m. with LN 2, Unit D Medication Cart 2 was inspected. One Lantus Solostar (insulin glargine) pen for Resident 74 was observed labeled with 1/13 on the label. LN 2 stated this was the medication's open date and confirmed the pen expired 28 days later, on 2/10/26. During a concurrent interview and record review on 2/26/26 at 12:01 p.m. with DON, Resident 74's February Medication Administration Record (MAR) was reviewed. DON confirmed the insulin pen identified on 2/23/26 had expired on 2/10/26, and acknowledged Resident 74 had the potential to receive ineffective insulin. A review of the manufacturer's prescribing information for Lantus (singleˆpatientˆuse Solostar prefilled pen), revised July 2023 and retrieved from DailyMed, indicated, Only use your pen for up to 28 days after its first use. Throw away the Lantus Solostar pen you are using after 28 days, even if it still has insulin left in it. During a concurrent observation and interview on 2/23/26 at 12:05 p.m. with the Assistant Director of Nursing (ADON) 2, Unit A Medication Cart 1 was inspected. An opened fluticasone/salmeterol (Wixela) inhaler (inhaled medication to treat breathing problems) for Resident 12 was observed stored in the cart with an open date of 1/5/26 written on the box. ADON 2 reviewed the manufacturer's product labeling which indicated, Discard the inhaler 1 month after opening the foil pouch or when the counter reads 0 (after all blisters have been used) whichever comes first. ADON 2 confirmed the inhaler in the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication cart was expired. During an interview on 2/24/26 at 2:17 p.m. with the DON, DON confirmed the inhaler expired and acknowledged the medication might not be effective. A review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, revised February 2023, indicated, .3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 3. During a concurrent observation and interview on 2/23/26 at 9:46 a.m. with LN 2 and ADON 1, Unit D Medication room was inspected. One opened, and undated foil pouch containing levalbuterol inhalation solution for nebulization (unit-dose vials used to relieve shortness of breath) for Resident 54 was observed. The pouch contained 21 unit-dose vials. ADON 1 and LN 2 reviewed the manufacturer's instructions printed on foil pouch which indicated, Once the foil pouch is opened, the vials should be used within two weeks. ADON 1 and LN 2 confirmed the pouch had no date opened and acknowledged that without an open date they could not confirm if the medication was expired or safe to use. During an interview on 2/24/26 at 2:17 p.m. with the DON, DON reviewed the pictures of the opened levalbuterol foil pouch observed on 2/23/26. DON confirmed there was no open date on the pouch and stated the medication was lightˆsensitive and its stability could have been compromised. 4. During a concurrent observation and interview on 2/23/26 at 3:01 p.m. with ADON 2, Unit B bottom medication refrigerator was inspected. Two sterile compounded IV preparations of daptomycin 500 milligrams (mg, a unit of measure) in 50 milliliters (ml, a unit of measure) normal saline for Resident 32 were observed stored in a sealed clear bag. ADON 2 reviewed the printed prescription label which indicated, Infuse . every 24 hours until 2/20/2026. ADON2 stated Resident 32 was currently in the hospital and confirmed the two compounded IV preparations were stored in the refrigerator. During a concurrent interview and record review on 2/24/26 at 2:53 p.m. with the DON, pictures of the compounded IV labels and Resident 32's electronic health record were reviewed. DON confirmed the daptomycin label for Resident 32 indicated to infuse until 2/20/26 and stated the antibiotic was discontinued on 2/9/26. DON acknowledged the medication should not have been in the refrigerator and should have been removed after the order was discontinued. A review of the facility's P&P titled, Medication Labeling and Storage, revised February 2023, indicated, .3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure texture modified diets were prepared to the correct texture in accordance with the International Dysphagia Diet Standardization Initiative (IDDSI) guidelines, when pureed and minced and moist trays did not meet required texture standards. This deficient practice placed the 17 residents on the pureed diet and the eight residents on the minced and moist diet at risk for choking and aspiration (food or liquid entering the airway).Findings: During a concurrent observation and interview on 2/24/26 at 10:17 a.m. with [NAME] 1 in the kitchen, [NAME] 1 removed turkey from the oven and added it to the food processor bowl to create texture modified diets. After grinding all the turkey to make the minced and moist texture, [NAME] 1 removed the minced and moist portions and placed it in a steam table pan. The remaining turkey in the processor bowl was mixed with an unmeasured amount of a chicken broth and margarine mixture. [NAME] 1 processed the turkey twice before deciding it was too chunky and proceeded to add additional broth/margarine mixture. When [NAME] 1 finished processing the turkey mixture, it appeared thin. [NAME] 1 stated it would thicken up while on the steam table. During an observation of the lunch meal plating on 2/24/26 at 11:53 a.m., the minced and moist trays and pureed meals were observed. The minced and moist vegetable texture was chunky and did not appear to fit through the prongs of a fork as required under IDDSI Level five standards. The pureed vegetables were liquid in consistency and did not hold their shape on the plate. The pureed vegetables expanded across the plate surface. The pureed roasted turkey was also thin and spread across the plate. During an observation on 2/24/26 at 1:28 p.m., a test tray was conducted. The puree bread item was observed to be thick and sticky. The item failed the spoon tilt test, as the food adhered to the spoon and did not slide off with gentle tilt which might adhere to the palate and increase choking risk for residents with swallowing disorders. A review of the facility's tray tickets for lunch meal, dated 2/24/26, indicated 17 residents were identified as receiving pureed diets and eight residents were identified as receiving minced and moist diets. During an interview on 2/24/26 at 3:38 p.m. with the Speech Language Pathologist (SLP), SLP stated kitchen staff must prepare meals according to IDDSI standards which had tests so staff can ensure the correct texture. SLP acknowledged that incorrectly prepared textures could place residents at risk for aspiration or choking. SLP reviewed the pictures of lunch meal trays taken earlier that day and further stated mashed potatoes and bread appeared too thick for the pureed diet. SLP also stated the minced and moist meat appeared not finely ground enough and needed more moisture added. A review of the facility's provided recipes titled, Pureed (IDSSI Level 4) Meats as well as the Pureed (IDSSI Level 4) Vegetables (Healthcare Menus Direct, LLC. 2025), indicated in bullet five of both recipes, The finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm, and should not weep. The finished pureed item must pass IDDSI level #4 testing requirements (i.e. the fork drip, fork pressure and spoon tilt tests). During an interview on 2/24/26 at 3:52 p.m. with the Registered Dietitian (RD), RD reviewed the pictures from lunch and stated the textures of the pureed and minced and moist diets appeared inconsistent and expressed concern that the minced and moist vegetable did not appear to be finely ground enough to fit between the prongs of a fork as required. RD acknowledged there was some work to do by the kitchen staff on preparing textured diets in accordance with IDDSI guidelines. A review of the pureed diet per the IDDSI diet website, indicated these foods were usually eaten with a spoon, do not require chewing . fall off a spoon in a single spoonful when tilted, are not sticky, liquid (like sauces) must not separate from solids. A review of the minced and moist texture per the IDDSI diet website, indicated these foods were soft and moist, but with no liquid leaking/dripping from the food, biting is not required, minimal chewing required, (food) lumps of 4 mm in size .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain the food preparation and storage areas in a sanitary condition for a census of 144 residents, when:Ice buildup was present on a pipe in the walk-in refrigerator and on the ceiling and cooling unit of the freezer;Racks holding food products were found coated with a rust-colored substance;Dirty dishes and mugs were left on clean nourishment room counters;Holes were found in kitchen wall along with chipping paint; andItems in the residents' refrigerator were not labeled and dated. These failures had the potential to allow contamination of food and food-contact surfaces, increasing the risk of bacterial growth and foodborne illness (illness caused by consuming contaminated food) for residents.Findings: 1. During an observation on 2/23/26 at 8:58 a.m. in the walk-in refrigerator, significant ice buildup was observed on an insulated black pipe descending from the ceiling at the back of the refrigerator near the entrance to the freezer. The ice buildup measured approximately eight inches (a unit of measure) in length over the pipe with an inch of thickness surrounding the pipe. During an observation on 2/23/26 at 9:01 a.m. in the freezer, frozen drops of water were observed on the ceiling, each drop was approximately an inch circumference. A large amount of ice buildup was noted on the bottom side of the freezer cooling unit that was approximately four inches circumference and two inches in-depth below the bottom of the freezer cooler unit. During an interview on 2/23/26 at 10:50 a.m. with Plant Operations Director (POD), POD concurred that there was ice buildup in both units. When asked to review the refrigerator/freezer manual, POD stated the facility no longer had one. During an interview on 2/25/26 at 4:26 p.m. with the Registered Dietitian (RD), RD stated they worked at the facility since 5/25 and the ice buildup has been there for a while. A review of the facility's policy titled, Refrigerators and Freezers, revised November 2022, indicated, 10. Supervisors inspect refrigerators and freezers monthly for . excessive condensation and any other damage or maintenance needs. Necessary repairs are initiated immediately. A review of the website www.hellosuper.com, indicated, Frost and ice buildup . can be a sign of faulty sealing and air leaks, or overworked systems. A review of the website www.wikihow.com, indicated five steps to correcting ice buildup including: 3. Tighten the door hinges if they're loose. 4. Wipe down the seals around the inside of each door to remove any residue. 5. Replace a damaged door seal (or gasket) with a new one. 2. During an observation on 2/23/26 at 8:58 a.m., a reddish-brown substance was observed on the interior wall directly beneath the ice-covered pipe. The discoloration was approximately five inches in length. During an observation on 2/23/26 at 9:01 a.m., a metal rack located in the corner of the kitchen next to the ovens and dishwashing sink was observed with a rust-colored substance on the shelving and wheel hubs. During an observation on 2/23/26 at 9:03 a.m., a second metal rack located to the right of the dishwasher machine under the stainless-steel dishwashing deck was observed with a rust-colored substance. During a concurrent observation and interview on 2/23/26 at 10:50 a.m. with POD, POD confirmed the rust-colored substance on the metal rack and acknowledged the discoloration. During a concurrent observation and interview on 2/23/26 at 10:51 a.m. with the Dietary Manager (DM), DM stated the rust-colored substance could serve as a mechanism for bacteria to spread to food, potentially causing foodborne illness.A review of the facility's policy titled, Sanitization, dated 11/2022, indicated, shelves and equipment are to be kept clean and free from breaks or corrosion. A review of the facility's policy titled, Refrigerators and Freezers, revised November 2022, indicated, 10. Supervisors inspect refrigerators and freezers monthly for . presence of rust . and any other damage or maintenance needs. Necessary repairs are initiated immediately. 3. During an observation on 2/23/26 at 9:51 a.m. in C wing nourishment room, two soiled resident coffee cups were on counter left side of the sink. No signage indicated the area was for soiled dishes. During an observation on 2/25/26 at 11:27 a.m. in D wing nourishment room, a soiled meal tray was left on counter right side of the sink under the paper towel dispenser. No signage was noted designating the area for soiled dishes. During (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an observation on 2/25/26 at 11:25 a.m. in D Wing nourishment room, two soiled resident coffee cups were to the left side of the sink, next to a box of clean straws. No signage designating the area of counter for soiled dishes. During an observation on 2/25/26 at 11:41 a.m. on C wing, two soiled resident meal trays were left on counter to the left of the sink. No signage designating the area of counter for soiled dishes. During an interview on 2/25/26 at 11:27 a.m. with Licensed nurse (LN) 1, LN 1 stated normally the nursing staff would walk the soiled trays and cups to the kitchen if the dirty meal cart had already been returned. During an interview on 2/25/26 at 11:52 a.m. with the Infection Preventionist (IP), IP stated the nourishment rooms should not store dirty dishes and the expectation was that dirty dishes were brought back to the kitchen. IP expressed concern of other residents finding and interacting with the dirty dishes leading to cross contamination. A review of the facility's policy titled, Sanitization (Med-Pass, 2001), indicated in bullet one, All kitchens, kitchen areas . are kept clean and free from garbage and debris, and protected from rodents and insects. 4. During an observation of the lunch meal plating on 2/24/26 at 12:17 p.m., a hole was observed in the wall under the handwashing sink of approximately 4 x 6 inches surrounding two pipes. During a concurrent observation and interview on 2/24/26 at 12:22 p.m. with DM, DM concurred there was a section of the drywall that had been removed and stated the previous sink was replaced and facility had a hole ever since. A circle of drywall was noted to be damaged above the area with an approximately one and a half inches in length section of drywall missing. On the corner, close to the entrance, paint had chipped off exposing the drywall in multiple areas, of up to five inches in length. DM stated the damage was likely from the carts entering the kitchen and hitting the wall. During an interview on 02/25/26 at 4:26 p.m. with RD, RD stated the holes in the drywall were a risk for critters coming into the kitchen as well as for cross contamination. A review of the United States (US) Food and Drug Administration 2022 Food Code, indicated in section 6-501.11 on Repairing, Physical facilities shall be maintained in good repair . Poor repair and maintenance compromises the functionality of the physical facilities. This requirement is intended to ensure that the physical facilities are properly maintained in order to serve their intended purpose. A review of the US Food and Drug Administration 2022 Food Code, indicated in section 6-202.15 on Outer Openings, Protected, indicated, a Food establishment shall be protected against the entry of insects and rodents by: (1) Filling or closing holes and other gaps along floors, walls, and ceilings. 5. During a concurrent observation and interview on 2/25/26 at 11:12 a.m. with Certified Nursing Assistant (CNA) 4, B Wing nourishment room was inspected. A bottle of Pedialyte (oral electrolyte solution designed for rapid, effective rehydration in both children and adults by replenishing fluids and minerals) in the refrigerator was found opened and with approximately a cup of the liquid remaining. No resident name or open date was written on the bottle. CNA 4 stated the unlabeled Pedialyte bottle was not correct and staff were expected to write the name of the resident on the bottle (or food) it belonged to. CNA 4 further stated without a name, the item could be given to the wrong resident. During a concurrent observation and interview on 2/25/26 at 11:42 a.m. with Assistant Director of Nursing (ADON) 1, ADON 1 stated nurses managed the labeling of resident foods from home in all nursing units. ADON 1 acknowledged Pedialyte was not labeled. A review of the facility's policy titled, Foods Brought by Family/Visitors, revised March 2022, indicated, 6b . Containers are labeled with the resident's name, the item and the ?use by' date.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to ensure resident food and beverages brought from outside of the facility were consistently stored and managed under sanitary conditions for a census of 144 residents, when staff demonstrated inconsistent knowledge regarding storage timeframes and reheating practices. This failure had the potential for allowing bacterial growth and cross-contamination, consumption of food beyond safe storage timeframes and limiting resident food options.Findings: During a concurrent observation and interview on 2/24/26 at 11 a.m. with the Dietary Manager (DM), the nourishment rooms were inspected. No microwaves were observed on the nursing units. DM stated staff could heat residents' food using the microwave in the dining room. During an interview on 2/24/26 at 8:04 a.m. with Resident 133 on Wing A, Resident 133 stated she and her previous roommate used to order food from an outside delivery source and share the meal; otherwise if she ordered by herself then it was too much food and would be thrown out in 48 hours as per facility's policy. During a concurrent observation and interview on 2/25/26 at 11:03 a.m. with Certified Nursing Assistant (CNA) 5 in the D wing, CNA 5 stated food brought from home could only be eaten for two hours before being discarded, as staff were not allowed to store or reheat food for residents. During a concurrent observation and interview on 2/25/26 at 11:42 a.m. with the Assistant Director of Nursing (ADON) 1, ADON 1 stated residents' food could not be reheated in the dining room microwave. ADON 1 expected staff to bring food to dietary for heating. During an interview on 2/25/26 at 12:12 p.m. with Licensed Nurse (LN) 9 in the B wing, LN 9 stated families could bring food, but they could not reheat it and the facility would store food for 24 hours before discarding it. LN 9 showed the instructions she follow on wing B refrigerator. During an interview on 2/25/26 at 2:39 p.m. with the Director of Nursing (DON), DON encouraged families to bring food for residents and acknowledged there were variations in how different nursing stations managed food from home. DON stated she and the ADONs had provided education to staff on shift regarding Foods Brought by Family/Visitor, dated March 2022. DON showed education pieces for residents' families indicating food would be stored for 72 hours and could be reheated per the section on rewarming. A review of the facility's policy titled, Foods Brought by Family/Visitors (Med-Pass, 2022), indicated, Food brought to the facility by family and visitors is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. The policy gave staff minimal guidance on the specifics of food storage and reheating practices for the facility. In bullet five, the policy further indicated, If staff is assisting family or visitors with reheating . staff must use safe food handling practices. No guidance was given on what this entails, or even where to reheat resident foods. In bullet seven, the policy also indicated, nursing staff will discard perishable foods on or before the 'use by ' date, but does not guide staff on how to determine this date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow proper infection control measures for two of 31 sampled residents (Resident 37 and Resident 157), when:1. Licensed Nurse (LN) 10 did not maintain proper hand hygiene practices during wound care for Resident 37; and2. Two Certified Nurse Assistants (CNAs) did not wear the required personal protective equipment (PPE, protective clothing/gown, gloves, facemasks/face shields designed to protect the wearer from injury or the spread of infection) while providing care to Resident 157 who was on enhanced barrier precaution (EBP, an infection control method).These failures decreased the facility's potential to prevent spreading an infection among vulnerable residents.Findings: 1. A review of Resident 37's admission Record, dated 2/26/26, indicated Resident 37 was admitted to the facility in 2025 with diagnoses including foot ulcer (an open sore) and diabetes (a chronic condition characterized by high blood sugar levels). A review of Resident 37's Medication Review Report, dated 2/26/26, indicated Resident 37 had a sacrum (tail bone) wound treatment order to cleanse with vashe (a wound cleaner), pat dry, triad (zinc oxide based cream) to wound bed, apply silver alginate (a type of wound dressing with silver), cover with foam dressing every evening shift and as needed for wound care. During an observation on 2/25/26 at 2:24 p.m., LN 10 was preparing the wound care materials for Resident 37's sacrum wound: triad in a cup, wound cleaner and gauze in a cup and other wound materials. LN 10 placed the wound materials directly on the bed without any barrier. Next, LN 10 cleaned Resident 37's buttock after a bowel movement and used a wet towel to wipe the buttock. LN 10 then removed the dirty gloves, put on a new pair of gloves and continued to clean the buttock with a wet towel. LN 10 again removed the soiled gloves, put on a new pair of gloves and removed the old dressing of the wound. Next, LN 10 removed the used gloves and put on a new pair of gloves. Three occasions were observed when LN 10 removed used gloves and donned new gloves without hand hygiene. During an observation on 2/25/26 at 2:35 p.m., LN 10 cleaned Resident 37's sacrum wound with gauze and wound cleaner, then removed the gloves and put on a new pair of gloves without hand hygiene. During an interview on 2/25/26 at 2:45 p.m. with LN 10, LN 10 confirmed she did not maintain hand hygiene after removing gloves and putting on new gloves. LN 10 stated good hand hygiene practice was to prevent infection and the spread of bacteria. During an interview on 2/26/26 at 11:03 a.m. with the Director of Nursing (DON), DON expected nurses to maintain hand hygiene standard of practice, to use hand sanitizer or hand washing after removing gloves and donning new gloves. DON also stated hand hygiene practice was good to prevent contamination of the wound. A review of the facility's policy titled, Handwashing/Hand Hygiene, dated 10/2023, indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. The policy further indicated, The use of gloves does not replace hand washing/hand hygiene. Perform hand hygiene before applying non-sterile gloves. 2. A review of Resident 157's admission Record, indicated she was admitted to the facility in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	February 2026 with multiple diagnoses including end stage renal disease (ESRD-an irreversible kidney failure) on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). A review of Resident 157's Medication Review Report (MRR), dated 2/20/26, indicated Resident 157 had a hemodialysis access port in the left upper arm and EBP was required. During an observation on 2/23/26 at 4:18 p.m. inside Resident 157's room, CNA 2 and CNA 3 were observed assisting Resident 157 change her clothes and transfer from her wheelchair to the bed. Both CNAs were not wearing a gown. During a concurrent observation and interview on 2/23/26 at 4:25 p.m. with LN 6 inside Resident 157's room, LN 6 confirmed CNA 2 and CNA 3 were not wearing gowns while providing care to Resident 157. LN 6 stated Resident 157 was on EBP and the CNAs should have worn the appropriate PPE while providing care. During an interview on 2/26/26 at 10:45 a.m. with DON, DON stated staff should follow infection control protocols when caring for residents on EBP to prevent the spread of infection and ensure resident safety. A review of the facility's policy titled, Enhanced Barrier Precautions, dated June 2024, indicated, Enhanced Barrier Precautions are used as an infection prevention and control intervention . Gloves and gown are applied prior to performing the high contact resident care activity . Examples of high-contact resident care activities dressing; transferring . EBPs are indicated for residents with . indwelling medical devices . include . dialysis access sites .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure a copy of advance directives was obtained for one of 31 sampled residents (Resident 87), when a copy of Resident 87's advance directive was not available in the facility's medical records.This failure decreased the facility's potential to honor the end-of-life wishes of its residents.Findings:A review of Resident 87's admission Record, dated 2/26/26, indicated Resident 87 was admitted to the facility in January 2026 for hospice care (compassionate care for people who are near the end of life provided at the person's home or within a health care facility).A review of Resident 87's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 1/8/26, indicated Resident 87's Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was eight out of 15 with moderate decline in mental capacity.During an interview on 2/23/26 at 10:11 a.m. with Resident 87, Resident 87 was incapable to be interviewed.During an interview on 2/24/26 at 11:30 a.m. with Resident 87's Representative (RR) 1, RR 1 stated Resident 87's advance directive was created in 2014 and the facility never asked for a copy of it.A review of Resident 87's Order Summary Report (OSR), dated 2/26/26, indicated an order to Do Not Resuscitate (DNR- a medical order written by a doctor to instruct health care providers not to do cardiopulmonary resuscitation if breathing stops or the heart stops beating) as per resident/RR's wishes. OSR also indicated Resident 87 did not have the capacity to understand choices and make health care decisions.During a concurrent interview and record review on 2/24/26 at 9:30 a.m. with Licensed Nurse (LN) 3, Resident 87's medical records and Physician Orders for Life-Sustaining Treatment (POLST- a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) were reviewed. LN 3 confirmed Resident 87's advance directive was prepared in March 2014 and a copy was not available.During an interview on 2/26/26 at 9:58 a.m. with the Director of Nursing (DON), DON confirmed a copy of advance directive was not present in Resident 87's medical records. DON expected staff to obtain a copy of advance directive from the RR upon admission and to place it in the medical records. DON stated missing a copy of advance directives posed a risk of not honoring Resident 87's preferences and potentially violating residents' rights.A review of the facility's policy titled, Advance Directives, dated September 2022, indicated, . If the resident or the residents representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 31 sampled residents (Resident 72) was free from abuse, when Resident 91 verbally abused Resident 72 for three nights.This failure decreased the facility's potential to protect Resident 72 from verbal abuse and maintain residents' psychosocial wellbeing.Findings:A review of Resident 72's admission Record, indicated she was admitted to the facility in January 2026 with a diagnosis of obesity (excess body fat that increases the risk of health conditions like heart disease).A review of Resident 72's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/6/26, indicated her Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 15 out of 15 with intact memory.A review of Resident 91's admission Record, indicated she was admitted to the facility in January 2026 with a diagnosis of cerebral infarction (a stroke caused by blocked blood vessels, leading to brain cell damage).A review of Resident 91's MDS, dated [DATE], indicated her BIMS score was 13 out of 15 with intact memory.During an interview on 2/24/26 at 1:46 p.m. with Resident 72 in her room, Resident 72 stated on the night of 2/3/26 Resident 91 started . calling me a ?big fat b*tch,' and that she didn't know how I got so fat. Resident 91 repeatedly told Resident 72 that she wished she would die a long death and go to h*ll. Resident 72 further stated the verbal abuse happened three nights in a row from 2/3/26 to 2/5/26 and the abuse stressed her to the point it made her cry. Resident 72 added she was worried that Resident 91 would come to her bed and hurt her and felt that staff should have noted her distress and prioritized her safety to move her sooner.During an interview on 2/24/26 at 2:17 p.m. with Resident 91, Resident 91 admitted being verbally abusive to Resident 72 and stated Resident 72 . was a 275-pounds [a unit of measure] b*tch. Resident 91 further stated her hostility toward Resident 72 began when she wanted the door closed for privacy and Resident 72 wanted it open.A review of Resident 72's Progress Notes, dated 2/6/26 at 10:22 a.m., indicated the Social Services Director (SSD) met with Resident 72 on 2/5/26 at 4:30 p.m. because Resident 72 was having difficulties with her roommate and wanted to be moved to a different room. SSD stated a room was not available for a room change, but one would be available the next day.During an interview on 2/24/26 at 2:50 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated he heard Resident 91 on the beginning of night shift on 2/5/26 verbally going hard on Resident 72 regarding her weight and hoped she would die. CNA 1 further stated Resident 72 was transferred to a new room within 10 minutes after the verbal altercation.A review of Resident 72's Progress Notes, dated 2/6/26 at 1:56 a.m., indicated around 11:20 p.m. on 2/5/26, Resident 72 told CNA 1 that her roommate was being verbally abusive. CNA 1 was in the room during the altercation and reported to Licensed Nurse (LN) 8 that Resident 91 called Resident 72 a fat b*tch and a pig, and told her she wanted her to die and go to h*ll. The notes further indicated the verbal abuse had been ongoing for three days, which caused Resident 72 stress and anxiety. LN 8 immediately relocated Resident 72 to a separate room.During an interview on 2/24/26 at 3:05 p.m. with the Director of Nursing (DON), DON confirmed Resident 91 verbally abused Resident 72. DON expected staff to recognize abuse among residents and take measures to ensure the victim felt safe and did not experience ongoing stress from the verbal abuse.A review of the facility's policy and procedures titled, Resident Rights, dated February 2021, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to . be free from abuse .A review of the facility's policy titled, Identifying Types of Abuse, revised September 2022, indicated, Abuse of any kind against residents is strictly prohibited . The policy further indicated verbal or mental abuse consisted of harassing a resident, in addition or mocking, insulting, ridiculing, or intimidating.A review of the facility's policy titled, Resident-to-Resident Altercations, revised September 2022, indicated, Facility staff monitor residents for (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aggressive/inappropriate behaviors towards other residents . Behaviors that may provoke a reaction by residents or others include verbally aggressive behavior, such as screaming, cursing . intimidating.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to provide services according to accepted standards of quality for two of six sampled residents (Resident 74 and Resident 148), when: 1. Licensed Nurse (LN) 1 administered Xeljanz (tofacitinib; an immune suppressant medication) to Resident 74 without following the required hazardousˆdrug handling procedures; and 2. LN 1 did not remain with Resident 148 to ensure MiraLAX (a powdered laxative) was taken as prescribed.These failures decreased the facility's potential to prevent hazardous drug exposure, incorrect dosing, wrong ingestion, and adverse effects due to lack of monitoring for residents.Findings: 1. During a medication pass observation on 2/23/26 at 8:28 a.m. on Unit D, LN 1 was observed preparing 13 medications for Resident 74, including Xeljanz without wearing gloves. During an observation on 2/23/26 at 8:40 a.m., LN 1 was observed at Resident 74's beside administering Xeljanz medication with a spoon, without wearing gloves. During a concurrent interview and label review on 2/23/26 at 8:49 a.m. with LN 1 at the medication cart, LN 1 read the Xeljanz bottle label, which indicated, Use gloves when handling. LN 1 confirmed she did not worn gloves during preparation or administration and acknowledged that gloves were required to reduce exposure to hazardous medications. During an interview on 2/24/26 at 2:17 p.m. with the Director of Nursing (DON), DON expected staff to wear gloves when handling hazardous medications to protect themselves from exposure. A review of the facility's policy and procedure (P&P) titled, Hazardous Drugs, revised April 2019, indicated, Hazardous pharmaceutical drugs are handled according to practice standards so as to minimize staff and resident exposure and environmental damage. P&P further indicated, 2. Hazardous drugs classified by National Institute for Occupational Safety and Health -NIOSH (A federal agency that provides guidance to prevent work related injuries and exposures) are drugs that exhibit one or more of the following criteria: a. Carcinogenicity (linked to cancer); b. Teratogenicity (linked to birth defects); c. Developmental toxicity (linked to developmental delay); d. Reproductive toxicity; e. Organ toxicity in low doses (animals or humans); f. Genotoxicity (linked to DNA damage); and g. Any new drugs that mimic existing hazardous drugs in structure or toxicity. A review of the NIOSH publication titled, NIOSH List of Hazardous Drugs in Healthcare Settings, 2024, dated December 2024, indicated, The drugs in Table 2 meet NIOSH definition of a hazardous drug . these drugs may also present an occupational hazard to those workers who are actively trying to conceive, who are pregnant or may become pregnant, and who are breastfeeding. The publication further indicated, tofacitinib listed under Table 2. 2. During a medication pass observation on 2/23/26 at 8:59 a.m. at unit D medication cart 1, LN 1 prepared eight medications for Resident 148, including MiraLAX mixed with eight ounces (measurement of volume) of water. During an observation on 2/23/26 at 9:10 a.m., LN 1 was observed at Resident 148's bedside administering medications. Resident 148 took the oral pills with the MiraLAX solution. Afterwards half of the MiraLAX solution remained on the bedside table after LN 1 finished the medication pass. During a follow-up interview on 2/23/26 at 11:20 a.m. with LN 1, LN 1 confirmed the remaining (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	half-cup of MiraLAX and acknowledged she did not observe Resident 148 taking the rest of the medication. During an interview on 2/24/26 at 2:17 p.m. with DON, DON expected nursing staff to observe the administration of all medications. A review of the facility's P&P titled, Medication Administration Schedule, dated 2001, indicated, The exact time of medication administration is documented on the MAR [Medication Administration Record].

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview, and record review, the facility failed to ensure ancillary services were provided for one of 31 sampled residents (Resident 44), when Resident 44's eyeglasses prescription was not carried out as ordered by the physician and a hearing consultation was not scheduled promptly.These failures had the potential for a delayed delivery of care to help improve Resident 44's vision and hearing.Findings:A review of Resident 44's admission Record, indicated he was admitted to the facility in June 2025 with diagnoses including severe protein-calorie malnutrition and repeated falls.During a concurrent observation and interview on 2/23/26 at 10:54 a.m. with Resident 44 in his room, Resident 44 spoke in a loud voice and stated he had been requesting from staff to see an eye and ear doctor to improve his vision and hearing. Resident 44 also stated he feared to potentially lose vision in one eye if the consultation will be delayed further.A review of Resident 44's optometry (comprehensive primary eye and vision care) consultation notes, dated 10/5/25, indicated Resident 44 had limited vision due to cataracts (clouding of the lens of the eye) and was prescribed new glasses to improve his eyesight.A review of Resident 44's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/25/26, indicated Resident 44 did not wear eyeglasses and had difficulty in hearing.During a concurrent interview and record review on 2/26/26 at 9:58 a.m. with the Social Services Director (SSD), Resident 44's MDS, optometry notes, and social services notes, were reviewed. SSD confirmed Resident 44 was prescribed new eyeglasses, but she could not find any documentation indicating Resident 44 had been assisted in obtaining them. SSD stated there was no record of a completed hearing consultation for Resident 44.During a concurrent observation and interview on 2/26/26 at 10:15 a.m. with SSD and Resident 44 in Resident 44's room, SSD searched Resident 44's bedside table drawer and dresser. SSD confirmed no eyeglasses, magnifying devices or amplifiers were found. Resident 44 stated he did not remember wearing eyeglasses at the facility.During an interview on 2/26/26 at 10:45 a.m. with the Director of Nursing (DON), DON expected staff members to assist residents acquire the assistive devices or consultations they need. DON stated assistive devices should be prioritized when medically necessary to ensure residents' safety, comfort and improve overall quality of life.A review of the facility's policy titled, Assistive Devices and Equipment, revised in January 2020, indicated, Our facility maintains the use of assistive devices for the residents . Facility provides the residents with assistance in locating available resources to obtain assistive devices . including glasses/magnifying devices and hearing aids/amplifiers.A review of the facility's policy titled, Care of Hearing-Impaired Residents, revised in February 2018, indicated, Staff will assist hearing impaired residents (or representative) with locating available resources, scheduling appointments and arranging transportation to obtain needed services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to provide a safe environment for one of 31 sampled residents (Resident 3), when floor mats were not placed beside Resident 3's bed as ordered.This failure increased Resident 3's potential to sustain injury after fall.Findings:A review of an admission record indicated Resident 3 was admitted to the facility in November 2025 with a diagnosis of repeated falls related to right hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body).A review of Resident 3's Care Plan, dated 11/18/25, indicated Resident 3 was at risk for falls due to impaired mobility related to cerebrovascular accident (CVA or stroke; loss of blood flow to a part of the brain) with right hemiplegia.A review of Resident 3's Medication Regimen Review (MRR), dated 11/21/25, indicated Resident 3 was at high risk for falls and staff should ensure floor mats were in place on both sides of Resident 3's bed every shift for fall prevention. During observations on 2/25/26 at 8:07 a.m., 11:15 a.m., and 12:10 p.m. in Resident 3's room, floor mats were not present on either side of Resident 3' bed.A review of Resident 3's Medication Administration Record (MAR), dated 11/21/25, indicated Licensed Nurse (LN) 7 signed on the morning shift of 2/25/26 indicating floor mats were placed beside Resident 3's bed.During a concurrent observation, interview, and record review on 2/25/26 at 12:15 p.m. with LN 7 inside Resident 3's room, Resident 3's MAR and MRR were reviewed. LN 7 confirmed floor mats were not in place and acknowledged her signature on Resident 3's MAR.During an interview on 2/26/26 at 10:45 a.m. with the Director of Nursing (DON), DON expected staff to follow the physician's order for placing floor mats to prevent Resident 3 from sustaining an injury in the event a fall occurred.A review of the facility's policy titled, Managing Falls and Fall Risk, revised in March 2018, indicated, Based on previous evaluations and current data, the staff will identify interventions related to the residents' specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.

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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. Based on observation, interview, and record review, the facility failed to provide pain management for one of 31 sampled residents (Resident 12), when Licensed Nurse (LN) 10 did not assess Resident 12's pain and administer pain medication prior to wound care.This failure decreased the facility's potential to provide Resident 12 with an effective pain management.Findings:A review of Resident 12's admission Record, dated 2/26/26, indicated Resident 12 was admitted to the facility in August 2025 with diagnoses including chronic pain (long term pain) and depression (a serious mood disorder characterized by persistent sadness, loss of interest in activities, and low energy).A review of Resident 12's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/31/25, indicated Resident 12 had some memory impairment.During a concurrent observation and interview on 2/25/26 at 2:56 p.m. with Certified Nursing Assistant (CNA) 5, CNA 5 assisted Resident 12 with turning and repositioning before wound care in bed. CNA 5 confirmed Resident 12 was moaning multiple times when turning on her side.During an observation on 2/25/26 at 3:07 p.m. during wound care treatment, LN 10 cleaned Resident 12's buttock wound while Resident 12 was moaning in pain.During a concurrent observation and interview on 2/25/26 at 3:16 p.m. with Resident 12 inside Resident 12's room, LN 10 assisted Resident 12 with repositioning after the wound care. Resident 12 stated her back was hurting.During an interview on 2/25/26 at 3:30 p.m. with LN 10, LN 10 confirmed Resident 12 was moaning and in pain during wound care. LN 10 acknowledged she did not offer Resident 12 a pain medication before wound care.A review of Resident 12's Medication Administration Record (MAR), dated 2/1/26 to 2/28/26, indicated Resident 12's pain was not assessed every shift in February 2026. The MAR further indicated an order for acetaminophen (a pain medication) 325 milligrams (mg, a unit of measurement), give two tablets by mouth every four hours as needed (PRN; pro re nata) for mild pain and oxycodone (a pain medication) five mg, give half tablet by mouth every six hours PRN for moderate to severe pain before wound care. LN 10 did not administer acetaminophen or oxycodone on 2/25/26 before wound care.During an interview on 2/26/26 at 9 a.m. with LN 11, LN 11 stated nurses should have monitored and assessed Resident 12's pain every shift, administered acetaminophen or stronger pain medication if needed, and assessed the effectiveness of medication. LN 11 further stated nurses should have given the pain medication before Resident 12's wound care, shower or therapy.During a concurrent interview and record review on 2/26/26 at 10:53 a.m. with the Director of Nursing (DON), Resident 12's medication orders and MAR were reviewed. DON confirmed there was no pain assessment in the orders. DON expected nurses to assess the residents' pain level and offer pain medications prior to wound care.A review of the facility's policy titled, Pain Assessment and Management, dated 3/2020, indicated, Observe the resident (during rest and movement) for physiologic and behavior (non-verbal) signs of pain. The policy further indicated during the comprehensive pain assessment to gather information from the resident (or legal representative) of the history of pain, location of pain, intensity of pain, characteristics of pain, pattern of pain, frequency, timing and duration of pain. Documentation of the resident's reported level of pain with adequate detail in the resident's medical record. A review of the facility's policy titled, Wound Care, dated 10/2010, indicated, PRN orders for pain medication to be administered prior to wound care.

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	02/26/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent a significant medication error for one resident (Resident 74) of a census of 144, when Resident 74 received 12 doses of insulin (a medication to regulate blood sugar) from a pen used past the manufacturer's opened expiration date. This failure resulted in the administration of expired medication to Resident 74, creating the potential for reduced potency, elevated blood sugar levels, adverse effects, and bacterial contamination.Findings: During a concurrent observation and interview on [DATE] at 9:19 a.m. with Licensed Nurse (LN) 2, Unit D Medication Cart 2 was inspected. One Lantus Solostar (insulin glargine-long-acting insulin) pen assigned to Resident 74 was observed with a handˆwritten date of 1/13 on the prescription label. LN 2 confirmed this was the open date, then calculated 28 days from the open date and stated the insulin pen expired on [DATE]. A review of Resident 74's order report, revised on [DATE], indicated an order for insulin glargine100 unit/milliliter (u/ml; a unit of measure): inject 15 units subcutaneously (under the skin) one time a day for diabetes. During a concurrent followˆup interview and record review on [DATE] at 11:08 a.m. with LN 2, Resident 74's Medication Administration Record (MAR) was reviewed. LN 2 stated Resident 74 had only one insulin glargine pen available for administration and that was the same pen observed during the [DATE] medication cart inspection. LN 2 confirmed February 2026 MAR indicated Resident 74 received 12 doses from the pen, which expired on [DATE]. During a concurrent interview and record review on [DATE] at 12:01 p.m. with the Director of Nursing (DON), Resident 74's February MAR was reviewed. DON confirmed the insulin glargine pen found on [DATE] expired on [DATE]. DON stated Resident 74 received 12 doses from the expired pen and might have received ineffective medication or experienced adverse effects due to the administration of expired insulin. A review of the manufacturer's prescribing information for Lantus (singleˆpatientˆuse Solostar prefilled pen), revised [DATE], and retrieved from DailyMed (drug information resource), indicated, Only use your pen for up to 28 days after its first use. Throw away the Lantus Solostar pen you are using after 28 days, even if it still has insulin left in it. A review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, revised February 2023, indicated, .3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. P&P further indicated, 5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or long date for the open vial.