STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and record review, the facility failed to treat the resident with respect for one of 12 residents (34) when Resident 34 requested to have female certified nursing assistant (CNA) to work with her, but male CNAs were still assigned to her. This failure violated the resident's rights and had the potential to cause frustration for the resident. Findings: Review of Resident 34's Admission Record indicated she was admitted to the facility on [DATE]. During an interview with Resident 34 on 4/1/25, at 9 a.m., she stated that she told licensed nurses and CNAs, and she also told the administrator (ADM) last week on Wednesday that she did not want male CNA and would prefer to have female CNA to work with her, but most of the time male CNAs were still assigned to her. During an observation and interview with certified nursing assistant B (CNA B) on 4/1/25, at 9:24 a.m., CNA B was in Resident 34's room, and he stated he was assigned CNA for Resident 34 today. He came to Resident 34's room to change her, but she did not want him and asked for a female CNA. During an interview with the ADM on 4/1/25, at 10:14 a.m., he confirmed that last Wednesday Resident 34 talked to him and requested to have female CNA assigned to her. ADM mentioned about Resident 34's request in the staff meeting last week. The ADM stated female CNA should have been assigned to Resident 34 per her request and preference. Review of the facility's policy, Resident Rights, dated 2/2021, indicated . 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . h. be supported by the facility in exercising his or her rights; .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on interview and record review, the facility failed to ensure two of five residents (20 and 38) had informed consents (written permission before implementing a healthcare intervention) prior to initiating psychotropic medication (medication capable of affecting the mind, emotions, and behavior). These failures resulted in the residents receiving psychotropic medications without being informed about their risks and side effects. Findings: 1. Review of Resident 20's Admission Record indicated he was admitted to the facility on [DATE] with dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) diagnosis. Review of Resident 20's physician order indicated he had orders for Seroquel (an antipsychotic medication) 25 milligrams (mg, unit of measurement) in the morning and Seroquel 37.5 mg in the afternoon for dementia with behavioral disturbance, dated 12/9/24. Review of Resident 20's clinical record indicated there were no informed consents for Seroquel 25 mg in the morning and Seroquel 37.5 mg in the afternoon. During an interview with the director of nursing (DON) on 4/4/25, at 1:44 p.m., he reviewed Resident 20's clinical record and was unable to locate the informed consent for Seroquel 25 mg in the morning and Seroquel 37.5 mg in the afternoon. 2. Review of Resident 38's Admission Record indicate he was admitted to the facility on [DATE] with insomnia (difficulty falling or staying asleep) diagnosis. Review of Resident 38's physician order indicated he had orders for Seroquel 25 mg in the morning, started on 1/23/25, and Seroquel 50 mg in the evening, started on 1/28/25, for psychosis (a loss of contact with reality); and Trazodone (an antidepressant medication) 50 mg in the evening for insomnia, started on 1/28/25. Review of Resident 38's clinical record indicated there were no informed consents for Seroquel 25 mg in the morning, and Seroquel 50 mg and trazodone 50 mg in the evening. During an interview with the director of nursing (DON) on 4/4/25, at 1:50 p.m., he reviewed Resident 38's clinical record and was unable to locate the informed consents for Seroquel 25 mg in the morning and Seroquel 50 mg and trazodone 50 mg in the evening. Review of the facility's policy, Psychotropic Medication Use, dated 7/2022, indicated . 15. Physician's orders related to the use of psychotherapeutic drug, antipsychotic drug shall not be initiated until the facility is able to verify that the resident or their authorized representative has given informed consent.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on interview and record review, the facility failed to timely complete and submit a Discharge Minimum Data Set (MDS, a clinical assessment tool) data to the Centers for Medicare & Medicaid Services (CMS, oversees federal healthcare programs) for two of four residents (25 and 31). This failure resulted in non-compliance with CMS regulatory requirements. Findings: Review of Resident 25's clinical record indicated he was admitted to the facility on [DATE] and discharged from the facility on 3/17/25. Review of Resident 31's clinical record indicated she was admitted to the facility on [DATE] and discharged from the facility on 12/12/24. On 4/4/25, review of Resident 25's and Resident 31's clinical records indicated their Discharge MDS were overdue, not started, and not submitted to the CMS. During an interview with the assistant director of nursing (ADON) on 4/4/25, at 2:02 p.m., she reviewed Resident 25's and Resident 31's clinical records and confirmed that their discharge MDS were overdue, not started, and not submitted to the CMS. The ADON stated the residents' Discharge MDS should be completed within 14 days and submitted to the CMS within 28 days after the residents were discharged . The ADON stated the discharge MDS of Resident 25 and Resident 31 should have already been completed and submitted to the CMS. Review of the facility's policy, MDS Completion and Submission Timeframes, dated 7/2017, indicated The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines. Review of the CMS's Resident Assessment Instrument (RAI) Version 3.0 Manual, dated 10/2024, indicated discharge MDS Completion Date was no later than discharge date plus 14 calendar days and the MDS Transmission Date was no later than MDS Completion Date plus 14 calendar days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and record review, the facility failed to ensure service provided to met professional standards when the licensed nurses did not follow the physician order to float Resident 27's heels while he was in bed. This failure had the potential for Resident 27 to develop skin damage to his heels. Findings: Review of Resident 27's Admission Record indicated he was admitted to the facility on [DATE] with protein -calorie malnutrition diagnosis. Review of Resident 27's physician order, dated 11/4/24, indicated he had a physician order to float Resident 27's heels with pillows at his calves or apply Prevalon boots (heel protector that floats the heel off the surface of the mattress, helping to reduce pressure) while he was in bed. During observations on 4/2/25, at 11:57 a.m., and on 4/3/25, at 6:46 p.m., Resident 27 was lying in his bed, and he did not have pillows at his calves or Prevalon boots on. During an observation and interview with registered nurse E (RN E) on 4/4/25, at 9:55 a.m., Resident 27 was in bed, and he did not have pillows at his calves or Prevalon boots on. RN E reviewed Resident 27's physician orders and confirmed that Resident 27's heels should be floated with pillows at his calves or Prevalon boots on while he was in bed as ordered by the physician. Review of the facility's undated job description, Licensed Vocational Nurse, indicated Duties and Responsibilities: Administrative Functions: . Provides basic wound care and other treatments as ordered by the healthcare provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 44577 Based on observation, interview, and record review, the facility failed to ensure the proper use of bed or side rails (adjustable rigid bars attached to the side of a bed) for 10 of 36 residents (9. 21. 24, 29, 30, 34, 41, 42, 145, and 146) when: 1. Alternatives were not attempted prior to the use of bed or side rails for Residents 9, 34, 41, 42, 145, and 146; and 2. Bed or Side Rail Assessment was not done quarterly for Residents 21, 24, 29, and 30. These failures had the potential to place the residents at risk of entrapment and serious injury. Findings: 1. During an observation, on 4/1/25 at 9:36 a.m., in Resident 41's room, Resident 41 was sleeping in the bed with left and right upper bed rails in upright position. During an observation, on 4/1/25 at 9:36 a.m., in Resident 42's room, Resident 42 was in the bed with left and right upper bed rails in upright position. During an observation, on 4/1/25 at 9:41 a.m., in Resident 145's room, Resident 145's bed had left and right upper bed rails attached. During an observation, on 4/1/25 at 9:42 a.m., in Resident 146's room, Resident 146's was in bed with left and right upper bed rails in upright position. During a concurrent interview and record review with the Assistant Director of Nursing (ADON), on 4/4/25 at 10:09 a.m., the ADON reviewed Resident 41's Side Rail Assessment for bed rail use dated 2/23/25. ADON confirmed the form was incomplete, Section C Recommendation was not completed, and there was no documentation that indicated alternatives were offered or attempted prior to Resident 41's bilateral upper bed rails used. The ADON stated a prior version of the form was used. During a concurrent interview and record review with the ADON, on 4/4/25 at 10:11 a.m., the ADON reviewed Resident 42's Side Rail Assessment for bed rail use dated 3/4/25. ADON confirmed the form was incomplete, Section F Alternatives was not completed, there was no documentation that indicated alternatives were offered or attempted prior to Resident 42's bilateral upper bed rails used. During a concurrent interview and record review with the ADON, on 4/4/25 at 10:12 a.m., the ADON reviewed Resident 145's Side Rail Assessment for bed rail use dated 3/13/25. ADON confirmed the form was incomplete, Section F Alternatives was not completed, there was no documentation that indicated alternatives were offered or attempted prior to Resident 145's bilateral upper bed rails used. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the ADON, on 4/4/25 at 10:13 a.m., the ADON reviewed Resident 146's Side Rail Assessment for bed rail use dated 3/28/25. ADON confirmed the form was incomplete, Section F Alternatives was not completed, there was no documentation that indicated alternatives were offered or attempted prior to Resident 146's bilateral upper bed rails used. During an observation on 4/3/25, at 3:05 p.m., Residents 9 and 34 had bilateral bed rails. Review of Resident 9's and Resident 34's Side Rails Assessments indicated alternatives were not attempted before implementing their side rails. During an interview with the Assistant Director of Nursing (ADON) on 4/4/25, at 10:09 a.m., she stated the prior version of the Side Rail Assessment form was used for Resident 9 and Resident 34, and there were no indication that the alternatives were attempted prior to the use of bed rails for Resident 9 and Resident 34. Review of the facility's policy, Bed Rails, dated revised August 2022, indicated The use of bed rails is prohibited unless the criteria for use of bed rails have been met., Prior to the use of bed rail, alternatives to the use of side or bed rails are attempted. Alternatives may include: a. roll guards; b. foam bumpers; c. lowering the bed; and/or d. use of concave mattresses to reduce rolling off the bed. 37409 2. During an observation on 4/3/25, at 3:05 p.m., Residents 21 and 24 had bilateral bed rails. Review of Resident 21's Side Rails Assessments indicated he had side rail assessment on 3/28/24 and did not have any side rail assessment until 2/20/25. Review of Resident 24's Side Rails Assessments indicated the only one side rail assessment he had was on 9/30/24. During an interview with the ADON, on 4/4/25 at 10:28 a.m., the ADON stated, the Side Rail Assessments are completed every quarter with the Minimum Data Set (MDS, standardized assessment tool used to evaluate and document the health status and functional capabilities of residents). During an observation on 4/1/25 at 8:15 a.m., in Resident 29's room, Resident 29's left and right upper bed rails were in an upright position. During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on 4/4/25 at 1:00 p.m., the ADON reviewed Resident 29's Side Rail Assessment for bed rail use, dated 10/1/2024. The ADON confirmed that this was the only side rail assessment available for Resident 29, and that the required quarterly bedside rail assessment had not been completed. During an observation on 4/1/25 at 8:20 a.m., in Resident 30's room, Resident 30 's left and right upper bed rails were in an upright position. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on 4/4/25 at 1:05 p.m., the ADON reviewed Resident 30's Side Rail Assessment for bed rail use, dated 8/15/2024. The ADON confirmed that this was the only side rail assessment available for Resident 30 and that the required quarterly bedside rail assessment had not been completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 44577 Based on observation, interview, and record review, the facility failed to ensure the nurse staffing information was posted clearly visible in a prominent place that was readily accessible to residents and visitors. This failure had the potential to result in nurse staffing information not available for resident's, families, and visitors. Findings: During an observation on 4/1/25 at 9:33 a.m., in the nurse station, there was no nurse staffing information and no total actual hours posted. During an observation on 4/2/25 at 1:50 p.m., in the nurse station, there was no nurse staffing information and no total actual hours posted. During a concurrent observation and interview on 4/3/25 at 1:10 p.m. with the Infection Preventionist (IP), the IP stated there was no staffing information and no total hours posted for residents or visitors for the daily staffing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on interview and record review, the facility failed to ensure the consultant pharmacist's recommendations were acted upon for two of 12 residents (14 and 20) when: 1. Resident 14's chewable Aspirin (a drug that reduces pain, fever, inflammation, and blood clotting) was not changed to plain film coated form of baby aspirin; and 2. Resident 20's consultant pharmacist's Note to the Attending Physician/Prescriber regarding duplicate therapy of Protonix (used to treat heartburn and certain other conditions caused by too much acid in the stomach) and Pepcid (used to treat heartburn and certain other conditions caused by too much acid in the stomach) was not presented to the physician. This failure had the potential for Residents 14 and 20 to receive ineffective and unnecessary medications that could negatively impact their health and well-being. Findings: 1. Review of Resident 14's Admission Record indicated he was admitted to the facility on [DATE]. Review of Resident 14's physician order, dated 1/28/25, indicated he had an order for Aspirin chewable 81 milligrams (mg, a metric unit of mass) via nasogastric tube (NG-tube, a thin, flexible tube inserted through the nose, down the throat, and into the stomach, used for delivering fluids, crushed medications, or nutrition, or removing substances from the stomach) in the morning. Review of Resident 14's Consultant Pharmacist's Medication Regimen Review (MRR, a comprehensive evaluation of a patient's medications to ensure their effectiveness and safety), dated 2/13/25, indicated the consultant pharmacist stated Resident 14's chewable Aspirin should have not crushed and pharmacy recommended a chewable Aspirin to be changed to plain film coated form of baby Aspirin, and crush, and give through NG-tube. During an interview with the director of nursing (DON) on 4/4/25, at 1:33 p.m., he reviewed Resident 14's clinical record and confirmed that the consultant pharmacist's recommendation for Resident 14 was not acted on. Resident 14 continue to received chewable Aspirin 81 mg in the morning. 2. Review of Resident 20's Admission Record indicated he was admitted to the facility on [DATE]. Review of Resident 20's physician order, dated 11/21/24, indicated he had orders for Protonix 40 mg every day and Pepcid 20 mg two times a day. Review of Resident 20's consultant pharmacist's Note to the Attending Physician/Prescriber, dated 1/21/25, indicated the consultant pharmacist asked the physician to evaluate the duplicate therapy of Protonix and Pepcid. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 20's consultant pharmacist's Note to the Attending Physician/Prescriber was not presented to the physician; there were no physician's response and no physician's signature on it. During an interview with the DON on 4/4/25, at 1:31 p.m., he reviewed Resident 20's consultant pharmacist's Note to the Attending Physician/Prescriber and confirmed that it was not presented to the physician. Review of the facility's policy, Medication Regimen Review and Reporting, dated 9/2008, indicated . 6. Resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 37409 Based on observation, interview and record review, the facility had a medication error rate of 25.93% when 7 medication errors occurred out of 27 opportunities during medication administrations for four out of six residents (5, 6, 14, and 146). This failure resulted in medications not given in accordance with the prescriber's orders which resulted in residents not receiving the full therapeutic effects of the medications. Findings: 1. During a medication pass observation on 4/1/25, at 10:29 a.m. with Licensed Vocational Nurse C (LVN C), LVN C stated he did not have gabapentin (pain reliever) 100 milligrams (mg, a metric unit of mass) and tamsulosin (helps increase the flow of urine) 0.4 mg on hand to give to Resident 146. During a concurrent medication pass observation LVN C also crushed levetiracetam (helps control seizures) one 500mg tablet and Klor-Con (used to treat and prevent low potassium) M10 Extended Release (ER) one 20 milliequivalent (mEq, a unit of measure that expresses the combining power of a substance) tablet, mixed with apple sauce, and administered to Resident 146. During a medication pass observation on the labels of levetiracetam 500 mg and Klor-Con 20 mEq bubble pads and interview with LVN C on 4/1/25, at 11:21 a.m., LVN C confirmed that he crushed levetiracetam 500 mg and Klor-Con 20 mEq, but their labels stated, Do Not Chew or Crush. Review of Resident 146's physician orders indicated Resident 146 was to receive gabapentin 100 mg, started on 4/1/25; tamsulosin 0.4 mg, started on 3/29/25; levetiracetam 500 mg, started 3/29/25; and Klor-Con 20 mEq, started on 3/29/25, at 9 a.m. Review of the facility's policy, Medication Administration - General Guidelines, dated 2007, indicated . 5. b. Long-acting, extended release or enteric-coated dosage forms should generally not be crushed; an alternative should be sought. Review of the facility's undated job description, Registered Nurse, indicated Job Functions: . Obtains medications, supplies, and medical records needed to provide safe, efficient, and therapeutic care to residents on a continuing basis. 2. During a medication pass observation on 4/1/25, at 4:07 p.m. with LVN D, LVN D administered calcium carbonate (used to treat low calcium conditions) 500 mg crushed through Resident 14's nasogastric tube (NG-tube, a thin, flexible tube inserted through the nose, down the throat, and into the stomach, used for delivering fluids, crushed medications, or nutrition, or removing substances from the stomach). Review of Resident 14's physician order, dated 1/29/25, indicated he was to receive calcium carbonate 1250 mg one tablet enterally two times a day at 8 a.m. and 5 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN D on 4/1/25, at 5:32 p.m., he reviewed Resident 14's physician orders and confirmed that the physician ordered calcium carbonate 1250 mg for Resident 14, but he administered calcium carbonate 500 mg to him. 3. During a medication pass observation on 4/1/25, at 4:46 p.m. with LVN D, LVN D gave Symbicort inhaler (helps reducing inflammation in the lungs and keeping airways open) to Resident 6 to administer herself two puff inhales orally without instructing her to shake the Symbicort inhaler well and rinse mouth after use. During a medication pass observation on the label of Symbicort inhaler and interview with LVN D on 4/1/25, at 5:03 p.m., LVN D confirmed that the label stated, Shake well before using; rinse mouth after each use, and he did not instruct Resident 6 to do that. 4. During a medication pass observation on 4/3/25, at 10:24 a.m. with registered nurse E (RN E), RN E administered one tablet of Multiple Vitamin to Resident 5. Review of Resident 5's physician order, dated 2/11/25, indicated she was to receive one tablet of Multiple Vitamin with 400 micrograms (ug, a metric unit of mass) of folic acid (helps the body make new cells) one time a day at 8 a.m. During an observation on the ingredients of Multiple Vitamin bottle and interview with RN E on 4/3/25, at 11:48 a.m., RN E confirmed that the Multiple Vitamin tablet that she administered to Resident 5 did not have folic acid ingredient in it. Review of the facility's policy, Administering Medications, dated 4/2019, indicated . 4. Medications are administered in accordance with prescriber orders . 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequence for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 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. 37409 Based on observation, interview, and record review, the facility failed to ensure medications were stored appropriately when expired medications and the medication opened over the period found in Medication Cart 1. This failure had the potential for residents to be given expired or over open period medication. Findings: On 4/1/25, at 11:24 a.m., during an observation on Medication Cart 1 with licensed vocational nurse C (LVN C), the following were observed: a. One bottle of Calcium Citrate Magnesium and Zinc with vitamin D3 (supplements) and one bottle of Centrum Silver Women 50+ (multivitamin) had an expiration date of 3/2025. b. A bottle of latanoprost 0.005% (used to treat increased pressure inside the eye) for Resident 6 was opened on 2/17/25, and a bottle of latanoprost 0.005% for Resident 22 was opened on 2/17/25 with the labels on them stated Discard 42 days after opening. During a concurrent observation on the labels of latanoprost 0.005% and interview with LVN C, LVN C confirmed that the labels stated Discard 42 days after opening. LVN C acknowledged that over open period and expired medications should have not be inside the medication cart. LVN C stated he would put them away. Review of the facility's policy, Medication Labeling and Storage, dated 2/2023, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 46001 Based on interview and record review, the facility failed employ sufficient staff with the appropriate competencies and skills sets to carry out the food service operations when the facility did not have a full-time dietitian and the requirements were not met as specified in established standards for food service managers as a full-time, qualified dietetic supervisor when the dietitian was not full time. This failure had the potential to unsafe food practices and food-borne illness for 38 residents eating facility-prepared foods. Findings: Reviewing the Food and Nutrition Services schedule for February, March, and April 2025 indicated no dietary manager (dietetic supervisor) was working in the facility. A review of the actual working schedules for all staff received on 4/1/2025 indicated that the Registered Dietician (RD) worked only two days a week. During an interview with the registered dietitian (RD) on 4/3/25 at 9:41 a.m., the RD stated that she was a part-time employee working approximately 20 hours per week and that the facility did not have a full-time dietary manager. She confirmed that the facility should have had a full-time dietary manager because she was a part-time RD. She further stated that as of 4/1/25, she became a full-time RD. During an interview with the [NAME] (CK) on 4/3/2025 at 1:37 p.m., the CK confirmed that the RD was a part-time employee and that the facility did not have a designated full time dietary manager. A review of the facility's policy and procedure titled Dietation indicated if a dietician is not employed full time (35 or more hours per week), a director of food and nutrition services will be designated . A Review of the California Code, Health, and Safety Code - HSC S 1265.4 indicated that a licensed health facility shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44577 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1. A Urinary catheter (a semi-flexible plastic tube, one end inserted into the bladder [body organ that stores urine] and the other end is attached to a bag that collects urine) drain bag and tubing was on the floor; 2. The staff provided ice to residents using ice from trays made in the employee room freezer; 3. Certified nursing assistant F (CNA F) brought the lunch tray to Resident 146 without sanitizing his hands; 4. Certified nursing assistant B (CNA B) walked out of Resident 17's room without removing his gloves and sanitizing his hands; 5. Licensed vocational nurse D (LVN D) administered eye drops to Resident 6 without changing his gloves and cleansing his hands; 6. After cutting docusate sodium (stool softener) 100 milligrams (mg, a metric unit of mass) tablet into two halves, registered nurse E (RN E) put one half of docusate sodium tablet back to its bottle; 7. RN E did not cleanse the blood pressure cup between residents; and 8. Licensed vocational nurse A (LVN A) did not change gloves and cleanse his hands before cleansing and applying dressing to Resident 14's right heel wound. These failures had the potential to spread infection to resident and staff. Findings: 1. During an observation on 4/2/25 at 8:51 a.m., the urinary catheter drainage bag and tubing was on the floor for Resident 22. During an interview with Licensed Vocational Nurse A (LVN A) on 4/2/25 at 8:55 a.m., LVN A confirmed Resident 22's urinary catheter drainage bag was on the floor. LVN A stated the drainage bag should have been off the floor, and hanging from the bed properly to prevent infection. Review of the facility's policy & procedure titled Catheter Care, Urinary, dated 8/2022, indicated, Infection Control . Be sure the catheter tubing and drainage bag are kept off the floor. 46001 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview with the Certified Nursing Assistant (CNA) G on 4/3/25 at 1:55 p.m., seven ice trays containing ice cubes were observed in the employee room freezer, located next to two boxes and a bag of employee food. The CNA G confirmed that they sometimes provide ice to residents using ice from the trays made in the employee room freezer. During an interview with the Activity Staff (AS) on 4/3/25 at 2:00 p.m., the AS stated that the facility staff provide ice to residents using ice from trays made in the employee room freezer. During an interview with the Registered Dietitian (RD) on 4/3/25 at 4:52 p.m., the RD stated that ice from the ice trays made by the employees are not allowed to be provided to residents due to infection control protocols. 37409 3. During an observation on 4/1/25, at 12:21 p.m., certified nursing assistant F (CNA F) brought the lunch tray to Resident 146 without sanitizing his hands. During a concurrent interview with CNA F, he stated he should sanitize his hands before carrying the lunch tray to Resident 146. During an interview with the infection preventionist (IP) on 4/4/25, at 3:06 p.m., she stated staff should have sanitize their hands before bringing the meal trays to the residents. 4. During an observation on 4/1/25, at 9:07 a.m., certified nursing assistant B (CNA B) carried a bag of soiled brief and linen with his gloved hand, walked out of Resident 17's room, walked in the hallway and went to the shower room to throw the bag in the big container bin. During a concurrent interview with CNA B, he stated he changed Resident 17 and transferred her to the wheelchair in her room. CNA B stated he should have remove his gloves in Resident 17's room and before walking in the hallway. During an interview with the IP on 4/4/25, at 3:08 p.m., she stated the staff should have remove their gloves in the resident's room. Review of the facility's policy, Handwashing/Hand Hygiene, dated 8/2019, indicated . 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: . b. Before and after direct contact with residents; . p. Before and after assisting a resident with meals; . 5. During a medication pass observation with licensed vocational nurse D (LVN D) on 4/1/25, at 4:46 p.m., LVN D administered oral medications to Resident 6, gave Symbicort inhaler (helps reducing inflammation in the lungs and keeping airways open) to Resident 6 to administered herself, then administered Artificial Tears (lubricating eye drops) one drop to each eye to Resident 6 without changing gloves and washing his hands. During an interview with LVN D on 4/1/25, at 5:03 p.m., he stated he should have change his gloves and wash his hands before administering Artificial Tears to Resident 6. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Instillation of Eye Drops, dated 1/2014, indicated . 2. Wash and dry hands thoroughly. 3. Put on gloves . 6. During a medication pass observation with registered nurse E (RN E) on 4/3/25, at 10:24 a.m., RN E needed half of docusate sodium (stool softener) 100 mg, so that she could administered two tablets and a half of docusate sodium to Resident 5. RN E cut one 100 mg docusate sodium tablet to two halves. She placed one half into the medicine cup to give it to Resident 5 and put the other half back to the docusate sodium bottle. During an interview with RN E on 4/3/25, at 10:33 a.m., RN E stated she should have not put the half of docusate sodium back to its bottle. Review of the facility's policy, Medication Administration - General Guidelines, dated 2007, indicated . 4. d. Unused tablet portions are disposed of . 7. During a medication pass observation with registered nurse E (RN E) on 4/3/25, at 9:53 a.m., RN E took Resident 196's blood pressure before giving her metoprolol (treat high blood pressure) 50 milligrams (mg, a metric unit of mass) and did not cleanse the blood pressure cup. During a medication pass observation on 4/3/25, at 10:33 a.m., RN E used the same blood pressure cup to take Resident 32's blood pressure before giving her metoprolol 25 mg without cleansing it. During an interview with RNE on 4/3/25, at 10:49 a.m., she stated the blood pressure cup should have been cleansed the blood pressure cup between each resident. During an interview with the infection IP on 4/4/25, at 3:10 p.m., she stated the nursing staff should have cleanse their hands and change gloves before giving eye drops; after cutting the medication, the left-over medication should have been discarded, and the staff should have cleanse the blood pressure cup between each resident. Review of the facility's policy, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 9/2022, indicated . 5. Reusable items are cleansed and disinfected or sterilized between residents. 8. During a treatment observation on Resident 14's right heel wound with licensed vocational nurse A (LVN A) on 4/2/25, at 2:05 p.m., LVN A cleansed his hands and put on gloves. LVN A pulled down the sock on Resident 14's right foot, opened a plastic bag for trash, removed the old dressing on Resident 14's right heel, then without changing gloves and cleansing his hands, LVN A cleansed Resident 14's right heel wound and applied new dressing. During an interview with LVN A on 4/2/25, at 2:14 p.m., he stated he should have change his gloves and cleanse his hands before cleansing Resident 14's right heel wound and applying new dressing. During an interview with the IP on 4/4/25, at 3:03 p.m., she stated the licensed nurse should have cleanse their hands and change gloves before cleansing the wound and applying treatment. Review of the facility's policy, Wound Care, dated 10/2010, indicated . 4. Put on exam glove. Loosen tape and remove dressing. 5. Wash and dry hands thoroughly. 6. Put on gloves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 46001 Based on observation, interview, and record review, the facility failed to maintain the kitchen freezer and the meal cart in a good and safe operating condition, when 1. Excessive ice buildup was observed in the reach-in freezer. 2. Kitchen Meal Cart 3 was missing a proper handle, and the meal cart door was no closing. These deficiencies could compromise the freezer's ability to keep food adequately frozen and the meal cart door may not prevent proper food temperature maintenance that could cause food-borne illness for 38 out of 39 residents who received meals prepared in the kitchen. Findings: 1. During a kitchen tour on April 3, 2024, at 11:51 a.m., significant ice buildup was observed inside the reach-in freezer, on the exterior of the freezer doors, and along both sides of the freezer gaskets. 2. During a meal pass observation on April 2, 2025, at 12:22 p.m., Meal Cart 3 was found to be missing a proper handle, the door was detached, and unable to close the door properly. During an interview with the Registered Dietitian (RD) on April 3, 2025, at 4:52 p.m., she confirmed that ice had built up inside the freezer, between the doors, and on the bottom. She stated that ice should have not accumulate in those areas and that maintenance was responsible for keeping the freezer in good condition. She further stated that the meal cart should have been maintained in proper working condition. During an interview with the Maintenance Manager (MM) on April 4, 2024, at 1:54 p.m., he stated that he was aware of the issue with the reach-in freezer and had removed the ice earlier that day. He acknowledged that ice should not have ice build up, as it may affect the freezer's functionality. He also stated that the meal cart should have been maintained in good condition. A review of 2017 Food Code Section 4-501.11 indicated that equipment must be maintained in a state of repair and condition that meets the requirements specified by the food code. A review of the facility's policy titled, Refrigerators and Freezers, dated November 2022, indicated . Supervisors inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs. Necessary repairs are initiated immediately. Maintenance schedules per manufacturer guidelines are scheduled and followed. Refrigerators and freezers are kept clean, free of debris, and disinfected with sanitizing solution on a scheduled basis and more often as necessary .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhills Manor	238 Virginia Avenue Campbell, CA 95008

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46001 Based on observation, interview, and record review, the facility failed to ensure three of resident rooms have at least 80 square feet per resident. Findings: 1. room [ROOM NUMBER], a four-person room, measured 73.4 square feet per resident. 2. room [ROOM NUMBER], a four-person room, measured 73.4 square feet per resident. 3. room [ROOM NUMBER], a four-person room, measured 73.4 square feet per resident. During the survey, none of the rooms were observed to inhibit the staff from providing care or services, or the residents from receiving adequate care and services. The staff and residents moved freely in the rooms unhampered by the lack of space. Wheelchairs were easily accommodated. The residents had no concerns regarding the space or privacy in their room. Recommend waiver remain in effect.