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	04/24/2024

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45718 Based on observation, interview, and record review, the facility failed to ensure 1 of three sampled residents (Resident 1) was treated with dignity and respect when a Certified Nursing Assistant (CNA 1) failed to honor her wish not be changed and re-approach her later. This failure resulted in Resident 1 being accidentally hit on the face by her dirty diaper (incontinent brief) while CNA 1 was providing care to her and had the potential to minimize her dignity and self-esteem. Findings: A review of Resident 1's clinical record indicated Resident 1 was admitted to the facility early 2023 with multiple diagnoses that included dysarthria following cerebral infarction (speech impairment that can occur after a stroke). Her Minimum Data Set (MDS, an assessment tool) indicated she was cognitively intact. A review of Resident 1's NURSE PROGRESS NOTE , effective date 4/19/24, indicated, ON 04/19/24 AT AROUND 0030, RESIDENT WAS NOTED TO BE CRYING OUT LOUD AND CNA WENT IN TO ROOM TO CHECK ON RESIDENT. PER CNA, NOTED RESIDENT POUNDING HER CHEST AND POINTING TO ANOTHER STAFF MEMBER CNA. RESIDENT UNABLE TO VERBALIZE NEEDS CLEARLY AND REQUESTED A PAPER TO WRITE ON. CNA INFORMED THIS LN WRITER OF THE NOTES THAT THE RESIDENT WROTE DOWN, SHE BEET MY FACE WITH DIRTY DIAPER, CNA DID NOT WANT TO CHANGE ME TO , SHE BEET W,TH HER HANDS, ASK [NAME] POLICE DO WELFER CHECK.UPON SPEAKING WITH RESIDENT, NOTED RESIDENT'S LOC AT BASELINE AND STARTED POUNDING HER CHEST, CRYING AND UPSET AND POINTING TO STAFF MEMBER CNA. RESIDENT VERBALIZED WITH HER BASELIIJE [sic] SPEECH AND HAND GESTURES THAT STAFF MEMBER CNA HIT HER WITH A DIAPER ON HER FACE . During a concurrent observation and interview on 4/24/24 at 10:59 a.m., in Resident 1's room, Resident 1 was sitting in a wheelchair. Resident 1 was using a clipboard with paper to communicate. When asked regarding the incident, Resident 1 responded by pounding on her chest 3 times. Resident 1 made gestures on her hand showing that she was hit on her face. When asked to describe what happened, Resident 1 wrote on the clipboard, she [CNA] hit me, my chest with her fist .Hit my face with diaper poop in it .She did not want to change me .I took the diaper off .Then she get[sic] angry and hit me with diaper on face and on chest . Resident 1 stated, felt scared in slurred speech. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/24/24 at 11:59 a.m., the Certified Nursing Assistant (CNA 1) stated, she was with another resident when she heard the call light for Resident 1. She then went to Resident 1's room and found Resident 1 was crying on the bed. CNA 1 stated, Resident 1 said uh .uh uh while pointing at her diaper. CNA 1 stated as she was cleaning Resident 1, Resident 1 started being combative and continued crying. Resident 1 then grabbed her dirty diaper with her left hand and hit her face with the dirty diaper. CNA 1 further stated, I told her give me your diaper, look at your diaper they have poop .even my arms they have poop because her diaper was all over .She was crying and combative .I did not ask for help because I was already starting to change her .she was combative only that day. CNA 1 stated, she left Resident 1 after cleaning her and went to her other residents because they were also calling. CNA 1 stated, she asked CNA 2 to check on Resident 1 because she was still crying when she left her. During an interview on 4/24/24 at 1:25 p.m., with the Social Service Director (SSD), the SSD stated, Resident 1 has never been combative and has always been quiet. The SSD further stated, Resident 1 was crying and tearful when she spoke to her regarding the incident, and it took hours to console Resident 1. During a telephone interview on 4/24/24 at 4:45 p.m., the Licensed Nurse (LN 1) stated he was taking care of another resident in the other room when he heard Resident 1 shouting. He then asked CNA 2 to check on Resident 1. CNA 2 then went back to LN 2 and told him that Resident 1 was pounding on her chest. He asked CNA 2 to let her write on the clipboard and Resident 1 wrote that the CNA hit her. When LN 1 went to Resident 1's room, she started pounding on her chest, was crying, and upset while pointing at CNA 1 demonstrating she was hit by CNA 1. LN 1 further stated, when he asked CNA 1 what happened, CNA 1 stated that during the diaper change, Resident 1 accidentally pulled her diaper and it fell off on her face. LN 1 stated, no one witnessed the incident and she had no injury upon assessment. During an interview on 4/24/24 at 1:58 p.m., the Director of Nursing (DON) stated, when a resident is combative and crying the CNA needed to let the nurse know. It is important to call somebody to help with the situation. The DON further stated, I think it is a dignity issue when CNAs continue giving care despite of resident being combative and crying . she should have called the nurse .I feel that Resident 1 had previous interaction with CNA 1 and she was scared of her . A review of facility policy titled, Resident Rights , Revised February 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 . b. be treated with respect, kindness, and dignity . A review of facility policy titled, Dignity , Revised February 2021, indicated, 1. Residents are treated with dignity and respect at all times .12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45718 Based on interview, and record review, the facility failed to ensure adequate supervision and assistive devices were provided to prevent falls for 1 of 4 sampled residents (Resident 2) when Resident 2 had an unwitnessed fall. This failure resulted in Resident 2 being admitted to the acute care hospital for scratches on left face and left hip and left rib pain. Findings: A review of Resident 2's clinical record indicated, Resident 2 was admitted to the facility fall of 2024 with multiple diagnoses that included, Diabetes Mellitus (uncontrolled blood sugar) and below knee amputation. Resident 2's Minimum Data Set (MDS, an assessment tool) indicated his memory was intact. A review of Resident 2's Order Listing Report indicated, Bilateral bed rails to enable mobility .Order date 4/10/24 . A review of Resident 2's Care Plan indicated the following: The Resident requires the use of side rails to assist in mobility and transfers .Date Initiated: 04/10/2024 . Interventions .Assess and document how the side rails are meeting the resident needs . 'At risk for fall r/t [related to] BKA [below the knee amputation] .date initiated 4/11/24 . Interventions .PT/OT [physical therapy/occupational therapy] eval [evaluation] and treat as ordered date initiated 4/10/24 .' A review of Resident 2's Side Rail Assessment effective date 4/10/24 indicated, D. Identify how the side rails will assist the resident .Bed mobility .a. Turning side to side/holding self to one side b. Moving up and down in bed c. Pulling self from laying to sitting position .Transfer .c. Entering/exiting bed more safely .d. transferring more safely .c. Recommended Side rail(s) use: b. Side rail(s) are recommended at all times when resident is in bed . A review of Resident 2's THERAPY NOTE dated, 4/10/24 indicated, PT [physical therapist] was approached by pis [sic] wife at 1615 [4:15 p.m.] on 4/10/24 requesting bed rails .Given pts [patient's] debility and amputation, pt can benefit from bed rails to assist with mobility .Nursing and maintenance made aware of recommendation for bilateral bed rails . A review of Resident 2's elNTERACT Change in Condition Evaluation effective date 4/11/24 indicated, RESIDENT HAD UN WITTNESSED FALL,CNA[certified nursing assistant] NOTIFIED RESIDENT ON THE FLOOR IN RESIDENT'S ROOM. UPON ENTRY RESIDENT NOTED TO BE SEEN ON THE FLOOR LYING ON BACK. RES WAS IN FRONT OF FACING BED. PRE [sic] RESIDENT HE fell OFF THE BED IN HIS SLEEP AND WAS HAVING PAIN IN HIS LEFT SIDE OF HEAD HIT BED SIDE TABLE AND RIBS AND HIP ALONG WITH A FUZZY FEELING IN HIS MIND .NP [nurse practitioner] ORDERED SENT OUT ER FOR FUTHER EVALUATION . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2's Acute Hospital progress notes, dated 4/17/24 indicated, [Resident 2's name] admitted on [DATE], s/p [status post] GLF [ground level fall] with complaint of left-sided rib and hip pain without acute traumatic injury . During a telephone interview on 4/26/24 at 2:00 a.m., Licensed Nurse (LN 2) stated, Resident 2 had a fall at around 2:15 a.m. that day. LN 2 stated, the CNA called her, and they found Resident 2 on the floor, lying on his back. She then asked Resident 2 how he fell , and he stated he slipped and hit the bedside table. Resident 2 was alert and oriented. LN 2 further stated, she thinks he did not have side rails at the time he fell . During a telephone interview on 4/26/24 at 2:24 a.m., CNA 3 stated she found Resident 2 on the floor when she went to answer his call light. CNA 3 asked him what happened, and Resident 2 stated he fell off his bed around 1 minute ago, and he had pain on his left side and his head. CNA 3 stated, Resident 2 did not have bedrails when he fell , and he kept stating that he requested bedrails. I explained to him, we don't use bedrails, it needs a doctor's order because it's a restraint . She then called for help and the nurse came and he was sent out to the hospital. CNA 3 further stated, during the shift change around 10:30 p.m., Resident 2 let her know he needed bedrails and that he requested bedrails when he arrived in the facility that afternoon. CNA 3 also stated, Resident 2 told her that he fell off his bed before and he was more comfortable with bedrails. CNA 3 stated, they did not have bedrails available in the unit and it's something the morning or evening shift does and that they did not have the capacity to install the bedrails on their shift. During an interview on 4/24/24 at 1:58 p.m. the Director of Nursing (DON) stated, typically the beds in the facility did not come with bedrails and they had a protocol for therapy to assess the resident prior to installing bedrails. If the resident needed bedrails according to the criteria for mobility, then the resident can have bedrails. She further stated, she expected that if a resident had an order for bedrails, then he should have bedrails. A review of facility policy titled, Care Plans, Comprehensive Person-Centered revised March 2022, indicated, Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to .receive the services and/or items included in the plan of care . A review of facility policy titled, Falls and Fall Risk, Managing revised March 2018, indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.