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	06/06/2024

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 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. 45718 Based on observation, interview and record review, the facility failed to provide supervision to ensure safety for one of three sampled residents, (Resident 2) when Resident 1 slapped Resident 2 on the face while both residents were in their wheelchairs at the nurse's station. This failure had the potential to cause Resident 2 physical injury and emotional distress. Findings: A review of Resident 1's clinical records indicated she was admitted to the facility fall of 2019 with multiple diagnoses that included Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks). Her Minimum Data Set (MDS, an assessment tool) indicated she had severe cognitive impairment. A review of the State Agency's records indicated Resident 1 had three previous incidents of alleged altercations with other Residents. A review of Resident 1's care plan indicated, [Resident 1] was involved in a resident to resident altercation on 05/26/2024 .interventions .redirect resident . Resident 1's care plan did not indicate that she had previous history of altercations with other residents and had no behavior monitoring in place. A review of Resident 1's Nurse Progress Notes, dated 5/26/24 indicated, At approximately 1425 [2:25 p.m.] this nurse was at the nurse's station on A wing when this nurse heard a CNA say, No, [Resident 1's name] you did not just slap him at which point this nurse turned towards [Resident 1 and Resident 2]. [Resident 1 and Resident 2] were by the nurse's station where both halls meet on A wing, both on WC [wheelchairs], side by side .This nurse assessed both cheeks, no edema, redness or skin tear noted. This nurse asked [Resident 2] why he thinks [Resident 1] did that he responded, I don't know but I will teach that bitch something [Resident 2] requested to be left alone and be taken to his room . (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 6/6/24 at 11:11 a.m., the Certified Nursing Assistant (CNA 1) stated, she was at the nurse's station with the two residents when the incident happened. She stated, Resident 2 was inside the nurse's station and Resident 1 was a little bit outside the nurse's station when Resident 1 blocked out the area and told Resident 2 that he had to pay to get out. Resident 1 then reached a little bit up across her wheelchair and slapped Resident 2 on his face and he was hit on the face with Resident 1's fingernails. Resident 2 was startled and tried to stand up to reach Resident 1, but he was not quick enough, and they then managed to separate the two residents. CNA 1 further stated, she does not know if Resident 1 had a history of altercation with other residents, but she recently experienced Resident 1 hitting her with a broom when she was passing by. She stated she informed the nurse about it, and she does not know if they did something. During a telephone interview on 6/6/24 at 11:15 a.m., the Licensed Nurse (LN 1) stated she was sitting in the nurse's station when she heard CNA 1 saying, oh no! you did not, did you just slap him? LN 1 stated, she immediately got up, ran towards them and CNA 1 stated, she just hit him. Resident 1 and Resident 2 were on their wheelchairs facing each other so they immediately got in between them. She stated, Resident 2 was a little thrown off and was very upset. During an interview on 6/6/24 at 11: 34 a.m., the Social Service Director (SSD) stated, Resident 1 had a diagnosis of Alzheimer's disease, and she had behaviors while Resident 2 was admitted to hospice, and he passed away a few days back. She stated this was the first incident of altercation between the two residents but Resident 1 had a previous history of altercations with other residents that happened in October and November last year. The SSD verified there was no care plan for the altercations and behaviors that happened last year. She further stated, this altercation could have been avoided or prevented if the staff knew that she had previous history of altercations with other residents but since it happened a while ago, they might not have been aware of it since it's not in the care plan. During a concurrent observation and interview on 6/6/24 at 11:40 a.m., in Resident 1's room. Resident 1 was lying in bed, she stated she was still sleepy. When asked regarding the incident of altercation with Resident 2 she stated she could not remember any incident with another resident. Resident 1 stated, why would I slap him, I don't remember anything . During an interview on 6/6/24 at 11:56 a.m., the Director of Nursing (DON) stated, Resident 1 had a previous history of altercations with other residents. She stated, she does not expect the altercation to happen again. She stated she expected the staff to be able to recognize it earlier when she is exhibiting some behaviors. She further stated, the CNA who saw the incident was not aware that Resident 1 could hit others. Since the previous altercation happened a long time ago, she did not have monitoring for behaviors for outburst. The DON stated, Resident 1 should have been monitored closely if she had a previous history of behaviors with other residents. The care plan for a previous altercation should have still been kept so the staff was aware that she had history of altercations and she could have been monitored for behavior and they could have recognized it earlier and prevented it from happening. (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 the facility policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, 7. The comprehensive, person-centered care plan .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11.Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change . A review of the facility policy titled, Resident-to-Resident Altercations, revised September 2022, indicated, .I. Facility staff monitor residents for aggressive/inappropriate behaviors towards other residents .4.If two residents are involved in an altercation, staff: d. review the events with the nursing supervisor and director of nursing services, and evaluate the effectiveness of interventions meant to address distressed behavior for one or both residents .f. make any necessary changes in the care plan approaches to any or all of the involved individuals .