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	02/26/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36681 Based on observation, interview, and record review, the facility failed to ensure necessary care was provided when the ordered liquid consistency was not followed as ordered by the physician for one of four sampled residents (Resident 1). This failure increased the potential for Resident 1 to experience aspiration (when food or liquid enters the airway and into the lungs by accident). Findings: A review of the Admission Record indicated Resident 1 was admitted [DATE] with diagnoses including dysphagia (difficulty swallowing) following cerebral infarction (stroke- disrupted blood flow to the brain causing brain tissue death). A review of Resident 1's Minimum Data Set (MDS- federally mandated assessment tool) dated 1/14/25 indicated Resident 1 had a 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 of 7 out of 15 which indicated Resident 1 had severe cognitive impairment. A review of Resident 1's Physician's Order Summary Report dated 2/24/25 indicated, .Nectar Thick [comparable to heavy syrup in canned fruit] consistency, no straw .ASPIRATION PRECAUTIONS . In an observation conducted on 2/26/25 at 9:54 a.m., Resident 1 was lying in bed with eyes closed and there was a plastic container with a straw half filled with regular water. In a concurrent observation and interview on 2/26/25 at 11:45 a.m., Certified Nursing Assistant (CNA) confirmed Resident 1 had regular water with straw at bedside. In a follow up interview on 2/26/25 at 12 p.m., the CNA stated she was the one who provided Resident 1 with the regular water and straw. The CNA further stated she put a straw since the water was dripping from resident's mouth when he was drinking. A concurrent interview and record review was conducted on 2/26/25 at 12:07 p.m. with Licensed Nurse (LN). The LN stated Resident 1's diet order dated 2/24/25 indicated nectar thick liquids, no straw. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Greenhaven Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 455 Florin Road Sacramento, CA 95831	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a concurrent observation and interview on 2/26/25 at 12:13 p.m., Resident 1's meal ticket indicated Nectar/Mildly Thick. The CNA confirmed Resident 1 was served with nectar thick liquids. The LN stated Resident 1's diet order should be followed. In an interview on 2/26/25 at 12:46 p.m., the Speech Therapist 1 (ST 1) confirmed she conducted the speech evaluation for Resident 1 on 2/24/25. The ST 1 stated the recommendation was regular bite size, nectar thick liquids and no straws for aspiration precaution. In an interview on 2/26/25 at 1:02 p.m., the Director of Nursing (DON) stated her expectation was for staff to follow the physician order. The DON further stated, if the order was thickened liquids, the staff should offer thickened liquids, and if the order specifically said no straw, the staff should not put a straw. In a telephone interview on 2/26/25 at 5:27 p.m., the DON confirmed Resident 1 had dysphagia. The DON stated the potential for not providing nectar thick liquids would cause possible aspiration. A review of the facility's policy and procedure revised September 2017 and titled, Dysphagia- Clinical Protocol indicated, .The staff and physician will identify individuals with a history of swallowing difficulties or related diagnoses such as dysphagia .Examples of situations in which speech therapy interventions may be helpful include individuals who have had a recent stroke with subsequent impaired .swallowing .The staff and physician will identify and address any complications of swallowing disorders .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 36681 Based on observation, interview, and record review, the facility failed to ensure the order and care plan for the use of left hand splint was documented in a consistent manner for one of four sampled residents (Resident 1). This failure had the potential for Resident 1 to experience further loss of function on the left hand. Findings: A review of the Admission Record indicated Resident 1 was initially admitted May of 2024 with multiple diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on side of the body) following nontraumatic intracerebral hemorrhage (bleeding within the brain without external trauma) affecting left non-dominant side and dementia (a progressive state of decline in mental abilities). A review of Resident 1's Minimum Data Set (MDS- federally mandated assessment tool) dated 1/14/25 indicated Resident 1 had a 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 of 7 out of 15 which indicated Resident 1 had severe cognitive impairment. A review of Resident 1's Order Summary Report dated 1/23/25 indicated, RNA [Restorative Nursing Assistant] for application of L [left] resting hand splint 7x/week for up to 4 hours or as tolerated x 3 months. There was no documented evidence Resident 1's left hand splint was applied from 1/24 to 1/27/25 (4 days). A review of Resident 1's Restorative Nursing Flowsheet indicated the left hand splint was applied on 2/7, 2/8 (resident refused), 2/9, 2/12, 2/17, 2/18, 2/23, and 2/24. There was no documentation on the time the hand splint was removed on 2/7, 2/9, 2/12, 2/17, and 2/18/25. A review of Resident 1's Task Report for RNA- Splint/Brace Assist for the month of February did not indicate the length of time splint was applied. There was no documented evidence Resident 1's left hand splint was applied on 2/11, 2/15, and 2/16/25. A review of Resident 1's care plan dated 1/23/25, indicated, RESTORATIVE: Pt [Resident 1] at risk for loss of ROM [Range of Motion] of L [left] UE [upper extremity]/hand. The goal of care was to maintain current ROM of L UE/hand digits. The interventions included, RNA for application of L resting hand splint 7x/week for up to 4 hours/day or as tolerated x 3 months. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent observation and interview was conducted on 2/26/25 at 11:48 a.m. with Certified Nursing Assistant (CNA). Resident 1 was up in a wheelchair in front of the nurses station with a left hand splint. The CNA stated the left hand splint is applied every day when Resident 1 is out of bed. The CNA further stated it depends when CNA was asked how long Resident 1 needed to wear the hand splint. In a concurrent interview and record review on 2/26/25 at 2:30 p.m., the Director of Rehabilitation (DOR) confirmed Resident 1's hand splint order was 7 days a week up to 4 hours. The DOR further stated RNA were putting on the splint. In a concurrent interview and record review on 2/26/25 at 2:35 p.m., the Director of Staff Development (DSD) confirmed there was no documented evidence Resident 1 was seen by RNA from the time he was discharged from therapy on 1/23/25 until therapy was started on 1/28/25. In a follow up interview and record review on 2/26/25 at 2:43 p.m., the DSD confirmed there was no consistency with RNA charting for Resident 1. The DSD further confirmed there were days when Resident 1's left hand splint was not documented as applied and documentation did not consistently include the time the splint was removed. In an interview on 2/26/25 at 3:07 p.m., the DOR and DSD confirmed there was no documented evidence Resident 1's left hand splint was applied on 1/24, 1/25, 1/26, and 1/27/25. In a interview on 2/26/25 at 3:24 p.m., the Director of Nursing (DON) stated her expectation was for the RNA program to be followed and documented. The DON further stated the potential outcome for not providing RNA program as ordered might be a decline or not maintaining resident's goal of care. A review of the facility's policy and procedure revised July 2017 and titled Restorative Nursing Services indicated, .Residents may be started on a restorative nursing program .when discharged from rehabilitative care .Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care.