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	04/10/2025

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 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. 36681 Based on observation, interview, and record review, the facility failed to ensure professional standards of care was provided for one of 4 sampled residents (Resident 1) when skin assessment (involves visual and tactile examination of the skin to identify potential issues such as change in skin color) was not conducted prior to resident's discharge. This failure to conduct skin assessment increased the potential for Resident 1 to not receive immediate treatment and prevent further skin breakdown. Findings: A review of the clinical record indicated Resident 1 was initially admitted December of 2023 with diagnoses including chronic venous hypertension with ulcer of bilateral lower extremities (persistent high blood pressure in the veins of both legs leading to open sores on the skin), lymphedema (swelling caused by buildup of fluid in the body's tissues often in the arms and legs), and type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 1's Discharge Instruction Form dated 3/31/25 did not contain information on the skin condition and management. Furthermore, Resident 1's Discharge Summary dated 4/1/25 did not indicate a skin assessment was conducted prior to discharge. In a concurrent observation and interview on 4/10/25 at 1:04 p.m., Resident 1 was sitting in his wheelchair with boots on both lower extremities. Resident 1 was able to state his first and last name. In a concurrent interview and record review on 4/10/25 at 2:07 p.m., the Treatment Nurse (TN) stated Resident 1 has scattered venous ulcers on bilateral legs, skin very thin and fragile, resident is noncompliant with elevating his legs, and resident uses ace wrap for compression. The TN stated the deep tissue injury (DTI, a type of pressure ulcer where damage occurs to the underlying tissue even when the skin's outer layer appears intact) on his left heel was identified on readmission. The TN further stated the other wound nurse classified the wound on the left heel as unstageable (the underlying tissue damage cannot be accurately assessed until the slough or dead tissue is removed) two days ago. The TN described Resident 1's wound on the left heel as maroon purple in color, had some slough on the wound bed and the edges were slightly macerated (softening of skin due to moisture). (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a concurrent interview and record review on 4/10/25 at 2:31 p.m., the Director of Nursing (DON) stated Resident 1 had a planned discharge on 4/1/25 to a lower level of care. On 4/2/25, Resident 1's Responsible Party (RP) came to the facility and informed DON and Administrator of Resident 1's wound on the left heel. The DON further stated when she did the investigation she spoke with the Unit Manager (UM) and the UM told the DON he was not able to conduct Resident 1's skin assessment. The UM further told the DON when [UM] went to Resident 1's room, Resident 1's RP informed UM [Resident 1] left the facility with a transport van at 3:30 p.m. The DON confirmed the UM did not have a documentation of his inability to conduct Resident 1's skin assessment on 4/1/25. The DON further confirmed the Discharge instruction form dated 3/31/25 under skin condition and management was blank. In a follow up interview on 4/10/25 at 4:45 p.m., the DON confirmed the facility did not follow their process of conducting a skin assessment prior to Resident 1's discharge. A review of the facility's policy and procedure revised December 2016 and titled, Discharging the Resident indicated, The purpose of this procedure is to provide guidelines for the discharge process .Assess and document resident's condition at discharge, including skin assessment .Report other information in accordance with facility policy and professional standards of practice. Based on observation, interview, and record review, the facility failed to ensure professional standards of care was provided for one of 4 sampled residents (Resident 1) when skin assessment (involves visual and tactile examination of the skin to identify potential issues such as change in skin color) was not conducted prior to resident's discharge. This failure to conduct skin assessment increased the potential for Resident 1 to not receive immediate treatment and prevent further skin breakdown. Findings: A review of the clinical record indicated Resident 1 was initially admitted December of 2023 with diagnoses including chronic venous hypertension with ulcer of bilateral lower extremities (persistent high blood pressure in the veins of both legs leading to open sores on the skin), lymphedema (swelling caused by buildup of fluid in the body's tissues often in the arms and legs), and type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 1's Discharge Instruction Form dated 3/31/25 did not contain information on the skin condition and management. Furthermore, Resident 1's Discharge Summary dated 4/1/25 did not indicate a skin assessment was conducted prior to discharge. In a concurrent observation and interview on 4/10/25 at 1:04 p.m., Resident 1 was sitting in his wheelchair with boots on both lower extremities. Resident 1 was able to state his first and last name. (continued on next page)

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