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	11/24/2025

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** Based on interview and record review, the facility failed to ensure physician orders were followed in accordance with professional standards of care and per facility policy for Resident 1, when Resident 1's physician ordered a CT scan (medical imaging technique used to obtain detailed internal images of the body) that was not implemented timely. This failure had the potential to negatively affect Resident 1's health and their ability to achieve their highest practical well-being by delaying ordered care. Findings:Resident 1 was admitted to the facility in January 2025 with multiple diagnoses which included traumatic hemorrhage of cerebrum (bleeding within the brain caused by a traumatic injury). A review of Minimum Data Set (MDS, an assessment tool), dated 7/2/25, indicated Resident 1 had severe cognitive impairment. A review of Resident 1's discharge document titled, SNF ORDERS, with faxed date of 1/8/2025, indicated, Lab/Imagining Orders.CT head without contrast in two weeks (around 1/20/2025).A Review of Resident 1's physician order, with order date 1/23/2025, indicated, Office Visit with: C T SCAN on 1/24/25.During an interview on 9/17/25, at 12:54 p.m., with the Director of Nursing (DON), the DON stated the expectation was for nursing staff to enter all orders and follow up appointments on day of admission for new admits. During a concurrent interview and record review on 9/17/25, at 2:20 p.m., with the Unit Secretary (US), the US reviewed Resident 1's admission documents and CT scan order summary. The US confirmed Resident 1 was admitted on [DATE] and had orders for a CT scan listed on his admission documents. The US further confirmed the CT scan order was not entered until 15 days after the admission date. The US stated the expectation was for the CT scan order to be entered on the day of admission. The US further stated she did not know why the CT scan order was entered late and not entering orders on time could potentially result in delayed care for residents.A review of the facility's policies and procedures (P&P) titled, admission Assessment and Follow Up: Role of the Nurse, revision date 9/12, indicated, .procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident.14. Contact outside services, such as laboratory or diagnostic services.

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