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	12/16/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to ensure safety for one of three sampled residents (Resident 1) when Resident 1 fell when alone and unsupervised outdoors. This failure resulted in Resident 1's fall and subsequent transfer to the acute care hospital for further evaluation. This evaluation indicated that Resident 1 had widespread bleeding on his head and later died in the hospital.Findings:A review of the admission Record indicated Resident 1 was admitted August of 2016 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness) following nontraumatic subarachnoid hemorrhage (bleeding into the spaces around the brain) affecting left dominant side and aphasia (a disorder that makes it difficult to speak) following cerebrovascular disease (loss of blood flow to a part of the brain). The Minimum Data Set (MDS- a standardized resident assessment tool) dated [DATE] indicated, Resident 1 had impairment (functional limitation that interfered with daily function) on both sides of upper extremities and required setup assistance (resident completes activity, helper assists only prior to or following the activity) once in a wheelchair to wheel at least 50 feet and make two turns and to wheel at least 150 feet in a corridor or similar space.Further review of Resident 1's clinical records indicated the following:-Care Plan, initiated [DATE] indicated, Resident 1 has confusion at times and impaired decision making per physician, diagnosis of anoxic brain injury (no oxygen in the brain causing brain cells to die) with cognitive dysfunction (impaired memory). The interventions included Provide cues and supervision as needed.;-Care Plan, initiated [DATE] indicated, Resident 1 had impaired vision and the intervention included Fall prevention/precaution per policy;-Care Plan, initiated [DATE] indicated, Resident 1 was at risk for falls, repeat falls with possible injuries due to impaired mobility, cognition (ability to think, learn, and understand) poor vision related to history of stroke (loss of blood flow to a part of the brain) , hypertension, and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) with neuropathy (numbness or weakness in the hands and feet) with contributing risk factors of cardiac (heart condition) and history of falls; and, -Care Plan, initiated [DATE] indicated, Resident 1 had impaired cognitive function/dementia (a progressive state of decline in mental abilities) or impaired thought processes. The interventions included to Cue, reorient and supervise as needed.During a review of Resident 1's Weekly Nursing Summary (WNS) dated [DATE], the WNS indicated, Resident 1 required supervision or touching assistance for LOCOMOTION ON [ability to move within the unit]/OFF Unit [ability to move to and from locations outside the unit such as outside the facility]- Wheel 50 feet with two turns; Wheel 150 feet. The WNS further indicated Resident 1 was alert/oriented with forgetfulness at baseline (usual or expected) and was able to self-propel around facility with little to no assistance and to continue with current plan of care. During a review of Resident 1's Social Services Note (SSN) dated [DATE], the SSN indicated, Resident 1 was alert and oriented x 3 (awareness to person, place, and time) and the 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 was 12/15 which indicated Resident 1 had moderate cognitive impairment (noticeable memory problem). The SS Note further indicated Resident 1 will remain in the facility due to Resident 1 requiring 24-hour care and supervision.During a review of Resident 1's Progress Note dated [DATE] indicated, [Resident1] had unwitnessed fall on 11/8 around 1120 AM in garden area between A wing & D wing.was found on floor on side walk [sic] on wheelchair with feet in air and back on sidewalk and head on the side walk [sic] and hit head on concrete sidewalk. [Resident 1] verbalized hitting head.Unable to assess any injuries due to resident stating pain and not medically safe to turn resident or get resident off ground.noted resident on floor when sitting out in patio during lunch.had BP [blood pressure] elevated 219/87 [normal BP is below 120/80]. 911 [emergency services] was called d/t [due to] medically not safe to transfer resident off sidewalk onto wheelchair.A review of Resident 1's Discharge Summary on [DATE] from the acute care hospital indicated the discharge diagnosis was Fall, initial encounter. The reason for admission indicated Resident 1 was status post (after or following) ground level fall (person's feet are on the same level as the ground before a fall) with diffuse intracranial hemorrhage (widespread bleeding inside the skull increasing the pressure in the brain, cutting off oxygen flow and causing cells to die) and was admitted for comfort care. Resident 1 passed away on [DATE] at 6:55 a.m. During a concurrent interview and record review with the Director of Nursing (DON) on [DATE] at 10:22 a.m., the DON showed the list of residents with incidences of falls for the past 2 months