

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 03/12/2026
NAME OF PROVIDER OR SUPPLIER Greenhaven Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>Based on interview and record review, the facility failed to allow one (Resident 1) out of four sampled residents to return to the facility after hospitalization. This failure resulted in the resident remaining in the hospital despite being medically stable for discharge and created the potential for the resident to have no safe discharge location once hospital-level care was no longer required. Findings: During a review of Resident 1's admission Record (AR), indicated, Resident 1 was admitted 4/2025 with the diagnosis including End Stage Renal Disease (ESRD- kidneys no longer work as they should to meet the body's needs), Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing.) During a review of interdisciplinary Note (IDT - shared record where different professionals [doctors, nurses, nurse practitioner, social worker] documents their findings together in one place) dated 2/18/26, indicated, .Left big toe infection. Suspected Osteomyelitis (osteomyelitis- inflammation of bone or bone marrow, usually due to infection). IDT recommended sending out Resident 1 to the Emergency department for further evaluation and treatment. During a review of Resident 1's admission Record, indicated a date of discharge 2/25/26 at 10:30 a.m., following expiration of a seven-day bed-hold period while the resident remained hospitalized . During a review of hospital case management correspondence records dated 3/9/26 at 11:22 a.m. indicated, . resident (Resident 1) was medically stable and ready to leave the hospital, and the hospital began planning for the resident to return to the facility. During a review of the intake notes from the complainant sent online to California Department of Health (CDPH) on 3/10/26 at 2:28 p.m. indicated, .Spoke with the facility administrator, and the facility is now refusing to readmit the patient [resident] after hospitalization, citing insurance lapse. During an interview on 3/12/26 at 12:30 p.m. with the Director of Nursing (DON), DON stated, the resident had some insurance issues that was why they did not take her back. DON stated, after 7-day bed hold dated 2/25/26, she was automatically discharged from the facility. DON further stated, there was no 30- day discharge notice, no Appeal Rights provided, and there was no discharge planning provided to the resident prior to hospitalization. The DON confirmed that Resident 1 was still considered a resident of the facility when she was transferred to the hospital. DON confirmed that the facility refused re-admission of Resident 1 due to insurance lapses. DON confirmed there was a bed available for Long Term care. During an interview on 3/12/26 at 1:45 p.m. with Admissions Coordinator (AC), the AC confirmed that the reason why she was not admitted was because of lack of insurance. During a review of the facility's policy and procedure titled, readmission to the Facility, dated 3/2017, indicated, .Residents who have been discharged to the hospital or for therapeutic leave will be given priority in readmission to the facility. 1) Resident whose hospitalization exceeds the bed hold period allowed by the state will be readmitted to the facility upon the first availability of a bed. if the resident requires the services provided by the facility. 4) readmission procedures apply equally to all residents regardless of race, color, creed, national origin, or payment source.</p>		

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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