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	04/02/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to implement a comprehensive person-centered care plan for one of three sampled residents (Resident 1) when a care plan for Resident 1's peripheral IV [(PIV) intravenous line-delivers fluids, medications or nutrients directly into a vein] was not developed. This failure had the potential to cause an increased risk of infection and bleeding.Findings:A review of Resident 1's clinical record indicated Resident 1 was admitted in January 2026 with multiple diagnoses which included atrial fibrillation (irregular heart rhythm), malignant neoplasm of esophagus (esophageal cancer), and Parkinson's Disease (progressive movement disorder of the nervous system).A review of Resident 1's Order Details dated 3/20/26 indicated, Place PIV for IV ATB [antibiotic] (medication to treat infection) one time only.A review of Resident 1's Order Details dated 3/20/26 for Ertapenem Sodium Injection Solution Reconstitutes 1 Gm [gram] (unit of measure) .Use 1 gram intravenously one time a day for UTI [urinary tract infection] for 7 days.During a telephone interview on 4/13/26 at 11:28 a.m. with the Director of Nursing (DON), the DON confirmed there was no IV care plan developed for Resident 1. The DON further stated she would expect there to be a care plan regarding the resident's IV.During a review of the facility's policy and procedure (P&P) titled, Goals and Objectives, Care Plans, with a revision date April 2009 indicated, Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence.1. Care plan goals and objectives are defined as the desired outcome for a specific resident problem.

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on interview and record review, the facility failed to ensure a peripheral IV (PIV- intravenous line-delivers fluids, medications or nutrients directly into a vein) for one of three sampled residents (Resident 1) was discontinued prior to being discharged from the facility. This failure had the potential for inadequate monitoring of Resident 1's PIV and could have resulted in an infection or bleeding for Resident 1.Findings:A review of Resident 1's clinical record indicated Resident 1 was admitted in January 2026 with multiple diagnoses which included atrial fibrillation (irregular heart rhythm), malignant neoplasm of esophagus (esophageal cancer), and Parkinson's Disease (progressive movement disorder of the nervous system).A review of Resident 1's Order Details dated 3/20/26 indicated, Place PIV for IV ATB [antibiotic] (medication to treat infection) one time only.A review of Resident 1's Order Details dated 3/20/26 for Ertapenem Sodium Injection Solution Reconstitutes 1 Gm [gram] (unit of measure) .Use 1 gram intravenously one time a day for UTI [urinary tract infection] for 7 days.During an interview on 4/2/26 at 10:29 a.m. with Licensed Nurse (LN) 1, LN 1 stated he did not know Resident 1 had an IV. LN 1 stated if he had known Resident 1 had an IV, he would have removed the IV before discharge. LN 1 further stated there was no physician's order to discontinue Resident 1's IV. LN 1 stated Resident 's 1 family called him, after being discharged , informing him that the resident still had an IV in her arm.During a concurrent interview and record review on 4/2/26 at 10:41 a.m. with the Director of Nursing (DON), Resident 1's clinical record was reviewed. The DON confirmed there was no documentation that Resident 1's PIV was discontinued prior to being discharged from the facility. During an interview on 4/2/26 at 12:12 p.m. with the DON, the DON stated she would expect Resident 2's PIV to be removed prior to being discharged . The DON further stated the PIV would be at risk for infection or becoming dislodged.During a review of the facility's policy and procedure (P&P) titled, Peripheral IV Catheter Removal, revised October 2024 indicated, The purpose of this procedure is to provide guidelines for safe, aseptic removal of a peripheral IV catheter.The following should be documented in the resident's medical record: 1. Date, time of procedure, and resident tolerance. 2. Location of catheter that was removed. 3. Reason for removal of catheter (end of treatment, complication, rotation of site, etc.). 4. Any complications and interventions taken. 5. Any communication with physician or oncoming shift.