

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/11/2026
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to eliminate accident hazards in the resident's environment for one of three sampled residents (Resident 1) when: Resident 1 sustained a hematoma (localized collection of pooled blood that gathers outside of a blood vessel, usually caused by injury, trauma, or surgery) after a chair was removed from the secure wall mount by a staff member and left leaning against Resident 1's room wall. Resident 1 later bumped into the chair, which then fell onto her left knee causing the accident. This failure resulted in an avoidable accident with a minor injury to Resident 1's left knee. According to the admission Record, the facility admitted Resident 1 in February 2022 with multiple diagnoses including heart failure and glaucoma (eye condition). Resident 1 was discharged in June 2026. A review of Resident 1's Change in Condition assessment dated [DATE] indicated, Resident 1 sustained a hematoma to her left knee after a chair hit her left knee in her room. A review of Resident 1's progress noted dated 5/11/26 indicated, Resident 1 reported the pain is worsening on her left knee. Resident 1 was sent to acute care hospital for treatment per physician order. During an interview on 6/11/26, at 11:14 a.m., with the Director of Nursing (DON) DON stated on 5/11/26 Resident 1 told one of the nurses a chair fell onto her left knee and it was painful. DON stated later that day Resident 1 was sent to the hospital after the pain was not resolved with an ice pack and Tylenol. DON stated the interdisciplinary team (IDT) did an investigation into the accident, and determined a staff member removed the chair from mount that day per the residents request and left it leaning against the wall. DON stated neither she nor any other staff were aware of Resident 1's request to keep the chair off the mount. DON stated Resident 1 is not strong enough to remove the chair from the secure wall mount, and that a staff member had to have removed it, and leaned it against the wall prior to the accident. A review of IDT Review of Change in Condition Incident dated 5/12/26 indicated, Res [Resident 1] stated that the chair leaning on the wall fell off and hit her Lt knee. Route Cause of Change in Condition/Incident: Folding chair fell and hit res Lt [left] knee. During an observation on 6/11/26, at 11:43 a.m, in the room Resident 1 resided in while she was admitted to the facility, with the DON, a wall mount was noted on the wall. The DON was observed to demonstrate the sturdiness of the mount, which held the chair and stayed on the mount after wiggling and bumping into it. The chairs used by the facility were observed to be foldable wooden chairs weighing approximately 5-6 pounds. During an interview on 6/11/26, at 3:13 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated she has taken care of Resident 1 many times before. CNA 1 stated Resident 1 would say no no no and point to the chair on the wall, then request staff remove the chair from the mount, and that she didn't want the chair near her side of the room on the mount. CNA 1 further stated there were no rules or procedures on what to do or not do with the chairs. CNA 1 stated the staff should not just leave the chair leaning against the wall because that is dangerous. A review of Resident 1's care plan reviewed on 6/11/25, care plan indicated no reference to Resident 1's preference of having the chair on off the secure mount, or that Resident 1 was educated on the risks of keeping the chair off the secure mount. Care plan did not instruct staff members to keep the chair off the secure mount prior to the accident. A review of Resident 1's (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress notes dated January 2026 to 6/9/26 indicated no reference from staff regarding Resident 1's preference to keep the chair off the secure mount, or any reference to staff educating resident on the risks of keeping the chair off the mount.		