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	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhaven Healthcare Center	455 Florin Road Sacramento, CA 95831

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 51078 Based on observation, interview, and record review, the facility failed to treat residents with dignity and respect, when staff referred to residents, who required assistance with eating, as feeders. This failure had the risk potential to minimize the residents self-worth and self-esteem. Findings: During an interview on 11/5/24 at 12:20 p.m. in the facility's dining room with Licensed Nurse (LN 3), LN 3 stated she was monitoring the dining room during lunch. LN 3 stated, The residents in the dining room are mostly independent but [we] do have some feeders. During an interview on 11/6/24 at 12:23 p.m. with Certified Nursing Assistant (CNA 9) during delivery of lunch trays to residents, CNA 9 stated, Two trays are for my isolation residents and one is for my feeder. When CNA 9 was asked to verify what she had stated, CNA 9 referred to one resident as my feeder. During an interview on 11/8/24 at 8:50 a.m. with the Director of Nursing (DON), the DON stated the expectation is that residents who require assistance with meals be referred to as assisted diners, not as feeders. A review of the facility's Policy and Procedure (P&P) titled Assistance with Meals, revised 3/22, indicated Residents shall receive assistance with meals in a manner that meets the individual needs of each resident . Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity . avoiding the use of labels when referring to residents (e.g. feeders) . A review of the facility's P&P titled Resident Rights, revised 2/21, indicated .Employees shall treat all residents with kindness, respect, and dignity .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 51078 Based on observation, interview, and record review, the facility failed to provide a homelike environment for one of 30 sampled residents (Resident 106) when the wall at the head of the bed was in disrepair. This failure had the potential to negatively impact Resident 106's psychosocial well-being. Findings: A review of the Admission Record for Resident 106 indicated diagnoses including history of stroke (a medical event that occurs when blood flow to the brain is disrupted, damaging brain tissue) and depression (a mental health disorder characterized by low mood or loss of interest in activities). A concurrent observation and interview was conducted on 11/5/24 at 10:33 a.m. inside Resident 106's room. There was a large hole on the wall above the bed measuring approximately 12 x 12 inches. Resident 106 stated the wall had been like that since he was admitted . A concurrent observation and interview on 11/5/24 at 3:41 p.m., Licensed Nurse (LN 6) verified there was a large hole in wall at the head of Resident 106's bed. LN 6 stated this should be fixed and it was not a good environment for the resident to see daily. An interview on 11/7/24 at 10:10 a.m., the Maintenance Supervisor (MS) stated maintenance concerns are written in the maintenance binder and addressed as soon as possible. The MS further stated the aesthetics of the facility is very important and the expectation was for residents to feel comfortable and for the facility to create a homelike environment for them. A record review of the Maintenance Log dated 7/9/24 to 11/7/24 indicated there was one request to fix the wall in Resident 106's room that was submitted on 7/25/24. No further requests were found for the repair of wall thereafter. A review of facility's Policy and Procedures titled Homelike Environment dated February 2021 indicated, Residents are provided with a homelike environment .the facility staff and management provides . characteristics that reflect a .homelike setting .this includes a clean and sanitary environment.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 43247 Based on observation, interview, and record review, the facility failed to protect one of 30 sampled residents (Resident 14) from abuse when Resident 93 inappropriately touched Resident 14's breast. This failure had the potential to result in Resident 14 experiencing discomfort and feeling unsafe in the facility. Findings: Resident 14 was admitted to the facility in October of 2024 with diagnoses that included: Cerebral infarction (condition that results in reduced blood flow to the brain) due to embolism (blood clot) of left middle cerebral artery, and aphasia (difficulty with speech). A review of Resident 93's Admission Record indicated Resident 93 was admitted to the facility in August 2022 with multiple diagnoses including multiple sclerosis (disease causing nerve damage disrupting communication between the brain and the body) and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction. A review of Resident 93's Minimum Data Set (MDS-federally mandated assessment tool), Cognitive Patterns, dated 9/4/24, indicated Resident 93 had a Brief Interview for Mental Status (BIMS-tool to assess cognition) score of 13 out of 15 that indicated he was cognitively intact. A review of Resident 93's Progress Note, dated 11/5/24 at 7:24 p.m., indicated, .Female Res [resident] in B wing made allegations of inappropriate touching apprx. [approximately] 5 days ago . A review of Resident 93's Progress Note, dated 11/5/24 at 7:45 p.m., indicated .Notified by unit manager that res is being accused of inappropriately touching another female res (B wing) on her breast about 5 days ago. Upon talking to res does not recall the incident and denies the accusation . A review of Resident 93's Progress Note, dated 11/5/24 at 8:43 p.m., indicated .Allegation of inappropriately touching towards a female resident that occurred about 5 days ago while he was in the lobby. SSD [Social Services Director] met with resident this evening regarding his involvement with the event. Resident denied this involvement and expressed that he was just talking to the receptionist and did not have any involvement with any female peers A review of Resident 93's Care Plan, initiated 3/20/24, revised 4/26/24, indicated . [Resident 93] has been making inappropriate/sexual comments/advances during the provision of care .Interventions .Monitor resident when he is with other residents ie [sic, namely] in common area, dining room, etc .Redirect resident and inform him that this inappropriate behavior is not acceptable . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 93's Care Plan, initiated 4/24/24, revised on 4/25/24, indicated .[Resident 93] is involved in a resident to resident, an event reported of being inappropriate towards a female peer. [Resident 93] attempts to lift/pull female peer's shirt .Interventions .Ensure resident is not left alone with any female residents .Monitor resident for inappropriate behaviors towards female residents . During an interview on 11/6/24 at 12:48 p.m. with Speech Therapist (ST), the ST stated on 11/5/24 Resident 14's Family Member (FM) notified her that Resident 14 told this FM that a male resident had touched her left breast 4 or 5 days ago while in the lobby. The ST stated that Resident 14 is minimally verbal and uses an electronic device to assist with communication. The ST stated she and Resident 14's FM took Resident 14 to D wing hallway and Resident 14 identified, by nodding vigorously, Resident 93 as the resident who touched her breast. The ST stated Resident 14 has difficulty communicating but is alert and oriented, and she does not doubt her account of incident. During an interview on 11/6/24 at 3:38 p.m., with Resident 14, Resident 14 nodded yes when asked if the incident with Resident 93 occurred. Resident 14 nodded yes when asked if the incident took place near the facility's outside court area. During an interview on 11/7/24 at 9:34 a.m. with Resident 93, Resident 93 stated he was in the lobby and said hello to the lady. Resident 93 stated the lady could not talk and just started making noise for no reason. During an interview on 11/7/24 at 9:42 a.m. with the Activities Assistant (AA), the AA stated Resident 93 has a history of inappropriate behavior. The AA stated if she sees Resident 93 approaching a female resident she stops him right away.The AA stated, Keeps an eye on him. During a concurrent interview and record review on 11/7/24 at 11:34 a.m. with the Social Services Director (SSD), the SSD stated the incident was reported to her on 11/5/24 by the ST. The SSD stated Resident 93 denied the incident. The SSD acknowledged Resident 93 had history of inappropriate behavior towards a female resident in April 2024 and was moved to B wing where there was more staff nearby to keep an eye on him. The SSD stated Resident 93 was then moved to D wing as he had not had any further incidents. The SSD acknowledged that D wing had less staff around to monitor Resident 93. Reviewed Resident 93's Care Plans that indicated Resident 93 was to be monitored in common areas and not to be left alone with any female residents. The SSD acknowledged that the Care Plans were not followed. A review of the facility's Policy and Procedure (P&P), titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/21, indicated .Residents have the right to be free from abuse .This includes but is not limited to freedom from . sexual or physical abuse .Protect residents from abuse . by anyone, including . other residents . Develop and implement policies and protocols to prevent and identify: .abuse or mistreatment of residents .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 51078 Based on interview and record review, the facility failed to ensure one of 30 sampled residents (Resident 79) received treatment and care in accordance with professional standards of practice when the licensed staff did not accurately document the BG (blood glucose is simple sugar- the body's primary source of energy from food) reading and notify the physician of BG readings below 100 as ordered for a total of 9 days. This failure had the potential to result in Resident 79's care being compromised, and necessary medication adjustments not being addressed. Findings: A review of the Admission Record for Resident 79 indicated he was admitted with a diagnoses including Type 2 Diabetes Mellitus (a disorder characterized by difficulty in blood sugar control). A Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/20/24 indicated Resident 79 was cognitively intact. A review of Resident 79's physician's order dated 11/16/23 indicated, . HOLD [medication] IF BG <100 AND NOTIFY MD [Medical Doctor]. A concurrent interview and record review was conducted on 11/7/24 at 1:29 p.m. with Licensed Nurse (LN 5). LN 5 confirmed Resident 79's BG reading in the MAR (medication administration records) on 11/1/24 was 29. The LN 5 stated this entry must be a documentation error and should have read 129. LN 5 confirmed he completed the MAR on 11/4/24 indicating BG 80 with note (Vitals Outside of Parameters for Administration). LN 5 further confirmed there was no documentation on 11/4/24 to notify physician of BG below 100. The LN 5 stated the expectation was to follow the physician orders. LN 5 stated the outcome of not communicating with physician and staff could result in them [physician and other staff] not being aware of BG issues and need for adjustment in medications, and patient care needs. A concurrent interview and record review was conducted on 11/7/24 at 2:27 p.m. with the Director of Nursing (DON). The DON confirmed Resident 79's BG reading on 11/1/24 indicated 29. DON confirmed the order indicated to notify physician of BG below 100. DON confirmed there were no progress notes indicating physician was notified of BG below 100 on 11/4, 11/1, 10/24, 10/21, 10/19, 10/14, 10/9, 10/7, 10/4, a total of 9 days. DON stated her expectation was for staff to follow physician orders, and to document accurately. DON further stated the result [of not following physician order and not charting accurately] could compromise resident care and potentially render unwarranted change of condition. A review of the facility's Policy and Procedure (P&P) titled Charting and Documentation dated July 2017, indicated The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .documentation will be complete and accurate .will include care specific details including notification of physician if indicated. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Nursing Practice Act, issued by the California Board of Registered Nursing, Article 2. Scope of Regulation 2725(b) The practice of nursing .means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill .direct and indirect patient care services that ensure the safety .and protection of patients . implementation of appropriate reporting .changes in treatment regimen in accordance with standardized procedures .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 49814 Based on observation, interview, and record review, the facility failed to promote and maintain ability to perform ADL's (Activities of Daily Living) for one of 30 sampled residents (Resident 348) when Resident 348 was not assisted to his wheelchair prior to meals. This failure had the potential to affect Resident 348's oral intake and ability to feed himself. Findings: Resident 348 was admitted to the facility in October of 2024 with diagnoses that included muscle weakness, lack of coordination, and unsteadiness on feet. A review of Resident 348's Minimum Data Set (MDS, an assessment tool), dated 11/4/24, indicated Resident 348 had no cognitive (ability to remember, think, and reason) impairment. A review of Resident 348's Physician Orders, dated 10/25/24, indicated, .PNA [Pneumonia, an infection of the lungs] Prevention: If not in conflict with Activity orders, Patient to be up in chair/wheelchair for all meals and 30 mins [minutes] after meals. During a concurrent observation and interview on 11/6/24 at 7:29 a.m., with Resident 348 and CNA 6 (Certified Nursing Assistant 6), Resident 348 was sitting up in his bed with his breakfast tray on his bedside table in front of him. Resident 348 indicated it was difficult for him to eat his food when he was sitting in bed due to the position of his arms relative to his meal tray. CNA 6 confirmed Resident 348 was not sitting up in his wheelchair. During a concurrent observation and interview on 11/6/24 at 7:32 a.m., with Licensed Nurse (LN 9), outside Resident 348's room, LN 9 stated, [Resident 348] needs assistance with tray set up and sitting up. LN 9 confirmed Resident 348 had experienced recent weight loss and indicated that positioning during meals had the potential to affect his food intake. LN 9 also indicated Resident 348 should be up in his wheelchair for meals. During the interview with LN 9, Resident 348 repeatedly asked two staff members to sit him up in his wheelchair and he was ignored. During an interview on 11/6/24 at 10:04 a.m., with the Director of Rehabilitation (DOR), the DOR stated, Repositioning has been put in [for Resident 348] as a CNA task and they should be repositioning and offering [Resident 348] to sit or be repositioned. The DOR indicated that assisting Resident 348 to his wheelchair was usually a task the rehabilitation department performs but the CNA staff should also be offering and assisting Resident 348 to his wheelchair. During an interview on 11/7/24 at 10:04 a.m., with the Registered Dietitian (RD), the RD indicated that not assisting Resident 348 to his wheelchair and positioning him so he has an easier time feeding himself could affect his food intake. The RD then stated, Staff should be positioning him and sitting him up to encourage him to eat. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, dated 2018, the P&P indicated, Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs) .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with . mobility (transfer and ambulation, including walking) .dining (meals and snacks).

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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. 36681 Based on observation, interview, and record review, the facility failed to ensure there was coordination of care for one of 30 sampled residents (Resident 66) when Resident 66's ulcer [shallow lesion, center was yellowish with redness on the border] on the tongue area was not communicated to the physician. This failure increased the potential for Resident 66 to experience pain and discomfort due to lack of coordination with care. Findings: A review of Resident 66's Admission Record indicated a diagnoses including encounter for palliative care (focuses on providing relief from pain and other symptoms of a serious illness). A review of Resident 66's clinical records indicated a care plan for open area on left lateral side of tongue dated 9/8/24 and a care plan for Hospice (a program that provides comfort, pain relief, emotional support and help with everyday tasks) services dated 10/11/24. A review of Resident 66's Treatment Administration Record (TAR) for September and October 2024 indicated a clobetasol cream (steroid, reduce redness and swelling) treatment for the tongue ulcer was started on 9/10/24 and discontinued on 10/10/24. A review of Resident 66's NURSE PROGRESS NOTE dated 10/29/24 at 22:32 [10:32 p.m.] indicated, [Resident 66] notified nurse that she has a sore on the left side of her tongue and its [sic] bothering her and wants the doctor to look at it. This nurse looked inside [Resident 66] mouth and noticed a small bump on . left side of tongue . Endorsed to noc [night] shift nurse. There was no documented evidence in Resident 66's clinical records the physician was notified of the said ulcer from 10/30/24 to 11/7/24. The Nurse Practitioner visit note dated 11/6/24 indicated Resident 66 was alert and oriented. The physical exam did not include the ulcer on the left side of the tongue. In a concurrent observation and interview on 11/5/24 at 10:18 a.m., Resident 66 stated she had a sore on her tongue. Resident 66 was able to stick out her tongue and there was an ulcer on left side of her tongue. Resident 66 further stated she told a staff and the staff told her she was going to inform the physician. In a follow-up observation and interview on 11/7/24 at 1:24 p.m., Resident 66 was lying in bed and stated the sore on her tongue still hurts. Resident 66 further stated she had the sore on her tongue about 6 weeks ago. Resident 66 stated she was receiving treatment 6 weeks ago and the treatment was discontinued. Resident 66 added the sore on her tongue was not healed even though the treatment had been discontinued. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/7/24 at 1:57 p.m., Certified Nursing Assistant (CNA 3) stated Resident 66 was alert and oriented. The CNA 3 further stated Resident 66 complained the sore on her tongue was hurting last Sunday (11/3/24) and the CNA 3 informed the nurse. In an interview on 11/7/24 at 2:14 p.m., the Licensed Nurse (LN 4) stated Resident 66 was alert and oriented x 4 [fully alert to person, place, time and event]. The LN 4 further stated Resident 66 took all her medications and she did not complain of pain. In a concurrent interview and record review on 11/7/24 at 2:20 p.m., the LN 4 confirmed there was a nursing progress note dated 10/29/24 regarding Resident 66's sore on the left side of her tongue. The LN 4 further confirmed there was no follow-up note regarding the sore. The LN 4 stated the nurse who received the complaint from Resident 66 should have notified the physician and hospice. In a concurrent interview and record review on 11/8/24 at 11:34 a.m., the Director of Nursing (DON) confirmed Resident 66 notified the registry nurse she had a sore on the left side of her tongue on 10/29/24. The DON stated her expectation was for licensed nurse to notify the physician and hospice as part of the coordination of care. The facility was unable to provide documented evidence the physician and/or hospice was notified of Resident 66's ulcer on the left side of her tongue from 10/29/24 to 11/7/24.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 43247 Based on observation, interview, and record review, the facility failed to ensure the orders and the care plan for use of a left hand splint were clear and documented in a consistent manner for one of thirty sampled resident's (Resident 97). This failure had the potential for Resident 97's left hand splint to be used incorrectly causing further loss of function. Findings: A review of Resident 97's Admission Record indicated Resident 97 was admitted to the facility in December 2022 with diagnosis of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on side of the body) affecting the left side due to cerebral infarction (stroke- disrupted blood flow to the brain causing brain tissue death). A review of Resident 97's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 9/23/24, indicated Resident 97 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 4 out of 15 that indicated Resident 97 was severely cognitively impaired. A review of Resident 97's Order Summary Report indicated order dated 5/22/24, RNA [restorative nurse assistant] to don resting hand splint 7 days a week, for 7 hrs [hours] a day A review of Resident 97's Order Summary Report indicated order dated 7/11/24, Left resting hand splint: Apply hand splint to left hand/wrist in the morning and leave on for 4-5 hours as tolerated .two times/day . A review of Resident 97's Task Reports for RNA- Splint/ Brace Assist and CNA (certified nursing assistant) (If RNA is unavailable)- Splint/ Brace Assist, 10/10/24 to 11/7/24, indicated splint was applied daily but did not indicate length of time splint was applied. A review of Resident 97's Care Plan, revised 6/20/24, indicated Focus Restorative Nursing: Resident has limited mobility and needs to be encouraged to stay active .Goal Reduce risk for worsening contractures/maintain ROM [range of motion] .Patient will tolerate resting hand splint on Lt [left] wrist and hand 7 hrs a day 7 days a week .Interventions RNA to don and doff resting hand splint 7 days a week, for up to 7 hrs a day, as tolerated .Date Initiated: 05/22/2024 . During a concurrent observation and telephone interview on 11/7/24 at 9:43 a.m. with Resident 97's Family Member (FM), observed Resident 97 did not have left hand splint on. The FM stated she had seen hand splint on resident occasionally. The FM stated it is put on by the CNA but not sure when it is put on or for how long. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/7/24 at 10:03 a.m. with CNA 5, CNA 5 stated she tried to place Resident 97's splint earlier today, but he did not want it so she removed it and will try to place again later. CNA 5 stated she is not sure how long the splint is applied for each day because it is removed during the PM (afternoon) shift. During an interview on 11/8/24 at 8:51 a.m. with the Director of Nursing (DON), reviewed Resident 97's two orders for left hand splint. The DON acknowledged that the orders were conflicting and confusing. The DON stated the RNAs are managed by the Director of Staff Development (DSD). During an interview on 11/8/24 at 8:59 a.m. with the DSD, reviewed Resident 97's two orders for left hand splint. The DSD acknowledged that the two orders were conflicting. Reviewed with the DSD that Resident 97's Care Plan indicated left hand splint to be placed 7 hours a day. The DSD stated the RNAs follow the care plans for their orders. The DSD stated that the RNAs are applying Resident 97's splint for 7 hours a day according to the care plan. The DSD acknowledged that Resident 97's Task Reports, 10/10/24 to 11/7/24, did not indicate how long the left splint was worn daily. During an interview on 11/8/24 at 9:10 a.m. with RNA 1, RNA 1 stated that the the RNA receives instructions from therapy when resident is discharged from therapy services. RNA 1 stated if there are any discrepancies in orders, the RNA will clarify the order with the DSD. RNA 1 stated the RNAs use the care plan, not the orders, to know what care to provide. During a telephone interview on 11/8/24 at 9:58 a.m. with RNA 2, RNA 2 stated Resident 97 has order for left hand splint for 7 hours a day, 7 days a week. RNA 2 stated she applies the splint approximately 1:30 p.m. to 2:00 p.m. and it is removed by the PM (afternoon) CNA. RNA 2 stated the CNA is supposed to remove the splint after 7 hours. RNA 2 acknowledged she does not know how long the splint is worn since it is not documented. RNA 2 stated that the order used is from the Care Plan, indicating apply for 7 hours a day. RNA was not aware that there was an updated order on 7/11/24 indicating applying splint for 4 to 5 hours a day. RNA 2 stated she had not seen that order in the electronic chart. A review of the facility's Policy and Procedure (P&P) titled Resident Mobility and Range of Motion, revised 7/17, indicated .The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed .The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion . Interventions may include therapies, the provision of necessary equipment, and/or exercises .The care plan will include the type, frequency, and duration of interventions .Documentation of the resident's progress toward the goals and objectives will include attempts to address any changes or decline in the resident's condition or needs . A review of the facility's P&P titled Restorative Nursing Services, revised 7/17, indicated Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care . Restorative goals may include .adjusting or adapting to changing abilities .

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	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43247 Based on observation, interview, and record review, the facility failed to document glucometer (machine to measure how much sugar is in the blood) calibration (ensures glucometer is working properly). This failure had the potential for residents' glucose readings to be inaccurate causing errors in residents' blood glucose management. Findings: A review of Unit C, Glucose Machine 2, Quality Control Record Blood Glucose Monitoring System, for September 2024 , indicated only six entries for the month. A review of Unit C, Glucose Machine 3, Quality Control Record Blood Glucose Monitoring System, for September 2024, indicated only six entries for the month. During an interview on 11/6/24 at 8:58 a.m. with Licensed Nurse (LN) 4, reviewed the glucose machine monitoring logs for glucose machine 2 and glucose machine 3 for September 2024. LN 4 confirmed that entries were missing for September 2024 for both machines. LN 4 stated the expectation is that the NOC (night) shift nurse checks the glucose machine calibration every day. LN 4 stated, If not checked we won't be getting the correct blood sugar readings. During an interview on 11/6/24 at 9:20 a.m. with the Infection Preventionist (IP), the IP stated glucose machines are checked every night. The IP stated, If it's not checked, we don't know if it's functioning right and accurate. If it's not documented, we don't know if it's done properly. During an interview on 11/6/24 at 9:32 a.m. with the Assistant Director of Nursing (ADON), reviewed the glucose machine monitoring logs for glucose machine 2 and glucose machine 3 for September 2024. The ADON acknowledged missing entries on the glucose machine monitoring logs. The ADON stated, The results might not be accurate if not checked. If not documented, we're not sure if it's really checked or not. A review of the facility's Policy and Procedure (P&P) titled Glucometer Calibration, revised 9/24, indicated . Calibration of glucometer system will be completed daily by the licensed nurse on the night shift . Logs of calibration checks are monitored monthly by the Director of Nursing or the Unit Manager to check for the accuracy and compliance with daily testing .

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	555098	A. Building B. Wing	11/08/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36681 Based on observation, interview, and record review, the facility failed to ensure two of 30 sampled residents (Resident 18 and Resident 117) were free of unnecessary psychotropic medications (drugs that affects behavior, mood, thoughts or perception) when residents were prescribed antipsychotic medication without adequate indication and target behaviors. These failures resulted in the use of unnecessary psychotropic medications that could cause adverse consequences. Findings: 1. A review of the Admission Record indicated Resident 18 was admitted with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and major depressive disorder (loss of interest in activities causing significant impairment in daily life). A review of Resident 18's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/15/24, indicated Resident 18 had severe cognitive impairment, had no verbal or physical behaviors directed toward others, and had no behaviors of rejection of care. A review of Resident 18's physician order dated 9/9/24 indicated, Seroquel (antipsychotic) 50 mg (milligram, unit of measure) 2 tablets (100 mg) by mouth 2 times a day (given at 9 a.m. and 2 p.m.) and Seroquel 100 mg 1.5 tablet [150 mg] by mouth at bedtime (given at 9 p.m.) for disturbed thought process r/t [related to] dementia. A review of Resident 18's care plan initiated 9/9/24 indicated, Resident 18 uses antipsychotic medication Seroquel r/t Alzheimer's. The interventions included, Provide non-pharmacological interventions for psychotic disorder . allow time for listening to concerns, reality orientation, redirection, validation, words of encouragement, positive and calm environment . A review of Resident 18's Medication Administration Record (MAR) for September, October, and November 2024 did not include non-pharmacologic interventions. Resident 18 had 1 documented episode of disturbed thought process from 9/9/24 to 10/22/24, and no documented aggressive behavior toward staff from 10/22/24 to 11/7/24. A review of Resident 18's Psychiatry consult, dated 9/8/24, indicated no psychosis and denies SI/HI [suicidal ideation/homicidal ideation]. A review of Resident 18's Physician Visit Note dated 9/17/24 indicated, .needs redirection often but no agitation. In an observation on 11/5/24 at 12:18 p.m., Resident 18 was quietly sitting in her wheelchair, in front of the nurses station. (continued on next page)

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	555098	A. Building B. Wing	11/08/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 11/6/24 at 8:22 a.m., Resident 18 was up in her wheelchair inside her room and a staff member was assisting her with breakfast. In an observation on 11/7/24 at 7:19 a.m., Resident 18 was up in her wheelchair inside her room. Resident was unable to state her name, the resident stated yes when she was asked if she ate. In an interview on 11/7/24 at 7:55 a.m., Certified Nursing Assistant (CNA 4) stated Resident 18 was a calm lady, she had no behaviors, and she was not resistive to care. The CNA 4 further stated resident was sitting at the edge of the bed this morning and she verbalized wanting to pee, resident refused to stand up and said no when CNA 4 offered to take resident to the bathroom. The CNA 4 added she offered to take resident to the bathroom [ROOM NUMBER] minutes later and resident said no. In a telephone interview on 11/7/24 at 10:28 a.m., the Pharmacy Consultant (PC) stated Resident 18 was ordered Seroquel for dementia with psychotic features. The PC further stated Seroquel can be used for behavioral and psychological symptoms of dementia (BPSD), and BPSD was similar with psychotic features. In a follow up interview on 11/7/24 at 1:37 p.m., the CNA 4 stated Resident 18 had no episodes of being physically aggressive to staff or other residents. In an interview and record review on 11/7/24 at 2:33 p.m., Licensed Nurse 5 (LN 5) stated resident is alert and confused. The LN 5 further stated Resident 18 was on Seroquel 100 mg twice a day and Seroquel 150 mg at bedtime. The LN 5 added Resident 18's behavior was mostly refusal of care, she would not let anybody help her, resident was a fall risk and sometimes she would wander out of her wheelchair. In an interview on 11/8/24 at 11:47 a.m., the Medical Doctor (MD 1) stated she did the admission notes for Resident 18. The MD 1 further stated at the time she assessed Resident 18; the Seroquel was appropriate for her. The MD 1 believed Resident 18 had psychosis, and she had been taking the Seroquel for a long time. The MD 1 stated she reviewed the progress notes from the Psychiatrist and she discussed plan with resident's daughter. The MD 1 provided the clinical document which indicated resident was on Seroquel since 2015. 2. A review of the Admission Record indicated Resident 117 was admitted with diagnoses including encounter for palliative care (focuses on providing relief from pain and symptoms of a serious illness) and dementia (a progressive state of decline in mental abilities) without behavioral disturbance. A review of Resident 117's MDS dated [DATE] indicated Resident 117 had severe cognitive impairment, had no verbal or physical behaviors directed toward others, and had no behaviors of rejection of care. A review of Resident 117's physician order dated 9/10/24 indicated, Seroquel 25 mg 1 tablet by mouth every 24 hours as needed for disturbed thought process M/B [manifested by] behavioral disturbances. The Seroquel order was changed on 9/13/24 to 25 mg, 1 tablet by mouth at bedtime for disturbed thought process M/B inability to sleep. (continued on next page)

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	555098	A. Building B. Wing	11/08/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 117's care plan initiated 9/16/24 indicated, Resident 117 uses antipsychotic medication Seroquel for dementia with behaviors m/b aggressiveness towards others. The interventions included, Provide non-pharmacological interventions for psychotic disorder . allow time for listening to concerns, reality orientation, redirection, validation, words of encouragement, positive and calm environment . A review of Resident 117's Physician History & Physical dated 9/12/24 indicated, Resident 117 was transferred to skilled nursing facility under hospice care (compassionate care for people who are near the end of life). The Assessment indicated, .Dementia- on Seroquel . A review of Resident 117's Medication Administration Record (MAR) for September, October, and November of 2024 did not include non-pharmacologic interventions. Resident 117 was not provided with Seroquel as needed from 9/10 to 9/12/24 and the routine Seroquel 25 mg at bedtime was started on 9/13/24. There were 4 episodes of disturbed thought process which occurred after resident was started on the routine Seroquel. The target behavior for the use of Seroquel was changed to restlessness on 9/30/24, resident had 12 documented episodes of restlessness from 9/30 to 10/26/24. On 10/26/24 the target behavior was changed to aggressiveness towards staff, resident had no documented episodes of aggressiveness from 10/26 to 11/7/24. In an observation on 11/5/24 at 11:05 a.m., Resident 117 was lying in bed, he did not verbally respond when his name was called. In an observation on 11/5/24 at 12:52 p.m., Resident 117 was outside his room, resident smiled when his name was called. In a telephone interview on 11/7/24 at 10:41 a.m., the PC stated Seroquel can be used for BPSD and she used clinical pharmacology (study of drugs) as a reference. The PC further stated she made the recommendation in September to review with Resident 117's physician to clarify the diagnosis/indication for use as disturbed thought process may not be specific enough of a diagnosis and the use of antipsychotic for inability to sleep may not be appropriate. The PC added if the Seroquel was used for BPSD m/b aggressiveness this could be appropriate for this medication. In an interview on 11/7/24 at 1:51 p.m., Certified Nursing Assistant (CNA 3) stated Resident 117 was nonverbal, the staff communicated with resident by body language and facial expression. The CNA 3 further stated resident will start taking off his pants when he wanted to use the bathroom. The CNA 3 added sometimes Resident 117 was agitated and he will not sit in his wheelchair, he had episodes of walking in his room and sometimes in the nurses station. The CNA 3 further added Resident 117 was not combative when redirected. In an observation on 11/7/24 at 1:57 p.m., Resident 117 was up in his wheelchair facing the nurses station, resident was smiling. The CNA 3 confirmed the observation and stated Resident 117 just smiles. In an interview on 11/7/24 at 2:42 p.m., Licensed Nurse (LN 5) confirmed Resident 117 was receiving Seroquel in the evening. The LN 5 stated Resident 117 had challenging behavior first couple of weeks, putting himself on the floor. The LN 5 further stated the hospice requested for the Seroquel since Resident 117 had behaviors. (continued on next page)

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	555098	A. Building B. Wing	11/08/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/8/24 at 11:16 a.m., the Nurse Consultant (NC) confirmed Resident 117 had no behaviors before the Seroquel was changed to routinely at bedtime on 9/13/24. A review of the facility's policy revised July 2022 and titled, Antipsychotic Medication Use indicated, . Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective .The attending physician will identify, evaluate and document .symptoms that may warrant the use of antipsychotic medications .Residents who are admitted .who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use .Diagnoses alone do not warrant the use of antipsychotic medications .antipsychotic medications will .only be considered if the following conditions are also met .behavioral symptoms present a danger to the resident or others .multiple non-pharmacological approaches have been attempted, but did not relieve the symptoms . A review of DailyMed (a nationally recognized drug reference), indicated Seroquel is used for the treatment of Schizophrenia (mental health condition that affects how people think, feel, and behave), Bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). The boxed warning (signifies the drug carries a significant risk of serious or even life-threatening adverse effects) indicated, Seroquel is not approved for the treatment of patients with dementia-related psychosis.

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	555098	A. Building B. Wing	11/08/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49814 Based on observation, interview, and record review, the facility failed to implement their medication storage policy when expired medications were not removed from a medication cart. These failures had the potential for residents to receive medications with unsafe and reduced potency from being used past their discard date. Findings: A review of the Fluticasone Propionate/Salmeterol (drugs to aide in breathing) manufacturer box indicated to discard the product one month after opening. During a concurrent observation and interview on 11/7/24 at 2:38 p.m., with Licensed Nurse 10 (LN 10), in the A wing of the facility, an expired medication bottle of 4 milligram (mg, a unit of measurement) glucose (sugar) tablets with an expiration date of 10/16/24 and a Fluticasone Propionate/Salmeterol inhaler 250 micrograms (mcg, a unit of measurement)/50 mcg with an opened date of 8/31/24 were found in medication cart one. LN 10 confirmed the glucose tablets were expired and the inhaler was expired with an opened date of 8/31/24. LN 10 indicated medications can lose effectiveness if they are past the expired date or past the manufacturers use by date. During an interview on 11/7/24 at 2:46 p.m., with the Director of Nursing (DON) and Nurse Consultant (NC), the DON indicated inhalers should be dated when they are opened and confirmed the inhaler with an opened date of 8/31/24 was expired. The DON then stated, Expired medications should not be in the cart and nurses should go through their cart once a month and toss out expired medications. During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, dated 11/20, the P&P indicated, Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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	555098	A. Building B. Wing	11/08/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38834 Based on observation, interview, and record review, the facility failed to ensure the food served to the residents was maintained at a proper temperature and was palatable when: 1. The kitchen staff did not calibrate (ensure they worked properly) thermometers used to measure food temperature during tray line (meal tray assembly); 2. Milk on residents' trays was not at acceptable holding temperature; 3. Resident 19's tray was evaluated and had menu items not at the proper temperature and not palatable; and 4. Resident 75, Resident 53, Resident 77, Resident 86, and Resident 107 complained of cold food. These failures had the potential to cause food poisoning after residents consumed milk that was not at proper temperature, resulted in dissatisfaction with meals for Resident 75, Resident 53, Resident 77, Resident 86, and Resident 107 with the potential for decreased food intake leading to weight loss and nutritional deficiencies. Findings: 1. During an initial tour of the kitchen on 11/5/24 commencing at 8:15 a.m., Dietary Director (DD) stated the kitchen staff performed the calibration of the thermometers used to measure food temperature periodically. The DD was not able to provide a date when the last time the calibration of thermometers was done and stated there was no documentation of thermometers calibration. A review of the facility's policy titled, Thermometer Use and Calibration, dated 2023, indicated, Food thermometers are to be used properly and calibrated to ensure accurate temperature reading. During an interview with Registered Dietician (RD) on 11/8/24, at 9:50 a.m., RD stated, I was made aware [by DD] that there is no records . the facility calibrated thermometers . Expectation [is] that kitchen staff calibrate thermometers at least weekly .Very important step to make sure the thermometers are working properly so when the staff tests food temperature, the hot food is hot and cold food is cold. 2. On 11/6/24, at 12:25 p.m., during an observation of the lunch tray line service, two glasses of milk were checked for proper holding temperature with the following results: glass of milk placed on a resident's tray cart waiting for delivery to Unit C was 46 degrees F (Fahrenheit) and a 2nd glass of milk on the tray cart was 43 degrees F. The DD acknowledged that the milk temperatures were out of acceptable range and discarded the milk. The DD added that per facility's policies and procedures, the milk served to residents should be at 40 degrees F or below. On 11/6/24, at 12:47 p.m., another glass of milk held on the tray waiting to be placed on a food cart was checked and was at 43 degrees F. (continued on next page)

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	555098	A. Building B. Wing	11/08/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled, Meal Service, dated 2023, indicated, Meals .will be served in an accurate and efficient manner, and served at the appropriate temperatures .Cold food item will be placed on the trays as close as possible to assure the temperature is below 41 F. During an interview with the RD on 11/8/24, at 9:50 a.m., the RD acknowledged that milk was potentially hazardous food and stated it should be at 40-41 degrees F. The RD agreed that milk served above the recommended temperature could cause food poisoning. 3. During an observation on 11/6/24, at 1:28 p.m., the temperature of the food from last tray ready to be delivered to Resident 19 on Unit D was checked. Resident 19's tray contained pureed meatballs, rice, carrot, bread, and milk. The recorded temperature for meatballs was 102 degrees F, carrot and bread were at 100 and 97 degrees F, and the milk was 53 degrees F. The DD acknowledged that the food that was supposed to be hot was not at acceptable temperature and was not palatable. The DD stated the milk was not at acceptable temperature and should not be served to the resident. The DD explained that the hot food had to leave the kitchen at 140 degrees F in order to be palatable and acknowledged that the food temperatures were not checked when the tray line was completed. During an interview with the RD on 11/8/24, at 9:50 a.m., the RD stated her expectation was that food temperatures were checked prior to leaving the kitchen to make sure the hot food was hot and cold food was cold and the food was appetizing and palatable. 4a. During a group resident council meeting on 11/6/24, commencing at 10:27 a.m., seven residents in attendance complained that cold food was served all the time, especially for breakfast and lunch. The residents stated that kitchen staff and facility's management were aware of issues with cold food but ignored their complaints by not addressing the issue. 4b. On 11/6/24, at 1:20 p.m., an observation of the dining area lunch meal service on Unit D was conducted accompanied by DD. Resident 75 and Resident 53 were sitting at the table with open trays. Both residents were not eating and stated the food was cold. Resident 75 stated that their food being delivered cold has been an ongoing problem. Resident 75 explained, They bring our trays here and [the trays are] sitting here in front of us. We are ready to eat, already sitting by the table, but they won't serve until the last cart to [Hall D] arrives . By the time the 2nd cart arrives, and they start serving food, the food is already cold. Resident 75 stated if the staff was busy the wait was longer and the food was served cold. When Resident 75 was asked if the staff offered to warm up their food, the resident replied, You're kidding me. We need a microwave to be able to warm up our food, but there is none. Resident 53, who was sitting at the same table, nodded her head while Resident 75 was talking and added, Every day, all the time our food is cold .We are eating it because we are hungry, but it's not appetizing to eat cold food. A review of the facility's policy titled, Meal Service, dated 2023, indicated, Meals .will be served in an accurate and efficient manner, and served at the appropriate temperatures .Temperature of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot. The policy indicated the recommended temperature at delivery to resident for milk was less than or equal to 45 F and for hot entree and vegetables was greater than or equal to 120 F. 43247 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4c. A review of Resident 77's Admission Record, indicated Resident 77 was admitted to the facility in August 2023 with multiple diagnoses including congestive heart failure (heart does not pump blood as well as it should), diabetes (too much sugar in the blood) and anxiety disorder (mental health disorder characterized by fear or dread out of proportion to the situation). A review of Resident 77's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 8/12/24, indicated Resident 77 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 13 out of 15 that indicated Resident 77 was cognitively intact. During an interview on 11/6/24 at 9:31 a.m. with Resident 77, Resident 77 stated food was cold night before last. A review of Resident 86's Admission Record, indicated Resident 86 was admitted to the facility in June 2023 with multiple diagnoses including chronic obstructive pulmonary disease (lung disease that blocks airflow), fibromyalgia (chronic condition that causes pain and tenderness throughout the body) and diabetes. A review of Resident 86's MDS, Cognitive Patterns, dated 9/14/24, indicated Resident 86 had a BIMS score of 15 out of 15 that indicated Resident 86 was cognitively intact. During an interview on 11/5/24 at 8:33 a.m. with Resident 86, Resident 86 stated food is often cold. Resident 86 stated staff used to be able to heat up food if it was cold, but the microwave was removed and staff has to go somewhere else to heat it up. During a follow up interview on 11/5/24 at 1:15 p.m. with Resident 86, Resident 86 stated lunch was warm today. Resident 86 stated this was the first time food was warm. Resident 86 stated food yesterday was cold. A review of Resident 107's Admission Record, indicated Resident 107 was admitted to the facility in January 2024 with multiple diagnoses including atrial fibrillation (an irregular rapid heart rate), diabetes, and congestive heart failure. A review of Resident 107's MDS, Cognitive Patterns, dated 8/31/24, indicated Resident 107 had a BIMS score of 15 out of 15 that indicated Resident 107 was cognitively intact. During an interview on 11/5/24 at 8:33 a.m. with Resident 107, Resident 107 stated food is either lukewarm or cold. Resident 107 stated there is no longer a microwave to heat up cold food. Resident 107 stated, Want hot food hot, cold food cold. During an interview on 11/7/24 at 9:57 a.m. with Certified Nursing Assistant (CAN 8), CNA 8 stated residents have complained about cold food. CNA 8 stated they no longer have a microwave to heat up food and have to go to the kitchen to warm up food. During an interview on 11/7/24 at 9:59 a.m. with Licensed Nurse (LN 8), LN 8 stated residents have complained of cold food. LN 8 stated had received a lot of complaints about cold food since microwave was removed. LN 8 stated that staff had to go to the kitchen to heat up food. LN 8 stated there is no specific meal that residents did not complain of cold food. (continued on next page)

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	555098	A. Building B. Wing	11/08/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Policy and Procedure (P&P) titled Meal Service, dated 2023, indicated . Meals that meet the nutritional needs of the resident will be served in an accurate and efficient manner, and served at the appropriate temperatures Temperature of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot . A review of the facility's P&P titled Assistance with Meals, revised 3/22, indicated .Hot foods shall be held at a temperature of 135 degrees or above until served .Nursing and dietary services will establish procedures such that delivery of food to serving areas accommodates this requirement .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 38834 Based on observation, interview, and record review, the facility failed to ensure the recipe for the preparation of pureed bread rolls was followed for 25 residents, who had chewing or swallowing difficulties and were on pureed diet (texture-modified, pudding like consistency), when the pureed bread served to residents was observed dry and lumpy. This failure had the potential to result in chewing difficulties and increase residents' risks for choking and/or aspiration (a condition in which food is breathed into the airway). Findings: A review of the facility's document titled, Recipe: Pureed Breads .Sweet Rolls .and Other Bread Products, dated 3/17, directed kitchen staff to measure out the number of portions needed, and then to puree it on low speed adding milk gradually, as needed to achieve the desired consistency. The recipe indicated further, Puree should reach a consistency of apple sauce. During a concurrent interview and observation of the preparation of pureed food on 11/6/24, commencing at 11 a.m., [NAME] 1 stated 25 residents received pureed diet from the kitchen due to their health conditions. During an observation of the process of pureeing bread rolls on 11/6/24, at 11:20 a.m., [NAME] 1 crumbled 25 bread rolls into small pieces, placed them into a food processor, added 1.5 cup of warm milk, and pureed on low speed. During the process, [NAME] 1 added additional 2 cups of milk and pureed the mixture again. The pureed bread looked thick and dry, but without testing the mixture for correct consistency and without tasting it, the [NAME] 1 placed the pureed bread into metal container and placed the container into the oven to keep warm. A concurrent observation and interview regarding pureed bread rolls consistency was conducted with the Dietary Director (DD) on 11/6/24, at 12:40 p.m. The DD acknowledged that the pureed bread was too thick, too dry, with lumpy texture and was not the applesauce consistency. The DD stated the pureed bread texture should have been a smooth consistency. A review of the facility's 'Standardized Recipes' policy, with the revision date of 4/2007, indicated, Standardized recipes shall be developed and used in preparation of foods. During an interview with the Registered Dietician (RD) on 11/8/24, commencing at 9:50 a.m., the RD stated that pureed bread rolls had to be properly pureed with enough liquid to achieve the right consistency. The RD explained that if pureed bread looked dry and clumpy, the staff should have added more liquid. The RD added, The main reason residents are prescribed pureed diet was because they have issues with swallowing and are at risk for aspiration .If the food is not right consistency, it could be dangerous and could place residents at risk for aspiration.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49814 Based on interview and record review, the facility failed to ensure one resident (Resident 49) of 30 sampled residents' records were accurate when Resident 49's admission assessment note did not reflect Resident 49's health status. This failure had the potential to result in Resident 49 receiving care not suited to their health status. Findings: Resident 49 was admitted to the facility in October of 2024 with diagnoses that included: Infection following a procedure, other surgical site, and Sepsis. A review of Resident 49's Admission Nursing Note ([NAME]), dated 11/5/24, indicated, SKIN ASSESSMENT SHOWED OPEN AREA 0.5CM [centimeters, a unit of measurement] X 0.5 TO COCCYX [tailbone] .PICC [peripherally inserted central catheter, a device inserted into the bloodstream to give medications and take blood samples] LINE TO RUA [right upper arm], SURGICAL SITE TO POSTERIOR RT [right] HIP 19.8CM WITH 23 STAPLES. During an observation on 11/6/24 at 12:35 p.m., Resident 49 was lying in his bed wearing a gown that allowed visual inspection of his upper arms. Resident 49 did not have a PICC line to either arm. During a concurrent interview and record review on 11/7/24 at 8:22 a.m., with Licensed Nurse 2 (LN 2), Resident 49's Admission Nursing Note, dated 11/5/24 was reviewed. The [NAME] indicated Resident 49 had a PICC line to his right upper arm. LN 2 confirmed Resident 49 currently did not have a PICC line and confirmed the [NAME] did not accurately reflect Resident 49's status. During an interview on 11/7/24 at 8:29 a.m., with LN 3, LN 3 stated, [Resident 49] has a right hip incision that is open to air. We are just monitoring it. [Resident 49's] coccyx wound has resolved. [Resident 49's] hip incision doesn't currently have staples. LN 3 confirmed the [NAME] from 11/5/24 contained outdated and inaccurate information regarding Resident 49's wounds. During an interview on 11/7/24 at 2:46 p.m., with the Director of Nursing (DON) and the Nurse Consultant (NC), the DON stated, I expect notes to be accurate. The DON also indicated inaccurate documentation could potentially give staff false information to base their care off. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 7/17, the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 49814 Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI, a data-driven proactive approach to improve quality of care and life for nursing home residents) Committee met with the required members for a census of 134, when the Medical Director (MED) did not attend the QAA meetings. This failure had the potential to negatively impact the quality of care for residents. Findings: A review of the facility's QAPI monthly meeting sign in sheets ranging from 11/2023 to 10/2024 indicated that the MED or their designee were not present during these meetings. During an interview on 11/8/24 at 1:39 p.m., with the Administrator (ADM) and Director of Nursing (DON), the DON stated, The Medical Director doesn't usually make it. The DON confirmed that the MED did not attend the QAPI meeting in October of 2024 or the last QAPI quarter meeting. The ADM indicated that the attendance of the MED is important to help guide health care decisions in the facility. During a review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership, dated 3/20, the P&P indicated, The following individuals serve on the committee .Medical Director.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49814 Based on observation, interview, and record review, the facility failed to follow proper infection control practices for four (Resident 349, Resident 97, Resident 79, and Resident 13) of 30 sampled residents when: 1. A Certified Nursing Assistant (CNA) did not don a gown when performing resident care; 2. Resident 97's enteral feeding pump (pump used to deliver liquid nutrition into the digestive tract) and pole (used to hold pump up) had brown crusted material; 3. Resident 79's CPAP (continuous positive airway pressure/a breathing machine designed to increase the air pressure, keeping the airway open when the person breathes) nasal face mask was not cleaned as ordered, and; 4. A BiPAP mask (bilevel positive airway pressure, a machine that delivers air through a mask to help person with breathing) hazy from condensation, was observed inside the plastic bag on the nightstand of Resident 13. These failures had the potential to increase the spread of infection among residents. Findings: 1. Resident 349 was admitted to the facility in October of 2024 with diagnoses that included: Hemiplegia (paralysis of one side of the body) and Hemiparesis (weakness on one side of the body) following cerebral infarction (decreased blood to the brain) affecting left non-dominant side, and need for assistance with personal care. A review of Resident 349's Care Plan (CP), dated 10/23/24, indicated, Resident requires Enhanced Barrier Precautions r/t [related to] presence of wounds .Implement enhanced barrier precautions (gown, gloves) when providing high risk care activities: dressing; bathing/showering; transferring; providing hygiene; changing linens; changing briefs or assisting with toileting; During a concurrent observation and interview on 11/5/24 at 12:02 p.m., with CNA 7, the CNA was observed changing Resident 349's soiled brief without wearing a gown. CNA 7 confirmed he was not wearing a gown while performing direct resident care for a resident on EBP and indicated that a gown is required to prevent the spread of germs and diseases. During an interview on 11/7/24 at 11:52 a.m., with the Infection Preventionist, the IP stated, The purpose for EBP is due to the increase in MDRO [multi drug resistant organisms] infections and there are certain residents that are more susceptible to getting MDRO infections. The IP then indicated that any staff performing direct resident care for a resident on EBP would need to wear a gown and doing so would help to prevent the spread of infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 6/24, the P&P indicated, Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include .changing briefs or assisting with toileting. 43247 2. A review of Resident 97's Admission Record indicated he was admitted to the facility in December 2022 with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction and dysphagia (difficulty swallowing). A review of Resident 97's Enteral Feed Order, ordered 1/9/24, indicated . Enteral Feed Order two times a day 90 ml [milliliters]/ hr [hour] for 10 hours via PEG [Percutaneous Endoscopic Gastrostomy -feeding tube inserted through the abdominal wall into stomach] . A review of Resident 97's Care Plan, dated 12/19/23, indicated .[Resident 97] requires tube feeding for nutrition support due to: Dysphagia .Interventions .Provide tube feeding as ordered . During an observation on 11/5/24 at 8:33 a.m. of Resident 97's enteral feeding pump, observed multiple brown crusted spots on pump and pole. The pump and pole appeared very soiled. During a concurrent observation and interview on 11/5/24 at 9:51 a.m. with Licensed Nurse (LN 8), observed Resident 97's enteral feeding pump and pole. LN 8 stated, Pump is very dirty. Should be cleaned. LN 8 further stated, Dirty pump increases risk of infection. Can cause contamination of tube feeding formula or lines. A review of the facility's Policy & Procedure (P&P) titled Infection Prevention and Control Program, revised 10/18, indicated . An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . Important facets of infection prevention include: .educating staff and ensuring that they adhere to proper techniques and procedures . Review of facility's P&P titled Homelike Environment, revised 2/21, indicated .The facility staff and management provides .the characteristics of the facility that reflect a personalized homelike setting. These characteristics may include: .Clean and sanitary environment . 51078 3. A review of Resident 79's Admission Record indicated a diagnosis of sleep apnea (a sleep disorder that causes breathing to repeatedly stop or become very shallow during sleep). A Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/20/24 indicated Resident 79 was cognitively intact. A concurrent observation and interview was conducted on 11/5/24 at 1:28 p.m. in Resident 79's room. A CPAP nasal mask in a large bag on top of the machine had residue around nasal padding area with light brown/white discoloration. Resident 79 stated he had never seen staff clean the mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A concurrent observation, interview, and record review was conducted on 11/5/24 at 3:43 p.m. with Licensed Nurse (LN 6) in Resident 79's room. LN 6 confirmed the nasal facemask looks dirty and he did not clean the face mask at any time during his shift on 11/4/24. LN 6 further confirmed there was a physician order to clean nosepiece once a day and let air dry. LN 6 further stated not cleaning mask daily could lead to respiratory infection or bacterial growth. In an interview on 11/6/24 at 8:58 a.m., the Licensed Nurse (LN 7) stated he did not wash/clean facemask yesterday or at the start of his shift today. LN 7 further stated if the mask was not properly cleaned it would place resident at risk for infection. In a concurrent observation and interview on 11/6/24 at 1:05 p.m., LN 7 confirmed the face mask had not been cleaned and left to air dry. In a concurrent interview and record review on 11/7/24 at 11:41 a.m., the Infection Preventionist (IP) stated the expectation was for staff to follow physician orders for Resident 79. IP further stated the possible outcome could be bacterial infection to resident. A review of the facility's Policies and Procedures (P&P) titled CPAP/BiPAP Support revised March 2015 indicated, masks, nasal pillows .clean daily by placing in warm soapy water and soaking and agitating for 5 minutes .rinse with warm water and allow to air dry between uses. A review of manufacturers cleaning recommendations for the CPAP machine dated 2022 reads clean daily with mild soap and water .must be handwashed to avoid damage and harmful residue. 38834 4. According to the Admission Record, the facility admitted Resident 13 in 2017 with diagnoses including atrial fibrillation (an irregular, rapid heart rate that causes poor blood flow, leading to shortness of breath). A review of the most recent quarterly MDS, dated [DATE] indicated that Resident 13 was cognitively intact. A review of the 'Altered respiratory status' care plan dated 7/23/24 indicated Resident 13 required the use of BiPAP machine. One of the interventions indicated, BiPAP SETTINGS and care maintenance: per MD [medical doctor] orders. A review of Resident 13's clinical records, had no documented evidence how the resident's BiPAP machine and mask were maintained and when they were cleaned. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 11/5/24, at 4:20 p.m., Resident 13 was in her room, sitting on the edge of the bed. During an interview, Resident 13 stated she did not sleep well at night due to having shallow breathing and her breathing would stop for a few seconds at night. Resident 13 stated she used the BiPAP machine to help with breathing every night. Resident 13 pointed to the BiPAP machine on her nightstand and added, I can't live without it. On every evening and off in the morning. Resident 13's BiPAP machine mask and coiled tube were observed in a plastic bag on the nightstand. The bag had a handwritten date of 10/22. The mask inside the bag looked hazy and had some condensation. When the resident was asked how often the nurses cleaned her breathing mask, Resident 13 stated, Not cleaned for a few weeks. Resident 13 added that 10/22/24 was the date her nurse cleaned the mask. During an interview and record review on 11/5/24, at 4:40 p.m., LN 1 stated that BiPAP mask was supposed to be cleaned with soap and water every morning after morning shift nurses removed it from the resident and before they put the mask in the bag. LN 1 stated reviewed Resident 13's Medication Administration Records (MARs) and was unable to see the documentation that the resident's mask was cleaned. On 11/6/24 at 4:45 p.m., a joint observation of the mask and tubing were conducted with LN 1 in Resident 13's room. LN 1 validated that the mask did not look clean and stated it was unknown when the mask was cleaned. LN 1 stated the staff was supposed to replace plastic bags holding the mask every week. A review of the facility's policy titled, CPAP/BiPAP Support, dated 3/15, indicated, Purpose: To provide spontaneously breathing resident with positive airway pressure .To improve oxygenation .To promote resident comfort and safety .General Guidelines for Cleaning .Clean daily by placing in a warm, soapy water and soaking/agitating for 5 minutes. Mild detergent is recommended. Rinse with warm water and allow air dry between uses. During an interview and record review with Nurse Consultant (NC) on 11/7/24, at 10:40 a.m., the NC stated that nurses were to clean the mask after each use. The NC added, Should be cleaned by morning shift nurses when the mask is removed and before it's placed in the bag . Once a week [nurses] need to clean the machine, take filter out and rinse . Must be documented .every day . reflected on MARs that it was done. Upon reviewing Resident 13's clinical records, the NC was unable to identify when the resident's BiPAP mask was cleaned and there was no physician's order pertaining to mask cleaning until 11/5/24. The NC validated that Resident 13's MARs reflected that the nurses started cleaning and documenting BiPAP mask's cleaning on 11/6/24.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 43247 Based on observation, interview, and record review, the facility failed to provide a safe environment when a raised round plate was loose with a large center bolt extending above the plate in the center of the floor of the resident hallway. This failure had the potential for residents to trip and fall in the hallway with resulting injury. Findings: During a concurrent observation and interview on 11/5/24 at 3:38 p.m. with Licensed Nurse (LN 12), observed in the center of the floor in D wing hallway an, approximately, 6 inch diameter loose round plate with large bolt extending from the plate. LN 12 pulled up on the plate and the bolt and was able to pull off the plate. Observed drain underneath. LN 12 acknowledged that the plate and bolt are a trip hazard for residents. During a concurrent observation and interview on 11/5/24 at 3:41 p.m. with the Maintenance Assistant (MA), observed the 6 inch loose round plate with large bolt extending from the plate in the center of D wing hallway. The MA stated the drain underneath the plate is used to clean out clogs in the pipes. The MA acknowledged that it is a hazard to the residents and will have it fixed. A review of the facility Policy and Procedure (P&P) titled Maintenance Service, revised 12/09, indicated . Maintenance service shall be provided to all areas of the building, grounds, and equipment . The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .Functions of the maintenance personnel include maintaining the building in good repair and free from hazards .