STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055858	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rancho Seco Care Center	144 F Street Galt, CA 95632

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45718 Based on observation, interview, and record review, the facility failed to protect the Resident's rights to be free from abuse for 1 of 3 sampled residents (Resident 1) when Resident 1's daughter witnessed Resident 2 throwing urine and feces at Resident 1. This failure resulted in Resident 1 abused by Resident 2 with the potential for Resident 1 to develop infection and emotional distress. Findings: A review of Resident 1 ' s admission record indicated he was admitted to the facility winter of 2024 with multiple diagnoses that included Chronic Osteomyelitis (infection in the bone), left ankle and foot. A review of Resident 1 ' s Minimum Data Set (MDS, an assessment tool), dated 5/27/24, indicated, he was cognitively intact. A review of Resident 1 ' s care plan, initiated, 8/19/24 indicated, The resident was the victim in a resident-to-resident altercation without injury on 8/19/2024 . A review of Resident 1 ' s SBAR [Situation, Background, Assessment, Recommendation] Communication form dated, 8/18/24, indicated, [Resident 1 ' s] neighbor [Resident 2] threw urine and feces on him and on floor . A review of Resident 2 ' s admission record indicated he was admitted to the facility summer of 2024 with multiple diagnoses that abscess of right foot. Resident 2 was discharged from the facility 8/21/24. A review of Resident 2 ' s MDS, dated [DATE], indicated, he was cognitively intact. His Behavior assessment indicated he exhibited verbal behavioral symptoms directed toward others. A review of Resident 2 ' s care plan, initiated 8/19/24, indicated, Resident had a res[resident]-to-resident altercation in which he threw on his next door neighbor urine and feces mixed . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2's Social Services Progress notes, dated 8/22/24, indicated, SSD [Social Service Director] spoke with resident regarding incident occurring 8/18 involving another resident. [Resident 2] states that he was very frustrated because he felt the other resident was smearing feces on a shared toilet on purpose. He also stated that he understood that it was wrong, and I shouldn't have done it. I should have called someone to clean it up. [Resident 2] stated that he was also upset because the other resident would often open the bathroom door when he was using it. He knows I am in there, but he still opens the door . During a concurrent observation and interview on 8/22/24 at 11:30 a.m., Resident 1 was in his room, sitting on his wheelchair. Resident 1 stated, He [Resident 2] tried to hit me and dumped his urine on me .it was water and toilet paper. The water went to my pants and the other stuff spilled on the floor by the door. It made me feel angry .He threatened to beat me when I was in the toilet, and it was in front of my daughter .It was embarrassing . During a telephone interview on 8/22/24 at 12:12 p.m., Resident 1 ' s Daughter (RD) stated she was with her father (Resident 1) when the incident happened. The RD stated, Resident 2 came to her father ' s room through the toilet, and he started yelling, saying there was a mess in the toilet. The RD stated, Resident 2 then took a plastic pan .with nasty pee water and toilet paper from the toilet. She stated, It had pee in it and maybe poop .something nasty in it .then I saw him throwing it on my dad, he poured it on him, it got it on his pants, shirt and his arm .I just feel bad for my dad . During a telephone interview on 8/22/24 at 12:20 p.m., the Licensed Nurse (LN) stated, Resident 1 ' s daughter approached the LN and reported that Resident 2 started yelling at Resident 1 and threw urine and feces at him. The LN stated, when she went to the room, there was urine and feces by the door. The LN further stated, I saw Resident 1 was wet with what Resident 2 had thrown at him and Resident 2 was upset yelling and was swearing, Resident 2 said it was an ongoing situation he [resident 1] uses the bathroom and leaves it dirty . During a telephone interview on 8/22/24 at 12:43 p.m., the Certified Nursing Assistant (CNA) stated, she was in another room when she heard the commotion and saw the nurses were in Resident 1 ' s room. The CNA stated the floor was wet and had dirty toilet paper. The CNA further stated, I saw [Resident1], his clothes were wet, and I helped him changed his clothes .shirt and the shorts were wet .it smelled like urine. The CNA stated, I heard [Resident 2] swearing, saying bad words to [Resident 1] .He said Fuck you . During an interview on 8/22/24 at 12:56 p.m., the Infection Preventionist Nurse (IP) verified the incident happened when Resident 1 ' s daughter was with him. The IP stated, All residents should be free from abuse .It [incident] should have not happened .we can prevent it from happening again . A review of Facility policy titled, Abuse Prevention Program, revised December 2016, indicated, Our residents have the right to be free from abuse . This includes but is not limited to freedom from .verbal, mental, .or physical abuse . As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including .other residents .