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	10/11/2024

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 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. 38834 Based on observation and interview, the facility failed to promote and maintain dignity and respect for one of three sampled residents (Resident 1) when the resident waited for 38 minutes to be assisted with feeding. This failure had the risk potential to minimize Resident 1's self-esteem and self-worth. Findings: A review of the facility ' s undated ' Promoting /Maintaining Resident Dignity During Mealtimes, ' policy, indicated, It is the practice of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhances his or her quality of life, recognizing each resident ' s individuality and protecting the rights of each resident .All staff members involved in providing feeding assistance promote and maintain resident dignity during mealtimes. A review of Admission Record indicated the facility admitted Resident 1 in 2023 with multiple diagnoses which included dysphagia (difficulty in swallowing) and Huntington ' s disease (a disorder that causes nerve cells in the brain to die leading to problems with movement, behavior, and communication). A review of Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/5/24 indicated that Resident 1 ' s cognition was severely impaired. A review of the physician progress notes dated 9/28/24 indicated that Resident 1 was alert, nonverbal and was dependent on staff for all activities of daily living (ADLs- routine tasks, such as bathing, dressing, toileting, feeding, any activities person performs daily to care for themselves). (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a meal observation in the dining room on 10/10/24 at 11:45 a.m., 40 to 50 residents were observed eating their lunch. Several residents were done eating their lunch and were observed leaving the dining room. Two of the staff were observed offering coffee and drinks to residents, and collecting the meal trays. Resident 1 was observed sitting in his wheelchair in the right corner of the dining room next to the table. A female resident seated at the same table had finished eating her lunch. Resident 1 ' s lunch tray was on the table untouched. Resident 1 was noted lifting his head as he watched other residents eating, and stared at his food in front of him. Resident 1 smiled but did not respond when the Department attempted to talk to him. During a concurrent observation and interview on 10/10/24 at 11:46 a.m., a Certified Nursing Assistant (CNA 2) was observed collecting the trays and placing them inside the food cart. CNA 2 stated that lunch was served around 11:20 a.m. CNA 2 stated more staff came and helped to serve residents ' trays and then they left to pass trays and assist residents with feeding in their rooms. CNA 2 stated there were two CNAs assisting residents with feeding. CNA 2 acknowledged that close to 10 residents had already eaten their lunch and left. CNA 2 validated that Resident 1 have not had his lunch yet and stated that he had not attempted to assist him because he was collecting trays. CNA 2 stated, I am about to feed him. CNA 2 stated, He [Resident 1] should be eating at the same time. It is not okay that he is sitting and watching others eating. I should have assisted him with feeding as soon as I passed trays. During a continued observation on 10/10/24 at 11:50 a.m., CNA 2 continued collecting trays. Resident 1 was offered his first bite of food at 11:58 a.m., 38 minutes after the lunch trays were served and after about half of the residents left the dining room. A review of the facility ' s policy titled, Dignity, with the revision date of 2/17, indicated, Residents are treated with dignity and respect at all times .The facility culture supports dignity and respect for residents .When assisting with care, residents .provided with dignified dining experience .Staff are expected to treat cognitively impaired residents with dignity . During an interview with the Director of Nursing (DON) on 10/10/24 commencing at 12:15 p.m., the DON stated that a resident should not have to wait longer than 10-15 minutes before they were fed their food. The DON stated it was her expectation the Resident 1 was assisted with feeding at the same time other residents at the same table were eating. It was inappropriate to let the resident sit at the table and watch other residents eating.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38834 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2), who had a known history of constipation, received treatment for bowel management as ordered by the physician and, failed to notify the physician when the resident had no bowel movement for 6 days. This failure resulted in Resident 2 experiencing abdominal pain, discomfort, was upset, frustrated and visibly shaken from inability to open his bowels. Findings: A review of Admission Record indicated the facility admitted Resident 2 in the summer of 2024 with multiple diagnoses which included diabetes (a disorder characterized by difficulty in blood sugar control), kidney disease with dependence on dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine) and below knee amputation A review of Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/14/24 indicated Resident 2 had intact cognition (ability to think, understand, and remember). The MDS further indicated Resident 2 was occasionally incontinent (having little or no control) for bowel movements. A review of Resident 2 ' s physician ' s Order Recap for the months of September and October 2024 indicated an order for Colace (a stool softener) and Senokot (laxative). In addition, Resident 2 ' s clinical records contained the following physician orders for bowel care dated 8/1/24: 1. Milk of Magnesia (MOM, (a medication used for a short time to treat to occasional constipation) oral suspension, give 30 ml (milliliters, unit of measurement for medication dosage) as needed for constipation if no bowel movement in 3 days; 2. Lactulose 20 gram/30 milliliters (units of measurement for medication dosage), 10 ml by mouth as needed for bowel care, daily; 3. Dulcolax rectal suppository (a medication in a solid, cone-shaped form that is inserted into the rectum where it dissolves) 10 mg every 24 hours as needed, if MOM is not effective and no BM (bowel movements) for 8 hours and, 4. Enema rectal 1 application as needed for bowel care if MOM and Dulcolax suppository are ineffective and no bowel movement in 8 hours. If no results from MOM, Dulcolax suppository, and enema, call physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 2 ' s care plan initiated on 8/11/24 indicated the resident was at risk for constipation due to impaired mobility, kidney disease, and side-effects of medication. The care plan ' s goal for Resident 2 indicated, The resident will have a normal bowel movement at least every (3) day through the review date . Target Date 11/14/24. The interventions included, to administer medications as ordered, record bowel movement pattern each day, describe amount. color and consistency of stool, monitor/document/report as needed signs and symptoms] of complications related to constipation, including change in mental status, slow, low pulse, abdominal distension, vomiting, bowel sounds, diaphoresis, abdominal tenderness, rigidity, fecal impaction, and keep physician informed of any problems. During a tour of Hall 2 on 10/10/24 at 10:23 a.m., a crying voice was heard from the last room in the hall calling loudly, Nurse .nurse, CNA .I need help . At 10:25 a.m., Licensed Nurse (LN 1) and CNA 1 entered Resident 2 ' s room, and the resident cried out, Help me please. I am very constipated .Please, help me to unclog my bowel. I need an enema . I am about to die due to pain .I can ' t eat or drink, can ' t take my pain medication because it will clog me even more. LN 1 explained to the resident that he did not have a physician order for the enema. Resident 2 started moaning and groaning while he continued complaining of abdominal pain and being constipated. In a loud voice Resident 2 added, Send me to the hospital, they can give enema like they did last time I went there. LN 1 continuously insisted that she was not able to administer enema because he had no physician order. During an observation and interview on 10/10/24 at 10:40 a.m., Resident 2 was observed sitting at the edge of the bed while his Certified Nursing Assistant was assisting him with attaching his left leg prosthesis (artificial limb). The resident ' s face was noted red and he was in visible distress. Resident 2 stated, I need an enema, I am unable to poop for 5 days. I ' m freaking out, feeling so full, hurting bad, afraid to take pain medications. I don ' t know what to do . nobody is listening to me and nobody helps me. During an interview and record review on 10/10/24 at 10:45 a.m., LN 1 validated that Resident 2 had history of constipation. Upon reviewing Resident 2 ' s orders, LN 1 acknowledged that since admission, the resident had multiple medications prescribed by the physician ' as needed for bowel management, ' including order for enema, Lactulose and Dulcolax suppository. LN 1 confirmed that Resident 2 received none of the ' as needed ' laxatives recently. LN 1 stated, Yes, I ' ve told the resident earlier today that he has no enema or MOM ordered. I was not aware that he has them ordered. This was before I checked his orders. I shouldn ' t say that. LN 1 added that she would have to contact a physician if the resident requested laxatives and they were not prescribed. LN 1 reviewed Resident 2 ' s flow sheet and acknowledged that the resident had no bowel movement since 10/4/24, for six (6) days. LN 1 stated that earlier this morning the resident received the stool softener and another laxative that were ordered to be given twice a day, and added, He definitely needs something stronger than stool softener and Senokot. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up observation and interview on 10/10/24 at 12 p.m., in Resident 2 ' s room, the resident was laying in bed and his lunch tray was sitting on the table untouched. Resident 2 ' s face was reddened and he grimaced and pointed to his food. Resident 2 stated, I can ' t eat, can ' t even have one bite. I ' m so uncomfortable, my abdomen is hard as a rock. I am diabetic, I know that I ' m supposed to eat because my blood sugar can drop, but I just can ' t. Resident 2 stated he was on the toilet for over 40 minutes and added, A small brick came out but I am still so full. Resident 2 stated that he has been having issues with constipation and explained that in September he was sent to ED because he was unable to urinate and to have a bowel movement. The resident stated that he begged nurses to give him an enema but they insisted that he had no order from physician. During a continued interview on 10/10/24 at 12 p.m., Resident 2 stated, I have told my nurses multiple times that I ' m constipated; in the last 2-3 days I asked [them] to give me the enema but they won ' t .They come, listen .and leave. The resident stated that because he felt lots of pain and was so uncomfortable, he had been refusing to go to dialysis and added, I have told them but nobody listens .They [nurses] .blame me for not wanting to go to dialysis. I just can ' t go when I ' m so uncomfortable and my abdomen is bloated and full, almost exploding. How am I going to sit in that chair for 4 hours .I ' m not going to dialysis in that condition. I shouldn ' t be mortified in public facility. During a follow up interview in Resident 2 ' s room with Director of Nursing (DON) present, on 10/10/24 at 12:15 p.m., Resident 2 stated, I need an enema to clean me out. I was on the toilet for more than half an hour and was able to get a small blob out, but still very uncomfortable and in a lot of belly pain .my stomach is hard and .full . I can ' t eat .I can ' t go to dialysis . It happened several times and the last time I had to go to the hospital to get the enema .I have asked several nurses to help me and they kept saying that I can ' t get the enema because it ' s not prescribed by physician .Everyone says the same . not prescribed . During an interview and record review with the DON on 10/10/24 at 12:40 p.m., the DON acknowledged the resident had no BM for 6 days. The DON was unable to find any progress note addressing the resident ' s constipation issue. The DON reviewed Resident 2 ' s medications list and stated that the resident had been prescribed multiple laxatives, including enema, lactulose, and MOM ' as needed ' . The DON validated that no ' as needed ' laxatives were administered, and there was no physician notification regarding Resident 2 ' s issues with constipation. The DON acknowledged that per food intake flowsheet, Resident 2 did not eat meals served and last meal eaten was dinner on 10/8/24. During a continued interview and record review on 10/10/24 at 12:40 p.m., the DON confirmed that dealing with constipation was an ongoing issue for Resident 2 in September 2024. The DON verified that there were multiple days when the resident had no bowel movement in September and the resident was not offered enema or Lactulose ordered to be given as needed. The DON acknowledged that the resident was not offered and was not administered enema or Lactulose during the entire month of September. The DON stated that the resident had change in condition on 9/21/24 at 4 p.m. and was sent to ED with excruciating abdominal pain and validated that his discharge diagnosis was constipation and inability to urinate. The DON stated it was her expectation the licensed nurses monitored Resident 2 ' s bowel movements every shift and if no BM in 2 days, they administered ' as needed ' laxatives ordered by the physician. The DON added, This should not have happened, and the resident should not be in so much pain due to constipation. The DON verified that the resident ' s ' at risk for constipation ' care plan was not followed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility ' s ' Bowel (Lower Gastrointestinal Tract Disorders-Clinical Protocol, ' with last revision date of 9/17, indicated that the staff and physician will identify residents with previously identified lower gastrointestinal tract conditions and symptoms and will identify risk factors related to bowel dysfunction, including alteration in bowel movements. The policy indicated, The staff and physician will monitor the individual ' s response to interventions and overall progress; for example, overall degree of comfort and distress , frequency and consistency of bowel movements, and the frequency, severity and duration of abdominal pain.