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	06/19/2025

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** Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 1 and Resident 2) in a census of 95 were free from abuse when Resident 2 hit Resident 1 with a wooden and metal reacher. This failure increased the potential for physical injury and psychosocial distress. Findings: Resident 1 was admitted to the facility in the fall of 2024 with multiple diagnoses which included dementia (a general term for impaired thinking, remembering, or reasoning that can affect a person's ability to function safely), abnormality of gait and mobility, visual loss, depression and anxiety. During a review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 6/4/25, the MDS indicated Resident 1 had severe memory impairment. During a review of Resident 1's nurses notes (NN), dated 6/16/25, the NN indicated Resident had an altercation with roommate. She lost balance and fell across room mate's bed and room mate [Resident 2] started hitting her in the face with a stick. Resident 2 was admitted to the facility in the fall of 2024 with multiple diagnoses which included abnormalities of gait and mobility. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was alert and oriented, able to make her needs known. During a review of Resident 2's SBAR [Situation, Background, Assessment, Recommendation] Communication Form, dated 6/16/25, indicated Resident had an altercation with roommate [Resident 1] which resulted with alleged abuse. Resident admitted to striking room mate across the face with a stick. This resident [Resident 2] received a skin tear to the right elbow. (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	During a concurrent observation and interview on 6/19/25 at 6:19 a.m. with Resident 2, a wooden reacher with metal claw on one end and a metal hook on the other end was laying on the bedside table within reach. Resident 2 was asked about the 6/16/25 incident with her former roommate and said she didn't remember the incident but I think they [Resident 1] accidentally fell on me and I pushed them [Resident 1] off. I was half asleep and can't tell you how it happened. When asked about whether she used the reacher, Resident 2 indicated she didn't remember taking the reacher and hitting anyone. I don't remember getting in a fight with anyone. During a concurrent observation and interview on 6/19/25 at 7:06 a.m. with Resident 1, Resident 1 was asked about the 6/16/25 incident with her roommate. Resident 1 stated I do remember [Resident 2] grabbed a stick .It's kind of hard to remember if [Resident 2] was in the bed or the chair when it happened. I called out 'She's hitting me.' She's done it before, but I didn't report it .The stick hit me on one side of my face [pointed to the left upper cheek .]. When she grabbed the stick, I said 'You're not going to do that again.' [Resident 2] said, 'I'll do that again!' She said she's going to defend herself . During an interview on 6/19/25 at 7:48 a.m. with Certified Nurse's Assistant (CNA) 3, CNA 3 was asked about the resident-to-resident altercation on 6/16/25 and said, That day .I heard a commotion. I went into [Resident 1 and 2's room] and found [Resident 1] was laying at the foot of [Resident 2's] bed. [Resident 1] was trying to stop [Resident 2] who had a stick in her hand. I saw [Resident 2] hitting [Resident 1] with the stick. [Resident 2] had blood on her arm like a small scratch. [Resident 2] was the one with the stick. [Resident 1] .was trying to push the stick and [Resident 2] away . [Resident 2] said she felt [Resident 1] on top of her feet and she was startled and grabbed the stick and started hitting the person laying on her feet with it .They were like fist fighting but it was more like [Resident 1] was trying to keep [Resident 2] from hitting her face .They were both upset that night . During an interview on 6/19/25 at 8:32 a.m. with the Director of Nurses (DON), the DON was asked her expectations and said, Abuse is never OK . During a review of the facility policy and procedure (P&P) titled Abuse Prevention Program, revised 12/16, the P&P indicated Our residents have the right to be free from abuse .This includes but is not limited to freedom from .physical abuse .Abuse is defined as the willful infliction of injury .with resulting physical harm . As a part of the resident abuse prevention, the administration will .Protect our residents from abuse by anyone including .other residents .