

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055858	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2025
NAME OF PROVIDER OR SUPPLIER Rancho Seco Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>Based on observation, interview, and record review, the facility failed to provide care in a manner that promoted dignity and respect for one of four sampled residents (Resident 1) when Resident 1 was observed spitting in hallways and was reported to open his bowels on the facility patio.</p> <p>This failure had the potential to minimize Resident 1's self esteem and to negatively impact the psychosocial well-being for other residents in the facility.</p> <p>Findings:</p> <p>During a review of Resident 1's clinical record, the record indicated Resident 1 was admitted in early 2023 with multiple diagnoses including Dementia (a decline in mental ability severe enough to interfere with daily life).</p> <p>A review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 3/21/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 3 out of 15 that indicated Resident 1 had severe cognitive impairment.</p> <p>During an interview on 6/18/25 at 12:36 p.m. with Certified Nurse Assistant (CNA 1), CNA 1 stated Resident 1 has been observed having bowel movements on the outside patio.</p> <p>During an interview on 6/18/25 at 12:49 p.m. with Licensed Nurse 1 (LN 1), LN 1 stated Resident 2 had bowel movements outside often and acknowledged it could be stressful for other residents to see.</p> <p>During an interview on 6/18/25 at 1:08 p.m. with Licensed Nurse 3 (LN 3), LN 3 stated that Resident 1 goes to the bathroom outside often and spits on the floor throughout the facility. LN 3 further confirmed Resident 1 was involved in an altercation with another resident who saw him with his pants down in the patio.</p> <p>During an observation on 6/18/25 at 3:51 p.m. Resident 1 was observed walking independently in the hallway while spitting on the floor.</p> <p>During a concurrent interview and record review on 6/18/25 at 3:09 p.m. with Director of Nursing (DON), the DON reviewed Resident 1's clinical record and stated there was no care plan or interventions related to Resident 1 having bowel movements outside and spitting on the facility floors. The DON further confirmed Resident 1 was involved in a physical altercation as a result of another resident seeing Resident 1 with his pants down in the patio.</p> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedure titled 'Resident Rights and Dignity' dated 2/2021 indicated, Employees shall treat all residents with kindness, respect, and dignity. Furthermore, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the right to: . a dignified existence .</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview, and record review the facility failed to protect one of 4 sampled residents (Resident 1) from physical abuse when Resident 2 pushed Resident 1 in the face.</p> <p>This failure resulted in Resident 1 sustaining a bloody nose.</p> <p>Findings:</p> <p>During a review of Resident 1's clinical record, the record indicated Resident 1 was admitted in early 2023 with multiple diagnoses including Dementia (a decline in mental ability severe enough to interfere with daily life).</p> <p>A review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 3/21/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 3 out of 15 that indicated Resident 1 had severe cognitive impairment.</p> <p>During a review of Resident 2's clinical record, the record indicated Resident 2 was admitted in late 2024 with multiple diagnoses including Diabetes Mellitus (a chronic disease where the body doesn't produce enough insulin (a hormone) to regulate sugar levels in the body and can cause slow wound healing.</p> <p>A review of Resident 2's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 3/24/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated Resident 2 was cognitively intact.</p> <p>During a concurrent observation and interview on 6/18/25 at 12:14 p.m. in Resident 2's room, Resident 2 stated the incident happened in the patio area. Resident 2 indicated that he was blocking Resident 1 from hitting him and he pushed Resident 1's face with his forearm causing Resident 1 to have a bloody nose.</p> <p>During a concurrent observation and interview on 6/18/25 at 12:30 p.m., Resident 1 was observed in the dining room during the lunch meal. Resident 1 refused to be interviewed.</p> <p>During an interview on 6/18/25 at 12:36 p.m. with Certified Nurse Assistant (CNA 1), CNA 1 indicated Resident 1 pooped on the patio often.</p> <p>During a telephone interview on 6/18/25 at 1:02 p.m. with Licensed Nurse 2 (LN 2), LN 2 stated she walked to the patio when the incident occurred and saw Resident 1's nose covered with blood and Resident 2 said he hit Resident 1 in the face because Resident 1 had his pants down and was attempting to have a bowel movement on the patio.</p> <p>A review of Resident 1's 'Change In Condition' document dated 6/16/25 indicated in part, . resident had a bloody nose due to another resident hitting [sic] him in this [sic] nose.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/18/25 at 3:09 p.m. with Director of Nursing (DON), the DON confirmed the facility was aware Resident 1 was having bowel movements out in the patio area and that the situation could have been prevented. DON further stated the facility does not approve of residents harming each other.</p> <p>During a review of facility policy and procedure (P&P) titled Abuse and Neglect ., dated March 2018, the P&P indicated . Abuse is . willful infliction of injury . with resulting physical harm .</p>		