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	07/23/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review, the facility failed to provide supervision and monitoring for one of three sampled residents (Resident 1) when Resident 1, after two attempts, eloped from the facility. This failure had the potential to result in serious injury or death for Resident 1.Findings:Resident 1 was admitted to the facility in 2025 with diagnoses that included stroke, aphasia (a language disorder that affects a person's ability to communicate), and Dementia (problems with reasoning, planning, judgement, and memory).Resident 1's admission MDS (Minimum Data Set-an assessment tool), dated 4/10/25, documented Resident 1 as having clear speech, usually able to understand others, usually able to make self-understood and his Brief Interview for Mental Status (BIMS) summary score as an 11 (moderate impairment). The MDS described Resident 1 as having no delirium or behavioral symptoms. The MDS also described Resident 1 as needing little to no assistance with bed mobility, transfers, locomotion on and off unit, dressing, and toilet use. During a review of Resident 1's Order Summary Report, for July 2025, a physician's order, dated 4/10/25, indicated, MD (Medical Doctor) determines that the resident does NOT have the mental capacity to make healthcare decisions as per history & physical or transfer orders or preferred intensity of care. During a review of Resident 1's care plan, dated 7/17/25, indicated Resident 1 was At Risk for Elopement and described his elopement attempt earlier that day and Resident 1 stating that he wanted to go home. During a review of Resident 1's Nurses Progress Note (PN), dated 7/17/25 at 12:15 p.m., the PN indicated the following: Resident 1 was restless and pacing walking in hallways, patio and inside his room. When Resident 1 went back to his room he attempted to climb out of the window by removing the screw which prevented the window from being opened more than three inches. Resident 1's roommate alerted staff Resident 1 was climbing out of the window and staff were able to get Resident 1 back inside his room. Safety checks every 15 minutes for 72 hours were implemented to keep Resident 1 from eloping. During a review of Resident 1's PN, dated 7/22/25 at 10:42 a.m., the PN indicated, During rounds around 07:30a.m. charge nurse was notified that [Resident 1] was not in his room. DON (Director of Nursing) and charge nurse went to [Resident 1] room and [Resident 1] bed was found with two pillows placed under the bed sheets and the window open with the screen outside of the building on the ground. [Resident 1's] personal belongings (suitcase, clothing) are still on the nightstand at bedside. Staff attempted to locate [Resident 1] throughout the facility in the building and surrounding areas, with no success in finding the resident. [Resident 1] last seen by night shift staff at approximately 06:00am. Administrator notified at 07:40am. Social Service Director (SSD) placed call to resident's brother [name] and nephew [name] and left voicemails, unable to contact either party. SSD was able to speak with Resident's son [name] and make him aware. Son stated, He's hitchhiking, he grew up in the 70's. Call placed to [NAME] PD at 08:35 by the DON and notified of resident missing. Officer [Name] in the facility shortly after to take the missing person's report.During an interview with the DON, DON stated that after his first attempt on 7/17/25, Resident 1 was offered another room with increased staff visibility but Resident 1 declined. When asked if additional methods were used to prevent this resident from eloping, the DON stated in this case a Wanderguard (a mechanism used to visually and audibly alarm when a resident wearing a device triggers the alarm when passing threshold) would not have activated, due to the resident climbing out of the window. The DON stated there are no alarms on the windows. During an interview with Maintenance Manager (MM), the MM stated he repaired the window, on 7/17/25, in Resident 1's room, replacing the screw that was removed and placing an additional screw on top of the window frame to prevent Resident 1 from climbing out of the window. MM also indicated on C hallway there was not an additional exterior gate or enclosure like there was for the rest of the building. When MM was asked how Resident 1 had eloped, MM stated that he most likely used a butter knife or some other tool and unscrewed both the lower window frame screw and the upper window frame screw, opened the window pushed out the screen and was able to climb out of the window. A review of the policy provided by the facility titled, Elopements and Wandering Residents, copyrighted in 2025, described, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The policy further stipulated, .3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing