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	12/10/2025

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three of three sampled residents (Resident 1, Resident 2, and Resident 3) were free from abuse when:1a. Resident 1 and Resident 3 were observed slapping each on the arms on 11/9/25; and 1b. Resident 1 and Resident 2 were observed slapping each other on the arms on 11/11/25.This failure resulted in Resident 1 and Resident 2 sustaining abrasions on their arms. Findings:1a. During a review of Resident 1's clinical record, the clinical record indicated she was admitted to the facility on [DATE] with diagnoses that included dementia with other behavioral disturbance, cognitive communication deficit, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities), and unspecified psychosis (psychotic symptoms such as hallucinations, delusions or disorganized thinking not aligned with a specific psychotic disorder or mental illness). During a review of Resident 1's Quarterly Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 8/15/25, indicated Resident 1's BIMS (a brief screening that aids in detecting cognitive impairment) score was 2 out of 15 which indicated severe memory impairment.During a review of Resident 1's Progress Notes (PN) dated 11/9/25 at 3:54 p.m., the PN indicated, Nurse was walking by common area when nurse heard Resident C bed [Resident 3] was arguing with resident A bed [Resident 1] about sitting her in walker and escalated to a physical altercation. Nurse witness resident in A bed [Resident 3] slapped Resident C bed [Resident 1] on the arms. Resident C bed [Resident 1] slapped resident A bed [Resident 3] back on arms. Nurse separated residents, did a room change, moved resident C [Resident 3] to a different hallway. Did vitals and head to toe assessment. Residents have no injuries noted or reported.During an interview on 11/17/25 at 11:49 a.m. with Resident 1 she was unable to recall or provide details of the incident on 11/9/25.During a review of Resident 3's clinical record indicated she was admitted to the facility 1/6/23 with diagnoses that included anxiety disorder and Schizophrenia disorder (mental disorder characterized by hallucinations, delusions, disorganized thinking or behavior).During a review of Resident 3's Quarterly MDS, dated [DATE] Resident 3's BIMS score was 12 indicating she was cognitively intact.During an interview on 11/17/25 at 11:50 a.m. with Resident 3 when asked about the incident on 11/11/25, resident stated, I don't remember.1b. During a review of Resident 1's SBAR (situation, background, assessment, recommendation- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 11/11/25 at 7:57 p.m., indicated Resident 1 and Resident 2 were sitting at the same table in the dining room. Resident 1 grabbed the belongings of Resident 2. Resident 2 reached back for them and both residents started hitting each other. Both Resident 1 and Resident 2 sustained abrasions with bleeding. A housekeeper separated them and informed the nurses.During an interview on 11/17/25 at 11:49 a.m. with Resident 1 she was unable to recall or provide details of the incident on 11/11/25.A review of Resident 2's clinical record indicated she was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD- chronic condition caused by damage to the lungs that causes difficulty in breathing) and hypertension (high blood pressure).During a review of Resident 2's Quarterly MDS dated [DATE], Resident 2's BIMS score was 13 indicating she was cognitively intact.A review of Resident 2's SBAR form dated 11/11/25 at 8 p.m. indicated Resident 2 was watching television in the dining room and had some of her belongings with her. Resident 1 reached back to take Resident 2's belongings. The residents started hitting each other and Resident 2 sustained an abrasion, with bleeding, on her right foreman.During an interview on 11/17/25 at 12:03 p.m. with Resident 2, she stated the other resident grabbed her right arm. Resident lifted her sleeve showing bruising on right her forearm. Resident 2 further stated it doesn't hurt.During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, copyright 2023, indicated, The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports.