

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/08/2026
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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than 5 percent (%) for one of 23 sampled residents (Resident 10), when three medications out of 34 opportunities were not given in accordance with the physician's orders and professional standards of practice. This failure resulted in a medication error rate of 8.82%. Findings: 1. A review of Resident 10's admission Record, indicated Resident 10 was admitted to the facility in July 2018 with diagnoses including diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and peripheral corneal degeneration (an eye condition where the outer edge of the cornea [the clear front layer of the eye] breaks down or changes over time). A review of Resident 10's Order Summary Report (OSR), dated 1/8/26, indicated, Resident 10 had an order for metformin (an oral medication that helps control blood sugar levels) 500 milligrams (mg, a unit of measurement), one tablet by mouth, two times a day. During a concurrent observation and interview on 1/6/26 at 8:33 a.m. with Licensed Nurse (LN) 1, LN 1 was preparing Resident 10's morning medications. LN 1 stated Resident 10 had an order for metformin, but it would not be given due to the medication not being available. During an interview on 1/6/26 at 1:43 p.m. with LN 1, LN 1 confirmed Resident 10's morning dose of metformin was not given because it was unavailable. LN 1 stated a missed dose of metformin could cause high blood sugar for Resident 10. During an interview on 1/7/26 at 12:28 p.m. with Director of Nursing (DON), DON stated metformin should have been given as ordered. 2. A review of Resident 10's OSR, dated 1/8/26, indicated Resident 10 had an order for timolol (an eye drop medication used to lower high pressure inside the eye), one drop in right eye, two times a day and artificial tears (an eye drop used to lubricate dry eyes and help keep moisture on the outer surface of the eyes), one drop in both eyes, every two hours. During an observation on 1/6/26 at 8:41 a.m. in Resident 10's room, LN 1 administered one drop of timolol in Resident 10's right eye and then immediately administered artificial tears eye drop in both eyes. During an interview on 1/6/26 at 8:45 a.m. with LN 1, LN 1 confirmed both eye drops were administered consecutively. During an interview on 1/8/26 at 11:26 a.m. with DON, DON expected LNs to wait five minutes between administering different eyedrops. DON stated it was important to wait five minutes in between eyedrops to prevent the eyedrops from being less effective and to avoid potential side effects from administering them consecutively. During an interview on 1/8/26 at 1:07 p.m. with Consultant Pharmacist (CP), CP stated waiting five minutes between administering different eyedrops was important. A review of the facility's policy titled, Administering Medications, revised 4/2019, indicated, Medications are administered in a safe and timely manner, and as prescribed.		

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: 055858	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were properly labeled and safely stored for a census of 95 residents, when:1. Expired and discontinued medications were stored in medication cart (med cart) C;2. Two bottles of wound treatment solutions and one tube of wound ointment were found stored in the treatment cart at station 2, opened and undated; and3. Three packets of antibiotic ointment (a thick, greasy cream applied to the skin to prevent bacterial infections in minor cuts, scrapes, and burns) were found expired and stored in the treatment cart at station 2. These failures decreased the facility's potential to safely store medications for residents. Findings:1. During a concurrent observation and interview on [DATE] at 3:17 p.m. with Licensed Nurse (LN) 2 in station 2, med cart C was inspected. LN 2 confirmed one medication had an expiration date of 11/2025, and five discontinued medications belonged to a resident that was discharged from the facility. LN 2 stated expired and discontinued medications should not be stored in the med cart due to the risk of administering these medications to residents. 2. During a concurrent observation and interview on [DATE] at 10:18 a.m. with LN 1 in station 2, the treatment cart was inspected. LN 1 confirmed one bottle of wound cleanser, one bottle of povidone-iodine solution (a liquid medicine used to apply to the skin to prevent infection), and one tube of calmoseptine ointment (a moisture barrier cream that protects and helps heal skin irritations) were found opened and undated. LN 1 stated wound treatment solutions and ointments should have an open and discard date.3. During a concurrent observation and interview on [DATE] at 10:18 a.m. with LN 1 in station 2, the treatment cart was inspected. LN 1 confirmed three packets of antibiotic ointment were stored with an expiration date of 11/2025. LN 1 stated expired ointments should not be stored in the treatment cart and should have been discarded. During an interview on [DATE] at 11:26 a.m. with Director of Nursing (DON), DON stated expired and discontinued medications should not be stored in the med cart or treatment cart. DON further expected LNs to label opened medications with open and discard date. A review of the facility's policy titled, Storage of Medications, updated [DATE], indicated, Discontinued, outdated, or deteriorated drugs or biologicals are returned to the pharmacy or destroyed. Drugs shall not be kept in stock after the expiration date. A review of the facility's policy titled, Administering Medications, revised 4/2019, indicated, . When opening a multi-dose container, the date opened is recorded on the container.		

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 01/08/2026
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)		
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to prepare food in a manner to conserve its nutritive value for a census of 95 residents, when the recipe was not followed for cooking carrot, pea, and fish. This failure had the potential for residents to experience decreased food intake and less nutrients in the served food. Findings: A review of the facility's menu served for lunch on 1/7/26 included oven crisp fish, tater tots, seasoned carrots, wheat roll, and apple hill cake. A review of the facility's recipe for seasoned peas, dated 2025, indicated the peas' cooking time was 10-15 minutes. A review of the facility's recipe for seasoned carrots, dated 2025, indicated the carrots' cooking time was 10-20 minutes. A review of the facility's recipe for oven crisp fish, dated 2025, indicated fish for 96 servings needed two cups of parsley flakes. The recipe also indicated to use thawed fillet fish of choice and coat both sides of the fish with ranch dressing. During an observation on 1/7/26 at 10:45 a.m., the [NAME] put carrots in a pot of water and peas in another pot of water and cooked them on the stove. The carrots were cooked until 11:20 a.m. and then placed on the steamer. The [NAME] added one teaspoon of salt and two ounces of butter in each pot of carrots. The peas were kept on the stove until tray line at 12 p.m. During an observation on 1/7/26 at around 10:30 a.m., the [NAME] opened frozen fillet fish, put it on the pan, spread one side of the fillet fish with ranch and some crushed potatoes chips. The [NAME] confirmed she did not use parsley. During an interview on 1/7/26 at 1:50 p.m. with the Registered Dietician (RD), RD stated it was important to follow the recipe regarding cooking time to maintain the food flavor and nutritive value. During an interview on 1/8/26 at 8:37 a.m. with Dietary Manager (DM), DM stated the [NAME] should have cooked carrots and peas for no more than 15-20 minutes as indicated in the recipe, because cooking more time might reduce the nutritive flavor of the vegetables and make it too soft. DM also stated the [NAME] should have followed the recipe and added parsley to the fish, thawed the fish fillet, and coated both sides of the fish with ranch dressing. A review of the facility's policy titled, Standardized Recipes, dated 2007, indicated, Standardized recipes shall be developed and used in the preparation of foods. A review of the facility's policy titled, Food Preparation, dated 2018, indicated, Serve vegetables promptly. Do not hold on the steam table for long period of time. (Maximum - 1 hour prior to serving). A review of the facility's policy titled, Food Preparation, dated 2020, indicated, Salt and season appropriately all meat, fish, and poultry according to the regular and special diets. Meats will be properly thawed.		

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 01/08/2026
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store and serve food in a sanitary manner for a census of 95 residents, when: The refrigerator and freezer temperature were not monitored on multiple dates of two months; An expired cinnamon stick bottle was available for use; and The [NAME] did not serve food in sanitary manner during tray line. These failures had the potential to result in foodborne illnesses among vulnerable residents. Findings: 1. During a concurrent interview and record review on 1/5/26 at 8:24 a.m. with Dietary Manager (DM), the October and November 2025 temperature record for the refrigerators and freezers were reviewed. DM confirmed there was no temperature monitoring for the walk-in and reach-in refrigerators and/or the walk-in and reach-in freezers in the p.m. shifts on 10/1/25, 10/25/25, 11/23/25, and 11/24/25. A review of the facility's policy titled, Procedure for Refrigerated Storage, dated 2019, indicated the refrigerator's temperature was 41-degree Fahrenheit (a unit of measure) or lower and the freezer's temperature was zero-degree Fahrenheit and lower. 2. During a concurrent observation and interview on 1/5/26 at 8:59 a.m. with DM, the spices rack was observed. DM confirmed the cinnamon stick bottle was available for use and had an expiration date 11/30/25. A review of the facility's policy titled, Storage of Food and Supplies, dated 2020, indicated, Food and supplies will be stored properly and in a safe manner. No food will be kept longer than the expiration date on the product. 3. During a concurrent observation and interview on 1/7/26 at 12:05 p.m. during tray line with the [NAME] and Registered Dietician (RD). The [NAME] used gloved hands, touched the handles of scoops and plates, and then used the same gloved hand to crush ready-to-eat food (fish) into smaller pieces. RD expected the [NAME] not to use the same gloved hands, after touching multiple surfaces, to touch ready-to-eat food, which could lead to food contamination. A review of the facility's policy titled, Food Handling, dated 2018, indicated, Food will be prepared and served in a sanitary manner. A review of the facility's policy titled, Maintaining a Sanitary Tray Line, dated 2025, indicated, This facility priorities tray assembly to ensure food are handled safely. The policy further indicated, Use utensils such tongs, serving spoons, etc. to handle food as much as possible.		

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 01/08/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure proper infection control measures were implemented for a census of 95 residents, when:1. Licensed Nurse (LN) 1 did not disinfect the blood pressure (BP) monitor in between resident use;2. Five sterile wound dressings (a medical covering completely free of germs and contaminants, designed to protect open wounds from bacteria) were opened and stored in the treatment cart at station 2; and3. A housekeeper (HK) did not wear the required personal protective equipment (PPE, any gear to protect your body from germs, hazardous chemicals in a medical setting like gloves, gowns, and masks) while deep cleaning the room of a resident on Enhanced Barrier Precaution (EBP, infection control method).These failures had the potential to spread infection among residents, staff, and visitors.Findings: 1. During an observation on 1/6/26 at 8:55 a.m. LN 1 went into a resident's room, checked the resident's BP then placed the BP monitor on the medication cart without disinfecting it. During an observation on 1/6/26 at 9:13 a.m. in the hallway, LN 1 used the same BP monitor to check another resident's BP. LN 1 did not disinfect the BP monitor prior to checking the resident's BP. During an interview on 1/6/26 at 1:56 p.m. with LN 1, LN 1 confirmed she did not disinfect the BP monitor in between use. LN 1 stated BP monitors were supposed to be disinfected before and after use to prevent the spread of infection between residents. During an interview on 1/8/26 at 11:26 a.m. with Director of Nursing (DON), DON expected staff to disinfect BP monitors in between resident use to prevent possible transmission of infection. A review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 10/2018, indicated, Reusable items are cleaned and disinfected or sterilized between residents . 2. During a concurrent observation and interview on 1/7/26 at 10:18 a.m. with LN 4, in station 2, the treatment cart was inspected. LN 4 confirmed five sterile wound dressings were found opened and stored in the treatment cart. LN 4 stated sterile wound dressings should not be kept in the treatment cart once it was opened to maintain sterility. LN 4 further stated not maintaining the sterility of the wound dressings would not be safe for the residents' wounds and could introduce more bacteria that could affect the residents' health. During an interview on 1/8/26 at 11:26 a.m. with DON, DON stated if a sterile wound dressing was opened, even if it was not used then the wound dressing should be discarded and should not be stored in the treatment cart due to possible contamination when placed on the residents' wounds. A review of the facility's policy titled, Storage of Medications, updated 7/10/24, indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner . deteriorated drugs or biologicals are . destroyed. 3. A review of Resident 5's admission Record, indicated she was admitted to the facility in July 2025 with a diagnosis of osteomyelitis (an infection of a bone caused by bacteria) of vertebra (spine) and sacral region (triangular shaped bone at the bottom of the spine). A review of Resident 5's Order Summary Report (OSR), dated 12/31/25, indicated, Resident 5 was (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/08/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ordered to be placed on EBP due to the presence of wounds and the use of a urinary catheter. During an observation on 1/5/26 at 10:10 a.m., HK was observed cleaning Resident 5's room. HK was not wearing a gown while disinfecting the bedside table, and the bed rail. HK stated she did not understand the meaning of the EBP sign posted outside the room. During a concurrent observation and interview on 1/5/26 at 10:40 a.m. with LN 3 in Resident 3's room, LN 3 confirmed HK was not wearing a gown while cleaning Resident 5's room who was on EBP. During a concurrent interview and record review on 1/7/26 at 10:05 a.m. with the Infection Preventionist (IP), Resident 5's physician orders were reviewed. IP confirmed Resident 5 was on EBP due to her wounds. IP stated staff should adhere to infection control practices which include wearing the required PPEs to effectively implement infection control measures. During an interview on 1/8/26 at 9:26 a.m. with the DON, DON stated staff should be knowledgeable about the proper procedure on what to do before entering a resident's room under any precautions. DON also stated as per the facility's policy, the use of appropriate PPE was required not only when providing direct care but also during the cleaning/disinfecting of a room under precautionary measures, to prevent exposing other residents to potential infections. A review of the facility's policy titled, Enhanced Barrier Precautions: Additional Considerations for California Skilled Nursing Facilities, updated in June 2024, indicated, Use of EBP by Environmental Services (EVS) personnel in rooms with Resident(s) on EBP . a specific example of high-contact EVS activities for which EVS personnel should use gown and gloves while cleaning and disinfecting the environment around residents on EBP . cleaning and disinfecting high touch surfaces such as bed rails, remote controls, bedside tables or stands on or near the resident's bedspace.		

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 01/08/2026
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)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to accommodate the needs and preferences for one of 23 sampled residents (Resident 94), when Resident 94 was not evaluated upon her request to use a motorized wheelchair at the facility. This failure decreased the facility's potential to maintain Resident 94's independent functioning, dignity, well-being and self-esteem. Findings: A review of Resident 94's admission Record, indicated she was admitted to the facility in February 2024 with diagnoses including muscle weakness and dystonia (a neurological disorder causing abnormal posture that can be painful). A review of Resident 94's Order Summary Report (OSR), dated 2/9/24, indicated Resident 94 was responsible for herself and could make her own healthcare decisions. A review of Resident 94's Minimum Data Set (MDS-a federally mandated assessment tool), dated 11/14/25, indicated Resident 94 was independent with bed mobility and only required set-up assistance for transfers. MDS also indicated Resident 94's Brief Interview of Mental Status score was 15 out of 15 with intact cognition and no memory issues. During a concurrent observation and interview on 1/5/26 at 10:35 a.m. with Resident 94 inside her room, Resident 94 stated she had a motorized wheelchair parked next to her bed, but she was not permitted to use it. Resident 94 further stated she was not assessed to determine if she could drive it safely and was simply told of the restriction without a clear explanation. A review of Resident 94's social services progress notes, dated 4/8/25, indicated, Resident 94 repeatedly requested assistance from the Social Services Director (SSD) to get permission to use her motorized wheelchair, but the request was always denied. During an interview on 1/8/26 at 9:40 a.m. with the Director of Rehab (DOR), DOR stated she recalled Resident 94 owning a motorized wheelchair and had expressed her desire multiple times to use it within the facility. DOR further stated an evaluation was not initiated because permission was denied by the previous administration. During a concurrent interview and record review on 1/8/26 at 9:26 a.m. with the Director of Nursing (DON), Resident 94's medical records were reviewed. DON stated there was no documentation indicating an evaluation was conducted for Resident 94 for the use of a motorized mobility device, which led to the decision to deny her the use of a motorized wheelchair. During an interview on 1/8/26 at 1:20 p.m. with the Regional Consultant (RC), RC confirmed an evaluation was not performed for Resident 94's request to use her own motorized wheelchair within the facility. RC expected staff to acknowledge and accommodate the residents' requests, provided they are safe for all the residents. A review of the facility's undated policy titled, Resident Rights, indicated, The resident has a right to be treated with respect and dignity including: the right to retain and use personal possessions. The right to receive services in the facility with reasonable accommodation of resident needs and preferences.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/08/2026
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan for one of 23 sampled residents (Resident 13), when the care plan did not address Resident 13's hospice (comfort-focused support for people with terminal illness) care and interventions. This failure decreased the facility's potential to address Resident 13's individualized care and specific needs. Findings: A review of Resident 13's admission Record, indicated she was admitted to the facility in June 2024 with diagnoses including hypertensive heart disease with heart failure (long-term high blood pressure causing the heart muscle to thicken and weaken which can lead to strokes). A review of Resident 13's hospice admission Order, dated 11/21/25, indicated she was admitted to hospice care in November 2025 with a diagnosis of cerebral atherosclerosis (hardening of the arteries in the brain which restricts blood flow raising risks for strokes). A review of Resident 13's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/26/25, indicated a significant change in status assessment was completed for Resident 13 following her admission under hospice care. During a concurrent interview and record review on 1/8/26 at 9:26 a.m. with the Director of Nursing (DON), Resident 13's admission order and care plans were reviewed. DON stated Resident 13 had been receiving hospice care since November 2025. DON confirmed there was no care plan in place for Resident 13's hospice care and further stated a care plan should have been developed by the nursing staff to ensure care was centered according to patient's wishes and necessary hospice care interventions were implemented effectively. A review of the facility's undated policy titled, Comprehensive Care Plans, indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . that includes . All services that are identified in the resident's comprehensive assessment and meet professional standards of quality.		

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 01/08/2026
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)		
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, the facility failed to provide necessary care and services for one of 23 sampled residents (Resident 48), when staff did not implement an appropriate communication system for Resident 48. This failure increased Resident 48's potential to experience delays in receiving necessary care and services. Findings: A review of Resident 48's admission Record, indicated he was admitted to the facility in October 2025 with a diagnosis of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During an observation on 1/5/26 at 9:08 a.m. in Resident 48's room, Resident 48 was seated on his bed and was observed asking a question to Certified Nurse Assistant (CNA) 1 in Spanish. CNA 1 responded in English, informing Resident 48 to wait while she looked for a staff who speaks the same language. CNA 1 returned and informed Resident 48 that she could not find an available Spanish-speaking staff and asked him to wait a bit longer. During a concurrent observation and interview on 1/5/26 at 1:06 p.m. with Licensed Nurse (LN) 3, in Resident 48's room, Resident 48 was talking in Spanish and appeared to be anxious. LN 3 listened but stated he could not understand Resident 48. LN 3 went to look for a staff who can translate for Resident 48. After several minutes LN 3 returned with the Activities Driver (AD). AD explained to LN 3 that Resident 48 was asking about his medications. LN 3 stated finding staff who can translate was the usual method of handling residents who spoke different languages. During a concurrent observation and interview on 1/6/26 at 2:20 p.m. inside Resident 48's room, CNA 2 was observed talking with Resident 48. CNA 2 stated she could not understand what Resident 48 was saying so she decided to give him some snacks, stating Maybe he is hungry. CNA 2 also stated she usually try to find staff who could translate to help communicate with residents who spoke a different language. During an interview on 1/7/26 at 3:25 p.m. with the Social Services Director (SSD), SSD confirmed many residents at the facility, including Resident 48, spoke different languages. SSD stated she prepared communication boards/binders for each resident to facilitate better communication between staff and residents. SSD also stated posters with the phone number for the translation application (app) were placed in the staff breakroom and clock-in room to ensure staff were consistently reminded of this resource. During a concurrent observation and interview on 1/7/26 at 3:40 p.m. with SSD, SSD visited Resident 48's room and confirmed she could not find a communication board/binder for Resident 48. SSD then checked the staff break room for the translation app phone number and stated there was no translation app poster available by the break room. During a concurrent observation and interview on 1/7/26 at 4:15 p.m. with the Director of Nursing (DON) in the clock-in room, DON stated she could not find the poster with the translation app phone number. During an interview on 1/7/26 at 3:45 p.m. with the Director of Staff Development (DSD), DSD stated she did not provide an in-service training for staff in 2025 on how to address language barriers between staff and residents. During an interview on 1/8/26 at 9:26 a.m. with the DON, DON expected staff to use the appropriate tools to assist residents with limited language skills in better expressing themselves while they were at the facility and to ensure they received the necessary care in a timely manner without delay. A review of the facility's undated policy titled, Non-Discrimination-Language Assistance Service, indicated, It is the policy of this facility to ensure that individuals with Limited English Proficiency (LEP) . have access to language assistance services . The facility must not rely on staff other than qualified interpreters . All staff will be trained in effective communication techniques, including the effective use of an interpreter.		

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 01/08/2026
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)		
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to review the pharmacist's recommendations for psychotropic medications (drugs that affect brain activities associated with mental processes and behaviors) for two of 23 sampled residents (Resident 19 and Resident 52), when:1. Resident 19's medication regimen review (MRR) for trazodone (a medication to treat depression) was not followed; and2. Resident 52's MRR for lorazepam (a medication to treat anxiety) was not followed.This failure increased the residents' potential to receive unnecessary medications.Findings:1. A review of Resident 19's admission Record, dated 1/8/26, indicated Resident 19 was admitted to the facility in 2019 with diagnoses including depression (mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress).A review of Resident 19's Order Summary Report, dated 1/8/26, indicated Resident 19 had an order, dated 9/7/23, for trazodone 25 milligrams (mg, a unit of measurement) by mouth at bedtime every Monday through Saturday for inability to sleep.A review of Resident 19's MRR titled, Note to Attending Physician/Prescriber, dated 11/13/25, indicated the Consultant Pharmacist (CP) recommended a gradual dose reduction (GDR, a tapering systematic steps to reduce dosage of medications) for trazodone 25 mg to every other night. MRR indicated no documentation of the physician/prescriber response of rationale, signature, and date.During a concurrent interview and record review on 1/8/26 at 10:34 a.m. with the Director of Nursing (DON), Resident 19's medical record was reviewed. DON confirmed Resident 19's order for trazodone 25 mg by mouth at bedtime every Monday to Saturday. DON stated the pharmacist's recommendation in November's MRR to reduce Resident 19's trazodone 25 mg to every other night was not followed, which might affect the resident's mental status.2. A review of Resident 52's admission Record, dated 1/8/26, indicated Resident 52 was admitted to the facility in 2025 with a diagnosis of depression.A review of Resident 52's Order Summary Report, dated 1/8/26, indicated Resident 52 had an order, dated 1/4/26, for lorazepam 0.5 mg by mouth as needed for anxiety for 14 days.A review of Resident 52's MRR titled, Consultant Pharmacist's Medication Regimen Review, dated 12/11/25, indicated CP requested clarification for the lorazepam order since there was no frequency in the order. MRR indicated no follow-up note documentation.During a concurrent interview and record review on 1/8/26 at 10:36 a.m. with the DON, Resident 52's medical record was reviewed. DON confirmed there was no frequency in the lorazepam order and stated without a frequency in the order, the nurse could have given an overdose.During an interview on 1/8/26 at 12:47 p.m. with CP, CP expected the facility to let the physician know and clarify the monthly MRR for Resident 19 and Resident 52. CP stated all orders should have a frequency and the MRR should have been updated as soon as possible.A review of the facility's policy titled, Medication Regimen Review and Reporting, dated 9/2018, indicated, Resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician. The policy further indicated, A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable format to nurses, physicians and the care planning team within 48 hours of MRR completion.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/08/2026
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)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure one of 23 sampled residents (Resident 53) was free from unnecessary medications, when Resident 53's lorazepam (an anti-anxiety medication) was prescribed without a stop date. This failure increased Resident 53's potential to receive an unnecessary medication. Findings: A review of Resident 53's admission Record, indicated he was admitted to the facility in October 2025 with a diagnosis of anxiety disorder. A review of Resident 53's Order Summary Report (OSR), dated 12/13/25, indicated an order for lorazepam 0.5 milligrams (mg; a unit of measurement) to be given every eight hours as needed (PRN) for anxiety with agitation with no stop date. A review of Resident 53's Medication Administration Record (MAR), dated 12/25 and 1/26, indicated Resident 53 received lorazepam 13 times in 12/25 and twice in 1/26. During a concurrent interview and record review on 1/8/26 at 9:26 a.m. with the Director of Nursing (DON), Resident 53's OSR and MARs were reviewed. DON confirmed Resident 53's order for PRN lorazepam did not indicate a stop date. DON stated lorazepam should have been ordered for a limited duration of 14 days only as per facility's policy to ensure the medication was used for specific symptoms only and not for staff convenience. A review of the facility's undated policy titled, Psychotropic Medications Policy, indicated, Psychotropic medications used on a PRN basis . is subject to the limitations as noted: PRN orders for psychotropic medications, shall be limited to no more than 14 days .		