

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

Printed: 10/09/2026
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 07/23/2026
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure informed consent was obtained prior to the administration of psychotropic medication (any drug that affects brain activities associated with mental processes and behavior) for three of 26 sampled residents (Resident 2, Resident 20, and Resident 30). This failure increased the potential for residents or their responsible parties (RP, legal representative) to not be informed of the risks and benefits of the medications and possible treatment alternatives. Findings: A review of Resident 2's medical record indicated a physician's order for duloxetine (a medication used to treat depression and anxiety) delayed release Sprinkle 60 milligrams (mg; a unit of measurement) capsule, give one capsule by mouth one time a day related to depression, ordered 4/13/26. During a concurrent interview and record review on 7/22/26 at 1:11 p.m. with the Director of Nursing (DON), Resident 2's physician's order for duloxetine and consents were reviewed. DON stated an informed consent for duloxetine was not obtained. A review of Resident 20's medical record indicated a physician's order for Lamictal (a medication to treat bipolar disorder, a mental health condition marked by extreme, disruptive shifts in mood, energy, and activity levels) 50 mg tablet, give 50 mg by mouth two times a day related to bipolar disorder, ordered 12/25/25. During a concurrent interview and record review on 7/22/26 at 12:47 p.m. with the DON, Resident 20's physician's orders and consents were reviewed. DON confirmed she did not see an informed consent for Lamictal and expected nursing staff to ensure an informed consent was obtained by the doctor prior to administering the first dose of psychotropic medication. DON stated the informed consent was important to ensure a resident understood the reason for receiving the medication, the risks that could come with its use, and there was no misuse of psychotropic medications. A review of Resident 30's medical record indicated a physician's order for the following psychotropic medications: -Citalopram (a medication to treat depression) 10 mg tablet: Give one tablet via percutaneous endoscopic gastrostomy tube (PEG tube; a flexible plastic feeding tube placed through a small incision in the belly directly into the stomach) one time a day for repetitive counting, and clapping related to unspecified psychosis (a mental state where a person loses touch with reality where they have trouble telling what is real and what is not), ordered 2/3/26; -Depakote (a psychotropic medication to treat bipolar disorder) delayed release Sprinkle 125 mg capsule: Give two capsules via PEG tube two times a day for agitation related to depression, ordered 2/3/26; -Quetiapine (a psychotropic medication to treat bipolar disorder) 25 mg tablet: Give one tablet via PEG tube one time a day for generalized anxiety disorder (GAD; a mental health condition marked by constant, excessive, and hard-to-control worry) related to unspecified psychosis manifested by episodes of continuous yelling, ordered 2/24/26; and -Trazodone (a medication to treat insomnia and depression) 50 mg tablet: Give one tablet via PEG tube at bedtime for inability to sleep related to depression, ordered 2/3/26. During a concurrent interview and record review on 7/22/26 at 12:57 p.m. with the DON, Resident 30's physician's orders and consents were reviewed. DON confirmed she did not see (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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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an informed consent obtained for citalopram, Depakote or quetiapine. DON stated an informed consent was obtained for trazodone, but it was not complete because the dosage was not indicated and expected the dosage and frequency to be documented on the consent. A review of the facility's undated policy and procedure titled, Use of Psychotropic Medication(s), indicated, Policy Explanation and Compliance Guidelines . 9. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings [the strictest safety alert the United States Food and Drug Administration can mandate for a prescription or over-the-counter medication] for antipsychotic [a type of psychotropic medication] medications, in advance of such initiation or increase. 10. The resident has the right to accept or decline the initiation or increase of a psychotropic medication. 11. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (e.g., written consent form, narrative note, etc.)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure professional standards of quality were followed for four residents out of a census of 92, when: 1. Licensed Nurse (LN) 6 did not sign and date Resident 98's medicated patch; 2. LN 5 did not wear appropriate personal protective equipment (PPE, equipment such as gloves, masks, or safety glasses worn to minimize exposure to hazards) while handling Resident 23's hazardous medication (medications that can cause serious effects including cancer, organ toxicity, fertility problems, genetic damage, and birth defects if not handled appropriately); 3. LN 5 did not crush Resident 81's medications for administration; and 4. Resident 34's controlled substance medications (medications with a high potential for abuse and addiction) were not accurately accounted for on the medication administration record (MAR) and the Controlled Drug Record (CDR, an accountability record). These failures decreased the facility's potential to prevent residents from experiencing adverse effects from medicated patches applied not in accordance with physician's orders, unwanted exposure to hazardous medications leading to health complications, choking from administration of medications whole, abuse or misuse of medications, and to maintain accurate accountability of controlled medications. Findings: 1. During a medication (med) pass observation on 7/20/26 at 8:39 a.m., LN 6 was observed applying a lidocaine (an anesthetic to relieve pain) patch on Resident 98. LN 6 removed the patch from the packaging, removed the adhesive backing, and applied the patch to Resident 98's middle upper back. During an interview on 7/20/26 at 11:45 a.m. with LN 6, LN 6 confirmed she did not sign or date the lidocaine patch that she applied to Resident 98. During an interview on 7/21/26 at 11:27 a.m. with the Director of Nursing (DON), DON expected nursing staff to sign, date and put the time on a medicated patch when applied to a resident. DON stated it was important to write the information so nursing staff could see when it was applied and to prevent a patch from being left on the resident beyond what was indicated in an order. A review of the facility's undated policy and procedure (P&P) titled, Administration of Medication Transdermal Patch, indicated, Policy: It is the policy of this facility to ensure residents receive transdermal medication in accordance with professional standards of practice. Policy Explanation and Compliance Guidelines . 6. Administration . c. Write the date and initials on the patch. 2. During a med pass observation on 7/20/26 at 9:27 a.m., LN 5 was observed preparing four medications for Resident 23 which included finasteride (a medication to treat an enlarged prostate gland) five milligrams (mg, a unit of measurement) one tablet. The package had a sticker affixed to and indicated it was hazardous. LN 5 prepared the medications without wearing gloves. During an interview on 7/20/26 at 1:02 p.m. with LN 5, LN 5 confirmed she did not wear gloves when she prepared the hazardous medication for Resident 23. LN 5 stated she should have worn gloves when handling the medication because it was hazardous. During an interview on 7/21/26 at 11:25 a.m. with the DON, DON expected nursing staff to follow directions for special handling when preparing and administering medications. DON also expected nursing staff to wear gloves to protect themselves and the residents when handling hazardous medications. During a telephone interview on 7/22/26 at 1:46 p.m. with the Consultant Pharmacist (CP), CP stated if a medication was categorized as hazardous, the nurse who prepared the medication should wear gloves to protect themselves and to prevent cross contamination. A review of an article published by the Centers for Disease Control and Prevention (CDC, the national public health agency of the United States) titled, Hazardous Drugs Exposures in Healthcare, dated 3/3/26, indicated, Who is at risk? Healthcare workers who prepare or (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administer hazardous drugs . or who work in areas where these drugs are used may be exposed to these agents in the workplace . Published studies have shown that workplace exposures to hazardous drugs can cause both acute [short term] and chronic [long-term] effects such as: skin rash, adverse reproductive outcomes . and other cancers. A review of the facility's undated P&P titled, Hazardous Drug Handling, indicated, Purpose: To establish safe handling of hazardous drugs (HDs), promote patient safety, worker safety, and environmental protection. Handling HDs includes, but is not limited to, the receipt, storage, compounding, dispensing, administration . This system shall include policies and procedures to prevent the unintentional entry of HDs into the body due to the handling of HDs and/or touching contaminated surfaces. Scope: The facility must develop and maintain a health and safety management system which shall, at a minimum, include the following . 4. Safe work practices; 5. Proper use of appropriate Personal Protective Equipment (PPE) . A review of The National Institute for Occupational Safety and Health (NIOSH, the federal organization responsible for making recommendations for the prevention of work-related injury and illness) List of Hazardous Drugs in Healthcare Settings, dated 2024, indicated, The drugs in Table 2 meet the NIOSH definition of a hazardous drug . These drugs may exhibit one or more of the types of toxicity described in the NIOSH definition of a hazardous drug . Some of these drugs may also present an occupational hazard to those workers who are actively trying to conceive, who are pregnant or may become pregnant, and who are breastfeeding because the drugs may be excreted in breast milk . Table 2 . finasteride . Developmental and/or Reproductive Hazard. 3. During a med pass observation on 7/20/26 at 9:11 a.m., LN 5 was observed preparing medications for Resident 81 which included eye drops, tablets, and an oral (by mouth) liquid medication. LN 5 entered Resident 81's room with the prepared medications and tried to hand Resident 81 the oral liquid medication in the medicine cup, but Resident 81 did not move his hands. LN 5 administered Resident 81's liquid medication and he was observed having difficulty swallowing the medication. LN 5 offered Resident 81 sips of water between sips of the liquid medication, and he was observed repeatedly belching and clearing his throat. LN 5 then administered Resident 81's oral tablets with a plastic spoon, one by one, and offered him sips of water in between. Resident 81 continued to [NAME] and clear his throat and had labored breathing that sounded wet. Resident 81 was then observed chewing the medications and the crunching of multiple tablets was heard. A review of Resident 81's medical record indicated the following diet and physician orders:- Pureed (completely smooth, thick, and uniform like pudding or applesauce) texture, thin consistency, ordered 6/10/26; and- May crush all crushable medications and open capsules until contraindicated, ordered 6/10/26. During a concurrent interview and record review on 7/20/26 at 1:11 p.m. with LN 5, Resident 81's orders were reviewed. LN 5 stated Resident 81 had difficulty swallowing his medications during the observed morning med pass and if she had taken the time to really look through the record, then she would have known how Resident 81 normally took his medications. LN 5 further stated she did not think it was safe for Resident 81 to take his medications whole since he had orders for a pureed diet. During a concurrent interview and record review on 7/21/26 at 11:30 a.m. with the DON, Resident 81's orders and nursing notes were reviewed. DON confirmed there were orders placed by the physician that would allow nursing staff to crush a resident's medications and expected nursing staff to get the medication out of the resident's mouth so they did not choke or aspirate, then to check the resident's orders to see if the medications could be crushed if a resident was having difficulty swallowing their medications whole. DON acknowledged Resident 81's pureed diet order and stated, Different nursing notes say that he takes his pills crushed. DON further stated it was not acceptable to administer tablets wholes since Resident 81 took his pills crushed and expected the nurse to crush the medications. A review of the facility's undated P&P (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	titled, Medication Administration, indicated, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . 4. A review of Resident 34's medical record indicated the following physician's orders:-Oxycodone (a potent pain medication) 10 mg tablet: Give one tablet by mouth every four hours as needed for mild pain; moderate pain, ordered 4/6/26; and-Oxycodone 20 mg tablet: Give one tablet by mouth every four hours as needed for moderate pain; severe pain if pain level 7-10 (a tool used by healthcare providers to help patients communicate the intensity of their physical discomfort where 0 represents freedom from pain, and 10 represents the worst, most excruciating pain imaginable), ordered 4/6/26.During a concurrent interview and record review on 7/21/26 at 12 p.m. with the DON, Resident 34's CDR and MARs dated May and June 2026 were reviewed. DON confirmed the CDR indicated oxycodone 10 mg was removed on the following dates and times, but their respective administrations were not documented on the MAR: one tablet on 5/29/26 at 5:31 p.m., and two tablets on 6/6/26 at 2:23 p.m. DON also confirmed the MAR indicated 20 mg (two tablets) were administered on 6/11/23 at 12:30 p.m. and 6/17/26 at 6 a.m. but the CDR indicated only one tablet was removed for each date. DON expected nursing staff to document on the CDR and the MAR whenever a controlled drug was removed and administered to a resident. DON stated it was important to maintain accuracy of controlled drug records to prevent possible medication overdose or misuse of the drugs.During an interview on 7/21/26 at 11:05 a.m. with the Assistant Director of Nursing (ADON), ADON expected nursing staff to check the CDR and compare it to the physical count when preparing controlled medications to verify that the counts match. ADON stated if the count was correct, then the dose could be prepared, administered to the resident, and documented in both the CDR and MAR.A review of the facility's undated policy and procedure titled, Medication Administration, indicated, 20. Sign MAR after administered. For those medications requiring vital signs, record vital signs onto the MAR. 21. If medication is a controlled substance, sign narcotic book.		

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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 had 8 percent (%) a unit of measurement) error rate when two medication errors out of 25 opportunities were observed during a medication (med) pass for one of five residents (Resident 72). This failure resulted in medications not given in accordance with the prescriber's order and the potential to affect the residents' clinical conditions leading to health complications. Findings: During a med pass observation on 7/20/26 at 9:41 a.m., Licensed Nurse (LN) 5 was observed preparing seven medications for Resident 72 including docusate sodium (a medication to soften the stool) 100 milligrams (mg, a unit of measurement) one tablet, and 10 ml of carbamazepine (a medication to stabilize mood) 100 mg/5 milliliters (ml, a unit of measurement) suspension (a liquid medicine where tiny, fine bits of solid medicine are floating or mixed around in a liquid, but have not actually dissolved). LN 5 removed the cap from the carbamazepine bottle without shaking the suspension and poured the medication into a plastic medicine cup. LN 5 poured the dose in the cup to approximately 12.5 ml. When LN 5 had finished pouring the carbamazepine dose, she confirmed where she measured the dose to and drew a line between the 10- and 15-ml line. A review of Resident 72's medical record indicated the following physician's orders: - Docusate sodium 100 mg tablet: Give two tablets by mouth two times a day for bowel care. Hold for loose stool, ordered 3/28/26; and - Carbamazepine 100 mg/5 ml suspension: Give 10 ml by mouth three times a day related to personal history of transient ischemic attack (TIA, when a blood clot or narrowed artery briefly blocks blood flow to a part of the brain) and cerebral infarction without residual deficits (a past stroke or brain tissue death caused by interrupted blood flow where there is no long term damage), ordered 3/28/26. During a concurrent interview and record review on 7/20/26 at 12:55 p.m. with LN 5, Resident 72's docusate and carbamazepine orders were reviewed. LN 5 reviewed the docusate order and stated she should have given two tablets but had only given one. LN 5 acknowledged she did not shake the carbamazepine suspension before she measured the dose and stated it was important to shake a suspension well before pouring it because the medication settled at the bottom of the bottle. LN 5 confirmed she measured the carbamazepine between the 10- and 15-ml marks on the medicine cup and acknowledged she had not measured the 10 ml prescribed dose correctly. During an interview on 7/21/26 at 11:14 a.m. with the Director of Nursing (DON), DON expected nursing staff to follow the instructions in a physician's order when preparing medications and if a medication required shaking then nurses should do that. DON also expected nursing staff to pour medicine in a cup and measure it at eye level and to measure to the line for the dosage indicated in the physician's order. DON stated it was important to shake a suspension well prior to pouring it to ensure the correct dosage was prepared and administered. During a telephone interview on 7/22/26 at 1:46 p.m. with the Consultant Pharmacist (CP), CP stated carbamazepine suspension needed to be shaken well before pouring to ensure the correct dosage was prepared. A review of the drug labeling for carbamazepine suspension, revised 5/2024, indicated, Medication Guide . How should I take carbamazepine? . Shake the bottle well each time before use. A review of the facility's undated policy and procedure titled, Medication Administration, indicated, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection . Policy Explanation and Compliance Guidelines . 10. Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation . 17. Administer medication as ordered in accordance with manufacturer specifications . b. ?Shake well' to mix suspensions .		

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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:1. Unauthorized nursing staff did not have access to medications once their employment with the facility ended;2. Safe medication labeling practices in accordance with accepted professional standards when opened inhalers and biologicals were not properly labeled with sufficient information to clearly identify the specific residents for which they were prescribed in medication (med) carts A and D; and3. Unwanted or refused doses of medication were not stored in the med cart. These failures decreased the facility's potential to prevent diversion or misuse of medications, medication errors and preventable infections from cross-contamination of resident medications from accidental misadministration of similar or same drugs for a census of 92 residents.Findings: 1. During a concurrent observation and interview on 7/20/26 at 12 p.m. with the Director of Nursing (DON), med storage room [ROOM NUMBER] was inspected. An Automated Drug Dispensing System (ADDS, a computer-controlled medication storage cabinet used to dispense medication) was identified. DON stated access to the ADDS was granted and removed by the facility and supplier pharmacy. DON logged into the ADDS computer system to reveal a list of nursing staff who had authorization to access medications inside it. DON reviewed the list and identified the names of two nursing staff and stated they were no longer employed by the facility. DON further stated she had not followed up with the pharmacy after the employees ended their employment at the facility to terminate their access to the ADDS and there was no process in place to ensure nursing staff who no longer worked at the facility had their access to the ADDS removed in a timely manner. A review of an email sent by the Administrator on 7/20/26 at 5:36 p.m. indicated the last day worked for Licensed Nurse (LN) 7 and LN 8 was 11/19/25 and 6/4/26, respectively. A review of the facility's undated policy and procedure (P&P) titled, Storage of Medications, indicated, Policy . The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 2. During an inspection of med cart A on 7/20/26 at 12:24 p.m. with the DON, the following medications were identified inside their manufacturer boxes with pharmacy labels affixed to the box, but without resident specific labeling on the medications themselves:- One fluticasone/salmeterol (medication to treat asthma; a long-term lung disease that causes swelling, tightening, and mucus buildup in the airways) 100 micrograms (mcg, a unit of measurement)/50 mcg inhaler;-One umeclidinium/vilanterol Ellipta inhalation powder (a medication to treat chronic obstructive pulmonary disease [COPD], a long-term lung condition that makes it hard to breathe because of airway damage, swelling, or clogging, trapping old air inside) 62.5 mcg/25 mcg;-One fluticasone diskus (medication to treat asthma) 100 mcg inhaler,-One Breo Ellipta (medication to treat COPD) 200 mcg/25 mcg inhaler; and-One unlabeled Novolog (rapid-acting insulin used to control high blood sugar) 100 units/milliliter (u/ml, a unit of measurement) vial.DON stated the medications needed to be stored in the manufacturer's boxes which contained the pharmacy label to be able to correctly identify which residents they were for. During a concurrent observation and interview on 7/20/26 at 12:51 p.m. with LN 6, med cart D was inspected. LN 6 confirmed the following findings:-One budesonide/formoterol (medication to treat asthma) 160 mcg/4.5 mcg inhaler and one budesonide/formoterol 80 mcg/4.5 mcg inhaler were identified inside their manufacturer boxes with pharmacy labels affixed to the box, but without resident specific labeling on the medications themselves;-One Breyana (medication to treat (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	asthma) 160 mcg/4.5 mcg inhaler in a box without a pharmacy label with the room [ROOM NUMBER]-A written on the box in blue marker; and-Three sterile saline vials for inhalation were identified in the med cart drawer without a pharmacy label. LN 6 stated the Breyna inhaler should have had a pharmacy label on the box. LN 6 further stated the supplier pharmacy did not open the boxes to label the inhalers, and the process was to store them in the labeled boxes to be able to identify which residents they were for. A review of the facility's undated P&P titled, Medications and Medication Labels, indicated, Policy . Medications are labeled in accordance with currently accepted professional principles . to promote safe medication use following state and federal law . Procedures . 4. The provider pharmacy permanently affixes label to the outside of prescription containers . For medications designed for multiple administration, (for example, inhaler or eye drops), a label is affixed to product to assure proper resident identification. A review of an article published by the Institute for Safe Medication Practices (ISMP, a nonprofit organization dedicated entirely to medication error prevention and safe medication use and who provide critical safety guidelines for healthcare worldwide) titled, Correct use of inhalers: Help residents breathe easier, dated 1/2017, indicated, Optimal use of inhalation devices . Dispensing and Consultant Pharmacists . Label the actual inhaler, not just the box in which it comes. 3. During a concurrent observation and interview on 7/20/26 at 9:10 a.m. with LN 5, LN 5 was observed exiting a resident's room holding a clear medicine cup with pills in it. LN 5 stated the resident did not take the medication and placed a second medicine cup on top of the pills so that the medication was sandwiched between the two cups and wrote the resident's room number with a marker on it. LN 5 stated she would dispose of it in a container located in the medication storage room later. LN 5 then placed the cups with the refused medications in them in the top drawer of the med cart. During an interview on 7/21/26 at 11:07 a.m. with the Assistant Director of Nursing (ADON), ADON expected nursing staff to document the refusal of medication, log the medication on the destruction log and then dispose of it in the designated bin in the medication storage room with another nurse to witness and cosign for the destruction. ADON also expected nursing staff to destroy the medication right then and there after resident refusal because some of the medications could be psychotropic medications. ADON stated it was not acceptable to store the refused medication in the med cart for later destruction because it was a concern for resident safety and could increase the chance for medication errors. ADON further stated it was also an infection control concern because the medication had entered and exited the resident's room. During an interview on 7/21/26 at 11:46 a.m. with the DON, DON expected nursing staff to immediately destroy refused doses of medication. DON stated it was not acceptable to store the medication in the med cart because doing so increased the potential for a medication error and was an infection control concern since the medication had entered the resident's room. A review of the facility's undated P&P titled, Disposal of Medications, indicated, Procedures 1. The director of nursing and the consultant pharmacist will monitor for compliance with federal and state laws and regulations in the handling of medications . 5. Medications not listed in Schedules II, III, IV and V (non-controlled medications) shall be destroyed by the nursing care center in the presence of a pharmacist or nurse and one other witness . 8. Outdated medications, contaminated or deteriorated medications, and the contents of containers with no label shall be destroyed according to the above policy.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to protect and keep secure when not in use, confidential resident health records for a census of 92 residents, when Licensed Nurse (LN) 5 left medication boxes with confidential resident information unattended during medication (med) pass. This failure had the potential to expose and disclose the residents' personal and confidential health information to unauthorized individuals. Findings: During a med pass observation on 7/20/26 at 9:07 a.m. in Hall C, LN 5 was observed preparing medications for Resident 81. Another resident's prescription phenytoin (a medication to treat seizures; a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) suspension medication box with a pharmacy label affixed to it was observed on top of the med cart. LN 5 removed a prescription eye drop from the manufacturer's box to administer it to Resident 81 and set the box on top of the med cart. Both boxes had pharmacy labels affixed to them that contained confidential resident information. LN 5 entered Resident 81's room to administer the prepared medications and left the boxes unattended and visible to staff and residents who passed by. During a second med pass observation on 7/20/26 at 9:43 a.m. with LN 5, the box for phenytoin suspension was observed on the med cart, unattended. During an interview on 7/20/26 at 12:59 p.m. with LN 5, LN 5 confirmed she had left confidential resident information accessible and unsecure when the boxes with pharmacy labels were left unattended on the med cart during the morning med pass. During an interview on 7/21/26 at 11:40 a.m. with the Director of Nursing (DON), DON stated it was not acceptable to leave resident medication information unattended on the med cart. A review of the facility's undated policy and procedure titled, Confidentiality of Personal and Medical Records, indicated, Policy: This facility honors the resident's right to secure confidential personal and medical records. This includes the right to confidentiality of all information contained in a resident's records, regardless of the form of storage or location of the record. Policy Explanation and Compliance Guidelines: 1. Personal and medical records include all types of records the facility might keep on a resident, whether they are medical, social, fund accounts, automated, or other. 2. 'Keep confidential' is defined as safeguarding the content of information from unauthorized disclosure without the consent of the individual and/or the individual's surrogate or representative.		

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 07/23/2026
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.			
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS, a federally mandated resident assessment tool) was accurate for two of 26 sampled residents (Resident 29 and Resident 30), when: 1. Resident 29's discharge assessment was not completed as required; and 2. Resident 30's nutritional status assessment for two quarterly reviews did not indicate enteral feeding (a medical method of delivering liquid nutrients directly into the stomach or small intestine using a feeding tube). These failures increased the facility's potential for incorrect submission and reporting of residents' assessments. Findings: 1. A review of Resident 29's admission Record, indicated he was admitted to the facility on [DATE] with a diagnosis of acute and chronic respiratory failure with hypoxia (a condition when the body's tissues and organs do not get enough oxygen to work properly) and was discharged on 3/7/26. During a concurrent interview and record review on 7/21/26 at 2:20 p.m. with the Director of Nursing (DON), Resident 29's progress notes dated 3/7/26, change in condition transfer form dated 3/7/26, and MDS assessments were reviewed. DON stated Resident 29 was transferred to the hospital on 3/7/26 at 2:30 p.m. due to shortness of breath and labored breathing, despite receiving oxygen therapy. DON further stated the facility received a call from the hospital later that day indicating Resident 29 passed away. DON acknowledged the MDS assessment prepared and submitted for Resident 29 was an entry assessment only, and no discharge assessment was completed. DON also stated a discharge assessment should have been created to ensure proper reporting and compliance with regulations. 2. A review of an admission record indicated Resident 30 was admitted to the facility on [DATE] with a diagnosis of dysphagia (trouble or difficulty swallowing food, liquids, or even saliva). During a concurrent observation and interview on 7/23/26 at 10:45 a.m. with Licensed Nurse (LN) 1, Resident 30's feeding tube was observed as intact. LN 1 stated Resident 30 received medications and Glucerna (a specialized nutritional shake) bolus (a large dose of food or liquid given quickly into the body) through the feeding tube daily. A review of Resident 30's Order Summary Report, indicated Resident 30 had an order for Enteral feed as needed started on 7/25/25. The record further indicated Resident 30 had an order for Glucerna one time a day for supplement give eight ounces (oz; a unit of measurement) bolus via gastric tube (a feeding tube inserted through the abdomen directly into the stomach). During a concurrent interview and record review on 7/22/26 at 2:02 p.m. with MDS Coordinator (MDSC), MDSC confirmed MDS quarterly assessments dated 1/30/26, and 4/30/26, did not have enteral feeding triggered in those assessments. MDSC stated missing the enteral feeding could have been inaccurate MDS assessment. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/22/26 at 2:16 p.m. with DON, Resident 96's quarterly MDS assessments were reviewed. DON confirmed the assessments dated 1/30/26 and 4/30/26 did not have enteral feeding triggered in those assessments. DON stated MDS should have been entered correctly otherwise; it could have been inaccurate MDS plan of care. A review of the facility's undated policy titled, Conducting an Accurate Resident Assessment, indicated, The purpose of this policy is to ensure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment by staff qualified to assess relevant care areas . The Administrator will ensure that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.		

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to confirm one of 26 sampled residents (Resident 96's) code status in an emergency, when Licensed Nurse (LN) 3 did not follow Resident 96's physician's order to do not attempt resuscitation (DNR). This failure resulted in delivering unwanted life-sustaining treatment that was inconsistent with Resident 96's wishes. Findings: A review of an admission record indicated Resident 96 was readmitted to the facility on [DATE] with a diagnosis of congestive heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).A review of Resident 96's Progress Notes, dated [DATE], indicated Resident 96 was found unresponsive on [DATE] and cardiopulmonary resuscitation (CPR; a life-saving emergency procedure performed on an individual who was found unresponsive, or showed no signs of breathing) was performed.A review of Resident 96's Order Summary Report (OSR), dated [DATE], indicated Resident 96 had an active code status order for DNR.A review of Resident 96's Minimum Data Set (MDS) Assessment, dated [DATE], indicated Resident 96's code status was DNR.A review of Resident 96's Physician/Provider Orders for Life-Sustaining Treatment (POLST), dated [DATE], indicated Resident 96 had chosen DNR and to allow natural death to occur.During an interview on [DATE] at 10:41 a.m. with LN 3, LN 3 stated CPR was performed on Resident 96 after he was found unresponsive on [DATE] at approximately 7:30 p.m. LN 3 further stated she reviewed Resident 96's physician's order at that time and confirmed Resident 96's code status was DNR.During a concurrent interview and record review on [DATE] at 2:02 p.m. with MDS Coordinator (MDSC), Resident 96's POLST and MDS assessment, dated [DATE] were reviewed. MDSC confirmed Resident 96's POLST and MDS assessment indicated DNR.During a concurrent interview and record review on [DATE] at 2:16 p.m. with Director of Nursing (DON), Resident 96's OSR dated [DATE], was reviewed. DON confirmed Resident 96's OSR indicated an active code status of DNR. DON expected Resident 96's physician's order and POLST to be carried out correctly otherwise; if not followed then Resident 96's wishes were not honored.A review of the facility's undated policy titled, Communication of Code Status, indicated, . this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 for one of 26 sampled residents (Resident 81), when Licensed Nurse (LN) 5 did not change gloves or perform hand hygiene between oral (by mouth) and eye medication administration for Resident 81. This failure decreased the facility's potential to prevent cross contamination and infections among vulnerable residents. Findings: During a medication pass observation on 7/20/26 at 9:11 a.m., LN 5 was observed preparing seven medications for Resident 81 which included tablets, an oral liquid, and an eye drop. LN 5 put on gloves and carried the prepared oral medications in plastic medicine cups and the eye drop into Resident 81's room. LN 5 administered Resident 81's liquid medication, followed by oral tablets. LN 5 held Resident 81's cup of water and assisted him with sips from a straw in-between each tablet that was administered. LN 5 then administered Resident 81's eye drops without changing gloves or performing hand hygiene in between. During an interview on 7/20/26 at 1:11 p.m. with LN 5, LN 5 stated nursing staff were expected to perform hand hygiene in between administering oral and eye medications. LN 5 confirmed she did not and should have performed hand hygiene after she administered Resident 81's oral medications and before instilling his eye drop. During an interview on 7/21/26 at 11:45 a.m. with the Director of Nursing (DON), DON stated nursing staff were expected to perform hand hygiene in between administering oral medications and eyes drops, and gloves should be worn to administer eye drops. A review of the facility's undated policy and procedure (P&P) titled, Hand Hygiene, indicated, Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. A review of the facility's undated P&P titled, Administration of Eye Drops or Ointments, indicated, Policy Explanation and Compliance Guidelines: 3. Wash hands or utilize alcohol-based hand rub and apply gloves. A review of the facility's undated P&P titled, Medication Administration, indicated, Policy: Medications are administered by licensed nurses in accordance with professional standards of practice, in a manner to prevent contamination or infection. A review of an article published by the Center for Disease Control (CDC) titled, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, indicated, Know when to clean your hands. Before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or patient's surroundings. After contact with blood, body fluids, or contaminated surfaces. (https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html; accessed 7/23/24)		