

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>055858</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>03/25/2025</b> |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>RANCHO SECO CARE CENTER</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>144 F STREET</b><br><b>GALT, CA 95632</b>   |                      |   |
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| F 000  | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of facility reported incident #CA00952195.<br><br>The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility.<br><br>The Department substantiated facility reported incident #CA00952195, and a violation of regulations was written under tag #F600.   | F 000   | Rancho Seco Care Center submits this response and Plan of Correction as part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements; it shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at anytime the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis. |                      |   |
| F 600<br>SS=D  | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse for one of three sampled residents (Resident 1) when Resident 2 punched Resident | F 600   | The provider reserves the right to challenge the cited findings if at anytime the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis.<br><br>F600 Free from Abuse and Neglect<br>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>A) On 03/14/2025 Resident #1 was moved to a different hallway of the facility.<br>B) Resident #1 monitored elbow  |                      |   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Cratt*

TITLE

Administrator

(X6) DATE

04/04/2025

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.

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| F 600  | <p>Continued From page 1<br/>1 on the head.</p> <p>This failure resulted in Resident 2 punching Resident 1 and sustaining a fall with an abrasion to the elbow.</p> <p>Findings:</p> <p>During a review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated, Resident 1 was admitted to the facility in September 2022 with diagnoses including pancytopenia (abnormally low amounts of all three types of blood cells). Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 3/18/25, indicated Resident 1 had moderate memory impairment.</p> <p>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) Communication Form dated 3/18/25, indicated, Resident 1 " ...was the victim of physical abuse by another resident during the smoke break that culminated with the victim [Resident 1] being thrown in his wheelchair on the concrete slab on the patio, being hit by the abuser [Resident 2] on the head with his fists ...left elbow, abrasion ... "</p> <p>During a review of Resident 2's face sheet, the face sheet indicated Resident 2 was admitted to the facility in December 2021 with unspecified dementia (a progressive state of decline in mental abilities) and anxiety. Resident 2's MDS, dated 2/16/25, indicated Resident 2 had severe memory impairment.</p> | F 600   | <p>abrasion and for delayed injury doctor will be notified of any changes.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken:<br/>C) DON completed an audit on 03/26/2025 of residents who pose a risk for altercation. All residents have the potential to be affected by this deficient practice.<br/>No other areas were identified with having this same deficient practice.</p> <p>What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur:<br/>D) An in-service was initiated by facility DSD on 03/26/2025 to licensed staff regarding the importance of preventing abuse and reporting abuse.<br/>E) Nursing staff to monitor resident #1's abrasion and for delayed injury for the next 7 days and report any changes to the doctor.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained.<br/>F) Nursing staff to monitor resident #1's abrasion and for delayed injury for the next 7 days and report any changes to the doctor.<br/>G) IDT team will review COC the following day during the five day a week clinical morning meeting to ensure abuse prevention efforts were made ensure reoccurrence does not</p> |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 600  | <p>Continued From page 2</p> <p>During a review of Resident 2's Interdisciplinary Post Event Note, dated 3/18/25 indicated, "Resident is the abuser in a physical abuse ...resident is alert and oriented ...he is aggressive towards a particular resident, confronting him, because he believes that he enters in his room at night stilling his wallet and \$90 to do drugs ... "</p> <p>During an interview on 3/25/25 at 2:34 p.m., with Restorative Nursing Assistant (RNA), RNA stated Resident 2 walked toward Resident 1 in the smoking patio and suddenly punched Resident 1 in the head. RNA stated he was inside watching and supervising through the window when incident occurred. RNA further stated it happened so quickly that he did not have enough time to stop the physical altercation. RNA confirmed he witnessed Resident 2 hit Resident 1 and saw both residents fall to the ground as Resident 1 was trying to block and defend himself from Resident 2.</p> <p>During a review of Resident 1's Order entry dated 3/18/25, indicated, "Monitor discoloration to Lt elbow for any pain/ discomfort and any active bleeding ... "</p> <p>During a concurrent observation and interview, on 3/26/25 at 3:50 p.m. in Resident 1's room, Resident 1 stated he felt "really bad " that the incident occurred. Resident 1 stated that his elbow still hurt, and a small dry scab was shown on his left elbow. Resident 1 further stated that his old room was in the same hallway as Resident 2 and Resident 2 had been accusing him of stealing money prior to the altercation. Resident 1 stated that staff were aware about Resident 2's accusations.</p> | F 600   | <p>happen and/or monitoring for delayed injury as appropriate.</p> <p>All non-compliance issues identified will be brought forth to the daily morning manager meeting and corrected immediately and reported to the Administrator for review, validation, and resolution.</p> <p>Administrator will do trending/analysis and will report quarterly to the QAPI Committee for further evaluation and/or recommendations.</p> <p>03/26/2025</p> |                      |   |

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| F 600  | Continued From page 3<br><br>During an interview on 3/25/25 at 4:15 p.m., with Director of Nursing (DON), DON stated that the altercation between Resident 1 and Resident 2 violated Resident 1's right to be free from abuse. DON further acknowledged that Resident 1 was mistreated.<br><br>During a review of the facility's policy and procedure (P&P) titled, "Abuse Prevention and Prohibition Program, " dated 8/2020, the P&P indicated, " ...Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property ... Staff must not permit ...physical abuse ...mistreatment ... " | F 600   |   |                      |   |