STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055858	A. BUILDING _____ B. WING _____	C 04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCHO SECO CARE CENTER	144 F STREET GALT, CA 95632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00952815. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	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 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761	F761 Label/Store Drugs and Biologics How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cmatt | TITLE: Administrator | (X6) DATE: 04/07/2025

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 761	Continued From page 1 by: Based on observation, interview, and record review, the facility failed to ensure medications were stored locked for a census of 93 residents, when two medication carts were left unlocked and unattended. This failure had the potential for medication misuse and drug diversion. Findings: During an observation on 4/1/25 at 11:03 a.m. in the facility ' s lobby, medication cart B was unlocked and unattended. During an interview on 4/1/25 at 11:06 a.m. with Licensed Nurse 1 (LN 1), LN 1 confirmed medication cart B was unlocked and stated it should have been locked. LN 1 further stated other people might take the medications if the medication cart was unlocked. During a concurrent observation and interview on 4/1/25 at 11:25 a.m. with LN 2, LN 2 confirmed medication cart A was left unlocked and unattended and stated the medication cart should always be locked. During an interview on 4/1/25 at 12:25 p.m. with the Director of Nursing (DON), DON confirmed the medication cart should be locked at all times to prevent drug diversion. A review of the facility ' s policy titled, "Medication Storage," dated 2024, indicated, "All drugs and biologicals will be stored in locked compartments ..."	F 761	A) On 04/03/2025 upon discovery of medication cart being unlocked Licensed Nurse 1 and Licensed Nurse 2 immediately locked both carts. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: B) DON / designee completed an audit on 04/03/2025 of medication carts to ensure all were locked. All residents have the potential to be affected by this deficient practice. No other areas were identified with having this same deficient practice. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: C) An in-service was initiated by facility DSD / DON on 04/03/2025 and will continue until completion of 100% of Licensed Nurses regarding the importance of locking medication carts. D) DON / designee will conduct random audits of medication carts during their rounds to ensure that the facility process for securing medications is being adhered to. How the facility plans to monitor its performance to make sure that solutions are sustained. E) DON / designee will conduct random audits of medication carts during their rounds to ensure that the facility process for securing medications is being adhered to.	

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F 880	Continued From page 2	F 880	Any issues identified during the audit rounds will be brought forth to the Department Managers five day a week morning meeting for review and immediate resolution. 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. Administrator will do trending/analysis and will report quarterly to the QAPI Committee for further evaluation and/or recommendations.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880	04/03/2025 F880 Infection Prevention & Control How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A.) On 04/01/2025 Licensed Nurse 2 immediately performed hand hygiene. On 04/01/2025 Licensed Nurse 2, Licensed Nurse 3 and Wound Doctor donned enhanced barrier precaution PPE. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: B.) Infection Preventionist completed an audit of staff to ensure no other staff were identified with having the same	

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F 880	Continued From page 3 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow infection control practices for one of three sampled residents (Resident 1), when: 1. Licensed Nurse 2 (LN 2) did not maintain hand hygiene before donning gloves; and 2. LN 2, LN 3, and the Wound Doctor (WD) did	F 880	deficient practice of not preforming hand hygiene and donning enhanced barrier precaution PPE. No other areas were identified with having the same deficient practice. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: C.) Staff have been in serviced 04/01/2025 through 04/04/2025 by Infection Preventionist regarding the importance of hand hygiene and ensuring that enhanced barrier precaution PPE is donned. D.) Infection Preventionist and/or designee will conduct random audits of staff to ensure that hand hygiene is preformed and enhanced barrier precaution PPE is donned. All non-compliance issues identified during these audits will be brought forth to the department managers five days a week morning meeting for review, validation and immediate correction. Administrator will do a trending/analysis and will report quarterly to the QAPI Committee for further evaluation and/or recommendation/s. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is	

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F 880	Continued From page 4 not use required Personal Protective Equipment (PPE, a gown) while providing wound care assessment for Resident 1 ' s right foot; and This failure had the potential to spread infection among residents. Findings: A review of Resident 1 ' s "Admission Record," indicated Resident 1 was admitted to the facility in 2025 with a diagnosis of diabetic foot ulcer (an open sore or wound that develops on the foot of a person with diabetes). During a concurrent observation and interview on 4/1/25 at 11:30 a.m. with LN 2, Resident 1 ' s right foot wound was observed inside the room. LN 2 entered an Enhanced Barrier Precaution (EBP, infection control intervention to reduce transmission of resistant organisms) room without wearing a gown. LN 2 donned gloves without providing hand hygiene and opened the wound dressing. LN 2 stated she should have used a gown and used hand sanitizer before putting on gloves to prevent infection. During a concurrent observation and interview on 4/1/25 at 11:44 a.m. with WD and LN 3, Resident 1 ' s right foot wound was observed inside the EBP room. The WD and LN 3 entered the room to assess the wound without wearing gown. WD stated she should have used the PPE requirement of gown and gloves in the EBP room. LN 3 confirmed there was no gown by the door entrance nor inside the medication cart and stated the use of gown and gloves help prevent the spread of infection.	F 880	integrated into the quality assurance system: E.) Infection Preventionist and/or designee will conduct random audits of staff to ensure hand hygiene is preformed and enhanced barrier precaution PPE is donned. All non-compliance issues identified during these audits will be brought forth to the department managers five days a week morning meeting for review, validation and immediate correction. Administrator will do a trending/analysis and will report quarterly to the QAPI Committee for further evaluation and/or recommendation/s. Include dates when corrective action will be completed. The corrective action completion date must be acceptable to the State: 04/04/2025	

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F 880	Continued From page 5 During an interview on 4/1/25 at 12:31 p.m. with the Infection Preventionist (IP), IP stated staff should wash hands or use hand sanitizer before donning gloves. IP further stated the PPE (gown) was kept inside Resident 1 ' s closet and labeled "supplies" and the PPE requirement for the EBP room included gown and gloves. A review of the facility ' s policy titled, "Enhanced Barrier Precautions," dated 2024, indicated, "Make gowns and gloves available immediately near or outside of the resident ' s room." The policy further stipulated to use gown and gloves during high contact resident care activities like wound care. A review of the facility ' s policy titled, "Hand Hygiene," dated 2024, indicated, "The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves."	F 880		