STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335366	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodside Manor Nursing Home Inc	2425 Clinton Avenue South Rochester, NY 14618

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 observations, interviews, and record review conducted during a Recertification Survey from 08/25/2025 to 08/29/2025, for one (1) of one (1) main kitchen, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, raw shell eggs and raw chicken were not stored in a sanitary manner to prevent cross contamination, temperature controlled for safety (potentially hazardous) foods were not hot-held for service at 140 degrees Fahrenheit (ˆ) or above, thermometers were not stored in a sanitary solution, there was a severely dented can of food, condensation was dripping onto a food container from a hole in a reach-in cooler, and food items were undated and unlabeled. The findings are:Record review of the facility policy titled food storage, dated January 2008, revealed the policy included the following:All food products must be stored, labeled, and dated appropriately by the department procedure to prevent spoilage and possibility of food borne illnesses.Items will be placed in the refrigerator and freezer in a manner to prevent cross contamination.Raw meat will be stored separately in pans, if necessary, on the bottom shelves of the refrigerator or freezer.Eggs will be stored separately on the bottom shelf of the refrigerator. The facility policy Food Temperatures, last revised September 2023, included the following:The facility will ensure that all food is cooked and maintained at proper temperatures.Foods should be stored at the appropriate temperature to maintain safety. Hot foods: hold at 135 Fahrenheit or higher.The facility policy Thermometers, revised May 2020, included the following:Thermometers should be sanitarily stored within the kitchen department when not in use. Observations and an interview during the initial tour of the main kitchen on 08/25/2025 from 8:55 AM to 9:40 AM included the following:There was an approximately 1/2-inch hole in the interior ceiling of the four-door Traulsen reach-in cooler with condensate liquid dripping down and pooling on the lid of a container of tomato soup.There was a stainless-steel pan of what appeared to be approximately 24 cooked shell eggs and a stainless-steel pan of cut cubes that appeared to be cantaloupe that were unlabeled and undated in the 4-door Traulsen reach-in cooler. During an interview at that time, the cook stated the eggs and cantaloupe were prepared the previous afternoon.There was a tray holding five (5) crates of raw shell eggs with five (5) 32-ounce containers of pasteurized liquid eggs stored together and immediately adjacent to each other on the same tray. This was located in the four-door Traulsen reach-in cooler.There was a stainless-steel pan of raw chicken breasts stored directly above a box of raw single sliced bacon in the four-door Traulsen reach-in cooler.There was a 6-pound and 10-ounce can of fruit cocktail in the dry storage room that was severely dented at the end seams on the top and bottom.During observations and an interview on 08/25/2025 at 12:05 PM, there were several cheeseburger patties being held for lunch service in an open-holed pan on the steam table in the main kitchen. When checked by the surveyor using a digital thermapen (a high-performance, instant-read digital thermometer), the temperatures of the cheeseburger patties ranged from 123 Fahrenheit to 133 Fahrenheit. During an interview at this time, the cook stated the burgers had been cooked to about 180 Fahrenheit in the oven and were placed on the steam table a few minutes ago. The cook then placed the burgers back into the oven for reheating.During observations and interviews on 08/25/2025 at 12:08 PM, the cook provided the (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surveyors with the kitchen food service thermometers. There were four (4) bimetallic dial type and one digital probe thermometers in a plastic cup filled with a partially clear liquid with visible debris. During an interview at that time, the cook stated the thermometers were stored in clean water and was not sure when the last time it was changed. During an interview at that time, the Food Service Director stated they should be using a sanitizer solution to store the thermometers. 10 NYCRR: 415.14(h), 10 NYCRR: Subpart 14-1, 14-1.30, 14-1.31(c), 14-1.43(c,e), 14-1.95, 14-1.110(b), 14-1.112

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, and record review conducted during a Recertification Survey from 08/25/2025 to 08/29/2025, for one (1) (Resident #48) of one (1) resident reviewed, the facility did not ensure the interdisciplinary team determined the Resident's right to self-administer medications was clinically appropriate. Specifically, Resident #48 was observed to have a bottle of antifungal powder at their bedside and the Resident stated they had been self-administering the medication. There were no medical orders in place for the powder, for the resident to self-administer or to keep medications at the bedside, and no comprehensive care plan was in place to address the self-administration of medications. This is evidenced by:Resident #48 had diagnoses including diabetes, chronic obstructive pulmonary disease (a disorder that restricts air flow in the lungs), and heart failure. The Minimum Data Set (a resident assessment tool), dated 08/27/2025, documented the resident was cognitively intact. During an observation and interview on 08/27/2025 at 9:17 AM, a bottle of miconazole nitrate 2% powder was at Resident #48's bedside. During an interview at that time, Resident #48 stated they had brought the medication with them when they were admitted to the facility, and the staff had been applying the powder underneath their breasts and within the skin folds of their groin.Review of Resident #48's Order Summary Report (medical orders), current as of 08/29/2025, included an order for miconazole nitrate topical cream 2%: apply to rash to right abdominal fold topically twice daily for 14 days. The orders did not include miconazole nitrate 2% powder, to self-administer medications, or for medications to be kept at the bedside. Review of the Comprehensive Care Plan, dated 08/21/2025, did not include measurable goals and/or interventions addressing Resident #48's ability to safely self-administer medications or store medications at the bedside. During an observation and interview on 08/28/2025 at 10:42 AM, the bottle of miconazole nitrate 2% powder remained at Resident #48's bedside. During an interview at that time, Resident #48 stated the powder was prescribed to them by a dermatologist and they had used the powder for a couple of years. During an interview on 08/28/2025 at 10:58 AM, Licensed Practical Nurse #3 stated Resident #48 did not have an order for miconazole nitrate 2% powder and the powder is considered a medication. They stated the resident should have had an order for the powder, been assessed for safety, and care-planned for the self-administration of medications.During an interview on 08/28/2025 at 11:04 AM, Nurse Practitioner #1 stated miconazole nitrate 2% powder is considered a medication and they did not know Resident #48 had been using the powder. During an interview on 08/28/2025 at 2:53 PM, the Director of Nursing, stated they were not aware Resident #48 had medications at the bedside. They stated for a resident to self-administer medications, they would have to ensure the resident was cognitively intact, could demonstrate safe self-administration of medications, the interdisciplinary team would discuss and approve the plan, provider orders for self-administration and having medications kept at their bedside would need to be in place, and the Resident's care plan would be updated to reflect this. The Director of Nursing stated Resident #48 had managed their medications independently prior to admission to the facility and was safe to self-administer medications. 10 NYCRR 415.3(f)(1)(vi)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review conducted during a Recertification Survey from 08/25/2025 to 08/29/2025, for two (2) (Residents #25 and #30) of two (2) residents reviewed, the facility did not ensure the residents' right to privacy and the confidentiality of their personal and medical records was maintained. Specifically, a computer stationed in a hallway by a resident's room was observed open, exposing Resident #25's personal and medical information, and there were no staff members present to secure the information for nine (9) minutes and a computer was observed open, exposing Resident #30's personal information and medication administration record and there were no staff members present to secure the information for several minutes. The findings are:The facility Workstation Security Policy, dated September 2013, included a laptop computer qualified as a workstation, and all staff should lock their computer when left unattended for any period of time. 1. Resident #25 had diagnoses including chronic pain, chronic kidney disease, and macular degeneration (a progressive eye condition). The Minimum Data Set (a resident assessment tool), dated 08/13/2025, documented the resident had moderately impaired cognition.During an observation and interview on 08/25/2025 at 9:25 AM, a computer was stationed on a medication cart in the hallway facing outward near a resident's room. The computer screen was open, exposing Resident #25's picture, name, date of birth , room number, and acetaminophen medication order. At 9:34 AM, Licensed Practical Nurse #1 returned to medication cart A and stated they should have closed the computer screen when they left the medication cart. 2. Resident #30 had diagnoses including Parkinson's Disease (nerve cell damage in the brain that affects movement), diabetes, and major depressive disorder. The Minimum Data Set, dated [DATE], documented the resident was cognitively intact.During an observation and interviews on 08/26/2025 at 8:16 AM with Licensed Practical Nurse #3 and the Administrator, Licensed Practical Nurse #3's medication cart was in the hallway, unlocked, and the computer screen was open with Resident #30's personal information and medication administration record exposed. During an interview at that time, the Administrator stated they should lock the medication cart and close the computer screen because they should not be open. The Administrator secured the medication cart and computer screen at that time. Licensed Practical Nurse #3 exited Resident #30's room, across the hall from the medication cart and stated they were in the resident's room administering a medication and had not been away from the cart for a long period of time.During an interview on 08/27/2025 at 9:39 AM, the Director of Nursing stated resident personal information should not be visible when the nurse is away from the medication cart. They would expect the nurse to close or minimize the computer screen when walking away.10 NYCRR 415.3(e)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, and record review conducted during a Recertification Survey from 08/25/2025 to 08/29/2025, for one (1) (Residents #12) of one (1) resident reviewed, the facility did not ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene. Specifically, for multiple days, Resident #12 was observed with dark brown debris underneath their fingernails and was observed eating food with their hands. This is evidenced by the following:The facility policy Care of Finger and Toenails, dated October 2023, documented in part the purpose of this procedure is to clean the nail bed, keep nails trimmed, and prevent infections. Nail care is to be completed/offered on shower days and as needed. Nail care includes cleaning and regular trimming. Length of nails/trimming is based on resident preference. Resident #12 had diagnoses that included vascular dementia, anxiety, and depression. The Minimum Data Set (a resident assessment tool), dated 07/16/2025, documented the resident had severe cognitive impairment and required assistance with personal hygiene.Review of the current Comprehensive Care Plan, last revised 05/02/2025, and Kardex (care plan used by certified nursing assistants to direct resident care), current as of 08/29/2025, revealed Resident #12 required staff assistance with grooming and the resident could be combative with nail trimming. Interventions included the staff redirecting the resident by calling it a ?'spa day, informing the resident their family had paid for a special nail day, and staff were encouraged to leave the resident in a position of safety and reattempt when they appeared calm. Review of current Order Summary Report (medical orders), dated 02/18/2025, revealed Resident #12 had a finger foods diet.During an observation on 08/27/2025 at 9:56 AM, Resident #12 was seated at the nurse's station and their fingernails on both hands were long with dark brown debris underneath multiple nails. The resident's nail polish was chipped or missing on most fingers and two fingers on their left hand had jagged nails. During an observation on 08/27/2025 at 3:05 PM, Resident #12 was seated at the nurse's station eating a slice of cake with their bare hands and continued to have dark brown debris underneath multiple fingernails.During an interview on 08/27/2025 at 3:12 PM, Certified Nurse Assistant #3 stated they used hand sanitizer to cleanse residents hands and Resident #12 required cueing with hand hygiene because they liked to eat with their hands. Certified Nurse Assistant #3 stated they did not clean Resident #12's hands that day and did not know if anyone else had prior to giving the resident a slice of cake. Certified Nurse Assistant #3 stated the resident should receive nail care on Tuesdays, it was apparent they had not received nail care, and staff would usually ensure nails and hands were clean before serving food and snacks. Certified Nurse Assistant #3 stated the resident had never refused care without eventually complying, especially when their family visited. During an observation on 08/28/2025 at 10:53 AM, Resident #12's fingernails on both hands had dark brown debris underneath and the thumb nail on their left hand had sharp edges. During an interview on 08/28/2025 at 11:07 AM, Licensed Practical Nurse #3 stated they had not received reports of Resident #12 refusing nail care. They stated the certified nursing assistants were usually able to provide nail care to the resident, but if they were to report a refusal, the nurse was expected to document the incident and reapproach the resident. During an interview on 08/28/2025 at 2:45 PM, the Director of Nursing stated Resident #12 had a history of digging in their brief and they suspected the dark brown debris underneath their fingernails was feces. The Director of Nursing stated they would expect staff to perform hand care before meals, as needed, and as tolerated. 10 NYCRR 415.12(a)(3)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, interviews, and record review conducted during a Recertification Survey from 08/25/2025 to 08/29/2025, for one (1) (Resident #4) of one (1) resident reviewed, the facility did not ensure a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. Specifically, a nurse was observed performing wound care to Resident #4's right heel pressure ulcer, did not follow the medical orders in place for the wound treatment, and did not change gloves or perform hand hygiene in between removing the old dressing and applying the new dressing. This is evidenced by: Review of the facility Wound Care Policy and Procedure, last updated June 2022, included the person performing wound care should remove soiled gloves after removing an old dressing and put on a new pair of gloves before applying a new dressing according to the physician order. Resident #4 had diagnoses that included dementia, dysphagia (impaired ability to swallow), a pressure ulcer on the sacral (tailbone) region, and a pressure ulcer on the heel. The Minimum Data Set (a resident assessment tool), dated 07/30/2025, documented the resident had severe cognitive impairment, was at risk of developing pressure ulcers, had unhealed pressure ulcers, and received pressure ulcer care.Review of the Order Summary Report (medical orders) included an order, dated 08/19/2025, to cleanse the right heel pressure ulcer with wound cleanser, pat dry with gauze, apply a layer of medi-honey (a medical-grade honey product used to promote wound healing), and cover with a 3-inch by 3-inch adhesive foam dressing every day shift.Review of the current comprehensive care plan, dated 08/05/2025, revealed Resident #4 had impaired skin integrity as evidenced by the presence of pressure ulcers. Interventions included, but were not limited to, provide treatment as ordered by the medical provider. During an observation on 08/27/2025 at 10:29 AM, Licensed Practical Nurse #3 performed a dressing change to Resident #4's right heel pressure ulcer. Licensed Practical Nurse #3 removed the old dressing from the wound, cleansed the wound, and applied a new dressing without changing their gloves or performing hand hygiene in between. Additionally, Licensed Practical Nurse #3 did not apply the prescribed medi-honey to the wound area. During an interview on 08/27/2025 at 11:51 AM, Licensed Practical Nurse #3 stated the process for Resident #4's wound care was to remove the old dressing, cleanse with wound cleanser spray, doff (remove) soiled gloves, don (put on) clean gloves, then cover the area with a new dressing. They stated they did not know the Resident's wound care order had changed to include the application of medi-honey and should have checked the medical orders prior to performing the dressing change.During an interview on 08/28/2025 at 2:26 PM, the Infection Preventionist stated a nurse should check the medical orders prior to performing a dressing change in case the order has been modified. They stated when a soiled dressing is removed during wound care, the nurse should remove their gloves, perform hand hygiene, and don new gloves before applying a new dressing. During an interview on 08/28/2025 at 3:00 PM, the Director of Nursing stated they would expect nursing staff to follow wound care instructions per the medical order, check the order prior to performing wound care, and notify the medical team if the order could not be followed as written. They expected the nursing staff to follow the appropriate technique and change their gloves between removing an old dressing and applying a clean dressing.10 NYCRR 415.12(c)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, interviews, and record review conducted during a Recertification Survey from 08/25/2025 to 08/29/2025, for two (2) (Hallway A Medication Cart and Hallway B Medication Cart) of two (2) medication carts and one (1) of one (1) Medication Storage Room, the facility did not ensure all drugs and biologicals were stored in locked compartments in accordance with State and Federal laws and did not ensure an account of all controlled drugs was maintained. Specifically, medication carts were left unlocked and unattended on multiple occasions, medications stored on top of a medication cart were left unattended, and a narcotic log was missing several nurse signatures to verify the accuracy of the narcotic count at shift change. The findings are:Review of the facility Medication Storage Policy and Procedure, last revised May 2023, included all medications will be stored within a locked medication room, cart, boxes, or refrigerators, and the handoff/sign off of keys will be conducted between each shift. Review of the facility policy Medication Administration, last revised 01/16/2022, included the medication cart is to be locked at all times when the nurse is not working at it, never leave the medication cart open and unattended, do not leave any medications on top of the cart when unattended, and medications should not be left bedside unless stated so in a physician's order.During an observation on 08/25/2025 at 9:27 AM, the Hallway B Medication Cart was unlocked, unattended, and there were medications sitting on top of the cart including one (1) unidentified blister pack (packaging for medications) of pills, one (1) bottle of latanoprost (eye drops), one (1) bottle of dorzolamide (eye drops), one (1) bottle of Rhopressa (eye drops), and one (1) bottle of nitroglycerin (heart medication). At 9:34 AM, Licensed Practical Nurse #1 returned to the cart. During an immediate interview, Licensed Practical Nurse #1 stated medications should not be left on top of the medication cart and the cart should be locked when unattended.During an observation and interview on 08/25/2025 at 12:55 PM, the August 2025 Narcotic Record Sign-in Sheet was reviewed and for 8 of 164 opportunities, there were missing signatures on various shifts and no documented evidence the narcotic count was verified by two (2) nurses. During an interview at that time, Licensed Practical Nurse #1 stated two (2) nurses should complete the narcotic count and sign the Narcotic Record with each shift change. They stated the narcotic logbooks should be checked and maintained by a nurse manager to ensure the narcotic count is verified every shift. During an observation and interview on 08/28/2025 at 8:16 AM, the Hallway A Medication Cart was unlocked, unattended, and there was an open, half-full bottle of Tylenol 500 milligrams tablets and a tube of muscle rub topical cream sitting on top of the cart. Licensed Practical Nurse #3 exited a resident's room and during an interview at that time, stated the bottle of Tylenol was left open because they had just administered it to a resident, and they had not left the medication cart unattended for long. During a continuous observation on 08/28/2025 from 11:07 AM to 11:43 AM, the Hallway A Medication Cart was unlocked and unattended. Licensed Practical Nurse #3 returned to the cart at 11:43 AM. During an immediate interview, Licensed Practical Nurse #3 stated they were moving too fast and forgot to lock their medication cart. During an interview on 08/28/2025 at 3:53 PM, the Director of Nursing stated that at no time should medications be left unattended on top of the medication cart and the cart should always be secured. During a follow-up interview at 4:21 PM, the Director of Nursing stated nurses are expected to verify the narcotic count by signing the Narcotic Record Sign-in Sheet at each shift change. 10 NYCRR 415.18(a), (e)(1-4)

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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 observations, interviews, and record review conducted during a Recertification Survey from 08/25/2025 to 08/29/2025, for one (1) (Resident #4) of two (2) residents reviewed, the facility did not 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. Specifically, a nurse was observed removing an old dressing from a wound and applied a clean dressing without changing gloves. Additionally, staff was observed handling soiled and potentially contaminated laundry wearing gloves and no gown to protect clean laundry from potential contamination and themselves from potential exposure. The findings are:The facility Wound Care Policy and Procedure, dated June 2022, included wounds should be treated and cared for in a manner which prevents infection, gloves should be removed and hand hygiene performed after removing an old dressing, and new gloves should be applied before applying a new dressing. The State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Care Facilities, revised 04/28/2025, documented gloves should be changed and hand hygiene performed before moving from a contaminated body-site to a clean body-site during resident care. Resident #4 had diagnoses including a stage two (2) pressure ulcer of the left heel, a stage four (4) pressure ulcer of the sacral region, and diabetes. The Minimum Data Set (a resident assessment tool), dated 07/30/2025, documented the resident had severely impaired cognition, one (1) or more unhealed pressure ulcers, and received pressure ulcer care.Review of Resident #4's Comprehensive Care Plan, dated 06/24/2025, revealed the resident had impaired skin integrity related to a stage two (2) pressure ulcer on their right heel and a chronic stage four (4) ulcer on their coccyx (tailbone region). Interventions included, but were not limited to, staff were to perform skin rounds and provide treatment to the area as ordered by the medical provider. During an observation on 08/27/2025 at 10:29 AM, Licensed Practical Nurse #3 removed the soiled dressing from Resident #4's right heel pressure ulcer, cleansed the wound bed, and applied a clean dressing without changing gloves or performing hand hygiene in between. During an interview on 08/27/2025 at 11:51 AM, Licensed Practical Nurse #3 stated they should have removed the soiled dressing, cleansed the wound, then changed their gloves before applying a new dressing to the wound. During an interview on 08/28/2025 at 2:28 PM, the Infection Preventionist stated the nurse should have removed their gloves and performed hand hygiene in between handling the soiled and clean dressings.The facility Infection Control Policy and Procedure, dated November 2024, included staff handling linen should follow Standard Precautions (basic infection control guidelines which include wearing a gown and gloves to prevent the spread of infection whenever there is a possible exposure).The State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Care Facilities, revised 04/28/2025, documented facility staff should handle all used laundry as potentially contaminated and use standard precautions and appropriate Personal Protective Equipment (items worn to prevent the spread of infection including gown, gloves, and masks). During an interview on 08/27/2025 at 8:53 AM, Laundry Staff #1 stated they only wore gloves to handle soiled linens and resident's personal clothing. The stated they wore gowns and gloves if residents were on isolation precautions (infection control practices used alongside standard precautions). During an observation on 08/28/2025 at 8:49 AM, Laundry Staff #1 was handling visibly soiled bed pads, towels, and hospital gowns which had a strong odor of urine and feces. Laundry Staff #1 was only wearing gloves while handling the soiled items.During an interview on 08/28/2025 at 10:34 AM, the Infection Preventionist stated housekeeping and laundry staff should wear gloves and a gown when handling soiled laundry. During an interview on 08/28/2025 at 11:52 AM, the Administrator stated staff should be wearing gloves and a gown when handling soiled laundry. 10 NYCRR 415.19 (a)-(c)