

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/27/2025
NAME OF PROVIDER OR SUPPLIER  Seneca Nursing & Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Douglas Drive Waterloo, NY 13165	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigation (NY00371778) from 06/23/2025 to 06/27/2025, for six (6) (Residents #1, #2, #27, #35, #37 and #46) of 20 residents reviewed, the facility did not promote and treat each resident with respect and dignity in a manner and an environment that promotes maintenance or enhancement of their quality of life. Specifically, for Residents #2, #35, and #46 staff were observed assisting residents during meals in an undignified manner. Residents #1, #27, #37 and #46 were observed eating with their hands/fingers while dropping food debris on themselves and no staff assist observed. The findings include but not limited to:</p> <p>The facility policy Dignity, dated February 2021, included each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Residents shall be treated with respect and dignity at all times and provided with a dignified dining experience.</p> <p>The facility policy Assistance with Meals, dated March 2022, included residents who could not feed themselves would be fed with attention to safety, comfort and dignity and included not standing over residents while assisting them with meals.</p> <p>1. Resident #46 had diagnoses including dementia, failure to thrive, and anxiety. The Minimum Data Set (a resident assessment tool), dated 03/21/2025, documented the resident had severe impairment of cognitive function and required partial/moderate assistance with eating (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort).</p> <p>The Comprehensive Care Plan, revised on 02/27/2025, documented Resident #46 required one (1) staff assistance for all meals.</p> <p>During an observation on 06/23/2025 at 12:45 PM, Certified Nursing Assistant #1 was assisting Resident #46 with their meal (cueing, handing the silverware, and at times feeding the resident), all while standing over the resident instead of sitting next to them.</p> <p>During observation on 06/25/2025 at 12:47 PM, the Administrator (identified as a paid feeding assistant [auxilliary stff that have completed specialized training in assisting/feeding residents who require assist]) entered the dining room and stated to Resident #46 (who was not eating) that they knew that they were hungrier than that, handed them a spoon, pointed to a piece of pie, and walked away from the table without assisting the resident. Resident #46 attempted to feed themselves but dropped their pie and their sandwich onto their lap and the floor. No further assist was offered.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 335400	If continuation sheet Page 1 of 3

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 06/26/2025 at 8:15 AM, Certified Nursing Assistant #6 was feeding Resident #46 bites of food from a fork while standing over them instead of sitting next to them.</p> <p>During an observation on 06/26/2025 at 12:30 PM, Certified Nursing Assistant #5 was feeding Resident #46 while standing over the resident instead of sitting next to them.</p> <p>2. Resident #1 had diagnoses including dementia, dysphagia (difficulty swallowing), and adult failure to thrive. The Minimum Data Set, dated [DATE], documented Resident #1 was severely impaired cognitively and required set-up/clean-up assistance with eating.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 12/13/2024, revealed the resident should eat in the main dining room for all meals and the resident may be fed by a trained feeding assistant if needed.</p> <p>During an observation on 06/25/2025 at 12:32 PM, Resident #1 was in the unit dining room with their lunch tray, eating independently. Food items were observed falling off the resident's plate and onto the tray and Resident #1 was observed spooning the food items off the tray into their mouth. There was no staff assisting the resident with their meal.</p> <p>During an observation on 06/26/2025 at 12:20 PM, Resident #1 was in the unit dining room and was observed eating their lunch meal with their fingers which consisted of cut up pork and cooked carrots. There was no staff assisting the resident with the meal.</p> <p>3. Resident #35 had diagnoses including dementia, dysphagia, and adult failure to thrive. The Minimum Data Set, dated [DATE], documented Resident #35 was severely impaired cognitively and was dependent on staff for eating.</p> <p>Review of Resident #35's Comprehensive Care plan, dated 12/02/2024, included the resident required one (1) staff assist for all meals and required being fed one item at a time with verbal prompts required for intake of drinks.</p> <p>During an observation on 06/23/2025 at 12:32 PM, Certified Nursing Assistant #1 was standing in the dining room going from table to table assisting Residents #35, #46, and two (2) other residents with eating (feeding the residents a bite or two and moving on to another resident and back again) throughout the meal. Residents #35 and #46, when not being assisted, were not eating independently.</p> <p>During an observation on 06/26/2025 at 8:17 AM, Certified Nursing Assistant #1 was feeding Resident #35 their meal while standing over the resident instead of sitting next to them.</p> <p>During an interview on 06/27/2025 at 9:39 AM, Certified Nursing Assistant #1 stated there were about seven (7) residents on the unit that needed assistance with eating and they were standing to assist multiple residents with eating because they were the only staff member in the dining room. Certified Nursing Assistant #1 stated the residents were at different tables and they should have finished with one resident and then gone onto the next.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/27/2025 at 10:43 AM, Licensed Practical Nurse Manager #1 stated staff should be sitting when assisting a resident with eating. Staffing is an issue (not enough staff), but staff are aware that if the residents require feeding assistance they should sit with the resident and never be standing.</p> <p>During an interview on 06/27/2025 at 11:50 AM, Registered Nurse Quality Care Coordinator stated staff should have been seated when assisting residents with eating their meals and that standing while assisting residents with eating was a dignity concern.</p> <p>10 NYCRR 415.3(d)(2)(i)</p>		