STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335504	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Health Care Center	2987 Seneca Street West Seneca, NY 14224

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review conducted during a Complaint investigation (2588244), the facility failed to ensure that each resident received adequate supervision to prevent accidents for one (1) of four (4) residents (Resident #1) reviewed for accidents. Specifically, Resident #1 was care planned not to be left alone in the bathroom while toileting. On 07/12/2025, Resident #1 was left unattended, fell off the toilet and sustained a left hip fracture requiring surgical intervention. This resulted in actual harm to Resident #1 that is not Immediate Jeopardy.The finding is:The policy titled Fall Prevention revised 08/2025, documented that all reasonable steps are taken to keep the resident safe from falls and related injury. Residents would be evaluated for their potential risk for falls to assure that measures were implemented to keep residents safe from falls and related injury. Recommendations from the interdisciplinary team members would be incorporated into the resident's individual care plan and the resident monitored for its effectiveness to prevent falls. The policy titled Interdisciplinary Care Planning revised 09/2025, documented the comprehensive resident-centered care plan was developed by the interdisciplinary team upon admission and reviewed/updated on a regular basis throughout the resident's length of stay. The comprehensive care plan and Kardex must always be current and accurately reflect the resident's status. The care plan/Kardex must always be reviewed by staff prior to initiating resident care. Care plans were accessible in electronic format to any person involved in care of the resident. Resident #1 had diagnoses including vascular dementia (type of dementia caused by reduced blood flow to the brain) with behavioral disturbances, Parkinson's disease (progressive neurodegenerative disorder that affects movement, balance, and coordination), and post-traumatic stress disorder (PTSD). The Minimum Data Set (a resident assessment tool) dated 06/17/2025, documented Resident #1 was severely cognitively impaired, was usually understood, and usually understands others. The Care Plan Report with a revision dated 09/19/2023 (current) documented Resident #1 was at risk for falls related to elimination, medication, and mobility. The plan documented interventions to remind the resident to call for assistance; required a low bed with a winged mattress and a gym mat on floor; non-skid shoes/slippers; safety education, and to monitor for medication side effects. Staff to stay with resident (inside the bathroom) for toileting. The Kardex dated 07/11/2025, documented Resident #1 required a moderate assist of one (1) staff member for transfers and a minimal assist of one (1) staff member for ambulation. Documented under elimination included instructions for 'Staff to stay with resident (inside bathroom) for toileting'. The facility investigation dated 07/12/2025 at 7:25 PM signed by the Director of Nursing, documented Resident #1 experienced a fall on the floor in their bathroom. Certified Nurse Aide #1 assisted Resident #1 onto the toilet in the bathroom in their room. Resident #1 was incontinent. Certified Nurse Aide #1 left the room to retrieve clean linen to provide care, taking approximately Less than two (2) minutes. Upon their return, Resident #1 was found on the floor in the bathroom doorway. A handwritten statement dated 07/12/2025 completed by Certified Nurse Aide #1documented they took Resident #1 to the bathroom and noticed they were incontinent of urine. They needed more supplies, so they stepped out of the room for thirty seconds to get supplies from the linen cart. Returned to the room and found Resident #1 lying outside the bathroom door. A nursing progress note by Registered Nurse #1 dated 07/12/2025 at 8:37 PM, documented status post (after) Resident #1 was found on the floor, they complained of left hip pain with passive (assisted movement) range of motion. Their left leg was slightly shorter and abducted (outwardly rotated). The family and Nurse Practitioner #1 were updated. A new order was received to obtain x-rays of the resident's left hip, pelvis, and femur. Nurse Practitioner #1 spoke with Resident #1's family and informed them that Resident #1 may need surgery if the x-rays were positive (for fractures). The note documented the family did not want surgery and may opt for comfort measures. A nursing progress note by Licensed Practical Nurse Supervisor #1 dated 07/12/2025 at 8:43 PM, documented Resident #1 was found lying flat on the floor on their back at the bathroom doorway. Licensed Practical Nurse Supervisor #1 documented that Certified Nurse Aide #1 stated they had put the resident on the toilet then stepped out to grab supplies to complete incontinent care. Resident #1 self-ambulated and fell. Resident #1 complained of left hip pain and that there were no visible injuries.The Radiology Results Reports dated 07/13/2025 with an examination date of 07/12/2025 documented an acute (new onset) fracture of the left proximal femur with displacement, and complex comminuted fracture of the intertrochanteric left femur (a broken hip where the femur meets the pelvis, at the top of the thigh bone) Review of untitled facility document dated 07/14/2025, Nurse Practitioner