

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/14/2026
NAME OF PROVIDER OR SUPPLIER  Seneca Hill Manor Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  20 Manor Drive Oswego, NY 13126	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interviews, the facility failed to report timely, verbal and physical abuse for one (1) of three (3) residents (Residents #1) reviewed, resulting in the alleged perpetrator having continued access to residents. Specifically, on 04/02/2026 at approximately 5:30 PM, Certified Nurse Aide #2 alleged they witnessed Certified Nurse Aide #1 handling and speaking to Resident #1 roughly during care. On 04/02/2026, Certified Nurse Aide #1 continued to have access to residents and worked until the end of their shift at 10:00 PM. Certified Nurse Aide #2 did not report the incident until 04/03/2026 at approximately 2:30 PM. Resident #1 was not assessed until 04/03/2026 at approximately 8:00 PM. Findings include: The 05/2023 facility policy, Resident Abuse documented in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must ensure that all alleged violations involving abuse, neglect or mistreatment, including injuries of unknown source or misappropriation of resident property, are reported immediately, but not more than two (2) hours after the allegation is made if the events that cause the allegation involve abuse. Resident #1 had diagnoses of Alzheimer's disease with severe cognitive impairment. The 03/02/2026 Minimum Data Set assessment documented Resident #1 required partial/moderate assistance of one (1) staff with personal hygiene and bathing, handheld assistance with ambulation and could be resistive to care. The Resident Incident Report, completed by the Director of Nursing on 04/03/2026, documented Certified Nurse Aide #2 reported Certified Nurse Aide #1 was rough with their voice when attempting to clean Resident #1 and heard Resident #1 say ouch and Certified Nurse Aide #1 told the resident to hold on. Certified Nurse Aide #2 admitted they could not see (the incident) totally. Registered Nurse Manager #3 was made aware on 04/03/2026 and reported the allegation to the Administrator on 04/03/2026 at 2:40 PM. Timely reporting was reviewed with Certified Nurse Aide #2 by the Administrator. Resident #1 was assessed by the Director of Nursing on 04/03/2026 with no noted injuries, marks, or signs of mental distress. There was no documented evidence Certified Nurse Aide #2 reported the alleged incident 04/02/2026 to a supervisor or the Administrator at the time it occurred. During an interview on 04/13/2026 at 12:35 PM, Registered Nurse Manager #3 stated on 04/03/2026 at 2:30 PM, they were approached by Certified Nurse Aide #2. Certified Nurse Aide #2 reported an alleged abuse allegation of an incident involving Certified Nurse Aide #1 and Resident #1. Certified Nurse Aide #2 stated the incident occurred during the 04/02/2026 evening shift and they did not report it for fear of backlash from staff. Registered Nurse Manager #3 stated as soon as the incident was reported to them, they notified the Administrator. During an interview on 4/13/2026 at 2:16 PM, Certified Nurse Aide #2 stated they were called to assist Certified Nurse Aide #1 with Resident #1's care. Resident #1 was standing in front of their bathroom sink and was incontinent of stool. The resident attempted to pull their pants back up and was combative. Certified Nurse Aide #2 stated they observed Certified Nurse Aide #1 standing off to the side of the resident and the bathroom sink. Certified Nurse Aide #2 stated they witnessed Certified Nurse Aide #1 push the resident towards the sink and speak sternly to them. They thought Certified Nurse #1 rushed the resident's care. Certified Nurse Aide #2 heard the resident say ouch but was unsure if it was related to care. Certified Nurse Aide #2 stated when Resident #1's care was completed; they continued to work until the end of their shift at 10:00 PM. (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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/14/2026
NAME OF PROVIDER OR SUPPLIER  Seneca Hill Manor Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  20 Manor Drive Oswego, NY 13126	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>They did not report the incident to anyone until they returned to work on 04/03/2026 for their 2:00 PM-10:00 PM shift. They reported the incident to Registered Nurse Manager #3 on 04/03/2026 at 2:30 PM. During an interview on 04/13/2026 at 2:37 PM, Certified Nurse Aide #1 stated they were not aware of any abuse allegations against them on 04/02/2026. On 04/03/2026 at 5:40 PM, they received a phone call from the Director of Nursing telling them they could not re-enter the building. They stated Resident #1 was incontinent of bowel on 04/02/2026 at 5:30 PM and had stool on their hands. Certified Nurse Aide #1 attempted to clean the resident, but they were combative and resistive to care. They did not want to leave the resident alone, so they called for Certified Nurse Aide #2 to assist them. Resident #1 was often resistive to care but they could not leave the resident due to the need to clean them, so they called for help. Certified Nurse Aide #1 stated they gave Resident #1 short, simple commands that the resident responded to. They denied pushing or yelling at the resident. During an interview on 04/14/2026 at 10:55 AM, the Director of Nursing stated they were not aware of the abuse allegation involving Certified Nurse Aide #1 and Resident #1 until 04/03/2026 at approximately 3:30 PM, while they were out of the building. The Director of Nursing stated when they returned to the facility, they immediately assessed Resident #1. They immediately suspended Certified Nurse Aide #2 pending investigation, and re-educated Certified Nurse Aide #1 on timely reporting. Resident #1 did not recall the incident and had no injuries, harm or psychological harm. The Director of Nursing concluded there was not sufficient evidence that abuse occurred as Certified Nurse Aide #2 was unsure of the events when interviewed. The Director of Nursing stated there were no incidents involving abuse or mistreatment to any residents by Certified Nurse Aide #1. During an interview on 04/14/2026 at 11:30 AM with the Administrator, they stated they were advised of an abuse allegation involving Certified Nurse Aide #1 and Resident #1 on 04/03/2026 at approximately 2:30 PM. They immediately went to the 3rd floor with Staff Educator #9 to assess the situation and interview residents. The Administrator stated they immediately re-educated Certified Nurse Aide #2 on timely reporting requirements for any allegation of abuse, neglect or mistreatment and Staff Educator # 9 completed education with all the staff in the building on timely reporting. New York Codes, Rules and Regulations 415.4 (b)(2)</p>		