STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335815	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Hill Manor Inc	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)
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. 48895 50561 Based on observation, record review, and interviews during the recertification survey conducted 10/3/2024-10/9/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 of 4 residents (Residents #25, #53, and #86) reviewed. Specifically, Resident #86 was not provided timely toileting assistance; Resident #53 was not provided nail care, facial hair care, or a weekly shower as planned; and Resident #25 was not provided their offloading boots (used to lessen pressure on the feet) as planned. Findings include: The facility policy, Positioning of the Resident, revised 10/12/2023, documented all residents who could not independently position themselves would be positioned by nursing staff to reduce risk for development of pressure areas; heels would be elevated and offloaded with a pillow, or booties as ordered when lying in bed; and positioning systems included heel protectors. The facility policy, Toileting Schedule for Residents, revised 6/5/2024, documented each resident that was at high risk for skin breakdown and/or incontinence would have an opportunity to void every 2 to 4 hours, and as needed. The facility policy, Standards of Care, revised 6/25/2024, documented every resident would be assisted as necessary to maintain personal hygiene for optimal physical and psychological well-being; residents would receive a shower or tub bath at least weekly; fingernails would be cleaned and/or cut weekly with the shower/tub; daily care would include facial shaving; residents would be offered to be taken to the toilet/bedpan every 2 to 4 hours and assisted as necessary; and incontinent residents would have briefs changed every 2 to 4 hours. 1) Resident #86 had diagnoses including Alzheimer's Disease, diverticulosis of the intestines (pouches in the wall of the colon), and constipation. The 7/17/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, was easily distractible and had difficulty keeping track of what was being said, was dependent with toileting, and was frequently incontinent of bowel. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan initiated 4/19/2024 documented the resident required assistance with activities of daily living related to decreased mobility, weakness, cognitive impairment, and poor safety awareness; had dementia; was incontinent of bowel and bladder and used incontinence briefs. Interventions included total dependence on two or more staff for transfers with the use of a mechanical sit to stand lift and monitor for signs and symptoms of skin breakdown during toileting and changing every 2 to 4 hours. Resident #86 was observed on 10/7/2024: - At 11:04 AM, telling Unit Helper #18 they needed to go to the bathroom, and they had a large bowel movement. - At 11:07 AM, telling Certified Nurse Aide #13 they had a bowel movement. Certified Nurse Aide #13 left the resident to find their aide. - At 12:47 PM, pulling at the front of their pants at the nurse's station. Staff did not acknowledge the resident. - At 12:51 PM, holding the front of their pants open with their hand at the waist band. Staff did not acknowledge the resident. - At 1:07 PM, the resident was with family who asked Licensed Practical Nurse #17 if the resident could be assisted to the bathroom. - At 1:10 PM, (1 hour and 56 minutes later) the resident was taken to the bathroom. The resident had feces up the front to their belly button, and in the back up to their lower back. Feces covered the inside of the resident's shirt on the lower seam, and the inside of the resident's pant legs. During an interview on 10/7/2024 at 1:20 PM, Certified Nurse Aide #13 stated there were originally 4 certified nurse aides on the unit, but 1 left early. They were not assigned Resident #86 and did not know the last time the resident was assisted with toileting. During an interview on 10/7/2024 at 1:23 PM, Certified Nurse Aide #19 stated they were not assigned Resident #86 and thought Certified Nurse Aide #20 assisted the resident with toileting before they left for the day at 10:00 AM. After viewing the resident assignment roster at the nurse's station, they stated the resident was documented as assigned to Certified Nurse Aide #16. No one took over the resident assignment for Certified Nurse Aide #20. Certified Nurse Aide #20 told them all their residents' care was done, so the remaining certified nurse aides only had to answer lights for those residents. During an interview on 10/7/2024 at 1:50 PM, Certified Nurse Aide #16 stated they were not assigned Resident #86, as they switched assignments with Certified Nurse Aide #20. They did not know the last time the resident was assisted with toileting. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/7/2024 at 2:13 PM, Licensed Practical Nurse #17 stated they did not know if Resident #86 was on a toileting schedule. They were not aware the resident needed to use the bathroom until the resident's family brought it to their attention. There were resident care instructions on the inside of the closet door in the resident's room. If a resident rang for assistance anyone could review the resident care instructions to determine how to assist the resident safety. If Resident #86 stated they needed to use the bathroom, they should have been taken to the bathroom. During an interview on 10/7/2024 at 4:18 PM, the Director of Nursing stated if a certified nurse aide was scheduled to leave early, they expected them to report to the licensed practical nurse and the other certified nurse aides on that hall before leaving so the other certified nurse aides could absorb the assignment. Residents should be assisted with toileting every 2-4 hours and as needed. It was important to assist residents with toileting timely to reduce maceration of skin, promote bladder emptying, and reduce urinary tract infections. Additionally, it was a dignity issue to make a resident sit in soiled clothing. 2) Resident #53 had diagnoses including Alzheimer's Disease. The 7/7/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, required maximum assistance for bathing and hygiene, and did not refuse care. The comprehensive care plan initiated 8/17/2022 documented the resident was dependent for all activities of daily living. Interventions included assist of one for showers and on Tuesdays during the day shift. The undated certified nurse aide resident care card (care instructions) documented the resident required extensive assistance of one for personal hygiene. Resident #53 was observed: - on 10/3/2024 at 10:39 AM, with facial hair on their chin, and long fingernails with brown debris underneath. - on 10/4/2024 at 12:45 PM, with facial hair on their chin, and long fingernails with brown debris underneath. - on 10/8/2024 at 9:06 AM, with facial hair on their chin, and long fingernails with brown debris underneath. The hair on the back of their head was flattened and unkempt. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/8/2024 at 1:57 PM, Certified Nurse Aide #13 stated morning care included washing, shaving, oral care, and nail care. The resident showers were listed on their assignments. Hair should be washed during a shower, or a waterless cap used if a bed bath was given. Nail care and facial hair removal should be done whenever needed or requested. Certified nurse aides could do nail care on everyone. If a resident refused, they would report to the nurse and document it in the computer. Resident #53 was on their assignment that day. They washed and dressed the resident and got them up into their chair. Later, they put them back to bed, changed them and got them back up into their chair. They did not give the resident their shower today because they did not have time to do so. They did not report that to anyone or document that a shower was not given. They also did not wash the resident's hair or provide nail or facial hair care. The resident should have received their shower that day. Showers and removal of facial hair were important to maintain good skin integrity and made residents feel better emotionally. Nail care was important as residents could scratch themselves which could result in infection. During an interview on 10/8/2024 at 2:47 PM, Licensed Practical Nurse #12 stated morning care included washing, dressing, dental care, hair care, facial hair care, and nail care. Showers were typically weekly and if a shower was not given or facial hair and nail care was not provided, they expected it to be reported to them so they could follow up. Nail care could be provided by certified nurse aides if the resident was not a diabetic. No one had reported to them that Resident #53 had not received their shower that day. They were unsure when the resident's shower was scheduled for, but if it was for that day they should have received their shower. It was important that residents received their shower because uncleanliness could lead to fungal and bacterial infections. Nail care was important as long nails could result in scratches to the skin which could lead to infections. Removing facial hair was important for dignity for some residents and female residents would likely want that taken care of. During an interview on 10/9/2024 at 12:32 PM, the Director of Nursing stated showers with hair washing were given at least once a week. Facial hair removal and nail care should be addressed on shower days but could be done any time it was needed. Certified nurse aides could not cut diabetic nails but could clean and file them and could shave residents if they were not taking coumadin (a blood thinner). Facial hair and nail care were part of the personal grooming task and if it was signed for it implied those services were completed. They expected uncompleted care to be reported to the nurse so the nurse could follow up. Resident #53 had chin hairs sometimes. They could be resistive at times, but usually was agreeable to care if reapproached. It was important that scheduled showers were given to maintain skin hygiene, prevent urinary tract infections, prevent skin maceration, and for resident dignity. 3) Resident #25 had diagnoses including diabetes, peripheral vascular disease (a disease that affects blood flow) and an unstageable heel ulcer (a wound caused by pressure where the base could not be seen). The 8/4/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, a Stage 2 pressure ulcer (partial skin loss), did not refuse care, and required extensive assistance with most activities of daily living. The Comprehensive Care Plan revised 6/5/2024 documented the resident required assistance of one with all activities of daily living and assistance of 2 two for transfers using a sit to stand mechanical lift. Interventions included offloading bilateral heel boots on at all times. The undated care instructions documented the resident had heel protectors. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/10/2024 physician order documented offloading booties to bilateral heels at all times. A 9/9/2024 progress note by the Director of Nursing documented the resident had a pressure injury to the left heel measuring 1.4 centimeters x 0.8 centimeters, without drainage. The skin surrounding the wound had good color. The plan was to continue with current order for treatment and off-loading booties. Resident #25 was observed: - on 10/3/2024 at 10:23 AM, in their room without off-loading boots, the offloading boots were in a chair by the window. - on 10/4/2024 at 9:32 AM, in the hallway wearing blue socks without off-loading boots. - on 10/7/2024 at 10:11 AM, in their room without off-loading boots, the offloading boots were in a chair by the window. The 10/2024 Treatment Administration Record documented off-loading booties to bilateral heels at all times from 6:00 AM-2:00 PM, from 2:00 PM-10:00 PM. and from 10:00 PM-6:00 AM. The off-loading booties were documented as administered by Licensed Practical Nurse #21 at 10:24 AM on 10/3/2024, and by Licensed Practical Nurse #22 on 12:43 PM on 10/4/2024. During a telephone interview on 10/3/2024 at 12:37 PM, the resident's family member stated the resident was supposed to wear big puffy boots to prevent pressure ulcers and they had not seen them on the resident lately. During an interview on 10/7/2024 at 4:18 PM, the Director of Nursing stated if a resident was care planned and ordered to have off-loading boots on at all times, they expected them to be on the resident. The resident could refuse, but an attempt should be made. Certified nurse aides placed the off-loading boots on, and the licensed practical nurse checked to ensure they were on and signed off on them. They should not be documenting the boots were in place if they were not and if they were on the resident's windowsill all day. The importance of off-loading boots was to reduce the chance of skin breakdown, promote healing, and prevent further skin breakdown. During an interview on 10/8/2024 at 1:28 PM, Certified Nurse Aide #16 stated they were responsible for placing the off-loading boots on Resident #25 on 10/3/2024. They did not put them on the resident that day. They did not tell staff they were not in place, because they did not know the resident needed to wear them all the time. They were new to the facility and wished they had more time to read about each resident and their needs but did not have time to do that. The off-loading boots were important to protect the resident's heels. During an interview on 10/9/2024 at 11:07 AM, Licensed Practical Nurse #23 stated they were responsible for ensuring the offloading boots were in place and applied correctly. They documented this in the treatment administration record after observing the boots in place. They were assigned to Resident #25 on 10/3/2024 and did not put on the resident's off-loading boots and could not recall if they saw them on the resident that day. They stated the boots were signed as in place on all 3 shifts on 10/3/2024. The off-loading boots were needed for Resident #25 to prevent breakdown. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10NYCRR 415.12(a)(3)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 35045 Based on record review and interviews during the recertification survey conducted 10/3/2024-10/9/2024, the facility did not ensure performance reviews for certified nurse aides were completed at least once every 12 months for 2 of 2 Certified Nurse Aides (Certified Nurse Aides #1 and #2) reviewed. Specifically, Certified Nurse Aides #1 and #2 did not have performance evaluations documented at least once every 12 months. Findings included: The facility Certified Nurse Aide job description dated 6/11/2020, documented the certified nurse aide reported to the Nurse Manager and was responsible for providing individual and comprehensive resident care in accordance with and under the supervision of licensed personnel. Personnel files for Certified Nurse Aides #1 and #2 did not include documented evidence of performance evaluations completed at least once every 12 months. During an interview on 10/8/2024 at 1:34 PM, Certified Nurse Aide #11 stated they had been employed by the facility for 2 years and never had a performance evaluation. They thought they were supposed to be completed annually. During an interview on 10/9/2024 at 10:06 AM, the Director of Nursing stated Certified Nurse Aides #1's and #2's personnel files did not have annual performance evaluations. At the beginning of the year, their Human Resources Department recognized a facility problem area that employee evaluations were not completed timely, and all employees were to be completed by the end of the year. The Director of Nursing stated the Unit Manager was responsible for the completion of their unit staff performance evaluations. The Unit 3 Manager had resigned in September 2023 and had not completed any performance evaluations. It was important employee performance evaluations were completed timely so staff were aware of how they were doing, where they could improve, and how to do better in their current position. During an interview on 10/9/2024 at 12:10 PM, the Administrator stated staff performance evaluations were lacking and the management team was retrained in the beginning of the year. The facility was trying to get all nursing staff performance evaluations caught up by the end of the calendar year. 10 NYCRR 415.26(d)(7)