STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395775	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sena Kean Nursing and Rehabilitation Center	17083 Route 6 Smethport, PA 16749

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, facility documentation, and clinical records, and staff interviews, it was determined that the facility failed to ensure that two of three residents reviewed were free of neglect during care which resulted in actual harm of left femur fracture for one resident (Resident R1) and actual harm of a laceration of the right eyebrow and forehead for one resident (Resident R2).Findings include: Facility policy entitled Abuse Investigation and Reporting dated 1/22/25, revealed The Administrator or designee will monitor that any further potential abuse, neglect, exploitation, or mistreatment is prevented while the investigation is in progress. Facility policy entitled Abuse Prevention Program dated 1/22/25, revealed Our residents have the right to be free from abuse, neglect, misappropriation of residents properly and exploitation. Facility policy entitled Safe Resident Handling and Movement Policies' dated 1/22/25, revealed Subject to Care Plan team determinations regarding rehabilitation, restoration or maintenance of functional abilities, medical contraindications, emergencies, or other exceptional circumstances, staff is expected to follow the individual resident's plan of care as written. And Transfer assistance, mobility assistance and other resident handling and movement tasks are to be carried out in accordance with the individual resident's care plan. Facility investigation refers to the regulatory definition of Neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Resident R1's physician's orders revealed an order dated 9/12/25, to transfer with staff assist of two with wheeled walker, stand up lift as needed. Resident R1's admission MDS dated [DATE], under Section GG 0170 Mobility for Sit to Stand. The ability to come to a standing position from sitting in a chair, wheelchair, or the side of the bed was coded as Dependent indicating Helper does ALL the effort. Resident does none of the effort to complete the activity OR, the assistance of 2 or more helpers is required for the resident to complete the activity. Resident R1's clinical record revealed a nursing note written by Registered Nurse (RN) Employee E13, dated 9/19/25, at 8:55 p.m. This writer called to [NAME] Wing shower room by Licensed Practical Nurse [LPN] due to Resident was on the floor. Upon entering room, note Resident lying supine [on back] on floor to left of the room with head toward the left side of room and legs stretched out with exception of left low extremity [LLE] which was slightly bent and externally rotated. Resident assessed. Skin pink, warm and dry. Respiration easy and regular with occasional dry cough noted. Skin assessed - Resident has old, scabbed abrasion to L knee noted. LLE noted to be slightly bent and externally rotated. Resident unable to participate in passive or active range of motion [ROM - how far you can move or stretch a part of your body such as a joint or muscle] in this leg. Resident indicated pain 9/10 across mid/posterior thigh. Denies hitting head. Note towels on the floor, Resident and Certified Nursing Assistant [CNA] explained that this was to keep him from slipping, however Resident stated that he stepped off of the towels and slipped. Resident was being assisted by CNA to wheelchair and was lowered to the ground. Certified Registered Nurse Practitioner [CRNP] was notified and resident sent to the ER. Resident R1's clinical record revealed a nurse's progress note dated 9/20/25, that identified the resident was sent from a local hospital ER to another medical center in another city due to Left hip/femur fracture due to this evening's fall. Daughter and CRNP notified. Documentation submitted by the facility dated 9/20/25, revealed that the facility initiated an investigation which revealed CNA Employee E9 provided a written statement with an incident date of 9/19/25, which revealed, When transferring from shower chair to wheelchair, towels were placed under feet to keep bottom of feet dry, he placed heel of foot at the top of towel and went to stand even with shower chair locked, he slid on towel and on the edge of shower chair. Employee E9, was able to catch his top half of body and carefully put him on the floor so that he didn't hit his head, but his bottom half had fallen onto the floor. He stated he had throbbing pain in hip and Nurse and RN were notified. The facility investigation revealed that LPN Employee E7 provided a written statement with an incident date of 9/19/25, which revealed at the beginning of the shift between 1600 and 1700, CNA E9 and 2 other CNA's approached LPN E7 asking if Resident R1 was able to be put on the toilet. LPN E7 replied, yes, he/she can transfer with two assist and walker. Around 2000 that evening, CNA Employee E9 came and said, I have an emergency. He is on the floor. LPN employee E7 followed CNA Employee E9 to the shower room and saw Resident R1 laying on his back in the shower stall. His left leg was bent up with the knee going outward and towards the ground. He said they couldn't move his leg and had fallen directly on the left hip that he had previously repaired. During an interview on 10/22/25, at 12:00 p.m. the Director of

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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)

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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 review of facility policy, facility documentation and clinical record, and staff interviews, it was determined that the facility failed to appropriately transfer a resident in accordance to facility policy which resulted in actual harm of a left hip and femur (upper leg) fracture for one of three residents reviewed (Resident R1). This deficiency is cited as past non-compliance.Findings include: Facility policy entitled Safe Resident Handling and Movement Policies, dated 1/22/25, revealed, staff is expected to follow the individual resident's plan of care as written. Residents identified using the Minimum Data Set Assessment as Totally Dependent or requiring Extensive Assistance for Transfer and/or Mobility will be handled by means of mechanical lift equipment and/or other resident assist devices; A total dependent transfer requiring a mechanical lift will require two staff for bed mobility; transfer assistance, mobility assistance and other resident handling and movement tasks are to be carried out in accordance with the individual resident's care plan; and individual employees shall not deviate from the individual resident's care plan. Resident R1's clinical record revealed an admission date of 8/8/25, with diagnoses that included fracture of left femur (upper leg), difficulty in walking, Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), and asthma. Resident R1's physician's orders revealed an order dated 9/12/25, to transfer with staff assist of two with wheeled walker, stand up lift as needed. Resident R1's admission MDS dated [DATE], under Section GG 0170 Mobility for Sit to Stand. The ability to come to a standing position from sitting in a chair, wheelchair, or the side of the bed was coded as Dependent indicating Helper does ALL the effort. Resident does none of the effort to complete the activity OR, the assistance of 2 or more helpers is required for the resident to complete the activity. Resident R1's clinical record revealed a nursing note written by Registered Nurse (RN) Employee E13, dated 9/19/25, at 8:55 p.m. This writer called to [NAME] Wing shower room by Licensed Practical Nurse [LPN] due to Resident was on the floor. Upon entering room, note Resident lying supine [on back] on floor to left of the room with head toward the left side of room and legs stretched out with exception of left low extremity [LLE] which was slightly bent and externally rotated. Resident assessed. Skin pink, warm and dry. Respiration easy and regular with occasional dry cough noted. Skin assessed - Resident has old, scabbed abrasion to L knee noted. LLE noted to be slightly bent and externally rotated. Resident unable to participate in passive or active range of motion [ROM - how far you can move or stretch a part of your body such as a joint or muscle] in this leg. Resident indicated pain 9/10 across mid/posterior thigh. Denies hitting head. Note towels on the floor, Resident and Certified Nursing Assistant [CNA] explained that this was to keep him from slipping, however Resident stated that he stepped off of the towels and slipped. Resident was being assisted by CNA to wheelchair and was lowered to the ground. Certified Registered Nurse Practitioner [CRNP] was notified and resident sent to the ER. Resident R1's clinical record revealed a nurse's progress note dated 9/20/25, that identified the resident was sent from a local hospital ER to another medical center in another city due to Left hip/femur fracture due to this evening's fall. Daughter and CRNP notified. Documentation submitted by the facility dated 9/20/25, revealed that the facility initiated an investigation which revealed CNA Employee E9 provided a written statement with an incident date of 9/19/25, which revealed, When transferring from shower chair to wheelchair, towels were placed under feet to keep bottom of feet dry, he placed heel of foot at the top of towel and went to stand even with shower chair locked, he slid on towel and on the edge of shower chair. Employee E9, was able to catch his top half of body and carefully put him on the floor so that he didn't hit his head, but his bottom half had fallen onto the floor. He stated he had throbbing pain in hip and Nurse and RN were notified. The facility investigation revealed that LPN Employee E7 provided a written statement with an incident date of 9/19/25, which revealed at the beginning of the shift between 1600 and 1700, CNA E9 and 2 other CNA's approached LPN E7 asking if Resident R1 was able to be put on the toilet. LPN E7 replied, yes, he/she can transfer with two assist and walker. Around 2000 that evening, CNA Employee E9 came and said, I have an emergency. He is on the floor. LPN employee E7 followed CNA Employee E9 to the shower room and saw Resident R1 laying on his back in the shower stall. His left leg was bent up with the knee going outward and towards the ground. He said they couldn't move his leg and had fallen directly on the left hip that he had previously repaired. During an interview on 10/22/25, at 12:00 p.m. the Director of Nursing confirmed that CNA Employee E9 had transferred Resident R1 on 9/19/25 without the assistance of a second staff member and did not follow orders which identified that Resident R1 required two staff for