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	04/22/2026

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of facility policy, Resident Council minutes, and resident interviews, it was determined that the facility failed to ensure that residents were updated in a timely manner regarding Resident Council concerns, and the facility failed to correct Resident Council concerns for a period of four months (January 2026, through April 2026). Findings include: A facility policy Resident Council dated 1/12/26, revealed the facility supports residents' rights to organize and participate in the resident council. The purpose of the resident council is to provide a forum for a) residents, families and resident representatives to have input in the operation of the facility; b) discussion of concerns and suggestions for improvement; c) consensus building and communication between residents and facility staff; and d) disseminating information and gathering feedback from interested residents. A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern. The quality assurance and performance improvement (QAPI) committee will review information and feedback from the resident council as part of their quality review. Issues documented on council response forms may be referred to the QAPI committee, if applicable. Review of the Resident Council minutes over the past three months, February 2026, through April 2026, revealed a pattern/trend with issues regarding staff shutting call lights off without meeting resident's needs, failure to follow the facility smoking plan to assist residents who desire to smoke, and dietary trays not being passed by nursing staff timely resulting in cold food for residents. During a Resident Council meeting on 4/20/26, at 10:00 a.m. interviews with Residents R72, Resident R89, Resident R90, Resident 95, and Resident R86, who all attend Resident Council meetings regularly indicated that the concerns noted above have been voiced in several past monthly meetings with no resolution. The residents further indicated awaiting until the next monthly Resident Council meeting was not a timely response to learn of facility resolutions. No evidence was provided to ensure the residents' concerns voiced and further stated in the Resident Council minutes for the past three months reviewed were noted of timely corrective actions, in addition to the residents being updated in a timely manner of those actions. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1)(4) Management 28 Pa. Code 201.29(a) Resident rights

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy, clinical records, observations, and staff interviews it was determined that the facility failed to appropriately maintain supplemental oxygen equipment for four of 23 residents reviewed for respiratory services (Residents R54, R38, R92, and R60).Findings include: A facility policy entitled Oxygen dated 1/12/26, indicated that any tubing not in use will be placed in a bag to ensure tubing remains clean and dry.Observations on 4/19/26, revealed:-At 3:20 p.m. Resident R38's oxygen tubing hanging on the portable oxygen tank attached to the back of his/her wheelchair and the tubing not in a bag, and the tubing for his/her respiratory nebulizer machine lying on the floor.-At 3:25 p.m. Resident R54's oxygen tubing lying next to his/her bed on the floor and not in a bag. -At 3:33 p.m. Licensed Practical Nurse (LPN) Employee E3 picked Resident R38's respiratory nebulizer tubing up from the floor then attached the tubing to Resident R38's nebulizer mask and was going to administer an as needed medicated nebulizer treatment. During an interview at that time Registered Nurse (RN) Employee E2 confirmed that Resident R38's oxygen and nebulizer tubing should be stored in a bag and should be discarded.During an interview at 3:35 p.m. RN Employee E2 confirmed that Resident R54's oxygen tubing should be stored in a plastic bag to prevent contamination. Observations on 4/20/26, revealed:-At 9:40 a.m. Resident R92 with a clear bag hanging on his/her concentrator [medical device that pulls oxygen in, filters it, and delivers purified oxygen to patients], and his/her oxygen tubing for the portable tank attached to the back of his/her wheelchair hanging over the top of the portable tank on the back of the wheelchair.-At 9:45 a.m. Resident R60's supplemental oxygen tubing for the portable tank wrapped around the right wheel of his/her wheelchair and required cutting to release it.-During an interview at that time, LPN Employee E4 confirmed the above-mentioned observations and cut Resident R60's oxygen tubing from the wheel of his/her wheelchair. Observations on 4/21/26, revealed:-At 10:38 a.m. Resident R38's oxygen tubing for the portable tank attached to the back of his/her wheelchair hanging over the top of the portable tank on the back of the wheelchair.-At 10:41 a.m. Resident R54's oxygen tubing for the portable tank attached to the back of his/her wheelchair hanging over the top of the portable tank on the back of the wheelchair.During an interview at 10:45 a.m. RN Employee E5 confirmed the above-mentioned observations and that the oxygen tubing should be stored in a bag to prevent contamination. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on review of facility policy and resident observations, and staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for seven of 23 residents (Residents R15, R23, R28, R38, R54, R82, and R83).Findings include:A facility policy entitled Cleaning of Wheelchairs and Geri-chairs dated 1/12/26, indicated that wheelchairs are cleaned according to the resident's shower schedule on the 11:00 p.m. - 7:00 a.m. shift prior to the shower day.Observations on 4/19/26, between 2:00 p.m. and 4:30 p.m. and 4/20/26, between 9:00 a.m. and 2:30 p.m. revealed that Residents R15, R23, R28, R38, R54, R82, and R83's wheelchairs with copious amounts of dried food particles, dried liquids, accumulation of dust and dirt, and debris on frames, wheels, arm rests, seats, seat cushions, and leg rests.During an interview on 4/21/26, at 10:41 a.m. Registered Nurse RN Employee E6 confirmed the condition of the above wheelchairs were as stated. During an interview on 4/22/26, at 9:41 a.m. the Nursing Home Administrator confirmed that the wheelchairs were to be cleaned on the overnight shift by nursing staff, and that they frequently failed to maintain adequate staff on that shift, and that could have contributed to failure to clean the wheelchairs. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3) Management28 Pa. Code 211.12(d)(1)(5)(f.1)(3) Nursing services

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on review of facility policy, observations and staff interview, it was determined that the facility failed to maintain privacy of confidential information during medication administration for two of five medication carts (West A Cart and East A Cart).Findings include:A facility policy entitled Computer Terminals/Workstations dated 1/12/26, indicated in so far as practical/feasible, computer terminals/workstations will be positioned or shielded so that screen are not visible to the public or to unauthorized staff; only authorized users are granted access to resident and facility information; and a user may not leave his/her workstations or terminal unattended unless the terminal screen is cleared and the user if logged off.Observation on 4/19/26, at 3:55 p.m. revealed the [NAME] A medication cart was parked in [NAME] A hallway and was unattended with the computer screen containing resident information visible to anyone passing by in the corridor. During an interview at the time of the observation, Licensed Practical Nurse (LPN) Employee E1 acknowledged the lack of privacy with resident information on the computer screen.Observation on 4/20/26, at 8:35 a.m. revealed the East A medication cart was parked in East A hallway and was unattended with the computer screen containing resident information visible to anyone passing by in the corridor. During an interview at the time of the observation, LPN Employee E5 acknowledged the lack of privacy with resident information on the computer screen. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policy, observations and staff interview, it was determined that the facility failed to prevent the opportunity for potential unauthorized access of medications on two of five medication carts (East A Cart and [NAME] B Cart).Findings include:A facility policy entitled Medication Labeling and Storage dated 1/12/26, indicated that compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.Observation on 4/19/26, at 3:51 p.m. revealed the [NAME] B Medication Cart was parked in the [NAME] B hallway unlocked and unattended. During an interview at 3:55 p.m. Licensed Practical Nurse (LPN) Employee E1 confirmed that the medication cart should have been locked.Observation on 4/20/26, at 8:35 a.m. revealed the East A Medication Cart was parked in the East A hallway unlocked and unattended.During an interview at that time, LPN Employee E5 verified the cart was not secured while he/she left the cart to attend to a resident. 28. Pa. Code 201.18(b)(1) Management28 Pa. Code 211.12(d)(1) Nursing services