STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425139	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Health & Rehabilitation Center	140 Tokeena Rd Seneca, SC 29678

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure that oxygen tubing, nasal cannula (NC) and mask were stored in a sanitary manner for 3 residents (Resident (R)4, R119, and R105) out of 24 sampled residents. In addition, 1 of 3 residents (R4) did not have an order for the use of the oxygen.Findings include: Review of the facility's policy titled Oxygen Administration dated 12/15/2022 revealed, . Oxygen is administered under orders from a physician, except in case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.Change oxygen tubing and mask/canula weekly and as needed if it becomes soiled or contaminated. Keep delivery devices covered in a plastic bag. Review of R105's Face Sheet located in the Profile tab of the EMR revealed R105 was admitted to the facility on [DATE], with diagnoses including but not limited to, acute right heart failure, acute respiratory failure with hypoxia, and acute on chronic diastolic congestive heart failure. Review of R105's annual MDS with an ARD of 12/26/25, located in the EMR under the MDS tab revealed a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. During an observation on 03/26/25 at 10:02 AM, R105 was in bed with the NC uncovered in a plastic bag and lying on the floor next to R105's bed. During an interview on 03/26/25 at 10:25 AM, the Infection Preventionist (IP) confirmed that when the resident was not using oxygen, the NC must be covered in a plastic bag. Review of R119's undated Face Sheet located in the EMR under the Profile tab revealed R119 was admitted to the facility on [DATE], with diagnoses including but not limited to, chronic obstructive pulmonary disease. Review of R119's annual MDS with an ARD of 01/24/26, located in the EMR under the MDS tab revealed a BIMS score of 2 out of 15, which indicated the resident's cognition was severely impaired. Review of R119's Physician Order dated 02/06/26, located in the EMR under the Orders tab revealed oxygen at one to ten LPM [liters per minute] via NC as needed for shortness of breath (SOB). During an observation on 03/24/26 at 12:11 PM, revealed R119 in bed with the NC without a plastic cover and lying on the floor. During an observation and interview on 03/26/26 at 10:11 AM, the Certified Nursing Aide (CNA)4 (continued on next page)

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 - Few	observed and confirmed R119's oxygen tubing hung off the mobility bar of R119's bed and was not stored in a plastic cover. During an interview on 03/26/26 at 1:15 PM, CNA2 stated, . The nasal cannula needs to be stored in a plastic bag when it is not in use. During an interview 03/26/26 at 1:19 PM, CNA3 stated, . The nasal cannula should be inside a plastic bag when the patient is not using it. During an interview on 03/26/26 at 2:00 PM, LPN1 stated, . When the NC is not in use, it must be stored inside a plastic bag. Review of R4's admission Record located in the Profile tab of the electronic medical record (EMR) revealed R4 was initially admitted to the facility on [DATE], with diagnoses including but not limited to, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, (COPD) and Alzheimer's disease. Review of R4's modified admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/09/26 located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident was severely cognitively impaired. During an observation on 03/24/26 at 1:18 PM, R4 was in bed with the oxygen concentrator running. The oxygen tubing and NC were lying on her food tray. Licensed Practical Nurse (LPN)2 entered R4's room and placed the NC back on R4. After a short time, R4 took the NC off and dropped the NC on the floor. LPN2 came back in the room and put the NC back on R4. During an observation on 03/26/26 at 12:40 PM, R4 was in bed, nebulizer and mask were lying directly on the overbed table. Review of R4's Physician Orders located in the EMR under the Orders tab, revealed there were no orders for the use of oxygen. During an interview on 03/26/26 at 3:45 PM, LPN2 was asked about putting the NC back on R4 after the NC was found on R4's lunch tray and later on the floor. LPN2 stated, [R4] is constantly pulling her NC off and laying it down, and that it was okay if it was on her food tray as long as it wasn't in the food. I just picked it up off the floor and put it back on [R4] automatically. LPN2 stated, I should have changed it. LPN2 stated, Yes, there should have been an oxygen order. [R4] has been on oxygen since she was admitted to the facility. During an interview on 03/24/26 at 4:15 PM, the Director of Nursing (DON) stated that R4 should have had an oxygen order. The DON stated, Oxygen tubing, NC and any masks should always be stored in a clear plastic bag and if the tubing/NC was dropped on the floor, it should be replaced and never put back on the resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to provide a safe, clean microwave for 1 of 3 Nourishment rooms (200-Hall). The failure to ensure the microwave was clean and in good repair had the potential to add metal paint flecks to the 43 residents on the 200 hall who may have their food heated/reheated in the microwave.Findings include:Review of the facility's policy titled Routine Cleaning and Disinfection dated 03/25/26 provided by the Administrator indicated, It is the policy of the facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Policy Explanation and Compliance Guidelines . 4. Routine cleaning of common areas, including clean utility/nourishment room, a. remove any items in disrepair, or items that are unwashable, stained, soiled or rusted.During an observation on 03/25/26 at 10:34 AM, the 200-hall nourishment room microwave had burn spots in the bottom front left corner, paint chipped on front bottom in two places, paint was chipped front top in two places, approximately two inches and rear across the back seam two inches. Further observation revealed paint peeling and metal exposed on four inches of the fan and rust was exposed. During an interview on 03/25/26 at 10:37 AM, Registered Nurse (RN)1 stated, the microwave looked burnt and overcooked. I do not know the cleaning schedule. Typically, housekeeping is in here. RN1 validated the paint was chipped.During an interview on 03/25/26 at 10:43 AM, the Dietary Manager (DM) stated, the paint is peeling and it was dirty. I would not use it. The paint was chipped over the fan area. I do not know who cleans it. During an interview on 03/25/26 at 11:00 AM, RN1 stated, housekeeping should be cleaning the microwave daily. We use the microwave for popcorn and residents' personal food. The microwave should be cleaned by anyone who uses it and makes a mess. During an interview on 03/25/26 at 11:02 AM, the Administrator observed the microwave and stated it would need to be replaced.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, facility staff failed use the required Personal Protective Equipment (PPE) of eye protection, gowns, and gloves, prior to entering the room, for 1 of 1 residents (Resident (R)102) reviewed for enteric precautions (enhanced infection control measures used to prevent the spread of spore-forming pathogens) out of a total sample of 24 residents. Specifically, R102 was in enteric precautions isolation for a potential C-Difficile (stool infection). This failure had the potential to increase the risk of transmission of C-Difficile to all residents in the facility.Findings include:Review of the facility's policy Management of C. Difficile Infection revised on 08/28/25 revealed, . Licensed nurses may implement preemptive contact precautions when C. difficile infection is suspected, pending results of testing. Once confirmed, contact precautions shall be implemented. General principles related to contact precautions for C. difficile: all staff are to wear gloves and a gown upon entry into the resident's room and while providing care; hand hygiene shall be performed by handwashing with soap and water.Review of R102's admission Record, located in the electronic medical record (EMR) under the Profile tab revealed R102 was admitted to the facility on [DATE], status post hospitalization for treatment of bowel obstruction. During an observation on 03/24/2026 at 12:00 PM, revealed on R102's door was a sign that indicated Enteric Precautions. There was PPE on the cart by the door that contained eye protection, gowns, and masks. Certified Nursing Assistant (CNA)5 enter R102's room to answer the call light. CNA5 did not complete hand hygiene or put on any PPE prior to entering the room. Further observation revealed CNA6 also entered R102's room and did not complete hand hygiene or apply the required PPE prior to entering the room.During an interview on 03/24/26 at 12:15 PM, when asked about the PPE, CNA6 stated she was unaware that R102 required any PPE. CNA6 acknowledged the sign on R102's door indicated hand hygiene; gloves and a gown were required prior to entering the room.During an observation on 03/24/26 at 12:20 PM, in R102's room, CNA5 provided personal care and the only PPE worn was gloves. When CNA5 exited R102's room, she had one glove on and was holding the garbage bag with the gloved hand. CNA5 did not perform hand hygiene prior to leaving R102's room, or after placing the garbage bag in the soiled utility room.During an interview on 03/24/26 at 12:25 PM, CNA5 stated she performed hand hygiene with the hand sanitizer outside the soiled utility room. CNA5 also stated she was unaware that R102 was on any type of isolation precautions even though the PPE cart was located outside the room and the notice was on the resident's door. She stated sometimes those are leftovers and she hadn't been given any report that R102 was on precautions. During an interview on 03/24/26 at 12:30 PM, Licensed Practical Nurse (LPN)4 stated that a stool specimen was obtained the evening of 03/23/26 and the PPE cart and sign was placed on 03/24/26. LPN4 was unsure if other staff on the unit had been notified of R102 being placed on enteric precautions. During an interview at on 03/24/26 at 12:40 PM, LPN3 stated the Infection Preventionist (IP) directed her this morning, 03/24/26 at 9:00 AM, during the facility morning meeting to place R102 on enteric precautions, put the sign on the door and the PPE cart in place. LPN3 further stated she did not . educate/inform . the staff of the rationale/requirements for the enteric precautions for R102. LPN3 presumed the staff would notice the sign and PPE cart and act accordingly.During an interview on 03/24/26 at 2:00 PM, with the Director of Nursing (DON) and IP, the IP stated R102 was the only resident on enteric, or contact, precautions. The IP also stated each unit has the notices needed to place on the door and at least one stocked PPE cart for use at any time. The DON and IP were unable to state why the precautions were not put into place on 03/23/26, and the IP was unaware there were no designated bins in R102's room for waste. The DON and IP stated that hand hygiene and PPE was to be put on prior to entering the resident's room and hand hygiene performed prior to leaving resident's room.