STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555022	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca District Hospital D/P Snf	130 Brentwood Dr Chester, CA 96020

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 - Minimal harm or potential for actual harm Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43031 Based on observation, interview and record review the facility failed to protect twelve (12) of twelve (12) residents (Resident 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12) from abuse by a staff member when Licensed Nurse (LN) A, with willful intent, deprived residents of necessary medical care and treatment by withholding Resident one (1) through 12 ' s medications that were ordered by their Medical Doctor (MD). This occurred during the morning (am) shifts of 5/25/24 and 5/26/24. LN A was observed via video from a camera located above the nurse ' s station medication desk throwing medications in the garbage, putting medications in her scrub (uniform) pockets, and leaving some medications in drawers that were subsequently found by LN B. LN A documented that the medications observed being withheld, were administered to residents one through 12. This failure had the potential to cause significant physical harm, pain, and mental anguish by depriving residents of necessary medications that were ordered by their MD, the residents did not receive required medical care and treatment in order to attain or maintain their physical, mental and psychological well-being and resulted in Substandard Quality of Care. Findings: During a review of facility ' s policy and procedure titled, Abuse Prevention, dated 3/5/2019, indicated, Each resident has the right to be free from abuse .by anyone, including but not limited to facility staff .Abuse is the willful infliction of injury .including the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. During a review of facility ' s policy and procedure titled, Medication Administration, dated 5/4/2017, indicated, The purpose of this policy is to ensure proper and safe medication administration practices as best practice .Any medication administered must be charted immediately .If the medication is not administered to the resident after it has been poured and is NOT a controlled substance, the licensed nurse will .Indicate non-administration of medication .note the reason the medication was held .If the medication is not administered to the resident after it has been poured and IS a controlled substance, the licensed nurse will, Indicate non- administration of medication .note the reason the medication was held .Two licensed nurses will verify the medication has been properly disposed of . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555022	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca District Hospital D/P Snf	130 Brentwood Dr Chester, CA 96020

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 - Minimal harm or potential for actual harm Residents Affected - Many	1. A review of Resident 1 ' s medical record indicated that Resident 1 was admitted on [DATE] with diagnoses that included, Atrial Fibrillation (Afib, irregular often rapid heart rate commonly causing poor blood flow), Heart Failure (heart muscle weakens and stiffens and doesn ' t pump blood effectively), and Hypertension (HTN, High Blood Pressure). The Minimum Data Set (MDS, a tool for evaluating and implementing a standardized assessment) Brief Interview for Mental Status (BIMS, Section C assessing cognitive function) dated 4/14/24, indicates Resident 1 rates 14/15, which equates to being cognitively intact. 2. A review of Resident 2 ' s medical record indicated that resident 2 was admitted on [DATE] with diagnoses that included, Psychosis (Mental disorder with disconnection from reality), Failure to Thrive (FTT, General decline in physical and mental health), HTN, and Dementia (Affects brain function such as memory, thinking, and social abilities, and interferes with daily lives). The MDS BIMS dated 5/14/24, indicates Resident 2 rates 3/15, which equates to severe impairment. 3. A review of Resident 3 ' s medical record indicated that resident 3 was admitted on [DATE] with diagnoses that included, Cancer, Chronic Obstructive Disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), and Depression. The MDS BIMS dated 4/6/24 indicates Resident 3 rates 9/15, which equates to moderate impairment. 4. A review of Resident 4 ' s medical record indicated that resident 4 was admitted on [DATE] with diagnoses that included, Afib, Chronic Kidney Disease (CKD, Gradual loss of kidney function, damage and unable to filter blood adequately), and Dementia (Affects brain function such as memory, thinking, and social abilities, and interferes with daily lives). The MDS BIMS dated 4/10/24 indicates Resident 4 rates 8/15, which equates to moderate impairment. 5. A review of Resident 5 ' s medical record indicated that resident 5 was admitted on [DATE] with diagnoses that included, Quadriplegia (Paralysis of all four limbs), Malnutrition (Not having enough to eat, not eating enough of the right things, or being unable to process or use the food eaten), and Depression. The MDS BIMS dated 3/11/24 indicates Resident 5 rates 15/15, which equates to being cognitively intact. 6. A review of Resident 6 ' s medical record indicated that resident 6 was admitted on [DATE] with diagnoses that included, Cerebrovascular Accident (CVA, Stroke), Coronary Artery Disease (CAD, Damage or disease in the heart ' s major blood vessels), and Heart Failure. The MDS BIMS dated 5/2/24 indicates Resident 6 rates 06/15, which equates to severe impairment. 7. A review of Resident 7 ' s medical record indicated that resident 7 was admitted on [DATE] with diagnoses that included, Heart Failure, HTN, and Chronic Respiratory Failure (Difficulty breathing, lungs cannot get enough oxygen to the blood or too much carbon dioxide exists). The MDS BIMS dated 3/7/24 indicates Resident 7 rates 0/15, which equates to severe impairment. 8. A review of Resident 8 ' s medical record indicated that resident 8 was admitted on [DATE]with diagnoses that included, Afib, HTN, and Osteoporosis (Loss of bone strength and density). The MDS BIMS dated 3/25/24 indicates Resident 8 rates 15/15, which equates to being cognitively intact. 9. A review of Resident 9 ' s medical record indicated that resident 9 was admitted on [DATE] with diagnoses that included, COPD, Dementia, and Respiratory Failure. The MDS BIMS dated 3/7/24 indicates Resident 9 rates 03/15, which equates to severe impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555022	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca District Hospital D/P Snf	130 Brentwood Dr Chester, CA 96020

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 - Minimal harm or potential for actual harm Residents Affected - Many	10. A review of Resident 10 ' s medical record indicated that resident 10 was admitted on [DATE] with diagnoses that included, HTN, Alcohol Abuse, Hyponatremia (Low blood sodium), and Hyperkalemia (High blood potassium). The MDS BIMS dated 4/9/24 indicates Resident 10 rates 14/15, which equates to being cognitively intact. 11. A review of Resident 11 ' s medical record indicated that resident 11 was admitted on [DATE] with diagnoses that included, CVA, HTN, and Diabetes Mellitus (DM). The MDS BIMS dated 3/5/24 indicates Resident 11 rates 07/15, which equates to severe impairment. 12. A review of Resident 12 ' s medical record indicated that resident 12 was admitted on [DATE] with diagnoses that included, Afib, Heart Failure, HTN, and CVA. The MDS BIMS dated 4/15/24 indicates Resident 12 rates 8/15, which equates to moderate impairment. 1. During a review of Resident 1's medical records titled, Orders, undated, the medication Orders indicated, Resident 1 was ordered Pantoprazole (treats gastroesophageal reflux disease (GERD), stomach problems) 40 milligrams (mg, measurement unit) 1 tablet (tab) by mouth (PO, per os) every (Q) day. The Pantoprazole was a routine (scheduled medication, assigned a specific time to be administered, not an as needed (prn) medication), medication scheduled to be administered daily at 08:00 am daily. During a review of Resident 1's medical records titled, Cerner Medication Administration Record (MAR) and Pyxis (Automated medication dispensing system), dated 5/25/24 through 5/26/24, indicated, on 5/26/24 at 07:51 am, LN A removed Pantoprazole from the Pyxis, and scanned the Pantoprazole into the MAR as having been administered. On 5/26/24 at 08:06 am LN A was observed via video throwing Resident 1 ' s Pantoprazole in the garbage. A review of Resident 1 ' s medical record indicated that Resident 1 ' s vital signs (VS) were taken on 5/27/24 as follows: blood pressure (BP) 138/77, and heart rate (HR) 78. 2. During a review of Resident 2's medical records titled, Orders, undated, the medication Orders indicated, Resident 2 was ordered Tramadol (pain medication) 50 mg 1 tablet PO Q 6 hours as needed (prn, pro re nata - as the situation demands) for moderate pain, Divalproex Sodium (antiseizure and bipolar treatment) 250 mg 1 tab two times per day (BID), Docusate (constipation treatment) 100 mg 1 tab PO Q day, Magnesium Oxide (mineral) 250 mg 1 tab PO Q day, Metoprolol (high blood pressure treatment) 50 mg 1 tab PO Q day, Calcium Carbonate (mineral) 1000 mg 2 chewable tabs three times per day (TID). Routine medications were scheduled to be administered at 09:00 am daily. During a review of Resident 2's medical records titled Cerner Medication Administration Record and Pyxis, dated 5/25/24 through 5/26/24, indicated, on 5/26/24 beginning at 08:21 am all the ordered medications were pulled from the Pyxis and scanned into the MAR by LN A. LN A was then observed via video putting Resident 2 ' s Tramadol in a medication cup and then throwing the other medications in the garbage. On 5/26/24 at 08:24 am, LN A was observed via video putting Resident 2 and Resident 11 ' s Tramadol in the same medication cup and left the station for 21 seconds then returned to the station empty handed. A review of Resident 2 ' s medical record indicated that Resident 2 ' s VS were taken on 5/27/24 as follows: blood pressure (BP) 138/75, and heart rate (HR) 78. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555022	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca District Hospital D/P Snf	130 Brentwood Dr Chester, CA 96020

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 - Minimal harm or potential for actual harm Residents Affected - Many	3. During a review of Resident 3's medical records titled, Orders, undated, the medication Orders indicated, Resident 3 was ordered Gabapentin (anticonvulsant and nerve pain treatment) 400 mg 1 capsule (cap) PO Q day, Lisinopril (high blood pressure, heart failure treatment) 10 mg 1 tab PO Q day, Sertraline (antidepressant treatment) 50 mg 1 tab PO Q day, Aspirin (Asa, Nonsteroidal anti-inflammatory drug (NSAID) and blood thinner) 81 mg PO Q day, Carvedilol (high blood pressure, heart failure treatment) 3.125 mg 1 tab PO BID, Cholecalciferol (Vitamin D) 1000 International unit (iu, unit of measurement) 1 tab PO Q day, Cyanocobalamin (Vitamin B12) 1000 microgram (mcg, unit of measurement) 1 tab PO Q day, Docusate 250 mg 1 cap PO BID, Loratadine (antihistamine, allergy treatment) 10 mg 1 tab PO Q day, Multivitamin with Minerals 1 tab PO Q day, Omeprazole (Stomach acid treatment) 20 mg 1 cap PO Q day, Vitamin A and D Topical Apply topical ointment BID, Zinc Oxide Topical Apply topical ointment BID, Levothyroxine (Low thyroid treatment) 100 mcg PO Q day. Routine medications were scheduled to be administered to Resident 3 at 09:00 am daily. During a review of Resident 3's medical records titled, Cerner Medication Administration Record and Pyxis, dated 5/25/24 through 5/26/24, indicated, on 5/25/24 beginning at 08:35 am all the ordered medications except for Levothyroxine were pulled from the Pyxis and scanned into the MAR by LN A. On 5/25/24 at 08:43 am, LN A was observed via video throwing Resident 3 ' s medication in the garbage. A review of Resident 3 ' s medical record indicated that Resident 3 ' s VS were taken on 5/27/24 as follows: blood pressure (BP) 199/76, and heart rate (HR) 80. Resident 3 ' s medications were administered, and VS were taken again BP 143/54. 4. During a review of Resident 4's medical records titled, Orders, undated, the medication Orders indicated, Resident 4 was ordered Amlodipine (high blood pressure and chest pain (cp) treatment) 5 mg 1 tab PO Q day, Clonidine (high blood pressure treatment) 0.1 mg 1 tab PO BID, Cyanocobalamin 500 mcg, .5 tab PO Q day, Docusate 100 mg 1 cap PO BID, Hydralazine (high blood pressure treatment) 25 mg 1 tab PO Q 8 hours, Insulin Glargine (high blood sugar treatment) 15 units (u, unit of measurement) 0.15 milliliters (ml, unit of measurement) subcutaneous (SQ) injection (inj) BID, Levothyroxine 50 mcg 1 tab PO Q day, Metoprolol Extended Release (ER) (high blood pressure, chest pain, and heart failure treatment) 100 mg 2 tabs PO Q day, Nystatin topical powder (fungal and yeast infection topical treatment) 1 application topical BID prn rash, and Multivitamin 1 tab PO Q day. Routine medications were scheduled to be administered to Resident 4 at 09:00 am. During a review of Resident 4's medical records titled, Cerner Medication Administration Record and Pyxis, dated 5/25/24 through 5/26/24, indicated, on 5/25/24 beginning at 08:43 am all the ordered medications except Hydralazine, Levothyroxine, and Insulin injection were pulled from the Pyxis and scanned into the MAR by LN A. On 5/25/24 at 08:47 am LN A was observed via video throwing Resident 4 ' s medication in the garbage. On 5/26/24 beginning at 09:20 am, all the ordered medications except Hydralazine, Levothyroxine, and Insulin injection were pulled from the Pyxis and scanned into the MAR by LN A. On 5/26/24 at 09:24 am, LN A was then observed via video throwing Resident 4 ' s medication in the garbage. A review of Resident 4 ' s medical record indicated that Resident 4 ' s vital signs were taken on 5/27/24 as follows: blood pressure (BP) 174/80, and heart rate (HR) 74. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555022	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca District Hospital D/P Snf	130 Brentwood Dr Chester, CA 96020

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 - Minimal harm or potential for actual harm Residents Affected - Many	5. During a review of Resident 5's medical records titled, Orders, undated, the medication Orders indicated, Resident 5 was ordered Amlodipine (for high blood pressure) 5 mg 1 tab PO Q day, Ascorbic Acid (vitamin C) 500 mg 1 tab PO Q day, Baclofen (muscle relaxant) 20 mg 1 tab PO four times per day (QID), Dantrolene (muscle relaxant) 25 mg 1 cap PO three times per day (TID), Diclofenac (pain relief, NSAID) topical gel 1 application BID, Docusate 250 mg 1 cap PO Q day, Fluoxetine (antidepressant) 60 mg 3 caps PO Q day, Gabapentin 400 mg 1 cap PO QID, Magnesium Oxide (mineral) 250 mg 1 tab PO Q day, Mirabegron (urinary incontinence treatment) 50 mg 1 tab PO Q day, Multivitamin 1 tab PO Q day, Omeprazole 20 mg 1cap PO Q day, Polyethylene Glycol 3350 (laxative) 17 grams (g, unit of measurement) 1 each PO Q day, Potassium Chloride 10 milliequivalent (mEq, unit of measurement) 1 cap PO BID, Saccharomyces boulardii lyso (probiotic) 250 mg 1 cap BID, Zinc Oxide topical 1 application topical ointment BID, and Methenamine (antibiotic for bladder and kidney infection treatment) 1 gram (g, unit of measurement) 1 tab PO BID. Routine medications were scheduled to be administered to Resident 5 at 09:00 am. During a review of Resident 5's medical records titled, Cerner Medication Administration Record and Pyxis, dated 5/25/24 through 5/26/24, indicated, on 5/26/24 beginning at 09:24 all ordered medication except Omeprazole, Polyethylene Glycol 3350 were documented as pulled from the Pyxis and scanned into the MAR by LN A. On 5/26/24 at 09:24 am, LN A was observed via video pouring five (5) tabs of Methenamine into a cup, Resident 5 only had 1 tab ordered. On 5/26/24 at 09:27 am, LN A was observed via video deliberately not removing several of Resident 5 ' s medications from the cabinet which the medications were located after LN A scanned the medications as being pulled including Ascorbic acid, Docusate, Magnesium Oxide, Multivitamin, and Saccharomyces boulardii lyo. A review of Resident 5 ' s medical record indicated that Resident 5 ' s vital signs were taken on 5/27/24 as follows: blood pressure (BP) 130/72, and heart rate (HR) 54. 6. During a review of Resident 6's medical records titled, Orders, undated, the medication Orders indicated, Resident 6 was ordered Cholecalciferol (vitamin D3), 1000 IU 1 tab PO Q day, Docusate 100 mg 1 tab PO Q day, Duloxetine (antidepressant and nerve pain treatment) 120 mg 2 caps PO Q day, Furosemide (diuretic) 40 mg I tab PO Q day, Gabapentin 300 mg 1 cap PO TID, Levetiracetam (antiseizure treatment) 500 mg 1 tab PO BID, Multivitamins with Minerals 1 tab PO Q day, Pantoprazole 40 mg 1 tab PO Q day, Potassium Bicarbonate (mineral) 10 mEq 1 tab PO Q day, Vitamin A and D 1 application Q day, Zinc Oxide topical 1 application Q day, and Oxycodone Acetaminophen (narcotic pain medication) 5 - 325 mg 1 tab PO Q 6 hours prn pain. Routine medications were scheduled to be administered to Resident 6 at 09:00 am. During a review of Resident 6's medical records titled, Cerner Medication Administration Record and Pyxis, dated 5/25/24 through 5/26/24, indicated, on 5/25/24 beginning at 09:07 am, all ordered medications except Vitamin A and D topical and Zinc Oxide topical were documented as pulled from the Pyxis and scanned into the MAR by LN A. On 5/25/24 at 09:07 am, LN A did not crush the medications (not including the oxycodone) per MD orders. Resident 6 cannot take pills that are not crushed thus, indicating the medications were not administered. The Oxycodone was not removed from its packaging and was kept by LN A at the nurse ' station then was removed from the station when LN A walked towards the break room, as observed on the video. A review of Resident 6 ' s medical record indicated that Resident 6 ' s vital signs were taken on 5/27/24 as follows: blood pressure (BP) 120/55, and heart rate (HR) 56. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555022	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca District Hospital D/P Snf	130 Brentwood Dr Chester, CA 96020

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 - Minimal harm or potential for actual harm Residents Affected - Many	7. During a review of Resident 7's medical records titled, Orders, undated, the medication Orders indicated, Resident 7 was ordered Amlodipine (high blood pressure and chest pain treatment) 10 mg 1 tab PO Q day, Apixaban (blood thinner) 5 mg 1 tab PO Q day, Asa 81 mg 1 tab PO Q day, Carvedilol (high blood pressure and heart failure treatment) 12.5 mg a half tab PO BID, Cholecalciferol 2000 iu 2 tabs PO BID, Diclofenac topical 1 application topically QID, Docusate 100 mg 1 cap PO Q day, Duloxetine 60 mg 1 cap PO Q day, Gabapentin 600 mg 2 caps PO BID, Hydralazine 25 mg 1 tab PO TID, Levothyroxine 100 mcg 1 tab PO Q day, Losartan 25 mg 1 tab PO Q day, Multivitamin with minerals 1 tab PO Q day, Oxybutynin (bladder relaxant treatment) 5 mg PO Q day, Vitamin A and D topical 1 application Q day, Zinc Oxide topical 1 application Q day, and Tramadol 50 mg 1 tab PO Q day PRN mild pain. Routine medications were scheduled to be administered to Resident 7 at 09:00 am. During a review of Resident 7's medical records titled, Cerner Medication Administration Record and Pyxis, dated 5/25/24 through 5/26/24, indicated on 5/25/24 beginning at 09:26 am all ordered medications except Apixaban and Levothyroxine were documented as pulled from the Pyxis and scanned into the MAR by LN A. On 5/25/24 at 09:26 am, LN A was observed via video deliberately not removing several of Resident 7 ' s medication from the cabinet which they are located after LN A scanned the medications as being pulled. On 5/25/24 at 09:30 am, LN A was then observed via video as finishing scanning medications for Resident 7 and throwing the medications in the garbage. On 5/26/24 at 09:14 am, Tramadol was documented as pulled from the Pyxis and scanned into the MAR by LN A. On 5/26/24 at 09:15 am, LN A was observed via video as putting Resident 7 ' s Tramadol (which was left in the packaging) in a cup and then placed it on the desk. At 09:38 am, LN A walked off the nurse ' station with the Tramadol. A review of Resident 7 ' s medical record indicated that Resident 7 ' s vital signs were taken on 5/27/24 as follows: blood pressure (BP) 135/80, and heart rate (HR) 75. 8. During a review of Resident 8's medical records titled, Orders, undated, the medication Orders indicated, Resident 8 was ordered Diclofenac topical 1 application TID, Docusate 100 mg 1 tab PO Q day, Fluticasone Nasal Spray (for seasonal allergies), 50 mcg 1 spray each nasal BID, Losartan 25 mg 1 tab PO Q day, Multivitamin with minerals 1 tab PO Q day, Polyethylene Glycol 3350 17 gm, 1 each PO Q day. Routine medications were scheduled to be administered to Resident 8 at 09:00 am. During a review of Resident 8's medical records titled, Cerner Medication Administration Record and Pyxis, dated 5/25/24 through 5/26/24, indicated, on 5/25/24 beginning at 09:31 am all ordered medications were documented as pulled from the Pyxis and scanned into the MAR by LN A. On 5/25/24 at 09:33 am, LN A was then observed via video throwing Resident 8 ' s medication in the garbage. A review of Resident 8 ' s medical record indicated that Resident 8 ' s vital signs were taken on 5/27/24 as follows: blood pressure (BP) 115/44, and heart rate (HR) 82. 9. During a review of Resident 9's medical records titled, Orders, undated, the medication Orders indicated, Resident 9 was ordered Docusate 100 mg 1 tab PO Q day, Calcium carbonate (TUMS), 1000 mg 2 chewable tabs Q 4 hours prn dyspepsia (upset stomach), Multivitamin with minerals 1 tab PO Q day, Sertraline (antidepressant) 25 mg 1 tab PO Q day, Fluticasone - Vilanterol (COPD treatment) inhaler 1 puff Q day, Pantoprazole 40 mg 1 tab PO Q day, Albuterol (COPD treatment) inhaler 2 puffs QID, Methylphenidate Hydrochloride (HCL) (stimulant) 5 mg 1 tab PO BID, and Lorazepam 0.5 mg 1 tab PO Q 4 hours prn anxiety. Routine medications were scheduled to be administered to Resident 9 at 09:00 am. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555022	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca District Hospital D/P Snf	130 Brentwood Dr Chester, CA 96020

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 - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 9's medical records titled, Cerner Medication Administration Record and Pyxis, dated 5/25/24 through 5/26/24, indicated, on 5/25/24 beginning at 09:37 am all medications were documented as pulled from the Pyxis and scanned into the MAR by LN A except Docusate, Fluticasone - Vilanterol, Pantoprazole, Albuterol, Lorazepam and Methylphenidate HCL. On 5/25/24 at 09:36 am, LN A was observed via video throwing Resident 9 ' s medication in the garbage. During a review of Resident 9's medical records titled, Cerner Medication Administration Record and Pyxis, dated 5/25/24 through 5/26/24, indicated, on 5/26/24 beginning 07:49 am, all medications were documented as pulled from the Pyxis and scanned into the MAR by LN A except for Calcium Carbonate, Multivitamin with minerals, and Sertraline. On 5/26/24 at 07:50 am, LN A was observed throwing resident 9 ' s medications in the garbage. A review of Resident 9 ' s medical record indicated that Resident 9 ' s vital signs were taken on 5/27/24 as follows: blood pressure (BP) 102/64. 10. During a review of Resident 10' s medical records titled, Orders, undated, the medication Orders indicated, Resident 10 was ordered Pantoprazole 40 milligrams 1 tab by PO Q day. The Pantoprazole was scheduled to be administered daily at 08:00 am daily. During a review of Resident 10's medical records titled, Cerner Medication Administration Record and Pyxis, dated 5/25/24 through 5/26/24, indicated, on 5/26/24 at 07:52 am, LN A removed Pantoprazole from the Pyxis, and scanned the Pantoprazole into the MAR as administered. On 5/26/24 at 08:06 am LN A, was then observed via video throwing Resident 10 ' s Pantoprazole in the garbage. A review of Resident 10 ' s medical record indicated that Resident 10 ' s vital signs were taken on 5/29/24 as follows: blood pressure (BP) 126/566, and heart rate (HR) 66. 11. During a review of records titled, Orders, undated, the medication Orders indicated, Resident 11 was ordered Amlodipine 5 mg 1 tab PO Q day, Ascorbic Acid 500 mg 1 tab PO Q day, docusate 100 mg 1 cap PO BID, Duloxetine 30 mg 1 cap PO Q day, famotidine (stomach acid treatment) 20 mg 1 tab PO Q day, Haloperidol (antipsychotic) 1 mg 2 tabs PO BID, Multivitamin with minerals 1 tab PO Q day, Oxybutynin 10 mg 1 tab PO Q day, Psyllium (laxative) 3.4 g 1 each, PO Q day, Asa 81 mg 1 tab PO Q day, and Tramadol 50 mg 1 tab PO Q 6 hours PRN pain. Routine medications were scheduled to be administered to Resident 11 at 09:00 am. During a review of Resident 11's medical records titled, Cerner Medication Administration Record (MAR) and Pyxis, dated 5/25/24 and 5/26/24, indicated, on 5/25/26 beginning 9:42 am, all medications were documented as pulled from the Pyxis and scanned into the MAR by LN A except Famotidine, Psyllium, and Tramadol. On 5/25/26 at 09:42 am, LN A was observed via video removing four (4) Haloperidol. Resident 11 only has two (2) Haloperidol ordered. Two (2) Haloperidol were placed in chocolate pieces for Resident 11, as ordered. The other two remained on the desk under papers. On 5/25/24 at 09:48 am, LN A was then observed via video throwing all other Resident 11 ' s medications in the garbage. On 5/26/24 at 08:23 am, Resident 11's Tramadol was documented as pulled from the Pyxis and scanned into the MAR by LN A. On 5/26/24 beginning at 08:23 am, LN A is observed via video pulling Tramadol for Resident 11 and placing it in a cup with Resident 2 ' s Tramadol. LN A left the station for 21 seconds then returned to the station empty handed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555022	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca District Hospital D/P Snf	130 Brentwood Dr Chester, CA 96020

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 - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 11 ' s medical record indicated that Resident 11 ' s vital signs were taken on 5/27/24 as follows: blood pressure (BP) 131/72, and heart rate (HR) 89. 12. During a review of Resident 12's medical records titled, Orders, undated, the medication Orders indicated, Resident 12 was ordered Apixaban (blood thinner) 2.5 mg 0.5 tab PO BID, Clonidine 0.1 mg (for blood pressure), 1 tab PO Q day, furosemide 40 mg 1 tab PO Q day, Multivitamin 1 tab PO Q day, Potassium Chloride 10 mEq 1 cap PO q day, Sodium Chloride (salt tablet) 1 g, 1 cap PO Q day, Aripiprazole (antipsychotic) 2 mg, 1 tab PO Q day, Bupropion (antidepressant) 300 mg, 1 tab PO Q day, Sotalol (heart rhythm disorder treatment) 80 mg, 1 tab PO Q day. Routine medications were scheduled to be administered to Resident 12 at 09:00 am. During a review of Resident 12's medical records titled, Cerner Medication Administration Record and Pyxis, dated 5/25/24 through 5/26/24, indicated, on 5/26/24 beginning 07:47 am all medications were documented as pulled from the Pyxis and scanned into the MAR by LN A except for Sotalol, Apixaban, and Clonidine. On 5/26/24 at 07:46 am, LN A was observed throwing resident 12 ' s medications in the garbage. A review of Resident 12 ' s medical record indicated that Resident 12 ' s vital signs were taken on 5/29/24 as follows: blood pressure (BP) 134/56, and heart rate (HR) 63. During an interview on 6/4/24 at 12:30 pm, with Chief Nursing Officer (CNO) in the Director of Nursing's (DON ' s) office, CNO confirmed that based on everything in the video, the hospital/facility administrative staff have substantiated the incident as there is no doubt that it happened. During a concurrent observation and interview on 6/4/24 at 2:45 pm, with DON in DON ' s office, video from the camera above the nurse ' station medication desk was viewed. In the video LN A was observed concealing medication in the palm of the hand and slipping the medictions into the pocket of LN A ' s scrub top, blatantly throwing medications that have been scanned to residents and placed in plastic cups, in the garbage and appearing to try to conceal the cups and medications under something in the garbage that is not viewable at the angle of sight, and scanning medications out of the pyxis but not removing them from the cabinet. DON stated all the rest of the video viewed is of the same level of depravation. DON confirms with confidence that the incident affected every one of the facility residents (15 residents), even though not all of the residents have been viewed on video as being affected. The video was not of LN A ' s entire 12-hour shift for either day 5/25/24 or 5/26/24. DON only received a total of six hours of video for both days and in the six hours observed 12 residents who were identified as having been affected. Once all video is retrieved and reviewed every one of the residents will, with certainty, be identified. There was no actual outcome where the residents appeared to have had issues or problems because of the incident. No one had to be transferred to the hospital, we didn ' t have any symptoms that would have inferred problems.