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	10/08/2025

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 - 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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to protect the residents' right to be free from physical abuse and verbal abuse by Certified Nursing Assistant (CNA) 2 for two of two residents (Resident 1 and 2) sampled for abuse when:1. CNA 2 roughly turned, slapped, and held down Resident 1's hands and arms during patient care. This resulted in Resident 1 receiving a skin tear to her left wrist on 10/1/25 at 9:30 pm and caused Resident 1 to yell and scream at CNA 2 whenever she was in the room. The treatment of Resident 1 by CNA 2 had the potential to have caused the bruise that was discovered on Resident 1's left arm on 10/1/25. 2. CNA 2 intentionally placed a pillow over Resident 2's face and verbally told her to shut up. This had the potential for Resident 2 to experience fear and anxiety when CNA 2 was doing her cares and a decline in her mental and emotional wellbeing.This failure had the potential to result in negative psychosocial outcomes for Residents 1 and 2.Findings:A review of the facility's policy and procedures (P&P) titled Abuse Prevention and Reporting revised 3/27/25, indicated [Facility's name] shall ensure an abuse-free environment for the residents of the Skilled Nursing Facility (SNF) by establishing an effective abuse prevention program and shall report suspected or known resident abuse per all state and federal regulations. The P&P defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. d. Mental abuse includes, but is not limited to, humiliation, harassment and threats of punishment or deprivation. e. Physical abuse includes, but not limited to, hitting, slapping, pinching, and kicking. i. verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms aimed at residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability.A facility reported incident, dated 10/3/25 at 10:54 am, by the Director of Nursing (DON), indicated CNA 1 had witnessed CNA 2 verbally and physically abuse Resident 1, and yell at and put a pillow over Resident 2's face on 10/1/25 during the night shift.1. A review of Resident 1's admission record indicated Resident 1 was admitted on [DATE] with diagnoses that included Alzheimer's dementia (a progressive, irreversible brain disorder that causes memory loss, confusion, and a decline in mental ability) and acute back pain. Resident 1 was unable to make her own health care decisions.During a review of Residents 1's Quarterly Minimum Data Set (MDS, a data driven clinical assessment) dated 7/30/25, section C -(Cognitive patterns, the ability to think clearly, reason and remember) indicated a Brief Interview for Mental Status (BIMS, a test for memory and thinking ability with scores from 00 having severe cognitive impairment to a score of 15 memory intact) was conducted, and Resident 1 scored a 4 indicating severe cognitive impairment. Section E- (Behavior assessment) indicated Resident 1 did not exhibit physical or verbal behavioral symptoms (i.e. hitting, pushing, screaming or cursing) directed toward others and did not have episodes of refusing care. Section GG-Functional Abilities indicated Resident 1 was dependent on staff for toileting. Section H -Bowel and Bladder indicated Resident 1 was incontinent (having no control with) bowel and bladder and wore briefs (disposable underwear that collects urine and feces) that required the staff to change.A review of Resident 1's Nursing Narrative Note dated 10/1/25 at 5:00 pm, by Licensed Nurse (LN) D, indicated .a new bruise appeared on her left forearm 9 cm (centimeters, a measurement) x 3 cm.A review of Resident 1's Nursing Narrative Note dated 10/1/25 at 11:50 pm, by LN B, indicated that CNA 1 notified LN B that Resident 1 had received a skin tear to her left forearm measuring 1.5 cm (cm- a measurement of length) x 3 cm skin tear during patient cares on 10/1/25 at 9:30 pm.During a concurrent interview with the DON and email review on 10/3/25 at 2:30 pm, DON stated she had read an email on 10/3/25 in the morning from LN A indicating CNA 2 was abusing residents. The email dated 10/2/25 at 6:58 pm, by LN A indicated: This staff (CNA 1) reported to me that they have witnessed [CNA 2's name] be verbally abusive towards multiple residents and physically abusive to [Resident1's name]. While I was completing wound care on [Resident 1's name] skin tear, this staff member stated to me that they feel like the skin tear was caused by [CNA 2's name] being too rough when completing care. I asked them to elaborate. This staff member stated that [CNA 2's name] often yelled at [Resident 1's name] and other residents when they (CNA 2) got frustrated and was rough when completing care on residents. This staff member also stated that [CNA 2's name] takes [Resident 1's name] hands and often slams them against her chest and slaps her arms and legs around. This staff [CNA 1] member also stated that they [CNA 1] try to complete rounds by themselves, especially [Resident 1's name] so that she isn't yelled at or hit again or any resident. This staff member also stated that other staff has

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to report physical and verbal abuse, and an injury of unknown origin within two hours to the state and federal entities (California Department Public Health, CDPH, the Ombudsman, [a person appointed by the government who ensures that residents are treated fairly and that their rights are protected], and the Sheriff's office) for two of two residents (Resident 1 and 2) reviewed for abuse, when:1. On 10/1/25 at 9:30 pm, Certified Nursing Assistant (CNA) 1 witnessed CNA 2 roughly turning, slapping and holding down Resident 1's hands and arms and causing a skin tear to Resident 1's left wrist during patient care. CNA 1 did not report the abuse of Resident 1 to state and federal entities and waited until 10/2/25 at 3:45 pm, (18 hours later) before reporting abuse to Licensed Nurse (LN) A.2. On 10/1/25 at10:30 pm, CNA 1 witnessed CNA 2 intentionally placing a pillow over Resident 2's face and verbally tell her to shut up. CNA 1 did not report this to state and federal entities and waited until 10/3/25 at 9:03 am (35 hours later), to notify the Director of Nursing (DON).3. On 10/2/25 at 3:30 pm, CNA 1 reported to LN A the witnessed abuse (roughly turning, slapping and holding down Resident 1's hands and arms and causing a skin tear) of Resident 1 by CNA 2 on 10/1/25 at 9:30 pm. LN A did not report the suspected abuse to state and federal entities.4. At the beginning of August 2025 LN B overheard unidentified staff talking about how CNA 2 was rough with residents during patient cares and LN B did not notify anyone.5. On 10/1/25 at noon, a bruise of unknown origin was discovered on Resident 1's left arm by LN B, and it was not reported to the state and federal entities and there was no investigation to determine the cause of the bruise. 6. The facility's Policy and Procedure (P&P) titled Abuse Prevention and Reporting revised 3/27/25, did not correctly indicate the CDPH and Ombudsman should be notified within two hours of known abuse.Refer to F600The failure to report these events immediately to a supervisor and within two hours to the appropriate state and federal entities allowed for the continued abuse, mental anguish, a skin tear and bruising for Resident 1 and verbal and physical abuse for Resident 2. Findings:During a record review of the facility's checklist titled Unusual Occurrence Alleged Abuse Reporting SNF Checklist (undated), indicated Unusual Occurrence is defined as: Any incident or event, especially one which happens without being designed or expected as an unusual occurrence or the ordinary occurrences of life. The checklist indicated that the person reporting the allegation is ultimately responsible for making sure the Sheriff, CDPH, and Ombudsman are verbally notified within 2 hours.1. During a record review of Resident 1's admission record, printed 10/3/25, indicated Resident 1 was admitted on [DATE] with diagnoses that included Alzheimer's dementia (a progressive, irreversible brain disorder that causes memory loss, confusion, and a decline in mental ability) and acute back pain. Resident 1 was unable to make her own health care decisions.During a review of Residents 1's Quarterly Minimum Data Set (MDS, a data driven clinical assessment) dated 7/30/25, section C -(Cognitive patterns, the ability to think clearly, reason and remember) indicated a Brief Interview for Mental Status (BIMS, a test for memory and thinking ability with scores from 00 having severe cognitive impairment to a score of 15 memory intact) was conducted, and Resident 1 scored a 4 indicating severe cognitive impairment. Section E- (Behavior assessment) indicated Resident 1 did not exhibit physical or verbal behavioral symptoms (i.e. hitting, pushing, screaming or cursing) directed toward others and did not have episodes of refusing care. Section GG-Functional Abilities indicated Resident 1 was dependent on staff for toileting. Section H -Bowel and Bladder indicated Resident 1 was incontinent (having no control with) bowel and bladder and wore briefs (disposable underwear that collects urine and feces) that required the staff to change.During an interview with CNA 1 on 10/8/25 at 3:16 pm, CNA 1 stated that during patient care for Resident 1 she had witnessed CNA 2 grab Resident 1's hands and arms and push them into Resident 1's chest. CNA 1 continued to say CNA 2 turned Resident 1 roughly and quickly when they were changing her brief. CNA 1 stated she had witnessed this treatment of Resident 1 by CNA 2 since September 1, 2025, but on 10/1/25 it was the worst she had seen. CNA 1 indicated that on 10/1/25 at 9:30 pm, Resident 1 obtained a skin tear when CNA 2 grabbed Resident 1's arm and rolled her roughly. CNA 1 indicated she reported the rough treatment of Resident 1 by CNA 2 to LN A on 10/2/25 at 3:45 pm (18 hours after the incident.) CNA 1 confirmed that she should have reported it right away.2. During a record review of Resident 2's admission record, printed 10/3/25, indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's dementia, chronic (on going) pain, joint pain of the leg, and anxiety disorder. Resident 2 was unable to make her own health care decisions During a record review of Resident 2's Quarterly MDS