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	12/12/2025

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, this requirement was not met when the facility failed to obtain the services of a registered nurse for eight consecutive hours, seven days a week. This had the potential to adversely affect residents' care, which could lead to potential negative clinical outcomes.Findings:During a concurrent interview and record review on 12/10/25 at 8:29 a.m. with the Director of Nursing (DON), of the facility's Registered Nurse (RN) staffing/schedule documentation from the period of 4/1/25 to 4/30/25 and 5/1/25 to 5/31/25 the documentation indicated that no RN was scheduled to work 4/16/25, 4/17/25, 4/18/25, and 5/26/25 when the DON was off. The DON confirmed that RN coverage was provided by RN E (a nurse from the hospital side of the facility down the hallway) on 4/16/25, 4/17/25, and 4/18/25 and that RN coverage was provided by RN F (a nurse from the hospital side of the facility down the hallway) on 5/26/25. The DON indicated that if the Licensed Vocational Nurses (LVNs) needed help they could get an RN from the hospital down the hall. The DON indicated that the facility would need to apply for the federal waiver for RN coverage.During the during the resident council meeting (a meeting for residents to voice their concerns regarding living in a facility) on 12/9/25 at 1:54 p.m., there were no complaints about staffing issues.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement and maintain infection control practices to prevent the transmission of infection when: 1. Staff failed to ensure proper hand hygiene and clean administration technique during the administration of eye drops to for one of 16 sample residents (Resident 8). 2. The facility failed to ensure the ice machine used by residents was maintained in a clean and sanitary condition, free from contamination. These deficient practices had the potential to put the residents at risk for unwanted infections, and negatively impact their quality of life.Findings: 1. During a review of the facility's policy and procedure titled, Medication Administration, dated 5/29/2025, indicated, that standard universal precautions, which include hand washing using soap and water or the hospital supplied hand antiseptic cleaner will be completed prior to and following all medication passes and after physical contact with residents. During a review of Resident 8's admission Record indicated that Resident 8 was admitted on [DATE] with diagnoses that included aphasia (a disorder that makes it difficult to speak), cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), high blood pressure, memory loss, and hypertensive retinopathy (damage to the eye caused by high blood pressure). During a review of Resident 8's medication order record, with a start date of 6/5/23, the order indicated Resident 8 was to receive Dorzolamide-Timolol Ophthalmic (an eye drop medication), 1 drop in the left eye, twice daily. During a concurrent observation and interview on 12/11/25 at 9:42 am, with Licensed Nurse (LN) B, LN B was observed administering medication to Resident 8 and administering eye medication without performing hand hygiene (washing hands), changing gloves, or ensuring Resident 8's eye was clean before putting the eye drops in. LN B confirmed that hand hygiene should have been performed and that the eye should have been cleaned prior to medication administration. During an interview on 12/11/25 at 9:55 am, with the Director of Nursing (DON), DON confirmed that proper hand hygiene is required prior to medication administration and that the eye should be cleaned before administering eye drops. 2. A review of a facility ice machine service manual titled, HID312, HID525 and HID540 dated March 2025, indicated that the ice machine was to be cleansed with a scale (mineral build-up that can harbor bacteria), remover mixed with water every 6 months. During a concurrent observation and interview on 12/11/2025 at 9:05 am, the Maintenance Director (Main) D, confirmed the presence of a visible white and black substance present along the interior surface of the ice machine dispenser and that the ice came into direct contact with that substance during dispensing. Main D stated they follow the manufacturer's instructions to clean the ice machine every six months, but that area of the machine had never been cleaned.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and revise care plans to meet the medical needs for two of eight residents sampled (Resident 7 and Resident 6) when:1. Resident 7's bladder incontinence (inability to hold urine) was not reflected on her care plan.2. Resident 6 had no care plan developed that addressed her heart condition.These failures had the potential to result in negative clinical outcomes for Resident 6 and Resident 7, by not receiving the care and services they needed.Findings: A review of the facility's Policy and Procedure titled, Comprehensive Care Policy effective 3/27/25, indicated the facility shall ensure a comprehensive care plan will be implemented for each skilled nursing facility resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. 6. The care plan will include the following information: b. All identified medical, physical and psychosocial problems, concerns and needs specific to the resident. Purpose: The purpose of this policy is to properly identify a resident's needs, with the help of IDT, to implement a plan of action to further improve a resident's quality of life. A review of Resident 7's admission Record indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included dementia, urinary frequency (having to urinate frequently), and high blood pressure. A review of Resident 7's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 7/10/25, indicated Resident 7 had a Brief Interview for Mental Status (BIMS, cognitive screening tool scored from 0 to 15) with a score of 9 (moderate cognitive impairment). MDS section H indicated that Resident 7 was always continent (full control) of her bladder. A comparison MDS of section H dated 10/08/25, indicated Resident 7 was occasionally incontinent, a decline from the previous MDS on 7/10/25. During interview on 12/10/25 at 4:52 pm, with Certified Nursing Assistant (CNA) C, CNA C stated Resident 7 gets up and uses the bathroom frequently. CNA C stated Resident 7 was toileted every two hours, but needs to go more frequently than that. During an interview and concurrent review of Resident 7's care plans and MDS assessments on 12/11/25 at 10:19 am, with Minimum Data Set Nurse (MDS) A, MDS A confirmed Resident 7 had a decline in her ability to control her urinary continence and the care plan had not been revised to reflect that. During an interview and record review of Resident 7's care plans on 12/11/25 at 10:40 am, the Director of Nursing (DON) confirmed Resident 7's bladder care plan had not reflected her current status and should have been revised to include that Resident 7 has incontinent episodes. 2. Review of Resident 6's medical record indicated that she was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (a cardiac condition which causes an irregular and often very fast heartbeat that can cause poor blood flow) and hypertension (HTN-high blood pressure: a major risk factor for worsening cardiac conditions). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 6's MDS, dated [DATE], and completed by the Director of Nursing (DON), indicated that Resident 6 had a BIMS score of 12 indicating moderate cognitive impairment. During a concurrent interview and record review of Resident 6's care plan on 12/10/25 at 12:53 pm, with the DON, the DON confirmed that there was not a cardiac care plan developed for Resident 6, and there should have been.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure controlled medications (medications with high potential for abuse and addiction) verification process was accurately completed for one of four medication carts when the medication verification documentation was not signed with two (2) licensed nurses. This failure had the potential to cause the diversion (illegal distribution of controlled drugs for any illicit use) of controlled medications by staff, compromising the facility's ability to ensure safe and appropriate medication management for its patients. Findings: During a review of the facility's policy and procedure titled, Medication Administration, dated 5/29/2025, indicated, that controlled substances will be counted at the change of each shift by the licensed on-coming and off-coming nurses and that each nurse will be responsible for assuring the completion of the record. During a concurrent interview and record review on 12/10/25 at 11:27 am with Licensed Nurse (LN) B, the facility's narcotic reconciliation (the comparison of controlled medication counts against medication records) record titled Narcotic End of Shift-Date, found on the facility medication cart was reviewed. The record indicated that documentation was not completed on 8/13/25, 9/17/25, 10/14/25, 10/20/25, 10/28/25, 11/11/25, and 12/2/25. LN B confirmed that the documentation was incomplete, and that controlled medication reconciliation must be completed at the change of each shift and documented. During an interview on 12/10/25 at 3:15 pm with the Director of Nursing (DON), the DON confirmed that the expectation is that controlled medication is reconciled at the end and beginning of each shift and confirmation is documented.