

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2025
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NAME OF PROVIDER OR SUPPLIER SENECA DISTRICT HOSPITAL D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 130 BRENTWOOD DR CHESTER, CA 96020
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during an abbreviated standard survey for three facility reported incidents.</p> <p>Facility reported incidents: CA00944587, CA00948686 and CA00954091</p> <p>The investigation was limited to the specific facility reported incidents investigated and does not represent the findings of a full inspection of the facility.</p> <p>One deficiency was issued for facility reported incident CA00954091 at F689.</p> <p>No deficiencies were issued for facility reported incidents: CA00944587 and CA00948686.</p>	F 000		
F 689 SS=D	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their policies to ensure that Resident 1 was kept safe after he bought two electronic hand warmers to use when we went outside.</p>	F 689	<div style="border: 2px solid blue; border-radius: 15px; padding: 10px; width: fit-content; margin: auto;"> <p style="text-align: center;">CA DEPT OF PUBLIC HEALTH CHCQ Field Operations North Division- Chico</p> <p>Received Date: <u>5/15/25</u></p> <p>Compliance Date: <u>5/14/25</u></p> <p>Approved Date: <u>5/15/25</u></p> <p>Approved By: <u>Yvonne Mulcahy, HFES</u></p> </div>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Lessa Paulson</i>	TITLE DON SNF	(X6) DATE 5/12/2025
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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.

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NAME OF PROVIDER OR SUPPLIER SENECA DISTRICT HOSPITAL D/P SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 130 BRENTWOOD DR CHESTER, CA 96020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 689	<p>Continued From page 1</p> <p>This resulted in an avoidable accident when Resident one sustained two blisters on his left hand from using the warmers.</p> <p>Findings:</p> <p>In an interview with the DON (Director of Nurses) on 4/28/25 at 10 am, she stated that on 3/27/25, CNA1 (Certified Nursing Assistant) reported that Resident 1 had "blisters on his hand that were not being addressed." The DON stated that she was unaware of the blisters and upon assessment of Resident 1's left hand she identified two blisters on his left palm, which measured 2.8 x 1 cm (centimeters) and 2 x 1.4 cm. Resident 1 told the DON that he had purchased lithium battery personal warmers that he attached to his body to keep him warm when he went outside. He stated that he had been using the warmers all winter. He further told the DON that usually there was a layer of clothing between the warmers and the skin, but on one occasion an unidentified staff member placed the warmer directly on his left hand without any protective barrier between the skin and the device. He refused to identify the staff member.</p> <p>The facility policy for "Arrival of New Electrical Equipment" read, "all new electrical equipment will be inspected for electrical safety and physical condition upon arrival at the facility by the Environmental Services department. After this equipment is inspected and approved, maintenance will place a sticker on it with the date of inspection. If the equipment is deemed unsafe and has the potential to cause harm to the residents or the facility, then the maintenance team will not approve the equipment and it should not be used."</p>	F 689			

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F 689	Continued From page 2 In an interview with the Director of Plant Operations (DPO) on 4/28/25 at 11 am, she stated that she remembered two CNA's (she could not remember which two nor could she remember when this occurred) "catch me in the hallway one morning as I was heading out the door and they showed me a personal electronic heating device that Resident 1 had bought for himself to keep warm when he goes outside, which is every day. I checked the devices by plugging them in and following the manufacturer's directions. I felt that the devices got too hot for safe use so I told the CNAs not to use the devices for Resident 1. Also, the directions did state that a protective barrier must be used between the skin and the device to prevent burns. I did not write any of this down, nor did I speak with Resident 1 or the DON. I failed to follow our own policy and I take responsibility for that." Resident 1 was discharged on 4/1/25 and was not available to be interviewed.	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

Name of Facility Surveyed: SENECA DISTRICT HOSPITAL		Provider/Supplier/CLIA Identification Number: 555022		
Facility Address (Street Address, City, State, Zip Code) 130 BRENTWOOD DR CHESTER, CA 96020		Date Survey Completed: 04/28/2025		
ID Prefix Tag	<u>SUMMARY STATEMENT OF DEFICIENCIES</u>	ID Prefix Tag	<u>PLAN OF CORRECTION</u>	Completion Date
F689	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) This requirement is not met as evidenced by: The facility failed to follow their policies to ensure that resident was kept safe after he bought electronic hand warmers to use when he went outside. This resulted in an avoidable accident when resident sustained two blisters on his left hand from using the warmers.	F689	Education prepared for staff by LTC DON regarding electrical equipment and resident safety, including the Arrival of New Electrical equipment policy for review. All staff are to review and sign acknowledgement. The policy MAIN-043 Arrival of New Electrical Equipment will be added to the admission packet. The DON will inform new residents and their responsible parties of the policy and they will sign an acknowledgement of understanding. Director of Plant Operations will amend her existing QA Patient Care Equipment Inspections to include Personal Equipment. The Director of Plant Operations will monitor all equipment to ensure the equipment has been inspected and approved for use during the Safety Hazard/Injury Prevention Inspection that is conducted at least monthly.	5/13/25 5/14/25 5/14/25



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