STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335504	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SENECA HEALTH CARE CENTER	**2987 SENECA STREET WEST SENECA, NY 14224**

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during a complaint investigation (Complaint #NY 489) during the Standard survey completed on 3/12/20, the facility did not ensure that all alleged violations of abuse including injuries of unknown origin are reported immediately in accordance with State Law through established procedures. One (Resident #101) of two residents reviewed for abuse reporting had an issue. Specifically, the facility did not report an allegation of abuse to the New York State Department of Health (NYS DOH) within the 2-hour required time frame. The finding is: A facility policy entitled Abuse Reporting and Facility Incident Reporting dated 7/2017 documented that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and reasonable suspicion of a crime against a resident are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the event that caused the allegation do not involve abuse and do not result in serious bodily injury, to the administrator and to the official in accordance with state law through established procedures. 1. Resident #101 has [DIAGNOSES REDACTED]. Review of a significant change Minimum Data Set (MDS - a resident assessment tool) dated 2/20/20 revealed the resident had severe cognitive impairment. Review of a Nursing Progress Note dated 9/30/19 revealed the resident was alert and oriented x3 (oriented to person, place and time) with confusion at times. Review of an untitled, undated investigation report documented that a Concern was identified on 9/23/19. The Report documented that a Resident Aide (RA #1) was talking to a Certified Nurse Aide (CNA #1) at the Nurses' Station and stated that CNA #2 was inappropriate with Resident #101. While in Resident #101's room, CNA #2 told RA #1 that the resident was crazy and had been locked up in a mental institution about six times. CNA #2 asked the resident if he/she was crazy and stated, tell her you are crazy. Tell her how many times you have been locked up. RA #1 stated she was the only one in the room with CNA #2 and while the CNA provided care to the resident, the resident's head hit the wall twice and the resident stated Ow, my head. CNA #2 mocked the resident and repeated what the resident said. CNA #2 provoked the resident to talk dirty and stated he/she is a perv (pervert) and makes dirty comments. The investigation report documented that RA #1 did not report the 9/19/19 incident until 9/23/19 at 8:00 PM. Review of a handwritten statement provided by RA #1 dated 9/23/19 revealed that while CNA #2 was changing Resident #101, she bounced his/her head off the wall. Both times the resident shouted Ow, my head and CNA #2 mocked the resident by saying Ow, my head. CNA #2 kept stating that the resident was a perv and that he/she makes dirty comments. RA #1 documented that the resident didn't initiate anything, CNA #2 provoked him/her to talk dirty. The resident agreed that he/she was better after being changed and CNA #2 leaned over the resident stating Why, cut my boobs are in your face? The resident laughed and CNA #2 said you are such a perv. CNA #2 repeated the same behavior on Friday 2/20/19. Review of an undated, written statement revealed CNA #2 documented the resident was joking around and she told the resident he/she was being crazy. When we do something he/she doesn't like, he says fxxx, then you know something happened. He did not say that. Even small stuff I report. Review of an untitled document dated 9/23/19 revealed that Resident #101 was interviewed by the Registered Nurse (RN #2) Nursing Supervisor and Resident #101 denied being fearful of anyone. When asked if anyone had ever hit his/her head on anything, the resident stated yes. When asked if the person made him/her feel bad about him/herself, the resident stated yes. When asked if the staff person was taking care of him this evening (9/23/19), the resident stated yes and identified CNA #2. The RN (#2) Nursing Supervisor inspected the resident's skin, head and scalp, no injury was noted, and the resident had no complaints of pain. Review of an email dated 9/23/19 at 10:10 PM, sent to both the Director of Nursing (DON) and the Administrator from the RN (#2) Nursing Supervisor revealed a statement was obtained from CNA #2 and she was sent home. The email documented that Resident #101 was not fearful. The resident stated yes when asked if anyone here made him/her feel bad and if the person that took care of him/her was working tonight. (CNA #2 was assigned to the resident on 9/23/19). Review of an on line submission email from the NYS DOH Bureau of Complaints and Analysis dated 9/24/19 at 11:37 AM revealed the facility submitted the incident to NYS on 9/24/19 at 8:22 AM and that the incident occurred 9/19/19 at 8:00 PM. During an interview on 3/6/20 at 12:30 PM, the DON stated she received a call from the RN (#2) Nursing Supervisor on 9/23/19 at about 8:45 PM. She directed the Supervisor to talk to the resident and send CNA #2 home. The DON stated that RA #1 was kind of a gossip and wanted to find out more to see if her story was reliable. The DON stated that she now knows she should have reported (the incident) within the two-hour time frame, as any allegation of abuse should be. During an interview on 3/12/20 at 2:30 PM, the Administrator stated she was aware that abuse allegations should be reported within a two-hour timeframe. 415.4(b)(4)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.