STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365819	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Siena Woods Care Center	6125 N Main Street Dayton, OH 45415

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff interview, and policy review, the facility failed to initiate treatment for a pressure ulcer in a timely manner. This affected one (#08) of three residents reviewed for wound care and treatment. The facility census was 81. Findings include: Review of the medical record for Resident #08 revealed an admitted [DATE] with medical diagnoses of moderate protein calorie malnutrition, diabetes mellitus with neuropathy, hypertension, anxiety, and chronic kidney disease. Review of the medical record for Resident #08 revealed a significant change Minimum Data Set (MDS) assessment, dated 09/06/24, which indicated Resident #08 had moderate cognitive impairment and was dependent upon staff for toilet hygiene, bathing, bed mobility, and transfers. The MDS assessment indicated Resident #08 had a stage four pressure ulcer (full-thickness skin and tissue loss) that was not present upon admission. Review of a wound observation assessment, dated 05/30/24, revealed Resident #08 had an unstageable pressure ulcer (obscured full-thickness skin and tissue loss) to the right buttock which measured 8.0 centimeters (cm) long by 5.0 cm wide by 0.1 cm deep. The assessment revealed a low air loss mattress was in place and the current treatment was to apply calcium alginate. Review of a wound nurse practitioner (NP) note, dated 05/31/24, revealed Resident #08 had an unstageable pressure ulcer to the right buttock due to necrosis (dead tissue). The wound measured 8.0 cm long by 5.0 cm wide by 0.1 cm deep, and a treatment was ordered to apply calcium alginate and cover with gauze and bordered dressing daily. Review of Resident #08's medical record revealed a physician order dated 06/04/24 to cleanse the right buttock wound with wound cleanser, pat dry, apply calcium alginate, and cover with bordered gauze daily. Review of the medical record revealed no documentation to support Resident #08's right buttock pressure ulcer treatment was started until 06/04/24. Further review of a wound NP note, dated 09/26/24, revealed Resident #08 had a stage four pressure ulcer to the right buttock and indicated the wound had improved as evidenced by decreased surface area and decreased undermining. (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
	365819	A. Building B. Wing	09/26/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/26/24 at 4:17 P.M. with Director of Nursing (DON) confirmed the medical record for Resident #08 had no documentation to support treatment to the right buttock pressure ulcer was started until 06/04/24. Review of the facility policy titled, Skin and Wound Management Program, effective 02/01/2020, revealed the intent of the program was to promote the prevention of pressure ulcer/injury development, promote the healing of existing pressure ulcers/injuries, and to promote the prevention of development of additional pressure ulcer/injury. This deficiency represents non-compliance investigated under Master Complaint Number OH00158220.

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	365819	A. Building B. Wing	09/26/2024

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on medical record review, observation, staff interview, and facility policy, the facility failed to provide timely incontinence care. This affected one (#53) of three residents reviewed for incontinence care. The facility census was 81. Findings Included: Review of medical record for Resident #53 revealed an admitted [DATE]. Diagnosis included dementia, psychotic mood disturbance, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #53 was severely cognitively impaired, required partial to moderate assistance for meals, and substantial to maximal assistance for personal hygiene and oral hygiene. Resident #53 was dependent for transfers, bathing, toileting, dressing upper and lower body, and placing shoes on and off. Review of the plan of care dated 08/08/24 revealed Resident #53 was at risk for alteration in elimination due to incontinence. Interventions included to assist with toileting needs daily, keep the call light within reach during toileting, provide incontinence care every shift and as needed for incontinence episodes, increase fluids between meals, laboratory values as ordered, observe for symptoms of urinary tract infection, peri-care after incontinence episodes as needed, and praise and encourage the resident to be as independent as able. Observations on 09/26/24 from 9:05 A.M. through 12:00 P.M. revealed State tested Nurse Aide (STNA) #159 had not provided incontinence care for Resident #53. Further observation at approximately 12:00 P.M. revealed, upon entering Resident #53's room, STNA #159 had already taken Resident #53's dirty sheet and soiled incontinence brief off. Resident #53's soiled bed linens and incontinence brief were in a trash bag on the floor, and when lifted were heavy. Interview with STNA #159 at the time of the observation verified that Resident #53's incontinence brief was heavily saturated with urine when she took it out of the trash bag to show the surveyor and was confirmed by a second surveyor in the room. STNA #159 refused to confirmed she did not check the resident for incontience between 9:05 A.M. and 12:00 P.M. with asked directly. Review of the activities of daily living policy, dated 03/2018, revealed appropriate care and services will be provided who are unable to carry out activity of daily living independently, with the consent of the resident and in accordance with the plan of care, including appropriate support assistance with hygiene, mobility, elimination, dining, and communication. Review of the facility policy titled, Urinary Continence and Incontinence Assessment and Management, dated 08/2022, revealed the physician and staff will provide appropriate services and treatment to help the resident restore or improve bladder function and prevent urinary tract infections to the extent possible. This deficiency represents non-compliance investigated under Complaint Number OH00157485.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, observation, staff interview, and policy review, the facility failed to follow infection control precautions when providing wound care. This affected one (#53) of three residents reviewed for wound care. The facility census was 81. Findings include: Review of the medical record for Resident #53 revealed an admitted [DATE] with medical diagnoses of dementia, chronic obstructive pulmonary disease, severe protein calorie malnutrition, and hypertension. Review of the medical record for Resident #53 revealed a quarterly Minimum Data Set (MDS) assessment, dated 08/08/24, which indicated Resident #53 had severe cognitive impairment and required partial to moderate staff assistance with meals and was dependent upon staff for transfers, bathing, toileting, and dressing. The MDS assessment indicated Resident #53 was always incontinent of bladder and bowel and Resident #53 had two stage four pressure ulcers (full-thickness skin and tissue loss). Review of Resident #53's medical record revealed a physician order dated 11/03/23 for enhanced barrier precautions related to a gastrostomy tube (g-tube). Further review of physician orders revealed an order dated 05/02/24 to cleanse the sacral wound with wound cleanser, pat dry, apply calcium alginate to the wound bed, and cover with bordered gauze every shift and as needed. Observation on 09/26/24 at approximately 12:00 P.M. of wound care for Resident #53 revealed Licensed Practical Nurse (LPN) #170 performed hand hygiene and applied gloves. Further observation revealed Resident #53's old wound dressing had been removed by a state tested nurse aide (STNA) during incontinence care directly prior to wound care. The observation revealed LPN #170 cleansed the resident's sacral wound and patted it dry. LPN #170 then removed her gloves, performed hand hygiene, and applied new gloves. Continued observation revealed LPN #170 applied calcium alginate to the wound bed and covered the wound with bordered gauze. LPN #170 removed the gloves and performed hand hygiene after wound care was completed. At no time during the treatment did LPN #170 put on a gown. Interview on 09/26/24 at 12:05 P.M. with LPN #170 confirmed Resident #53 was on EBP and verified she did not put on a gown during wound care. Review of the undated facility policy titled, Enhanced Barrier Precautions, revealed EBPs are utilized to prevent the spread of multi-drug resistant organisms (MRDOs) to residents. EBPs employed targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. The policy revealed examples of high-contact resident care activities include wound care and changing of briefs. The deficiency is based on incidental findings discovered during the course of this complaint investigation.