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	02/18/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observations, policy review, record review and, staff and resident interviews the facility failed to provide residents, who required assistance with activities of daily living (ADL), timely assistance with incontinence care and personal hygiene. This affected two (#45 and #65) of two residents reviewed for ADLs. The facility census was 91.Findings include:1) Review of the medical record for Resident #45 revealed admission date of 01/29/25. Diagnoses included diabetes mellitus type two, chronic kidney disease and hypertension.

The five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45 had impaired cognition. Resident #45 was dependent upon staff with toileting hygiene and was frequently incontinent of bowel and bladder.

Review of the care plan revealed Resident #45 required assistance with her ADLs related to a self-care deficit, weakness and decreased mobility. Interventions included for staff to assist with completion with ADLs on a daily basis.

Interview on 02/12/26 at 8:55 A.M. with Certified Nursing Assistant (CNA) #56 revealed she was preparing to do resident rounding. She verified the start of her shift was 7:00 A.M. and anticipated providing care for Resident #45 at 9:45 A.M.

Observation on 02/12/26 at 9:45 A.M. revealed Resident #45 was in the bathroom with Physical Therapist (PT) #120. Resident #45's bed had a large wet area on the bath blanket in the middle of the bed. The room had a strong smell of urine. Licensed Practical Nurse (LPN) #25 entered the room and knocked on the bathroom door prior to entering. LPN #25 informed Resident #25 he would assist in getting her cleaned up. PT #120 then exited the bathroom.

Interview on 02/12/26 at 9:54 A.M. with PT #120 revealed she had entered Resident #45's room to provide a physical therapy evaluation. She shared Resident #45 was laying in bed and her gown was wet with urine. She assisted Resident #45 to the bathroom to assist in getting her out of the wet gown. She verified the bed was wet and a strong odor of urine was prevalent in the room.

Observation on 02/12/26 at 9:59 A.M. revealed LPN #25 exited the bathroom with Resident #45. LPN #25 assisted Resident #45 to a chair in the room and informed her he was going to have her sit in the chair until he could get an CNA to change the bed linens.

Interview on 02/12/26 at 10:00 A.M. with Resident #45 revealed staff did not change her incontinence product through the night and she had laid in her wet gown until PT #120 came in.

(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: 365819	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER Siena Woods Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6125 N Main Street Dayton, OH 45415	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Second interview on 02/12/26 at 12:21 P.M. with CNA #56 revealed she did not round with the off going CNA at the start of her shift (7:00 A.M.). She acknowledged she did not know the last time Resident #45 had been provided with incontinence care and verified she had not been in to provide care prior to 9:45 A.M. 2) Review of the medical record for Resident #65 revealed admission date of 09/06/23. Diagnoses included multiple sclerosis, morbid obesity and paraplegia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #65 had intact cognition and was dependent upon staff with personal hygiene. Interview and observation on 02/10/26 at 10:11 A.M. with Resident #65 revealed she had facial hair stubbles. Resident #65 acknowledged she was aware of her facial hair and stated she did not want to look like a man. Interview on 02/11/26 at 8:32 A.M. with Certified Nursing Assistant (CNA) #108 verified facial hair was present on Resident #65. CNA #108 stated residents get assistance with shaving on their shower days. Observation on 02/12/26 at 7:38 A.M. revealed Resident #65's facial stubbles were still present. Review of the facilities ADL policy titled Activities of Daily Living, Supporting revised 03/2018 revealed residents would be provided with care, treatment and services as appropriate to carry out ADLs. This deficiency represents non-compliance investigated under Complaint Numbers 2715256, 2687005, 2650868 and OH00165691 (1363724).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365819	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2026

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, and record review, the facility failed to ensure a resident who had a history of falls had their fall interventions in place. This affected one (Resident #9) of five residents reviewed for accidents. The facility census was 91.Findings include:Review of the medical record revealed Resident #9 was admitted to the facility on [DATE]. Diagnoses included type two diabetes mellitus with diabetic neuropathy, spinal stenosis, and major depressive disorder. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #9 was cognitively intact and was dependent of staff with toileting and bathing, and required supervision with personal hygiene. Review of Resident #9's care plan dated 06/19/25 revealed the resident has had an actual fall. Interventions included to ensure a reacher (or also known as a grabber and it is designed to help one with limited mobility or bending restrictions to maintain independence) was accessible to the resident while in bed.Review of the physician orders dated 06/20/25 revealed Resident #9 required a reacher in reach of the resident every shift for intervention. Observation and interview on 02/17/26 at 11:00 A.M. with Licensed Practical Nurse (LPN) #103 revealed Resident #9 was lying in his bed and did not have his reacher within reach of him. The reacher was in a chair next to the opposite wall away from Resident #9's bed. LPN #103 confirmed the reacher was not within reach of Resident #9.Interview and observation on 02/18/26 at 10:30 A.M. with the Director of Nursing (DON) revealed Resident #9 was lying in his bed and did not have his reacher within reach of him. The reacher was across in the room. The DON confirmed the reacher was not within reach of Resident #9.This deficiency represents non-compliance investigated under Complaint Numbers 2684676, 2679812 and 2650868.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record review, the facility failed to ensure the medication error rate was less than five percent (%). There were six medication errors out of 25 opportunities resulting in a 24% medication error rate. This affected two (#5 and #84) of four residents observed for medication administration. The facility census was 91. Findings include:1. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE]. Diagnoses included type one diabetes mellitus, underweight, and tachycardia. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #5 was cognitively intact. Review of the physician orders dated 02/05/26 revealed Coreg (carvedilol) 12.5 milligrams (mg) give one tablet by mouth two times a day for beta blocker. Observation and interview with Licensed Practical Nurse (LPN) #66 on 02/11/26 at 10:31 A.M. revealed LPN #66 administered Coreg to Resident #5. LPN #66 confirmed Resident #5's Coreg was ordered to be administered at 9:00 A.M. and she administered it outside the one hour window at 10:31 A.M. 2. Review of the medical record revealed Resident #84 was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease stage two and type two diabetes mellitus (DM). The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #84 was cognitively intact. Review of physician orders for Resident #84 on 02/11/26 revealed the following medications were to be administered by mouth: duloxetine (antidepressant) oral delayed release 60 milligrams (mg) by mouth one time a day; famotidine (treats heart burn) oral tablet 20 mg by mouth one time a day; MiraLAX (laxative) oral packet 17 gran (gm) give one packet by mouth one time a day; Norvasc (treats high blood pressure) oral 2.5 mg give one tablet by mouth one time a day; and metformin (treats DM) oral tablet give 500 mg by mouth two times a dayObservation and interview with Licensed Practical Nurse (LPN) #59 on 02/11/26 at 11:30 A.M. revealed LPN #84 administered Resident #84's medication through her gastrostomy tube (G-tube). The medications were duloxetine, famotidine, MiraLAX, Norvasc, and Metformin. LPN #59 confirmed she administered the five medications to Resident #84 through the G-tube and were not administered orally. LPN #59 confirmed Resident #84's five medications including metformin were scheduled for 9:00 A.M. and stated she always administers her medications late. Interview on 02/11/26 at 3:13 P.M. with the Director of Nursing (DON) verified there was no order for Resident #84's medications to be administered through the G-tube and were only ordered to be administered by mouth. This deficiency represents non-compliance investigated under Complaint Number 1363724 (OH00165691).

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

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, policy review, and records reviews, the facility failed to ensure residents received their therapeutic diets as physician ordered. This affected two (#17 and #68) of three residents reviewed for therapeutic diets. The facility total census was 91. Findings include:1. Record review for Resident #68 revealed the resident was admitted to the facility on [DATE]. The Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed Resident #68 had impaired cognition and required maximum assistance from staff with feeding. Review of the physician orders revealed Resident #68 was to receive a regular puree thickened liquid diet and provide gravy with all meals. Review of the meal ticket for Resident #68 revealed the resident should have received extra gravy on the side. Observation and interview on 02/12/26 at 8:18 A.M. revealed Certified Nursing Assistant (CNA) #109 was feeding Resident #68. There was no extra gravy as a side on or near the resident's meal tray. CNA #10 verified verified Resident #68 did not receive extra gravy on the side. CNA #109 stated the resident at times needs additional gravy to ensure a smooth swallow. Observation and interview on 02/11/26 at 1:30 P.M. revealed Resident #68 had few teeth and was being fed CNA #108. There was no extra gravy as a side on or near the resident's meal tray. Observation and interview on 02/18/26 at 8:18 A.M. revealed Resident #68 was being fed by CNA #108. There was no extra gravy as a side on or near the resident's meal tray. There was a pitcher of water at the bedside which was not nectar thickened. CNA #109 verified Resident #68 did not receive extra gravy on the side and the pitcher of water was not thickened. 2. Record review for Resident #17 revealed the resident was admitted to the facility on [DATE]. Diagnoses included hemiplegia, convulsions, cerebral infarction, dementia, and aphasia. The Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed Resident #17 had severely impaired cognition and was total dependent on staff for feeding assistance. Review of the physician orders revealed the resident was to receive a regular dysphagia advanced thickened nectar liquid diet. The resident may have regular texture food for pleasure. Observation on 02/11/26 at 1:30 P.M. revealed Resident #17 had few teeth and was being fed Certified Nursing Assistant (CNA) #108. There was a dark soda drink poured into a cup on the bedside table with a straw. The liquid was not thickened. Interview on 02/11/26 at 1:35 P.M. with CNA #108 verified Resident #17's liquid was not thickened. Observation on 02/18/26 at 12:31 P.M. revealed Resident #17 had a dark soda liquid poured into a cup. It was not thickened. Interview on 02/18/26 at 12:35 P.M. with Registered Nurse (RN) #63 verified Resident #17's order (continued on next page)

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

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	permitted regular texture foods for pleasure but did not specify regular liquids. Interview on 02/18/26 at 3:25 P.M. with Speech Therapist (ST) #300 verified Resident #17's physician order for regular pleasure foods did not include regular consistency liquids for pleasure. Review of the facility policy titled Therapeutic Diets, dated 2022, revealed the therapeutic diet is ordered by the physician to increase nutrients or to provide foods residents are able to eat. This deficiency represents non-compliance investigated under Complaint Number OH00165691 (1363724).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, policy review, interviews and records reviews, the facility failed to label and date foods stored in resident designated refrigerators and failed to ensure temperatures were obtained daily for the resident designated refrigerators. This had the potential to affect all residents on Unit 400, except Resident #14 who received no food by mouth, and all residents on the Rehabilitation Unit and the Secured Care Unit. The facility total census was 91. Findings include:Observations on 02/09/26 at 10:30 P.M. revealed the refrigerator designated for residents on the Secured Care Unit had a lunch bag unlabeled and undated. There were six opened containers of nutritional supplements dated 12/18/25. The refrigerator temperature log had no temperatures logged for the refrigerator from 02/04/26 through 02/08/26. The ice machine ice scoop did not have ice scoop holder and the ice scoop was stored on a table with the dipper side up. There was a wet towel on the floor at the base of the ice machine.Interview on 02/09/26 at 10:30 P.M., Licensed Practical Nurse (LPN) #33 verified the refrigerator was designated for residents only, and employees' lunches were to be stored elsewhere. LPN #33 verified the lunch bag was not for a resident and the containers of nutritional supplements were expired. LPN #33 verified the refrigerator must be monitored daily for temperature and the temperature log had not been completed four days out of 11 days in February 2026. LPN #33 stated the ice scoop should be stored upright in a holder to permit proper water drainage. LPN #33 stated the ice machine had overflowed earlier in the week and a towel was there to catch the water. LPN #33 verified the towel should not remain on the floor.Observation on 02/12/26 at 8:35 A.M. revealed the resident designated refrigerator on Unit 400 had two bags of unidentified foods with no label and date. There was a box of food dated 01/21/26 with no label. There was one bag of bread which was undated. There were three pitchers of unidentified liquid unlabeled and undated. There was a sign on the refrigerator door which identified the refrigerator for residents and the foods must be labeled and dated.Interview on 02/12/26 at 8:35 A.M., Certified Nursing Assistant (CNA) #56 verified the designated resident refrigerator was for resident food storage only. She verified the foods were undated and unlabeled, the bread was undated, and the three pitchers of liquid were undated and unlabeled.Observation on 02/12/26 at 1:20 P.M. revealed the designated resident refrigerator on the Rehabilitation Unit revealed an open bag of food with no label. There was a opened gallon container of a brown liquid dated 02/07/26. There was no refrigerator temperature log for 02/01/26 through 02/11/26. Interview on 02/12/26 at 1:20 P.M., LPN #107 verified the designated resident refrigerator was only for resident food storage. LPN #107 verified the unlabeled open bag of food and gallon of liquid should have been labeled. She verified there was no refrigerator temperature log for February 2026, and daily temperatures must be monitored. Review of the facility policy titled Food From Approved Source, dated 2022, revealed the facility staff will assist with proper food storage and handling of foods brought into the facility. Food will be dated as appropriate.This deficiency represents non-compliance investigated under Complaint Number OH00165691 (136724).

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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** Based on observations, staff interviews, policy review, review of Centers for Disease Control and Prevention (CDC) guidance, and record review, the facility failed to ensure staff were following Enhanced Barrier Precautions (EBP) for high contact care activities with the residents. This affected three (#65, #77, and #84) of three residents reviewed for EBP precautions. The facility census was 91.Findings include: 1. Review of the medical record for Resident #65 revealed an admission date of 09/06/23. Diagnoses included multiple sclerosis, stage four pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle.), morbid obesity, and open wound to left lower leg. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #65 had intact cognition. Review of the physician orders dated 06/02/25 revealed EBP were ordered for Resident #65 related to colostomy and wound care. Personal Protective Equipment (PPE) was to be worn during high contact care activities with a start date of 06/02/25. Observation of wound care on 02/12/26 at 3:01 P.M. revealed Licensed Practical Nurse (LPN) #25 entered Resident #65's room with wound supplies and placed them on a clean bedside table. LPN #25 did not don a gown and proceeded to wash his hands and informed Resident #65 he was preparing to provide wound care. LPN #25 applied gloves and went to the bedside. He assisted Resident #65 onto her right side and removed an undated dressing. He removed his gloves and washed his hands. He continued to provide wound care when Assistant Director of Nursing (ADON) #1 knocked on the door and offered to assist with positioning of Resident #65. She entered with two gowns in her hands. LPN #25 then stepped away from the bedside, removed his gloves and washed his hands. He took the gown from ADON #1 and both staff donned gowns and completed the dressing change with no additional concerns for infection control. Interview on 02/12/26 at 3:25 P.M. with LPN #25, directly following wound care, verified a gown was not worn at the start of wound care and acknowledged Resident #65's wound care was considered high contact and a gown had been required. Interview on 02/18/26 at 9:01 A.M. with ADON #1 revealed she was the Infection Preventionist at the facility and shared getting staff to follow EBP was an ongoing issue. ADON #1 stated she did provide consistent reminders to staff to follow the policy when she was on the floor. 2. Review of the medical record revealed Resident #77 was admitted to the facility on [DATE]. Diagnoses included neuromuscular dysfunction of bladder. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #77 had moderately impaired cognition. Review of Resident #77's physician orders dated 12/18/25 revealed an order for EBP related to an indwelling urinary catheter. Observation and interview on 02/11/26 at 10:45 A.M. revealed Licensed Practical Nurse (LPN) #66 repositioned Resident #77 up in bed and was not wearing a gown. LPN #66 stated she did not wear a gown and only wears the gown for high contact direct care. LPN #66 revealed an EBP sign on cart in doorway of Resident #77's room read 'wear a gown for high contact activity including repositioning. LPN # 66 confirmed a gown should have been worn for repositioning the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record revealed Resident #84 was admitted to the facility on [DATE]. Diagnoses included dysphagia. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #84 was cognitively intact. Review of Resident #84's physician orders dated 06/02/25 revealed an order for EBP related to gastrostomy tube (G-tube). Observation and interview on 02/11/26 at 11:54 A.M. revealed Licensed Practical Nurse (LPN) #59 entered Resident #84's room to administer medications to the resident. LPN #59 did not don a gown prior to medicaiton administration. LPN #59 proceeded to administer medications to Resident #84 via G-tibe with no gown. LPN #59 confirmed a gown should have been worn for Resident #84 g-tube administration. Review of CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP is an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status. Review of the policy titled Enhanced Barrier Precautions, dated 12/2024, revealed examples of high-contact resident care activities requiring the use of gown and gloves for EBP include providing bed mobility, device care or use and wound care. This deficiency represents non-compliance investigated under Complaint Number OH00165691 (1363724).