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

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siena Woods Care Center | 6125 N Main Street<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>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). |

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 |
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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to ensure the interdisciplinary team determined whether a resident was clinically appropriate to self-administer their own medications prior to allowing a resident to self-administer. This affected one (Resident #11) of four residents reviewed for medication administration. The facility census was 91.Findings include:Review of the medical record revealed Resident #11 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD). The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #11 had moderately impaired cognition.Review of the care plan dated 11/14/18 for Resident #11 revealed the resident had an alteration in respiratory status and to administer medications as ordered; observe labs, and response to medication and treatment. The care plan did not state Resident #11 was able to self-administer any medication.Review of the physician orders dated 01/20/25 for Resident #11 revealed an order for albuterol sulfate inhalation nebulization solution (2.5 milligrams (mg)/three milliliters (ml) 0.083% three ml, inhale orally via nebulizer every four hours as needed for shortness of breath and three ml inhale orally via nebulizer three times a day for COPD. The physician orders did not state Resident #11 could self-administer this medication.Observation and interview on 02/12/26 at 8:30 A.M. with Licensed Practical Nurse (LPN) #59 revealed Resident #11 self-administers the nebulizer albuterol sulfate inhalation nebulization solution. LPN #59 stated the nurses fill the chamber with the medication for Resident #11 and when Resident #59 administers the nebulizer, she then lets the nurses know to refill it for the next one. LPN #59 confirmed Resident #11's nebulizer with the medication in the chamber stays in Resident #11's room at all times and night shift and day shift fill it when Resident #11 uses it. Interview on 02/12/26 at 9:19 A.M. with Registered Nurse MDS Coordinator #8 confirmed Resident #11 did not have a physician order to self-administer any of her own medications due to safety. |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide residents with an Skilled Nursing Facility Advanced Beneficiary Notice on Non-coverage (SNF ABN) when their skilled services ended, had skilled days remaining and remained in the facility. This affected two (#31 and #67) of three residents reviewed for beneficiary notices. The facility census was 91.Findings include:1. Review of the medical record revealed Resident #31 was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy and cognitive communication deficit. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #31 had moderately impaired cognition. Review of the primary payor dated 01/30/26 revealed Resident #31 had Medicare part A. The level of care revealed Resident #31 received skilled services effective 12/22/25 through 02/06/26. On 02/07/26, the payor source changed to MyCare Medicaid [NAME].There was no evidence Resident #31 and/or representative received an SNF ABN when skilled services ended.Interview with Business Office Manager (BOM) #13 on 02/11/26 at 1:30 P.M. confirmed Resident #31 was not given an SNF ABN notice when skilled services ended and confirmed Resident #31 had skilled days left. 2. Review of the medical record revealed Resident #67 was admitted to the facility on [DATE]. Diagnoses included type two diabetes mellitus, peripheral vascular disease, and osteomyelitis. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #67 was cognitively intact.Review of the primary payor dated 08/07/25 revealed Resident #67 had Medicare part A. The level of care revealed Resident #67 received skilled effective 08/07/25 through 10/25/25. On 10/26/25, the primary payor source changed to Medicaid.There was no evidence Resident #67 and/or representative received an SNF ABN when skilled services ended.Interview with Business Office Manager (BOM) #13 on 02/11/26 at 1:30 P.M. confirmed Resident #67 was not given an SNF ABN notice when skilled services ended and confirmed Resident #67 had skilled days left. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, observation, record review, and policy review, the facility failed to implement Resident #9's care plan interventions for quarter side rails for the resident's bed and develop a mood care plan for Resident #10. The facility census was 91.Findings include-<br><br>1. 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.<br><br>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.<br><br>The care plan dated 08/18/25 revealed Resident #9 required assistance with activities of daily living (ADLs) related to decreased mobility, pain, and self-care deficit. Interventions included a left quarter side rail to assist with bed mobility.<br><br>Observation and interview on 02/17/26 at 11:00 A.M. with Licensed Practical Nurse (LPN) #103 in Resident #9's room revealed Resident #9's bed did not have the quarter side rails attached his bed as care planned.<br><br>Interview on 02/18/26 at 8:28 A.M. with Resident #9 revealed he hasn't had a quarter side rail for movement in the last five weeks and Resident #9 confirmed he does need the side rails.<br><br>Interview and observation on 02/18/26 with the Director of Nursing (DON) in Resident #9's room revealed no quarter side rail on his bed.<br><br>2. Review of the medical record for Resident #10 revealed an admission date of 06/20/24. Diagnoses included depression. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #10 was cognitively intact.<br><br>Review of the Prospective Payment System (PPS) discharge assessment dated [DATE] revealed Resident #10 had little interest/pleasure in doing things two to six days and was feeling down, depressed or hopeless for two to six days of the two week look back period. A mood care plan was marked as being in place.<br><br>Review of the psychosocial quarterly assessment dated [DATE] revealed Resident #10 had little interest/pleasure in doing things for two to six days of the two week look back period. A mood care plan was marked as being in place.<br><br>The physician orders revealed an order for Mirtazapine (antidepressant) 7.5 milligrams (mg) tablet at bedtime with a start date of 02/04/26.<br><br>Review of the comprehensive care plan for Resident #10 revealed no documentation a mood care plan had been implemented.<br>(continued on next page) |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 02/18/26 at 10:17 A.M. with Minimum Data Set (MDS) Nurse #8 verified Resident #10 did not have a mood care plan that had been implemented despite documentation on the psychosocial evaluations and the initiation of an antidepressant medication.<br><br>Review of the policy titled Care Plans, Comprehensive Person Centered revised 03/2022 revealed the comprehensive, person-centered care plan would include services which would be furnished to attain or maintain physical, mental and psychosocial well-being. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, resident and staff interviews, the facility failed to hold quarterly care conferences for the residents. This affected one (#65) of two residents reviewed for care conferences. The facility census was 91.Findings include:Review of the medical record for Resident #65 revealed an admission date of 09/06/23. Diagnoses included multiple sclerosis. morbid obesity, paraplegia, and open wound to left lower leg. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #65 was cognitively intact and required supervision with eating, maximum assistance with bed mobility and was dependent upon staff with toileting and transfers.The medical record review revealed the last documentation of a care conference for Resident #65 was on 09/03/24.Interview on 02/10/26 at 9:50 A.M. with Resident #65 revealed she did have a concern because a conference had not been offered for a while.Interview on 02/11/26 at 2:19 P.M. with Social Services Designee (SSD) #14 verified Resident #65's last care conference was on 09/03/24. SSD #14 shared the staff member who did the care conferences was no longer employed at the facility and she was in the process of getting them scheduled.Review of the facility policy titled Care Plans, Comprehensive Person Centered, revised 03/2022, revealed a resident has a right to participate in his or her treatment and provided advanced notice of care planning conferences. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>2) Review of the medical record for Resident #65 revealed admission date of 09/06/23. Diagnoses included multiple sclerosis, morbid obesity and paraplegia.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #65 had intact<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | cognition and was dependent upon staff with personal hygiene.<br><br>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.<br><br>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.<br><br>Observation on 02/12/26 at 7:38 A.M. revealed Resident #65's facial stubbles were still present.<br><br>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.<br><br>This deficiency represents non-compliance investigated under Complaint Numbers 2715256, 2687005, 2650868 and OH00165691 (1363724). |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and resident and staff interviews, the facility failed to ensure activities were offered and or provided for Resident #65. This affected one (#65) of two residents reviewed for activities. The facility census was 91.Findings include:Review of the medical record for Resident #65 revealed admission date of 09/06/23. Diagnoses included multiple sclerosis, morbid obesity and paraplegia. The care plan revealed Resident #65 was dependent on staff for meeting emotional, intellectual, physical, and social need due to cognitive deficits, physical limitations, legally blind and needs assistance with reading and organizing things, one-to-one (1:1) room visits on scheduled days, and activities were offered when visits being completed. An intervention dated 12/26/23 revealed Resident #65 would be provided 1:1 bedside/in-room visits and activities if unable to attend out of room events.The comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed it was somewhat important to the resident to have books, newspapers, and magazines to read, keeping up with the news, do things with groups of people, and participate in religious services or practices. It was very important to Resident #65 to listen to music she liked.The quarterly MDS assessment dated [DATE] revealed Resident #65 had intact cognition and was dependent upon staff with personal hygiene, required supervision with eating, maximum assistance with bed mobility and was dependent upon staff with transfers and toileting.Review of Resident #65's activity calendar from 04/01/25 to 02/12/26 revealed there were no activities were documented in April 2025. On 05/31/25, it was documented resting-cover over head and no other activities were documented in May 2025. In June 2025, there were two listed activities provided to the resident, which included on 06/11/25 of reading bible verses and on 06/23/26 the activity documented was up watching television. Activity documented on 07/16/25 was up watching television doing good and feeling better. There were no other activities documented in July 2025. There were no activities documented for August 2025. Documentation for 09/01/25 was church service discussion, and on 09/25/25 the activity log documented she was watching television and eating snacks. There was no further documentation for September 2025. There was no documentation for activities in October 2025. The 11/06/25 documentation was Resident #65 was in bed requesting aid to get her up, 11/13/25 documentation was Resident #65 was happy staff were getting her up, 11/17/25 documented Resident #65 was in bed and needed assistance finding her writing tablet. There was no further documentation for November 2025. There was no documentation of activities for the month of December 2025. The next activity was documented on 01/10/26 which documented patient care and on 01/27/26 documentation for activity was doing well and in good spirits. There was no further activity documented as of 02/12/26. Interview on 02/10 /26 at 9:45 A.M. with Resident #65 revealed the facility did not provide her with in room activities as she required.Interview on 02/12/26 at 12:44 P.M. with Activity Manager (AM) #16 revealed Resident #65 was to be offered one-on-one activities in her room three times a week. He acknowledged there was missing documentation to verify activities were offered. AM #16 also acknowledged documenting Resident #65 was watching television, requesting to get up and having the blanket over her head were descriptions and not activities.Review of the facility policy titled Resident Life Enrichment dated 06/05/25 revealed the facility would develop and implement activities which reflect the resident interests and functional abilities, maintain attendance records for activities and evaluate activity effectiveness at least quarterly. |

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|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**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. |

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

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siena Woods Care Center | 6125 N Main Street<br>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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**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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| | 365819 | A. Building<br>B. Wing | 02/18/2026 |

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

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|---|---|
| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**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].<br><br>The Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed Resident #68 had impaired cognition and required maximum assistance from staff with feeding.<br><br>Review of the physician orders revealed Resident #68 was to receive a regular puree thickened liquid diet and provide gravy with all meals.<br><br>Review of the meal ticket for Resident #68 revealed the resident should have received extra gravy on the side.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>Interview on 02/11/26 at 1:35 P.M. with CNA #108 verified Resident #17's liquid was not thickened.<br><br>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.<br><br>Interview on 02/18/26 at 12:35 P.M. with Registered Nurse (RN) #63 verified Resident #17's order<br>(continued on next page) |

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|---|---|---|---|
| | 365819 | A. Building<br>B. Wing | 02/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siena Woods Care Center | 6125 N Main Street<br>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.

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|---|---|
| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | permitted regular texture foods for pleasure but did not specify regular liquids.<br><br>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.<br><br>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.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00165691 (1363724). |

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

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|---|---|
| F 0810<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide special eating equipment and utensils for residents who need them and appropriate assistance.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, policy review and records reviews, the facility failed to ensure the residents received their adaptive feeding equipment with meals as physician ordered. This affected three (#10, #57, and #79) of three residents reviewed for adaptive equipment. The facility census was 91. Findings include: 1. Record review for Resident #79 revealed the resident was admitted to the facility on [DATE]. Diagnoses included atherosclerosis, diabetes, dementia, and osteoarthritis left shoulder and unspecified pain. The Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed Resident #79 had intact cognition and required set up assistance for feeding. Review of the physician orders revealed Resident #79 was to receive a two handled cup with spout lid for liquids.Review of the meal ticket for Resident #79 revealed the resident should have received a two handled cup with a spouted lid.Observation and interview on 02/11/26 at 1:30 P.M. revealed Resident #79 received a two handled cup with no lid. The resident had contracted fingers and was unable to get the cup to her mouth safely. Resident #79 received straight handled flatware. Resident #79 stated she had not received a lid with a spout for several weeks. She stated she wanted a lid with a spout so she could continue to feed herself without assistance and stated hot beverages were dangerous for a burn without the spouted lid. The resident said she had not had evaluations for other flatware, and she had difficulty getting the food to her mouth with straight handled spoons and forks. Certified Nursing Assistant (CNA) #43 verified Resident #79 received a cup without the spouted lid as listed on the meal tray ticket. CNA #43 verified Residents #79 did not have a lid with a spout for several weeks and had difficulty drinking from the cup without the spouted lid. CNA #43 verified the resident had difficulty getting food to her mouth without spilling with the straight handled flatware.Observation and interview on 02/12/26 at 8:05 A.M. revealed Resident #79 received a two handled cup with plastic lid covering and not a lid with a spout. The resident had straight handled flatware and was having difficulty getting the food to her mouth without spilling the food. Resident #79 stated she had to remove the plastic lid and would not be able to get the liquid safely to her mouth. She sated she was having difficulty using the straight spoon feeding herself the breakfast cereal. Assistant Director of Nursing (ADON) #1 verified Resident #79 should have received a cup lid with a spout and not a plastic lid covering. ADON #1 stated the resident was spilling the food when using a straight handled spoon and could benefit from an evaluation of adaptive flatware.2. Record review for Resident #10 revealed an admission date of 06/20/24. Diagnoses included chronic kidney disease and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident had intact cognition and required supervision with eating.Review of the physician orders revealed the Resident #10 was to receive food was to be served in separate bowls at mealtimes.Observation and interview on 02/11/26 at 1:35 P.M. revealed Resident #10 received the meat, vegetable and starch on one plate. There was no bowl near Resident #10 and the resident was attempting to feed herself in bed. Resident #10 stated she preferred the food in bowls because she could get the food closer to her mouth while she was in bed. She stated she could better feed herself independently when each food was served in bowls. Certified Nursing Assistant (CNA) #43 verified Resident #10 received all the foods on the plate and the resident should have had the foods in bowls as listed on the meal tray ticket.Observation and interview on 02/12/26 at 8:10 A.M. revealed Resident #10 received all the breakfast foods of egg and meat on the plate. There were not separate bowls for each food item. The resident was in bed attempting to feed herself with the plate on an overbed table.Resident #10 stated she was able to feed herself better when the food was in separate bowls. Interview on 02/12/26 at 8:15 A.M. with Assistant Director of Nursing (ADON) #1 verified Resident #10 should have received foods in separate bowls as listed on the mal tray ticket. ADON #1 verified Resident #10 was able to feed herself better when the resident could hold the bowl closer<br>(continued on next page) |

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| | 365819 | A. Building<br>B. Wing | 02/18/2026 |

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|---|---|
| F 0810<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | while eating herself in the bed. 3. Record review for Resident #57 revealed the resident was admitted to the facility on [DATE]. Diagnoses included Parkinson's disease and dysphagia. The Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed Resident #57 had intact cognition and was independent with feeding.Review of the physician orders revealed Resident #57 was to receive a regular diet, have cut meats and lid and straws for drinks.Review of the Resident Adaptive Equipment Report, provided by the facility, revealed Resident #57 was to receive weighted gray utensils, drinks with a lid and straw at all meals.Observation and interview on 02/11/26 at 12:50 P.M. revealed Resident #57 received a cup with no straw, the chicken was not cut off the bone and there were no weighted gray handled utensils. The resident was attempting to feed herself in the main dining room. Resident #57 stated she was able to feed herself better when the meat was cut up, she had a straw with her liquids, and she had the weighted utensils. The resident stated the weighted utensils helped when her hands were shaking to keep her independent in feeding herself.Interview on 02/12/26 at 12:50 P.M. with Dietary Manager (DM) #5 verified Resident #57 did not receive a straw with her liquids, the chicken was not cut off the bone and here were no weighted utensils provided for the resident. DM #5 stated it was the responsibility of the staff serving the residents in the dining room to provide the straw and cut the meat for the resident while in the dining room. Review of the facility policy titled Meal Distribution, dated 2023, revealed meals will be assembled with the individualized diet order, plan of care and preferences. Meals are delivered in an accurate manner. |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**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:<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>Review of Resident #77's physician orders dated 12/18/25 revealed an order for EBP related to an indwelling urinary catheter.<br><br>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.<br>(continued on next page) |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Review of Resident #84's physician orders dated 06/02/25 revealed an order for EBP related to gastrostomy tube (G-tube).<br><br>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.<br><br>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.<br><br>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.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00165691 (1363724). |

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|---|---|
| F 0814<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Dispose of garbage and refuse properly.<br><br>Based on observation, staff interview, and policy review, the facility failed to ensure garbage and refuse was properly placed inside lidded garbage containers. This had the potential to affect 88 residents. Resident #14, #79, and #103 were on nothing by mouth. The facility census was 91.Findings include:Observation and interview on 02/17/26 at 12:32 P.M. in the kitchen revealed a large garbage bin on wheels with no lid and full of garbage next to a food prep area. There was a garbage bin near a kitchen hand wash station by the freezer and it had garbage sitting on top of the lid, and a garbage bin near hand wash station by kitchen entry doors was full of garbage overflowing, not allowing the lid to close. Kitchen District Manager #120 confirmed there was a garbage bin without a lid, one garbage bin had garbage sitting on the top, and another garbage bin was full of garbage and was overflowing. Review of the facility policy titled Dispose of Garbage and Refuse HCSG 030 revised 02/2025 revealed appropriate lids are provided for all containers and garbage and refuse will be removed from the kitchen area routinely during the day. |