STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366331	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Skilled Nursing & Rehabilitation	250 Cadiz Road Wintersville, OH 43953

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on closed medical record review, review of photos, and interview the facility failed to ensure podiatry services and foot care were provided. This affected two residents (#81 and #82) of three closed records reviewed. Findings included: 1. Closed medical record review revealed Resident #82 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes, end stage renal disease, restless leg syndrome, and anemia. Review of Resident #82's ancillary service consent dated 01/16/24 revealed the resident's son had signed a consent for podiatry services. Review of Resident #82's closed paper and electronic medical record revealed no evidence the resident had been seen by podiatry. Review of photos of Resident #82's feet (provided by the resident's family) revealed the resident's left great, second, third, and forth toenails were long and extended out past the end of the toe. There was old nail polish on the toenails that extended to the end of the toe. There was dry, thick scaly skin noted on bilateral feet. The other toenails were brittle, and some nails were broken. The nails were thick, yellow, and had a substance built up under the nails. Review of Resident #82's hospital note dated 03/24/25 revealed the family had moisturized and cut and painted the resident toenails. Interview on 04/24/25 at 8:42 A.M., with Resident #82's daughter-in-law confirmed the resident had dry and dead skin on her feet, her toenails were thick and brittle with buildup under the nails, and foot and nail care had not been performed since the resident was admitted to the facility. Her husband was the power of attorney and signed consent for podiatry services. Resident #82's daughter-in-law added that Resident #82 enjoyed having her feet and nails done and had went with her niece frequently to have pedicures. The resident had a pedicure done right before she was admitted to the facility. The daughter-in-law provided before and after photos of Resident #82's feet/toes to confirm the condition of Residents #82's feet/toes when the resident had went to the hospital on 03/22/25. (continued on next page)

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
	366331	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Skilled Nursing & Rehabilitation	250 Cadiz Road Wintersville, OH 43953

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/25/25 at 7:55 A.M. and 9:29 A.M., with the Director of Nursing (DON) confirmed the family had signed consent for podiatry services. The DON confirmed there was no evidence the podiatrist had seen the resident. The DON reported she called the ancillary service company, and the company reported the physician never returned the signed consent. The DON confirmed the facility was unaware the provider had not signed the consent. The DON reported the social services designee had quit without notice. The DON reviewed the photos and confirmed Resident #82 was the resident in the pictures. 2. Closed record review Resident #81 was admitted to the facility on [DATE] with diagnoses including type two diabetes, acute and chronic respiratory failure, anemia, and heart failure. Review of Resident #81's podiatry consent (date not legible) revealed Resident #81 had signed consent for podiatry services. Review of Resident #81's paper and electronic medical record revealed no evidence Resident #81 had been seen by podiatry. Review of a photo of Resident #81's toes revealed the resident's great toes toenails revealed the toenails were long and extended past the end of the toe. The nails were yellow in color. Interview on 04/22/25 at 1:54 P.M., with Resident #81's husband revealed he had requested his wife be seen by the podiatrist due to her toenails being long and she had complaints her nails were hurting. He was told his wife's name was on the list. Per Resident #81's husband, the day the podiatrist visited the facility, Resident #81 was not seen and he questioned why she was not seen. He was told her name was not on the list to be seen. Interview on 04/24/25 at 9:30 A.M. and 12:02 P.M., with the Director of Nursing (DON) confirmed Resident #81 had signed consent to see the podiatrist, however there was no evidence the resident had been seen by podiatry. The DON reported she called the ancillary service company, and the company reported they had sent an order to the physician to be seen, however the physician had never signed the order. The DON confirmed the facility was unaware the resident needed a signed physician consent, and the social worker designee had quit recently without notice. This deficiency represents non-compliance investigated under Complaint Number OH00164618.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366331	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Skilled Nursing & Rehabilitation	250 Cadiz Road Wintersville, OH 43953

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 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** 32801 Based on medical record review, review of fall investigation, observation, and interview the facility failed to ensure fall interventions were in-place per the resident's plan of care. This affected one (Resident #66) of three records reviewed for falls. Findings included: Medical record review revealed Resident #66 was admitted to the facility on [DATE] with diagnoses including history of falls, cerebrovascular disease, diabetes, seizures, and absent of right great toe. Review of Resident #66's census sheet revealed Resident #66 was moved to room [ROOM NUMBER] on 03/20/25. Review of the fall investigations dated 12/2024 to 04/2025 with the Director of Nursing (DON) revealed Resident #66 had sustained three falls. On 12/20/24 the resident had fallen out of bed because she felt like she had to get out of bed. The new intervention was to hang a sign to ask for help and to use call light. On 12/27/24 the resident had fallen out of bed reaching for her phone. The new intervention was to move items within reach. The third fall occurred on 02/01/25 and the resident was trying to get out of bed unassisted. The new intervention included a low bed. Review of Resident #66's current fall care plan related to history of falls, seizure, and diabetes revealed the resident's bed was in the lowest position when occupied, the body pillow to the right side of the bed, personal and commonly used items within reach, and visual reminder to utilize call light for assistance. Observation on 04/24/25 at 12:33 P.M., of Resident #66's room with the DON revealed Resident #66 did not have a body pillow, sign to ask for help/use call light, and the bed was not in a low position. The DON reported the resident had a recent room change on 03/20/25 (over a month ago) and the body pillow and sign must have not been brought to the new room. The DON reported she didn't believe Resident #66 wanted the bed in the lowest position and she was going to update the plan of care to have the bed mid between low and high (midway). This deficiency represents non-compliance investigated under Complaint Number OH00164618 and Complaint Number OH00164233.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366331	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Skilled Nursing & Rehabilitation	250 Cadiz Road Wintersville, OH 43953

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 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 32801 Based on observation, medical record review, interview, and policy review the facility failed to ensure urinary catheter care was provided and failed to assess the resident's urinary status and condition when the resident experienced no urinary output for two days and minimal output the third day resulting in transfer to the hospital for treatment of a clogged urinary catheter. This affected three residents (#14, #66, and #80) of three residents reviewed for urinary catheters. Actual Harm occurred on 02/12/25 when the facility failed to provide timely and necessary indwelling urinary catheter care to Resident #80 resulting in increased pain and the resident being transferred to the hosptial. Hospital care included replacing the urinary catheter, treatment with continuous bladder irrigation, and pain management due to the facility failure to properly and timely irrigate the urinary catheter, accurately assess the resident's condition, and monitor urinary output. Findings Include: 1. Closed medical record review revealed Resident #80 was admitted on [DATE] with diagnoses including chronic lymphocytic leukemia of B-Cell, stage four chronic kidney disease, malignant neoplasm of kidney and brain, neuromuscular dysfunction of bladder, and benign prostatic hyperplasia with lower urinary tract symptoms. The resident discharged to the hospital on 02/27/25 and did not return to the facility. Review of Resident #80's alternation in elimination plan of care initiated 02/07/25 and revised on 04/22/25 (after the resident discharged from the facility) revealed to assess for abdominal distention as needed initiated on 04/22/25, change Foley catheter per physician orders and as needed initiated on 02/07/25, empty Foley catheter every shift and as needed initiated on 02/07/25, irrigation per physician orders initiated on 04/22/25, and medicate per physician order initiated on 04/22/25. Review of the five-day minimum data set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of four indicating the resident had severe cognitive impairment. The assessment also revealed the resident had an indwelling urinary catheter (Foley catheter). Review of Resident #80's urinary output dated 02/2025 revealed no output was documented for 02/10/25 or 02/11/24, and only 100 ml on 02/12/25. Review of Resident #80's progress note authored by the Assistant Director of Nursing (ADON) dated 02/11/25 at 10:49 A.M., revealed the resident's urine in the foley was clear, yellow, and patent. The note included the resident had not had any significant changes in the last 24 hours. Review of Resident #80's progress note authored by Licensed Practical Nurse (LPN) #104 dated 02/12/25 at 11:35 A.M., revealed urine was normal. There had not been any significant changes in the last 24 hours with the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366331	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Skilled Nursing & Rehabilitation	250 Cadiz Road Wintersville, OH 43953

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 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #80's progress note authored by LPN #104 dated 02/12/25 at 3:45 P.M., revealed the resident continued to have bright red blood draining into the Foley. The physician was notified and stated if the bleeding or discomfort continued tomorrow to send the resident to the emergency room and keep attempting to flush the Foley. Review of Resident #80's progress note authored by Registered Nurse (RN) #102 dated 02/12/25 at 7:00 P. M., revealed the family came to the nurse's station just after shift change around 6:35 P.M. and asked for the resident's Foley to be irrigated. The author informed the family that she would be down as soon as possible. The wife also asked if there was anything else that could be done and the author informed her that the doctor said that staff could send the resident to the emergency room . The wife stated, No I don't want him going over there. The author told the wife once again she would be down as soon as possible. At 6:50 P.M., a certified nursing assistant (CNA) came and told the author that the resident's wife told her that if her husband was not sent to the emergency room within 20 minutes she was going to call the police about the lack of care. The transport company was called, and the resident left the facility via stretcher at 7:00 P.M. Review of Resident #80's progress note authored by RN #102 dated 02/12/25 at 11:42 P.M., revealed the resident returned from the emergency room with a new three way 16 french Foley and continuous bladder irrigation (CBI) was done at the emergency room . New orders to follow up with the urologist within one week. Review of Resident #80's emergency room notes dated 02/12/25 revealed at 7:16 P.M. and 7:30 P.M. the resident's blood pressure was 132/91 mg/Hg and pulse was 118 (beats per minute). The resident's wife reported his heart rate was normal for him, but he was also in pain from his distended bladder. The resident appeared quite uncomfortable and was administered Toradol 15 milligrams (mg) IV for pain, Urispas and Pyridium for bladder spasms. A bladder scan was performed at 7:32 P.M., that indicated the resident had greater than 600 milliliters (ml) of urine in the bladder. At 8:43 P.M., there was minimal drainage noted from the foley catheter after multiple attempts to flush the current catheter. A three-way catheter was placed. Several small and moderate size clots were noted in the tubing with flushes. The note included continuous bladder irrigation (CBI) ordered. At 10:56 P.M., CBI was completed with 2500 ml of clear pale colored urine returned. Review of Resident #80's hospital discharge summary records dated 02/12/25 revealed the resident was seen for Foley malfunction and the resident was brought in from the skilled nursing facility for complaints of blood in his urine after having his catheter removed today. There was a large amount of gross red blood noted in the catheter bag. The resident was in pain from a distended bladder. The bladder scan noted greater than 600 milliliters (ml) of urine. It was noted the resident had a clot blocking the catheter passage. A triple-lumen catheter was placed instead of a two way which can be irrigated properly. The discharge summary included to follow-up with urologist in one week. Further review of Resident #80's progress notes dated 02/12/25 revealed no evidence the urinary Foley was changed or irrigated and no documented evidence included as to when the blood was first noted in the Foley. Review of Resident #80's orders and medication and treatment administration records dated 02/2025 revealed no evidence Resident #80's Foley catheter was changed by facility staff or irrigated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366331	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Skilled Nursing & Rehabilitation	250 Cadiz Road Wintersville, OH 43953

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 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Further review revealed on 02/12/25 LPN #104 administered Tylenol 650 milligrams (mg) at 3:54 P.M., for a pain rated an eight out of 10 (1-10 pain scale). The follow up indicated the Tylenol was effective however there was no time noted when the medication was effective or pain rating noted. Interview on 04/21/25 at 9:29 A.M. with Resident #80's wife (a retired nurse) revealed on 02/11/25 she noticed blood in the resident's Foley bag. Staff told her it was due to the resident pulling on his Foley sometime during the night. On 02/12/25 when she came to visit her husband she stated there was blood in the Foley bag. She stated she had to beg for the nurse to irrigate and change the Foley. LPN #104 attempted to irrigate the Foley while the resident was in his wheelchair, which was not effective. The wife reported the resident should have been laid down in bed to properly irrigate the Foley. The LPN got blood on the floor in the resident's room and did not clean it up. LPN #104 then changed the Foley about 2:00 P.M. and no urine was ever obtained, just frank blood. There was no urine output for the rest of the afternoon. The wife asked the evening change shift nurse (Registered Nurse (RN) #102) to check the blood and she reported she would get to it later that she had discharges, tube feeds, and had no time to check the blood with no urine out in the foley bag. The resident's wife stated the resident was in so much pain she had requested the resident to go to the emergency room . The emergency room inserted a three-way catheter and continuously flushed the catheter until it was clear. The resident was transported back to the skilled facility. RN #102 never came back to the room to check the resident in. The emergency squad remarked that nurse should have come back to check the resident in. The next day, 02/13/25 the wife stated she had spoken to the Director of Nursing (DON) who defended the nurses stating the nurse had to triage care. Interview on 04/22/25 at 1:52 P.M., with Licensed Practical Nurse (LPN) #104 revealed she recalled Resident #80. The LPN recalled the resident had blood in his Foley bag for a couple days because he was attempting to get out bed unattended and was pulling on his Foley. The LPN confirmed she had changed the resident's urinary Foley and attempted to irrigate the Foley without success. The LPN reported the resident ended up going to the emergency room for treatment. Interview on 04/23/25 at 7:21 A.M., with the Director of Nursing (DON) confirmed there were no orders to change Resident #80's Foley or irrigate the Foley. The DON confirmed the resident had 100 ml output on 02/12/25 and there was no documentation of urine output on 02/10/25 or 02/11/25. The DON also confirmed there was no documented evidence the physician was notified the Foley irrigation was not successful or the resident had no output after the Foley was changed. The DON confirmed to irrigate a Foley the resident should have been laid down and irrigation should not have been attempted while the resident was sitting up in a wheelchair. Review of the facility's policy titled Foley Catheter Care, undated, revealed the Foley catheter bag would be changed as needed, the catheter would be replaced as needed, or in accordance with physician orders. The staff would monitor intakes and output and record finding on the MAR, as needed. The staff would observe and report to the licensed nurse any signs or symptoms of UTI to include blood, odor, cloudiness, pain, elevated temperature, or absence or decrease in urine output. 2. Medical record review revealed Resident #66 was admitted to the facility on [DATE] with diagnoses including neuromuscular dysfunction of the bladder, cerebrovascular disease, diabetes, chronic kidney disease, and paralysis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366331	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Skilled Nursing & Rehabilitation	250 Cadiz Road Wintersville, OH 43953

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 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #66's alteration in elimination (indwelling Foley catheter) dated 09/26/25 and revised on 04/21/25 revealed to empty Foley catheter every shift and as needed, irrigation per physician orders, monitor for signs and symptoms of urinary tract infection (UTI) including foul smelling urine. Report to physician to seek diagnoses and treatment promptly. Review of Resident #66's infection care plan related to indwelling Foley catheter dated 09/26/24 revealed to monitor for signs and symptoms of UTI: foul smelling urine, cloudy urine, sediment, and decreased output. Review of Resident #66's urinary output revealed at 5:20 A.M. on 04/22/25 the resident had 500 ml of urine output. Review of Resident #66's progress notes dated 04/21/25 and 04/22/25 revealed no evidence of milky urine. The last urinary assessment completed was dated 03/23/25 that indicated the resident had a Foley catheter that was draining cloudy yellow urine. Review of Resident #66's progress notes dated 04/22/25 and 04/23/25 revealed no evidence the physician had followed up on the resident's foul milky urine. Review of Resident #66's orders and medication and treatment administration orders dated 03/2025 to 04/2025 revealed no evidence to change the Foley drainage bag or irrigation. The Foley was last changed on 03/13/25. Observation on 04/22/25 at 7:18 A.M. of Resident #66's Foley catheter with Certified Nurse Aide (CNA) #113 revealed the urine was not visible due to the Foley bag was tinted and the urine was not visible. This observation was confirmed with CNA #113. At this time, CNA #113 emptied the Foley catheter and the urine was milky in color and had a strong odor. Resident #66 had 150 ml out (was just emptied at 5:20 A.M). Observation on 04/22/25 at 7:40 A.M. of Resident #66 with the DON revealed the bag was tinted and the urine was not visible. The DON requested the nurse to change out the bag and tubing and to update the doctor on the resident's urine being milky and see if he wanted a urinalysis. Interview on 04/22/25 at 10 :00 A.M. with Licensed Practical Nurse (LPN) #173 and the DON revealed LPN #173 changed the Foley bag but had not faxed the doctor yet regarding the milky urine. The DON confirmed the order to change the urinary bag, and irrigation was just added today. Interview on 04/22/25 at 10:51 A.M. LPN #161 revealed she had provided care to Resident #66 last week and her urine was orange in color which was normal for her because she had a diagnosis diabetes. Interview on 04/23/25 at 8:45 A.M., with the DON revealed the nurse had faxed the physician yesterday (04/22/25) regarding the resident's urine being milky and had an odor, however there was no evidence the physician had responded back to the fax yet. Interview on 04/23/25 at 9:16 A.M., with the DON revealed the physician had called back this morning and he wanted a urinalysis with a culture and sensitivity to be done tomorrow since the resident was not having symptoms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366331	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Skilled Nursing & Rehabilitation	250 Cadiz Road Wintersville, OH 43953

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 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/28/25 at 10:20 A.M., with the DON via email revealed Resident #66's urine culture and sensitivity was positive for Proteus Vulgaris (Bacteria) and Klebsiella Aerogene (Bacteria) on 04/26/25 and the physician ordered Cipro 250 mg twice daily for seven days this morning (04/28/25). Review of the facility's policy titled Foley Catheter Care, undated, revealed the Foley catheter bag would be changed as needed, the catheter would be replaced as needed, or in accordance with physician orders. The staff would monitor intakes and output and record finding on the MAR, as needed. The staff would observe and report to the licensed nurse any signs or symptoms of UTI to include blood, odor, cloudiness, pain, elevated temperature, or absence or decrease in urine output. 3. Review of Resident #14's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including transient cerebral ischemic attack, multiple sclerosis, neuromuscular dysfunction of bladder and heart failure. Review of Resident #14's alteration in elimination care plan related to supra pubic catheter and neuromuscular bladder dated 09/26/24 revealed to change appliance per physician orders, intermittent catheterization per orders, irrigation per physician orders and change supra pubic catheter every 30 days in the morning, if unable to get in, send the resident to the hospital per physician. Review of the urology note dated 03/18/25 revealed to change supra pubic catheter every 30 days in the A. M. If unable to get in, send the resident to the hospital per urologist in the morning every 30 days. Review of Resident #14's current orders dated 04/2025 revealed no evidence of orders to change the resident's catheter every 30 days, irrigation, or changing equipment (bag). Interview on 04/21/25 at 1:10 P.M., with the DON confirmed the resident did not have current orders to change the supra pubic catheter every 30 days, irrigation, or changing the catheter bag. The DON reported the resident was hospitalized last month and the orders were not re-written on re-admission. Interview on 04/22/25 at 7:15 A.M., with the DON revealed the resident had to be sent to the emergency room due to staff attempted to change the supra pubic catheter but were not successful. The last time the resident's catheter was changed was on 03/22/25 because he refused to have it changed on 03/21/25. Review of the facility's policy titled Foley Catheter Care, undated, revealed the Foley catheter bag would be changed as needed, the catheter would be replaced as needed, or in accordance with physician orders. The staff would monitor intakes and output and record finding on the MAR, as needed. The staff would observe and report to the licensed nurse any signs or symptoms of UTI to include blood, odor, cloudiness, pain, elevated temperature, or absence or decrease in urine output. This deficiency represents non-compliance investigated under Master Complaint Number OH00164936, Complaint Number OH00164233.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366331	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Skilled Nursing & Rehabilitation	250 Cadiz Road Wintersville, OH 43953

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on closed medical record review, review of drug information, and interview the facility failed to ensure a resident's drug regimen was free from unnecessary medication when the resident was administered morphine not in accordance with hospice orders. This affected one resident (#81) of three resident records reviewed for death. Findings included: Based on closed medical record revealed Resident #81 was admitted to the facility on [DATE] and expired on [DATE]. Diagnoses included tracheostomy, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, type 2 diabetes, history of malignant neoplasm of tongue and breast, malignant neoplasm of tonsils, disease of intestine, neuromuscular dysfunction of bladder (urinary catheter), gastrostomy, heart failure, gastro-esophageal reflux disease, constipation, depression, adjustment disorder with depressed mood, abdominal aortic aneurysm, anxiety, and anemia. Review of Resident #81's orders dated ,d+[DATE] revealed Lorazepam (benzodiazepine) 0.5 milligram (mg) twice daily for restlessness and anxiety and every four hours as needed via peg tube, Escitalopram (Serotonin) 10 mg two tablets via peg tube at bedtime for sadness, teary, and depressive episodes, and Gabapentin (anticonvulsant/neuropathic pain)100 mg two tablets via peg-tube every morning for muscle weakness. The resident's original Morphine (opioid analgesics) order was 5 mg (0.25 milliliter (ml)) every four hours for pain and dyspnea as needed. On [DATE] at 10:00 A.M., the order was increased to 10 mg (0.5 ml) every 2 hours as needed for pain and shortness of breath. The order was clarified on [DATE] at 9:18 P.M. and changed to every four hours (not 2 hours). Review of Resident #81's Ativan control sheet revealed the resident was administered Ativan 0.5 mg at 8:00 A.M (scheduled time), 11:00 A.M (as needed dose), 2:00 P.M. (as needed dose) and 9:21 P.M. (scheduled dose), however review of the Medication Administration Record (MAR) dated ,d+[DATE] revealed the resident received the Ativan A.M., 10:32 A.M., 2:35 P.M. There was a discrepancy in times administered for the as needed dose when the MAR was reconciled with the narcotic control sheet. Review of Resident #81's Morphine control sheet revealed the resident was administered Morphine 0.25 ml (5 mg) at 4:30 A.M., 8:00 A.M., 11:30 A.M., 11:50 A.M., and 12:30 P.M. The resident received 0.5 ml (10 mg) at 1:00 P.M., 1:59 P.M., 2:15 P.M., 2:45 P.M., 4:00 P.M., and 9:21 P.M., however review of the MAR dated , d+[DATE] revealed the resident only received Morphine 0.25 ml at 4:31 A.M. for dyspnea, 9:06 A.M. (discrepancy in time) for pain, 10:32 A.M. (discrepancy in time) for dyspnea, 11:53 A.M. for pain, and 0.5 ml (10 mg) 1:59 P.M. for shortness of breath, and 9:21 P.M. for pain. The resident received one dose of 10 mg on [DATE] at 5:14 A.M. for dyspnea, which was not documented on the Morphine control sheets. The 0.25 ml at 12:30 P.M., 0.5 ml at 1:00 P.M., 2:15 P.M., 2:45 P.M., and 4:00 P.M. were not documented on the MAR. The 11:50 A.M. dose was signed out as 0.25 ml on the control sheet, however on the MAR it was signed off as 0.5 ml was administered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366331	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Skilled Nursing & Rehabilitation	250 Cadiz Road Wintersville, OH 43953

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the MAR dated ,d+[DATE] Escitalopram 20 mg was administered at 8:00 P.M. from [DATE] to [DATE] and Gabapentin 100 mg two tablets from [DATE] to [DATE]. The resident's A.M., blood sugar on [DATE] was 581. Review of Resident #81's hospice note dated [DATE] revealed the nurse visited from 8:50 A.M. to 9:30 A.M. The residents' eyes were closed, restless, fidgeting, grimacing, non-verbal/unable to respond at this time. The resident had minimally responsive, mottled/cool extremities, terminal restlessness, and darkened/decreased urine output. The resident heart rate was 80, respiration was 22, blood pressure was , d+[DATE], and pulse oximetry (ox) was 94% on five liters of oxygen via trach. The resident was able to respond to tactile stimuli. Resident receiving tube feeds via peg tube on continuous pump. Five liters of supplement oxygen via trach mask. A telephone call to the resident's husband was made and he was agreeable to increase in comfort medication at this time, he was also requesting a visit from the facility's doctor if possible to assess wife's condition. Spoke to staff nurse (Licensed Practical Nurse) #104, updated on phone call with spouse, she was agreeable to reach out to the facility doctor to request updated medication orders Morphine 10 mg every four hours as needed, and advised LPN to medicate resident at this time. Nurse verbalized understanding. Review of hospice communication note dated [DATE] revealed at 8:50 P.M., the facility called to clarify Morphine orders. Morphine 10 mg every four hours per hospice physician was clarified. Review of Resident #81's nursing progress notes dated [DATE] revealed: -Progress note authored by LPN #145 at 1:20 A.M., revealed the resident was resting quietly at this time without signs or symptoms of pain or discomfort. -Progress note authored by LPN #145 at 2:04 A.M., revealed the resident was resting quietly without signs and symptoms of pain or discomfort. Lungs remain clear but were tachypneic at 24. Tracheostomy clear, not need for suction at this time. -Progress note authored by LPN #145 at 3:09 A.M., revealed the resident was resting quietly without signs and symptoms of pain or discomfort. No response to verbal stimuli but responds to tactile. Lungs remain clear, no need for suctioning, pulse ox remains at 89%. -Progress note authored by LPN #145 at 4:31 A.M. revealed Morphine 5 mg was administered. -Progress note authored by LPN #145 at 4:33 A.M. revealed Resident #81 was slightly tachypneic, facial grimacing, medicated with morphine as per order. Continues to be responsive to tactile stimuli, pulls away while attempting to put pulse ox on finger. When asked if she could hear me or asked to open her eyes there was no attempt to do so. Oxygen remains on via trach mask. Pulse ox 89%. -Progress note authored by LPN #104 at 9:06 A.M. revealed Morphine 5 mg was administered for pain. At 10:14 A.M. the morphine was effective. Follow up pain scale was four. The Morphine narcotic control sheet indicated the Morphine was administered at 8:00 A.M. not 9:06 A.M. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366331	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Skilled Nursing & Rehabilitation	250 Cadiz Road Wintersville, OH 43953

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Progress note authored by LPN #104 at 10:00 A.M , revealed the resident was noted to be agitated with facial grimacing, breathing heavily with respiration at 25. Only responding to physical stimuli. Hospice notified and in to see resident. Hospice recommendation to increase Morphine to 0.5 ml every two hours (was supposed to be every four hours), as needed for pain and shortness of breath. Discontinue all routine medication. Resident seems to still tolerate tube feeding, but okay to stop when resident was unable to tolerate it. Covering physician agreement with all new orders. Blood glucose was 581 this morning. Sixteen (16) units administered for formula and new order received to give an additional 10 units and recheck in one hour. Husband and daughter notified. Husband reported he would be in to see her soon. -Progress note authored by LPN #104 at 10:32 A.M. revealed Lorazepam 0.5 mg was administered and was effective at 12:13 P.M. -Progress note authored by LPN #104 at 10:32 A.M. revealed Morphine 5 mg was administered for dyspnea and was effective at 12:13 P.M. The Morphine narcotic sheet indicated the resident received Morphine 5 mg at 11:30 A.M. -Progress note authored by LPN #104 at 11:53 A.M. revealed Morphine 10 mg was administered for pain and was effective at 12:14 P.M. The Morphine narcotic sheet indicated the resident received Morphine 5 mg (not 10 mg) at 11:50 A.M. -At 12:30 P.M. and 1:00 P.M., there was no documented evidence that the resident had received Morphine per the control narcotic sheet that indicated the Resident had received 0.25 ml (5 mg) of Morphine at 12:30 P. M. and 1:00 P.M. -Progress note authored by LPN #104 at 1:59 P.M. revealed Morphine 10 mg was administered for shortness of breath and was effective at 3:01 P.M. for pain and at 3:02 P.M., it was effective for shortness of breath. -Progress note authored by LPN #104 at 2:09 P.M., revealed the Resident was resting quietly with eyes closed. Husband at bedside. Blood glucose 381. Respirations 20. -At 2:15 P.M., 2:45 P.M., and 4:00 P.M., there was no documented evidence the resident had received Morphine per the control narcotic sheet that indicated the resident had received 0.5 ml (10 mg) of Morphine at 2:15 P.M., 2:45 P.M., and 4:00 P.M. -Progress note authored by LPN #104 at 2:35 P.M., revealed Lorazepam 0.5 mg was administered and at 3:00 P.M it was effective. -Progress note authored by LPN #145 at 6:04 P.M., revealed the Resident was resting quietly without signs or symptoms of pain or discomfort. Responsive to tactile stimuli only. Oxygen via trach mask. Trach clear of secretions. Respirations quiet and easy at this time. Pulse ox was 89%. -Progress note authored by LPN #145 at 9:20 P.M., revealed the resident was showing signs and symptoms of pain. Facial grimacing noted. Tensed arms and clenched fist. Medicated with as needed morphine and routine Ativan as ordered. Aspirated 60 ml from the peg tube. Tube feeding placed on hold as per order. Continues to be responsive to only tactical stimuli. At 10:41 P.M. the morphine was effective. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366331	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Skilled Nursing & Rehabilitation	250 Cadiz Road Wintersville, OH 43953

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Progress note authored by LPN #145 at 10:30 P.M., revealed the resident appeared more relaxed, no facial grimacing or tensed extremities. Respirations were quiet and easy. Tube feeding remains on hold due to residual. -Progress note authored by LPN #145 at 11:00 P.M , revealed residual (tube feeding) was checked again but continues to be 60 ml. Color of aspiration much darker than previous assessment, color similar to coffee ground but not quite as dark. Tube feeding remains on hold. Resting quietly without signs or symptoms of pain or discomfort. Review of progress notes dated [DATE] revealed: -Progress note authored by LPN #145 at 3:57 A.M., revealed the resident was resting quietly without signs and symptoms of pain or discomfort. Tube feeding remains on hold due to 60 ml of residual. -Progress note authored by LPN #145 at 5:14 A.M., revealed the resident was administered 0.5 ml of Morphine for dyspnea. There was no documented evidence on the Morphine narcotic sheet the resident had received 0.5 ml of Morphine on [DATE] at 5:14 A.M. -Progress note authored by LPN #145 at 5:41 A.M., revealed the nurse went to the resident's room to reassess resident after morphine administration, upon entering the room the resident was found to absent of respiration and not able to auscultate a heartbeat. Registered Nurse (RN) called to room to verify absence of heartbeat and respirations. Hospice notified of the situation and will call family to notify them. The Director of Nursing was also notified. Review of Resident #81 death certificate dated [DATE] revealed the expired on [DATE] at 5:41 A.M. as a result of chronic hypoxic respiratory failure and malignant neoplasm of the tonsils. Other significant conditions that contribute to death was lung cancer, breast cancer, diabetes, and cancer (eligible). The onset of death was less than 3 months and manner of death was natural. Interview and reconciliation of Morphine and orders on [DATE] at 10:45 A.M., with the Director of Nursing (DON) confirmed the Morphine narcotic control sheet indicated Morphine 0.25 ml (5 mg) was administered on [DATE] at 8:00 A.M., however the MAR indicated 9:06 A.M. The Morphine narcotic control sheet indicated Morphine 0.25 ml was administered on [DATE] at 11:30 A.M., however the MAR indicated 10:32 A.M. The Morphine control sheet indicated 0.25 ml was administered at 11:50 A.M., however the MAR indicated 0.5 ml (10mg) was administered at 11:53 A.M. The Morphine control sheet indicated 0.25 was administered at 12:30 P.M., 0.5 ml was administered at 1:00 P.M., 2:15 P.M 2:45 P.M., and 4:00 P.M., however they were not documented on the MAR. The DON reported the resident was ordered 0.25 ml; however, hospice had visited on [DATE] at 10:00 A.M. and changed the order to 0.5 ml every four hours but the nurse transcribed the orders incorrectly and entered every 2 hours as needed instead of every 4 hours as needed. The DON confirmed the Morphine was not administered per either order for every 2 hours or 4 hours due to the Morphine was administered on [DATE] at 11:30 A.M. then 20 minutes later at 11:50 A.M., then 40 minutes later at 12:30 P.M., then 30 minutes later at 1:00 P.M., then 59 minutes later at 1:59 P.M., then 16 minutes later at 2:15 P.M., then 30 minutes later at 2:45 P.M., then one hour and 15 minutes later at 4:00 P.M. The DON also confirmed the 5:14 A.M., dose on [DATE] was not documented on the Morphine control sheet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366331	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Skilled Nursing & Rehabilitation	250 Cadiz Road Wintersville, OH 43953

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Medscape revealed Morphine had a serious contraindication with escitalopram and to monitor closely if taking Lorazepam. Use caution when selecting dosage for an elderly resident, usually starting at low end of dose range because elderly patients are more likely to have decreased renal function, care should be taken in dose selection and may be useful to monitor renal function. This deficiency represents non-compliance investigated under Complaint Number OH00164618.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366331	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Skilled Nursing & Rehabilitation	250 Cadiz Road Wintersville, OH 43953

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on review of email communication, observation, and interview the facility failed to ensure the facility units for heating and cooling (packaged terminal air conditioner/PTAC) were maintained. This was observed in four rooms (Rooms 101, 215, 303, and 412) out of five heating and cooling units observed. Findings included: Observation on 04/22/25 at 7:42 A.M., with Maintenance Director (MD) of PTAC's in the resident rooms 101, 215, 303, and 412 revealed the filters and vents were covered with dirt, dust, and the filters were in despair (ripped). room [ROOM NUMBER] was missing one of the two filters. The MD reported the PTAC systems were about [AGE] years old, and it was difficult to find parts. The MD confirmed each PTAC had two filter, and the filters were to prevent the coils from getting dirty and dusty. The MD confirmed findings during observation and reported the cleaning of the filters was housekeeping responsibility. Interview on 04/22/25 at 7:57 A.M., with Housekeeping Supervisor # 177 revealed the facility did not have a cleaning schedule for the PTAC's filters, however they should be cleaned weekly. Review of an email communication dated 04/22/25 from the Executive Director of Facilities Management #300 revealed the vent screens were an intake to the evaporator for cooling. The vent screen on the PTAC's would need to be clean to prevent air flow across the coil but was not a filter for the exhaust to the residents' rooms. This deficiency represents non-compliance investigated under Complaint Number OH00164233.