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	11/17/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interviews, review of the National Pressure Injury Advisory Panel (NPIAP) guidelines and facility policy review, the facility failed to ensure comprehensive and accurate pressure ulcer assessments. The facility also failed to ensure treatments were implemented timely and pressure-relieving interventions were implemented per the care plan. This affected one (Resident #7) of three residents reviewed for pressure ulcers. The facility census was 75. Findings include:Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including right femur fracture, chronic kidney disease, anemia, diabetes, protein-calorie malnutrition, dementia, heart disease, venous insufficiency, and pressure ulcer. Review of Resident #7's consents revealed on 08/15/25 the resident signed consent to be seen by the wound nurse. Review of Resident #7's impaired skin integrity/pressure ulcer plan of care related to diabetes, dementia, chronic kidney disease, anemia, neuropathy, fistula, surgical site hip, moisture-associated skin damage (MASD), and left heel dated 08/15/25 and revised 09/17/25 revealed interventions including treatments per order, pressure reduction devices as ordered, and inspect the skin during daily routine care. Review of Resident #7 re-admission skin grid pressure ulcer assessment dated [DATE] revealed the resident had a new suspected deep tissue injury (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shearing) on the sacrum that measured 1.5 centimeters (cm) by 1.5 cm by 0.01 cm (skin not intact). The area was noted to be red, non-blanchable, no drainage noted, possible sheering injury around area. Foam placed and wound nurse to be consulted. There was no documented evidence that the physician was notified or that the wound nurse was consulted until 09/26/25. Further review of Resident #7's orders revealed the resident was ordered a pressure reducing cushion on 08/21/25. Review of Resident #7's weekly skin observation dated 08/27/25 revealed the resident's skin was intact. The area for previously identified and newly acquired areas was left blank. Review of Resident #7's admission and five-day [NAME] Data Set (MDS) dated [DATE] revealed the resident did not have a pressure ulcer; however, was assessed to be at risk for developing a pressure ulcer/injury. The resident had pressure-reducing devices for the chair and bed. The resident was receiving an application of a non-surgical dressing to an area other than the feet. Review of Resident #7's dietary note dated 08/28/25 revealed no evidence of skin alterations. Review of Resident #7's skin grid non-pressure assessment dated [DATE] revealed the resident had MASD on the sacrum that was acquired on 08/21/25 that measured 1.2 cm by 1.2 cm by 0.1 cm. There was no documented evidence of the amount of drainage, odor, tunneling/undermining, or description of the wound or physician notification. Review of Resident #7's weekly skin observation dated 09/03/25 revealed the resident's skin was not intact. The resident had MASD and a surgical area. There was no documented evidence of descriptions of the wounds. Review of Resident #7's weekly skin observation dated 09/10/25 revealed the resident's skin was not intact. The resident had MASD, surgical area and a newly acquired pressure and surgical area. There was no documented evidence of descriptions of the wounds. Review of Resident #7's skin grid non-pressure assessment dated [DATE] revealed the resident had MASD on the sacrum that was present on admission [DATE]) that measured 1.1 cm by 1.3 cm by 0.1 cm. There was moderate drainage, the type of drainage was not identified. No odor or tunneling/undermining. There was no description of the wound or evidence the physician was notified. Review of Resident #7's actual skin impairment integrity/pressure ulcer related to MASD, left heel/sacrum plan of care dated 09/17/25 revealed interventions including complete skin documentation per facility policy, provide wound care per physician order, and refer to wound physician as needed. Review of Resident #7's weekly skin observation dated 09/17/25 revealed the resident's skin was not intact. The resident had MASD and pressure previously identified. There were no descriptions of the wounds. Review of Resident #7's skin grid non-pressure dated 09/19/25 revealed the resident had MASD on the sacrum that was acquired on 08/21/25 that measured 1.0 cm by 1.2 cm by 0.1 cm and 100% granulation. There was scant drainage, type not of drainage not identified. No odor or tunneling. There was no evidence that the physician was notified. Review of Resident #7's weekly skin observation dated 09/24/25 revealed the resident's skin was not intact. The resident had MASD and pressure previously identified. There were no descriptions of the wounds. Review of Resident #7's weekly skin grid pressure ulcer assessment for 08/28/25, 09/04/25, 09/11/25, 09/18/25, and 09/25/25 revealed no evidence a skin pressure ulcer assessment was completed on the