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	02/09/2026

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. Based on closed medical record request, medical request fee schedule and interview, the facility failed to ensure ease of access in obtaining medical records. This affected one (Resident #83) of three residents reviewed for medical record request. The facility census was 82.Findings include: Review of Resident #83's closed medical record revealed an admission date of 07/14/25 with diagnoses including peripheral vascular disease, hypertensive heart disease without heart failure, encephalopathy, difficulty walking, dysphagia (difficulty swallowing), atherosclerotic heart disease, kidney disease, alcohol abuse and chronic peripheral disease. The resident was discharged from the facility on 08/27/25.Review of the 08/04/25 admission Minimum Data Set Assessment revealed the resident was severely impaired for daily decision making and utilized a wheelchair and front wheeled walker for mobilityReview of a Medical Records Release Authorization Form dated 09/12/25 included a request for physical and occupational therapy reports. The reports were to be released to the resident's family and the form was signed by Resident #83.Interview on 02/05/26 at 3:31 P.M. with Resident #83's daughter revealed therapy cut her father saying he was able to walk but when she brought him home he was unable. He was starting home health for therapy and they wanted to see what the facility was doing with him so she requested the records from the facility. She was told her dad would need to come to the facility and sign a release form as they would not accept a verbal request. Since he was not moving well and it was very cold, she did not get him there until 09/12/25. The daughter stated she was pretty sure the therapist told her it would cost 60 to 80 dollars to get a copy of the therapy records and due to the reported cost, they did not get a copy of the records.Interview on on 02/05/26 at 3:45 P.M. with the local Steubenville Library revealed it cost 15 cents per page to make black and white copies and 50 cents per page to make color copies at the library.Interview on 02/05/25 at 4:52 P.M. with Medical Records (MR) #155 revealed when a family member requests a copy of a medical record they sign a release form and the form is sent to Quality Assurance and legal. MR #155 shared the business office had a price sheet they followed for the cost of medical record copies but MR #155 does not tell them the price of the copies. Interview on 02/09/26 at 12:30 P.M. with the Administrator revealed therapy was a contracted company employed by the facility and used a different computer system. They would set the price for obtaining their medical records and she did not know what their price was or if it met the requirement but the facility used the state fee requirements and not federal. She further verified they required the resident to sign a release form unless they had a power of attorney. The Administrator also verified the facility's fee structure included additional fees for locating records. Lastly, the Administrator verified the facility required the resident to sign the request unless they have a legal representative to sign as the facility would not accept a verbal request.Interview 02/09/26 at 2:23 P.M. with Corporate Business Office #182 included when family or a resident request copies of the medical records a lot of time they do not charge depending on the amount of pages. It is a decision of corporate so, the facility business office would (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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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not be able to give the resident/representative a price. Therapy is separate because it is by a third party. The request goes through the facility medical records department, obtained and sent to the requesting agency. When it comes to the cost, it is processed through the agency based on pages.Review of the facility's Medical Records Release Authorization Form included this form must be fully completed before signing. If authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.Review of the fee structure revealed it was based on the Consumer Price Index in accordance with the Ohio Revised Code Section 3701.742. It included a fee structure for request made by a resident or resident representative up to $3.88 per page. There was a fee schedule for other than by the resident or residents personal representative with an initial fee which shall compensate for the records search. The initial fee was $23.94 and a per page cost up to $1.58.This deficiency represents non-compliance investigated under Complaint Number 2734445.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interview and policy review the facility failed to provide a summary of baseline care plans to residents and/or responsible parties. This affected two (Residents #13 and #44) of three residents reviewed for care planning.Findings include: 1. During an interview on 02/05/26 at 11:35 A.M., Resident #13 ' s power of attorney (POA) stated he did not recall anybody discussing Resident #13 ' s medications with him as part of the care conference/review of the plan of care when Resident #13 was admitted . The POA indicated he did not recall being offered or given a copy of the summary of the baseline care plan. Review of Resident #13 ' s medical record revealed diagnoses included Alzheimer ' s disease and dementia. Review of Resident #13 ' s admission assessment dated [DATE] indicated Resident #13 was confused and was oriented to person only. Review of Resident #13 ' s Multidisciplinary Care Conference form dated 12/24/25, staff documented the Social Service Designee (SSD) #167 and Physical Therapy Assistant (PTA)/Rehab Director #185 were present. Two of Resident #13 ' s sons participated by phone (one being the POA). The notes indicated medications were among the items discussed. The notes revealed Resident #13 was offered a copy of the plan of care. On 02/05/26 at 5:46 P.M., SSD #167 verified the multidisciplinary care conference notes indicated a copy of the baseline care plan was offered to Resident #13 but verified Resident #13 was very confused and had poor vision. SSD #167 stated the form only had an option of marking a copy was offered to the resident or that the resident received a copy. SSD #167 verified there was no evidence a copy was provided to Resident #13 ' s POA. 2. Review of Resident #44's medical record revealed a 10/22/26 admission with diagnoses including chronic obstructive pulmonary disease, hypertensive heart disease, weakness, dependence of ventilator, cerebrovascular disease, alopecia, chronic respiratory failure, morbid obesity, gout, type 2 diabetes, gastroesophageal reflux disease, heart failure, hypothyroidism, rheumatoid arthritis, presence of artificial right elbow, hip joint, artificial knee joint and arthritis. Review of the 10/24/25 Multidisciplinary Care Conference, baseline care plan, included a therapist, social service designee and Minimum Data Set Assessment nurse were present. The conference revealed they discussed admission, goals,therapy, discharge, health and code status. She declined ancillary services. The form was marked plan of care reviewed and resident offered copy of plan of care. There was no indication of the initial goals being based on admission orders, or a review of physician orders including dietary orders being reviewed. There was no evidence of the facility providing the resident and their representative with a copy of the baseline care plan. Review of the 01/28/26 Quarterly Minimum Data Set Assessment revealed the resident was independent for daily decision making, no upper or lower extremity impairment, dependent for shower, substantial/maximum assist for upper body dressing and lower body dressing, personal hygiene, rolling, sitting on side of bed, and chair and toilet transfer. The resident was dependent for 150 feet wheeled in wheelchair. Interview and observation on 02/09/26 at 1:38 P.M. with Resident #44 revealed the facility did not (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	go over her medications or treatments at the conference. She included she was not asked if she wanted a copy and was not she has never worn compression hose at the facility. She said no one asked her about wearing them. She stated at her old facility they would wrap her legs for the edema. She did not have compression stockings on at the time of the interview. Interview 02/09/26 at 4:41 P.M. with Social Service Designee #167 revealed she was not employed at the facility at the time of the October Care Conference. She verified the facility does not provide a copy of the baseline careplan unless requested. She verified there was no evidence in the notes of the physician orders, medications, treatments, or dietary orders being reviewed during the meeting. Review of the facility's undated Care Plan and Advanced Care Plan Process included the resident and/or sponsor will sign the care conference form to verify they were present and reviewed the care plan. The policy did not address giving the resident a copy as regulated This deficiency represents non-compliance investigated under Complaint Number 2734445.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review and interview, the facility failed to ensure physician ordered interventions were implemented for the treatment of edema. This affected one (Resident #44) of three residents reviewed for skin impairment. The census was 80.Findings include: Review of Resident #44's medical record revealed a 10/22/26 admission with diagnoses including chronic obstructive pulmonary disease, hypertensive heart disease, weakness, type 2 diabetes, heart failure, and arthritis.Review of the 01/28/26 Quarterly Minimum Data Set Assessment revealed the resident was independent for daily decision making, no upper or lower extremity impairment, dependent for shower, substantial/maximum assist for upper body dressing and lower body dressing, personal hygiene, rolling, sitting on side of bed, and chair and toilet transfer. Review of the 12/09/25 weekly skin check included resident bilateral legs cracking and seeping clear liquid.Review of the 12/10/25 Health Status Note included resident ' s bilateral lower extremities noted to be edematous and hard with scant clear drainage. Review of Physician orders included compression stockings on in the morning and off at bedtime every day and night shift for edema to legs starting 12/10/25. Interview 02/09/25 at 10:30 A.M. with Certified Nurse Aide (CNA) #166 revealed the resident was retaining a lot of fluid in her legs. Observation 02/09/26 at 10:40 A.M. with Resident #44 revealed she did not have compression stockings on. Her lower legs were edematous and red. She had some thin scabs on her left lower shin. Interview with the resident revealed her skin itched and she scratches causing the scabs on her legs.Interview and observation 02/09/26 at 1:38 P.M. with Resident #44 revealed she has never worn compression hose at the facility. She said no one asked her about wearing them. She stated at her old facility they would wrap her legs for the edema. She did not have compression stockings on.Review of the Treatment Record revealed it was signed off for 02/09/26 the resident had compression stockings on.Interview 02/09/26 at 1:41 P.M. with CNA #166 revealed she has never seen the resident with compression stockings. She included there were not any in her room and it doesn't come up on their electronic charting to apply the stockings.Interview 02/09/26 at 1:44 P.M. with Registered Nurse #135 verified she signed the treatment sheet that the resident had compression stockings on when she did not. Interview 02/09/26 at 3:45 P.M. with Resident #44 revealed she was told they were going to start putting compression hose on her in the morning.This deficiency represents non-compliance investigated under Complaint Number 2734445.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and policy review, the facility failed to ensure medications were stored to prevent access by unauthorized persons. This had the potential to affect 23 (Residents #3, #16, #19, #23, #24, #26, #27, #28, #31, #33, #35, #39, #47, #49, #50, #51, #54, #64, #65, #67, #71, #72, and #73) residents who the facility identified as cognitively impaired and independently mobile. The census was 80.Findings include: During the tour on 02/05/26 at 7:52 A.M., Registered Nurse (RN) #140 was observed walking away from her medication cart and entering a room down the hall out of sight of the cart. The medication cart was left unlocked.On 02/05/26 at 7:54 A.M., RN #140 returned to the medication cart and verified she had left the medication cart unlocked and unattended.The facility identified Residents #3, #16, #19, #23, #24, #26, #27, #28, #31, #33, #35, #39, #47, #49, #50, #51, #54, #64, #65, #67, #71, #72, and #73 as being cognitively impaired and independently mobile.Review of the facility ' s Storage of Medication policy, dated January 2025, revealed in order to limit access to prescription medications, only licenses nurses, pharmacy staff and those lawfully authorized to administer medications were allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended to by persons with authorized access. This deficiency represents non-compliance investigated under Complaint Number 2734445.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on temperature logs, policy and interview, the facility failed to consistently monitor food and drink serving temperatures. This affected all but one Resident #15 who did not receive nutrition from the kitchen. The census was 80.Findings include: Tour of the kitchen was on 2/5/26 at 8:19 A.M. Review of the food temperature log revealed the following:On 01/23/26 there were no coffee temperatures recorded for the dinner meal.On 01/28/26 there were no food or drink temperatures recorded for dinner.On 01/29/26 there were no food or drink temperatures documented for breakfast or lunch.On 01/30/26 there were no food or drink temperatures documented for the whole day.On 01/31/26 there were no food or drink temperatures for the dinner meal recorded.On 02/01/26 there were no food or drink temperatures recorded for the dinner meal. On 02/02/26, 02/03/26 and 02/04/26 there were no food or drink temperatures logged for the dinner meal. Interview 02/05/25 at 8:45 A.M. interview with Dietary Manager #153 verified there were days the food and drink temperatures were not recorded. Interview at 2:10 P.M. revealed she found seven individual sheets of paper with temperatures written on them that were not recorded on the daily logs. She identified five of them had dates on them. Four of the seven sheets did not have the milk or coffee temperature recorded. She included some staff are writing the temperatures on a sheet of paper and not writing them in the daily log. Review of the facility ' s undated Food Temperature Logs Policy included food temperatures of cold and hot items will be recorded on all menu items for meal service. This deficiency represents non-compliance investigated under Complaint Number 2734445.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record review and interview, the facility failed to maintain an accurate medical record. This affected one (Resident #44) of eight records reviewed. The census was 80.Findings include: Review of Resident #44's medical record revealed a 10/22/26 admission with diagnoses including chronic obstructive pulmonary disease, hypertensive heart disease, weakness, type 2 diabetes, heart failure, and arthritis.Review of the 01/28/26 Quarterly Minimum Data Set Assessment revealed the resident was independent for daily decision making, no upper or lower extremity impairment, dependent for shower, substantial/maximum assist for upper body dressing and lower body dressing, personal hygiene, rolling, sitting on side of bed, and chair and toilet transfer. Review of the 12/09/25 weekly skin check included resident bilateral legs cracking and seeping clear liquid.Review of the 12/10/25 Health Status Note included resident ' s bilateral lower extremities noted to be edematous and hard with scant clear drainage. Review of Physician orders included compression stockings on in the morning and off at bedtime every day and night shift for edema to legs starting 12/10/25. Further review of the Treatment Administration Record were 13 days in January, 01/01/26, 01/02/26, 01/05/26, 01/09/26, 01/15/26, 01/17/26, 01/18/26, 01/20/26, 01/22/26, 01/23/26, 01/27/26, 01/29/26 and 01/30 26 and seven days in February, February 1st through the 6th and 02/09/26 of the first nine days in February the staff documented the compression hose were on when the resident was not provided compression stockings during her stay.Interview 02/09/25 at 10:30 A.M. with Certified Nurse Aide (CNA) #166 revealed the resident was retaining a lot of fluid in her legs. Observation 02/09/26 at 10:40 A.M. with Resident #44 revealed she did not have compression stockings on. Her lower legs were edematous and red. She had some thin scabs on her left lower shin. Interview with the resident revealed her skin itched and she scratches causing the scabs on her legs.Interview and observation 02/09/26 at 1:38 P.M. with Resident #44 revealed she has never worn compression hose at the facility. She said no one asked her about wearing them. She stated at her old facility they would wrap her legs for the edema. She did not have compression stockings on.Review of the Treatment Record revealed it was signed off for 02/09/26 the resident had compression stockings on.Interview 02/09/26 at 1:41 P.M. with CNA #166 revealed she has never seen the resident with compression stockings. She included there were not any in her room and it doesn't come up on their electronic charting to apply the stockings.Interview 02/09/26 at 1:44 P.M. with Registered Nurse #135 verified she signed the treatment sheet that the resident had compression stockings on when she did not. Interview 02/09/26 at 3:45 P.M. with Resident #44 revealed she was told they were going to start putting compression hose on her in the morning.This deficiency represents non-compliance investigated under Complaint Number 2734445.