

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/08/2024
NAME OF PROVIDER OR SUPPLIER Sienna Extended Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 9221 Harmony Drive Midwest City, OK 73130	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>46216</p> <p>Based on observation, record review, and interview, the facility failed to ensure medications were administered as ordered for one (#1) of one sampled residents reviewed for intravenous medications as order by the physician.</p> <p>Social Services identified 73 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #1 had diagnoses which included sepsis, unspecified organism and cellulitis of left upper arm.</p> <p>A physician's order, dated 09/19/23 documented ceftriaxone sodium injection solution, reconstituted 2 GM (Ceftriaxone sodium) use 2 gram intravenously one time a day for eight days with a start date of 09/20/23.</p> <p>A physician's order, dated 09/20/23 documented flush NS 10 ml per lumen every shift.</p> <p>The September MAR documented blanks on 09/25 and 09/26/23 for the ceftriaxone sodium and the flush documented four blanks out of 21 opportunities.</p> <p>On 02/08/24 at 11:38 a.m., the DON stated I can not verify by the MAR that she received the antibiotic or flushes or not.</p> <p>On 02/08/24 at 12:03 p.m., LPN #1 stated if there are blanks on the MAR it is assumed it wasn't given, and if there is no documentation, you didn't do it.</p> <p>On 02/08/24 at 12:13 p.m., LPN #2 stated blanks meant the medication was not given. If it's not documented, you didn't do it.</p>

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
-----------------------------------------------------------------------	-------	-----------