STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555744	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Siena Skilled Nursing & Rehabilitation Center	11600 Education Street Auburn, CA 95603

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 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 interview and record review, the facility failed to ensure care and services were provided in accordance with professional standards of practice to attain and maintain the highest practicable well-being for one of four sampled residents (Resident 1) when Resident 1's change in condition (CIC) was not documented in the clinical record, the physician was not notified of the CIC, and there was no monitoring done related to the CIC.These failures resulted in the delay in the management of Resident 1's change in condition.Findings:During a review of Resident 1's admission records, the records indicated Resident 1 was admitted to the facility in December 2025 with diagnoses that included wedge compression fracture of fifth lumbar vertebra (occurs when the bone collapses and the front of the backbone forms a wedge shape), giant cell arteritis (inflammation of the lining of the arteries), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/24/25, indicated Resident 1 had moderate cognitive impairment.During a review of Certified Nurse Assistant 1's written statement, dated and signed on 1/1/26, the statement indicated, .During my PM [evening] shift on Sunday December 28, 2025, I answered [Resident 1's] call light. [Resident 1] needed to be scooted up in her bed, and [Resident 1's family member (FM)] offered to help me do so. We stood on either side of the bed, counted to three, and evenly lifted [Resident 1] to the top of the bed, where [Resident 1's] head was bonked on the headboard. As I was getting [Resident 1] comfortable and putting call light in reach, I stated that I would notify the nurse. The [FM] replied with, Oh no, that's okay. To which I said, I will tell her anyways, just in case. I am unsure what time [Licensed Nurse 1 (LN 1)] did the assessment.During a review of LN 1's written statement, dated and signed on 1/1/26, the statement indicated, [Resident 1] had stated to [LN 1] regarding of [CNA 1] and [FM] pulling her up and hit her head on the baseboard of the bed. Nurse asked [Resident 1] and [FM] if [Resident 1] was okay, [Resident 1] stated she was fine and allowed [LN 1] to check the scalp of the [Resident 1]. There was no drainage or openings noted on the scalp area. [LN 1] confirmed twice with [Resident 1] and [FM] if [Resident 1] was fine, both stated She is okay. It was just a quick pull-up .During a review of Resident 1's CIC note, dated 1/1/26, the note indicated, .[FM] reports alleged event happened 4 days ago during ADL [Activities of Daily Living] care. [Resident 1] reports 10/10 pain [worst pain].DON [Director of Nursing], Admin, and ADON [Assistant Director of Nursing] notified.A. Recommendations: Send to ER [Emergency Room] for further eval.During a review of Resident 1's Change in Condition Note x 72 hours, dated 1/1/26, the note indicated, .The Change in Condition Type: 10/10 Headache.[FM] reports alleged event happened 4 days ago during 10/10 pain, demanding send out.During a review of Resident 1's Emergency Department provider note, date 1/1/26, the note indicated, .[Resident 1] presenting with headache and dizziness that started yesterday morning and then worsened again tonight. [Resident 1] had a head injury while getting into bed at the skilled nursing facility that occurred earlier this week. [Resident 1] did not initially have any significant headache or dizziness at that time. [Resident 1] states that she had symptoms starting yesterday morning and then seem to have improved and then got worse again tonight. [Resident 1] has had no further injuries.During a telephone interview on 3/3/26 at 12:01 p.m. with FM, FM stated that on 12/28/25 at about 5:30 p.m., CNA 1 came to (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's room and told FM that Resident 1 needed to be adjusted so Resident 1 can eat. FM stated she assisted CNA 1 in adjusting Resident 1's position and stated, .we started lifting [Resident 1], [CNA 1] flung [Resident 1] so hard and hit [Resident 1's] head to the headboard. FM stated she told LN 1 about what happened and LN 1 assessed Resident 1's head. FM stated Resident 1 had a bump lump at the top of the head. FM further stated that on 1/1/26, the physical therapist came to Resident 1's room but Resident 1 was having headache and dizziness. FM stated that the physical therapist was not aware of the incident that happened on 12/28/25. FM added that the physical therapist talked to Licensed Nurse 2 (LN 2) about the incident, but LN 2 was also not aware of what happened. FM stated LN 2 reported the incident to management because the incident was not in Resident 1's clinical records.During an interview on 3/3/26 at 2:07 p.m. with LN 2, LN 2 stated Resident 1 complained of headache on 1/1/26 and was sent out to the ER. LN 2 stated Resident 1 said she hit her head but unable to remember when it occurred. LN 2 stated she did not get any report regarding the incident. LN 2 further stated that the incident should have been considered as a change in condition and the physician should have been notified. LN 2 stated it was important to document the change in condition so that all the details of the incident were documented. LN 2 added that staff should notify the physician for any change in condition and monitor the involved resident for further injuries.During a telephone interview on 3/3/26 at 2:25 p.m. with LN 1, LN 1 stated that on 12/28/25, FM told LN 1 that FM and CNA 1 pulled Resident 1 up and hit Resident 1's head on the headboard. LN 1 stated she did the assessment on Resident 1's head and did not see any bumps or anything abnormal. LN 1 stated she documented the incident on paper, and not on Resident 1's progress notes.During an interview on 3/3/26 at 4:02 p.m. with the DON, the DON confirmed that there was no documentation in Resident 1's clinical record and there was no physician notification related to the incident that happened on 12/28/25. The DON stated the incident should have been documented as a change in condition and the physician should have been notified about the incident. The DON further stated the expectation was for staff to document any change in condition, the physician should be notified for any noticeable change in a resident, and for interventions to happen in a timely manner. The DON stated the incident that happened to Resident 1 should have been documented and Resident 1 should have been monitored.During an interview on 3/3/26 at 4:33 p.m. with the Administrator (ADM), the ADM stated that the expectation was for staff to document changes in residents' conditions and to notify the doctor. The ADM further stated it was important for healthcare as a whole and for patient care.During a review of the facility's policy and procedure (P&P) titled Change in a Resident's Condition or Status, revised 2/2021, the P&P indicated, .Our facility promptly notifies the resident, his or her attending physician, and the resident representative of the changes in the resident's medical/mental condition and/or status.1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): a. accident or incident involving the resident.8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.