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	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Siena Skilled Nursing and 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46872 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for three out of 21 sampled residents (Resident 24, Resident 23, and Resident 25) when: 1. Resident 24's care plan interventions did not accurately reflect Resident 24's physician's orders for insulin (controls the amount of sugar in the blood) and anticoagulation (used to prevent and treat blood clots in blood vessels and the heart) medication; 2. Resident 23's oxygen therapy care plan was not developed; and, 3. Resident 25's antipsychotic medication (a medication used to treat symptoms of losing touch with reality such as disrupted thoughts and perceptions) care plan was not developed. These failures had the potential to result in Resident 24, Resident 23, and Resident 25 not attaining their highest practicable physical, mental, and psychosocial well-being. Findings: 1. Resident 24 was admitted to the facility May 2024 with multiple diagnoses which included type 2 diabetes mellitus (a disease where blood sugar is too high), atrial fibrillation (irregular heart rhythm), and long-term use of anticoagulants. During a review of Resident 24's Order Summary Report, dated 9/10/24, Resident 24 had orders for Humalog [rapid acting insulin] Solution 100 unit/ML [unit of measure] (Insulin Lispro (Human)) Inject as per sliding scale . with a start date of 05/30/2024, Levemir [long acting insulin] Subcutaneous [under the skin] Solution 100 unit/ML (Insulin Detemir) Inject 10 unit subcutaneously at bedtime for diabetes mellitus with a start date of 07/18/2024, and Eliquis [blood thinner] Oral Tablet 2.5mg [unit of measure] (Apixaban) Give 1 tablet by mouth two times a day for DVT Proph [Deep Vein Thrombosis treatment to prevent blood clots]. During an interview and record review on 9/10/24, at 2:01 p.m., with Licensed Nurse 2 (LN 2), LN 2 confirmed Resident 24 had an order for Eliquis (anticoagulation medication) 2.5mg daily and there was no care plan for Eliquis in Resident 24's medical record. LN 2 stated there should be a care plan for monitoring side effects. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 9/10/24, at 2:07 p.m., with the Director of Nursing (DON), the DON confirmed Resident 24 was on an anticoagulation medication and there was no care plan for the medication in his medical record. The DON stated the expectation was for him to be care planned for that medication and it was the MDS (Minimum Data Set) Coordinator's responsibility to ensure accurate care plans are in place. During a follow up interview and record review on 9/10/24, at 2:57 p.m., with the DON, the DON confirmed Resident 24 had an order for insulin and there was no care plan for the medication in Resident 24's medical record. The DON stated the resident should have been care planned for insulin. During a review of the facility's policy and procedure (P&P) titled, Care and Services-Care Plan, dated 6/2016, the P&P indicated, Upon admission the Licensed Nurse initiates a care plan addressing the resident's most immediate needs .updates individual care plan as necessary. 47197 2. A review of Resident 23's clinical record indicated Resident 23 was admitted May of 2024 and had diagnoses that included chronic obstructive pulmonary disease (a group of diseases that causes airflow blockage and breathing-related problems), congestive heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), and dementia (memory loss that interferes with daily functions). A review of Resident 23's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 8/9/24, indicated Resident 23 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 8 out of 15 which indicated Resident 23 had moderately impaired cognition. During a concurrent observation and interview on 9/9/24 at 10:07 a.m. with Resident 23, at Resident 23's room, Resident 23 was observed to be using oxygen delivered using a nasal cannula (a medical device with two prongs that is connected to an oxygen source used to deliver supplemental oxygen directly into the nostril) with oxygen concentrator set at 3.5 LPM (liters per minute- unit of measurement for oxygen administration). Resident 23 stated she just recently started getting oxygen. During a concurrent interview and record review on 9/9/24 at 11:39 a.m. with LN 3, Resident 23's clinical records were reviewed. LN 3 confirmed Resident 23's oxygen therapy care plan was not developed. LN 3 stated the oxygen therapy should also be care planned. During a concurrent observation and interview on 9/9/24 at 11:45 a.m. with LN 3, at Resident 23's room, LN 3 confirmed that Resident 23 was using oxygen delivered using a nasal cannula with oxygen concentrator set at 3.5 LPM. During an interview on 9/11/24 at 3:25 p.m. with the DON, the DON stated that oxygen therapy should be care planned so staff would know how to treat the resident and what the oxygen was to be used for. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of Resident 25's clinical record indicated Resident 25 was admitted June of 2023 and had diagnoses that included congestive heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), and an anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities, altered mental status, and need for assistance with personal care. A review of Resident 25's MDS Cognitive Patterns, dated 7/22/24, indicated Resident 25 had a BIMS score of 6 out of 15 which indicated Resident 25 had severely impaired cognition. A review of Resident 25's MDS Mood Status, dated 7/22/24, indicated Resident 25 experienced feeling down, depressed, or hopeless for several days. A review of Resident 25's MDS Behavior Status, dated 7/22/24, indicated Resident 25 had physical and verbal behavioral symptoms directed toward others which occurred 1 to 3 days within a week. A review of Resident 25's active physician's order with start date of 8/27/24, indicated, Haloperidol Lactate Concentrate [an antipsychotic medication] 2 MG [milligrams]/ML [milliliters, units of measurement] Give 1 ml by mouth every 4 hours as needed for delirium [an altered state of consciousness, characterized by episodes of confusion] and agitation [a state of anxiety] until 09/16/2024 23:59 [11:59 p.m.]. During a concurrent interview and record review on 9/11/24 at 10:47 a.m. with LN 2, Resident 25's clinical records were reviewed. LN 2 confirmed that Resident 25's antipsychotic medication care plan was not developed. During an interview on 9/11/24 at 1:29 p.m. with the DON, the DON stated that the antipsychotic medication should be care planned so the staff would know how to treat the resident. During an interview on 9/12/24 at 9:23 a.m. with the Consultant Pharmacist (CP), the CP stated the antipsychotic medication should have been care planned. A review of the facility's P&P titled, CARE AND SERVICES- CARE PLAN, revised 10/2017, indicated, .The care plan is comprehensive for each resident including measurable objectives and timeframes to meet residents' medical, nursing, mental and psychosocial needs.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47197 Based on observation, interview, and record review, the facility failed to ensure proper delivery of respiratory care consistent with the facility's policy and procedures (P&P) and the professional standards of practice for one out of 21 sampled residents (Resident 23) when Resident 23 had no physician's order for the use of oxygen therapy and the oxygen therapy was not care planned. These failures had the potential to result in unsafe delivery of oxygen to Resident 23, and for Resident 23 to not receive appropriate respiratory care and not achieve his highest practicable well-being. Findings: A review of Resident 23's clinical record indicated Resident 23 was admitted May of 2024 and had diagnoses that included chronic obstructive pulmonary disease (a group of diseases that causes airflow blockage and breathing-related problems), congestive heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), and dementia (memory loss that interferes with daily functions). A review of Resident 23's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 8/9/24, indicated Resident 23 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 8 out of 15 which indicated Resident 23 had a moderately impaired cognition. During a concurrent observation and interview on 9/9/24 at 10:07 a.m. with Resident 23, at Resident 23's room, Resident 23 was observed to be using oxygen delivered using a nasal cannula (a medical device with two prongs that is connected to an oxygen source used to deliver supplemental oxygen directly into the nostril) with the oxygen concentrator set at 3.5 LPM (liters per minute- unit of measurement for oxygen administration). Resident 23 stated she just recently started getting oxygen. During a concurrent interview and record review on 9/9/24 at 11:39 a.m. with Licensed Nurse (LN) 3, Resident 23's clinical records were reviewed. LN 3 confirmed Resident 23 had no physician's order for the use of oxygen therapy and the oxygen therapy was not care planned. LN 3 stated she is aware that Resident 23 is on hospice (a specialized care that provides physical comfort and emotional, social and spiritual support for people nearing the end of life) and was using oxygen. LN 3 further stated that oxygen therapy needs a physician's order and should also be care planned. During a concurrent observation and interview on 9/9/24 at 11:45 a.m. with LN 3, at Resident 23's room, LN 3 confirmed that Resident 23 was using oxygen delivered using a nasal cannula with oxygen concentrator set at 3.5 LPM. During a concurrent interview and record review on 9/10/24 at 11:46 a.m. with LN 3, Resident 23's clinical records were reviewed. LN 3 confirmed that there was no signed physician's order of Resident 23's oxygen therapy from the hospice doctor as well. LN 3 stated, .I'm not sure when she [Resident 23] started using the oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/11/24 at 3:25 p.m. with the Director of Nursing (DON), the DON stated it is not okay to deliver oxygen without a physician's order for oxygen therapy because it is a treatment, and it could be unsafe for the resident. The DON also stated that oxygen therapy should be care planned so staff would know how to treat the resident and what diagnosis the oxygen was being used for. A review of the facility's P&P titled, Oxygen Administration, revised 7/1/22, indicated, 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. A review of the facility's P&P titled, CARE AND SERVICES- CARE PLAN, revised 10/2017, indicated, .The care plan is comprehensive for each resident including measurable objectives and timeframes to meet residents' medical, nursing, mental and psychosocial needs.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47197 Based on interview and record review, the facility failed to ensure one out of 21 sampled residents (Resident 25) did not received unnecessary antipsychotic medication (a medication used to treat symptoms of losing touch with reality such as disrupted thoughts and perceptions) when Resident 25 received an antipsychotic medication with no monitoring of disruptive behavior, no monitoring of antipsychotic medication side effects, and the antipsychotic medication care plan was not developed. This failure had the potential for Resident 25 to unsafely receive an antipsychotic medication, and experience overdose (an excessive and dangerous dose of a drug), and/or other side effects of antipsychotic medication. Findings: A review of Resident 25's clinical record indicated Resident 25 was admitted June of 2023 and had diagnoses that included congestive heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), altered mental status, and need for assistance with personal care. A review of Resident 25's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 7/22/24, indicated Resident 25 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 6 out of 15 which indicated Resident 25 had severely impaired cognition. A review of Resident 25's MDS Mood Status, dated 7/22/24, indicated Resident 25 experienced feeling down, depressed, or hopeless for several days. A review of Resident 25's MDS Behavior Status, dated 7/22/24, indicated Resident 25 had physical and verbal behavioral symptoms directed toward others which occurred 1 to 3 days within a week. A review of Resident 25's active physician's order with start date of 8/27/24, indicated, Haloperidol Lactate Concentrate [an antipsychotic medication] 2 MG [milligrams]/ML [milliliters, units of measurement] Give 1 ml by mouth every 4 hours as needed for delirium [an altered state of consciousness, characterized by episodes of confusion] and agitation [a state of anxiety] until 09/16/2024 23:59 [11:59 p.m.]. A review of Resident 25's Medication Administration Record (MAR, a legal document used to record medications given to the residents) for the month of August 2024 indicated Resident 25 received Haloperidol Lactate Concentrate 1 ml on 8/17, 8/28, 2/29, 8/30, and 8/31. A review of Resident 25's MAR for the month of September 2024 indicated that as of 9/11/24, Resident 25 received Haloperidol Lactate Concentrate 1 ml only on 9/1. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/11/24 at 10:47 a.m. with Licensed Nurse (LN) 2, Resident 25's clinical records were reviewed. LN 2 confirmed Resident 25 received an antipsychotic medication with no monitoring of Resident 25's delirium and agitation. LN 2 also confirmed that there was no monitoring in place for the antipsychotic medication side effects. LN 2 further confirmed that Resident 25's antipsychotic medication care plan was not developed. During an interview on 9/11/24 at 1:29 p.m. with the Director of Nursing (DON), the DON stated she would expect that there should be a monitoring of Resident 25's delirium and agitation in place, and there should be a monitoring of the antipsychotic medication side effects in place to see if the medication is working, or if the order is right for the resident. The DON also stated that the antipsychotic medication should be care planned so the staff would know how to treat the resident. During an interview on 9/12/24 at 9:23 a.m. with the Consultant Pharmacist (CP), the CP stated she could not explain why there were no monitoring of Resident 25's behaviors and the antipsychotic medication side effects in place. The CP also stated there should be a monitoring of behavior and antipsychotic medication side effects in place for Resident 25 and the antipsychotic medication should have been care planned. A review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, revised 07/2022, indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition . 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics . 3 . Psychotropic medication management includes: a. indications for use .d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying and responding to adverse consequences . 13. Residents receiving psychotropic medications are monitored for adverse consequences .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 47197 Based on observation, interview and record review, the facility failed to provide an accessible call system for one of 21 sampled residents (Resident 25) when Resident 25's call light button was not within his reach. This failure has the potential to result in the residents' not attaining their needs and not maintaining their highest practicable physical, mental, emotional, and psychosocial well-being. Findings: A review of Resident 25's clinical record indicated Resident 25 was admitted June of 2023 and had diagnoses that included congestive heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), and an anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities, altered mental status, and need for assistance with personal care. A review of Resident 25's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 7/22/24, indicated Resident 25 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 6 out of 15 which indicated Resident 25 had severely impaired cognition. A review of Resident 25's MDS Mood Status, dated 7/22/24, indicated Resident 25 experienced feeling down, depressed, or hopeless for several days. A review of Resident 25's MDS Functional Abilities and Goals, dated 7/22/24, indicated Resident 25 needed partial/moderate assistance with toileting hygiene, shower/bathing, and upper body dressing; and substantial/maximal assistance with lower body dressing, putting on/taking off footwear, and personal hygiene. Resident 25's MDS Functional Abilities and Goals, dated 7/22/24, further indicated Resident 25 needed partial/moderate assistance with rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/toilet/shower transfers. During a concurrent observation and interview on 9/9/24 at 10:15 a.m. with Resident 25, at Resident 25's room, Resident 25 was observed awake and was lying on his bed. Resident 25's call light was placed inside a gray plastic bucket, together with two blue phones, which was placed on top of the bedside cabinet, approximately 3 feet away from the side of Resident 25's bed. A bedside table was also placed in between Resident 25's bed and the bedside cabinet. Resident 25 stated he does not know where his call light button is located. When the surveyor stated his call light button was inside the bucket on top of the bedside cabinet, Resident 25 stated he was not able to reach his call light button. During a concurrent observation and interview on 9/9/24 at 10:19 a.m. with Licensed Nurse (LN) 3, at Resident 25's room, LN 3 confirmed that Resident 25's call light button was not within his reach. LN 3 stated Resident 25 was able to use his call light button when he needs help. LN 3 stated, .I think it [call light button] should not be there [inside a gray bucket, on top of the bedside cabinet which not within Resident 25's reach] . I don't know why, this [call light button not within Resident 25's reach] is not how it should be, just in case he [Resident 25] needs help .Definitely, he [Resident 25] needs to have it [call light button] . (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/11/24 at 3:25 p.m. with the Director of Nursing (DON), the DON stated she would expect that the call light button would be within reach of the resident so the resident could call staff when he/she needs something or needs help. A review of the facility's policy and procedures titled, CALL LIGHTS, revised 10/2017, indicated, 5. When the resident is .confined to his/her bed, be sure to provide resident with call light access. A review of the Centers for Medicare & Medicaid Services document titled, .Physical Environment, undated, indicated, The call system [call light] must be accessible to residents while in their bed or other sleeping accommodations within the resident ' s room. (https://qsep.cms.gov/data/352/PhysicalEnvironment.pdf)