STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675928	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Nursing and Rehabilitation	2510 W 8th Street Odessa, TX 79763

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on staff interview and record review, the facility failed to implement the facility's Quality Assessment and Performance Improvement plan and program, in which data was to be gathered and analyzed, and plans of action were to be developed, implemented, and evaluated to address adverse events related to potential deficient practice for 4 of 10 residents (Resident #1, Resident #2, Resident #3, Resident #4) reviewed for quality assurance and performance improvement 1. The facility did not identify a pattern of Resident # 1's behaviors directed toward Resident #2 three times in six (6) months. 2. The facility did not complete incident/accident reports for Resident #3's physical behaviors. 3. The facility did not complete incident/accident reports for Resident #4's physical behaviors. These failures could place residents at risk for physical and psychosocial harm and at risk for not receiving appropriate care and services. Findings include: Review of Resident #1's Admission Record, dated 6/20/24, identified she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including neurocognitive disorder with Lewy Bodies (a type of dementia with hallucinations), bipolar disorder, psychotic disorder with hallucinations, and anxiety. She was on the facility's women's secured unit. Review of Resident #1's Quarterly MDS Assessment, dated 5/14/24, revealed: She had a mental status score of 3 of 15 (indicating severe cognitive impairment). Her depression screening score was 15 of 27 with sometimes feeling lonely or isolated (indicating probable depression). Wandered daily. She was independently ambulatory. (continued on next page)

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

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She reported experiencing no pain. She was on an antidepressant. Review of Resident #1's Care Plan revealed: Revised 5/27/21: Resident #1 had impaired cognitive function/dementia related to Lewy body dementia. The identified goal was Resident #1 would develop skills to cope with cognitive decline and maintain safety by the review date. Identified interventions included: administer medications as ordered, Revised 5/13/23: Resident #1 demonstrated physical behaviors (hitting other residents, bending resident's hands and fingers, and pulling their hair) dementia, poor impulse control. The identified goal was Resident #1 will not harm self or others through the review date. Identified interventions included: analyze of key times, places, circumstances, triggers, and what de-escalates behaviors and document; if she has physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance, if intervening would be unsafe, call out for staff assistance immediately; Monitor/ document / report to doctor or danger to self and others; notify the charge nurse of any physically abusive behaviors; behavioral health hospital to evaluate for services if doctor orders social worker will send referral, notify responsible party for approval; intervene before agitation escalates; guide away from source of distress, engage calmly in conversation, if response is aggressive staff to walk calmly away and approach later. Revised on 2/28/24: Resident #1 had mood problem related to Disease Process and took Divalproex Sodium for mood disorder due to known physiological condition with major depressive-like episode and psychotic disorder with hallucinations due to known psychological condition. The identified goal was Resident #1 would have improved mood state, less signs and symptoms of depressions through the review date. Identified goals included Administer medications as ordered, monitor for side effects and effectiveness (sertraline); behavioral consults as needed (psycho-geriatric team, psychiatrist etc.) monitor/record mood to determine if problems seem to be related to external causes i.e. medications, treatments, concern over diagnosis. Review of Resident #1's Order Summary Report, dated 6/20/24, revealed: Orders dated 12/20/23 for the mood stabilizer Divalproex Sprinkles 125 mg 2 capsules, three times a day for Bipolar disorder. Orders dated 6/2/22 for the antidepressant Sertraline 50 mg once a day for depression. Review of Resident #1's electronic notes revealed: Behavior Note 12/20/23 at 11:42 a.m.: Resident pulled on another resident's hair while walking by the resident. Resident is being monitored at this time. Nursing Progress Note 12/20/23 at 2:43 p.m.: Nurse Practitioner with psychiatric service at resident's bedside. Nurse Practitioner gave order to increase the Divalproex Sprinkles to 125 mg 2 capsules by mouth three times a day. Will continue to monitor. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Behavior Note 5/2/24 at 6:25 p.m.: Resident walking down the hallway, attempting to shove other residents and to hit them. Resident is compliant to redirections for a brief moment then goes back to hit other residents. DON notified of behavior. Behavior Note 5/11/24 at 8:27 p.m.: Resident was seen walking into the TV room in the unit and grabbed another resident's left index finger and forcefully bent in the other way. The other resident screamed in pain and both residents were immediately separated. Resident's responsible party was notified of incident. DON, ADON, notified. Activity Notes 6/19/24 at 1:35 p.m.: CNA told nurse that resident pulled out a chunk of another resident's hair. Resident assessed, no injuries noted, resident separated from other resident. ADON notified, family notified, resident was placed on 1:1 monitoring immediately. Activity Note on 6/19/24 at 2:21 p.m.: Social Worker follow up with resident. Resident was able to recall incident. Education provided on respecting others. Resident understood, continued with good eye contact. Resident does have a history of altercations. At this time, doctor wants a referral to behavioral hospital. Social Worker spoke with resident's responsible party. Responsible party in agreement and would like to try behavioral hospital. Referral has been sent. Observation on 6/20/24 at 12:13 p.m. revealed an off-site psychiatric hospital coming to pick up Resident #1. Review of Resident #2's Admission Record, dated 6/20/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a type of dementia). She was on the facility's women's secured unit. Review of Resident #2's Quarterly MDS Assessment, dated 5/31/24, revealed: She had a mental status exam score of 4 of 15 (indicating severe cognitive impairment) She exhibited no signs or symptoms of depressions. She exhibited no behaviors. She used a wheelchair. She reported experiencing no pain. No psychotropic medications were identified. Review of Resident #2's Care Plan revealed: (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Updated 6/19/24 Resident had a history of trauma that could have a negative impact. The trauma was related to getting hair pulled. The identified goal was to maintain resident's safety and integrity during post trauma episode, using appropriate interventions. Identified interventions included: identify situations/ event/ images that trigger recollections of the traumatic event and limit the resident's exposure to these as much as possible. These triggers could include seeing the other resident that pulled her hair. Social worker spoke with the resident who stated it did not affect her to see the other resident. Monitor for escalating anxiety, depression, or suicidal thought and report immediately to the nurse, the physician, and to the mental health provider as applicable. Review of the Electronic Notes revealed: Nursing Progress Note dated 12/20/24 at 11:40 a.m.: Resident's hair was pulled on by another resident. Resident complained of pain. Acetaminophen with codeine administered, Resident's responsible party notified. Nursing Progress Note dated 5/11/24 at 8:11 p.m.: Resident had a witnessed incident with another resident where the other resident grabbed this resident's left index finger and bent it upwards, and the resident screamed in pain. Resident stated that her finger was hurting. Upon assessment, resident's left finger was red. Resident does not want staff to touch the finger saying it will hurt. Stat (immediate) x-ray to left hand ordered. Resident responsible party contacted and informed of incident. Nursing Progress Note dated 5/12/24 at 10:37 a.m.: No complaint of pain in hand/finger. X-ray back and is negative for fracture at that time. Resident unable to recall incident from yesterday when she is asked about it. Activity Note dated 6/19/24 at 1:08 p.m.: CNA notified nurse that some of resident's hair was pulled off by another residents. Assessment completed, no injuries noted at this time. Resident verbalized pain 7 of 10. Two Acetaminophen tablets given. Family notified, physician notified, ADON and administrator notified. Activity Note dated 6/19/25 at 2:16 p.m.: Social Worker followed up with resident. Resident was able to recall incident. Resident stated it did not affect her psychologically; denied depression or anxiety. Resident asked if she continued to feel safe in the unit and she stated yes. Resident asked if she was afraid of other resident or concerns. Resident stated no. Resident declined counseling services. Trauma informed form completed, care plan updated. Social worker will continue to monitor resident's mood and behaviors and assist with non-medical interventions. Observation on 6/20/24 at 11:24 a.m. revealed Resident #2 outside of her room visiting with another Spanish-speaking resident. Interview on 6/19/24 at 2:17 p.m., the Administrator stated that Resident #1 and Resident #2 had an altercation on 6/19/24 and they were reporting it to the state agency. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/20/24 at 3:56 p.m. the ADON stated she remembered one previous incident between Resident #1 and Resident #2. She said the facility addressed it by putting Resident #1 and Resident #2 at opposite ends of the hall. The ADON pulled up Resident #1's incident/accident reports and said on 11/26/23 Resident #1 hit Resident #2. The ADON said all I'm seeing is her! (Resident #1's altercations all involved Resident #2) The ADON stated, on 12/20/23, there was an altercation between Resident #1 and #2 where #1 was the aggressor and they changed Resident #1's medications. The ADON read Resident #1's 5/2/24 Behavior Note, and said she thought there was no incident/accident report because there was no physical contact made and the DON was notified. The ADON said she knew there was no Incident/Accident report on Resident #1's and Resident #2's 5/11/24 altercation, but Resident #1's sertraline was increased. The ADON stated she was unaware that was Resident #2. The ADON said on 6/19/24 Resident #2 was sitting in her doorway watching everyone go by and Resident #1 was walking by and just snatched her by her hair as Resident #1 was pacing the hallway. The ADON said she personally called the psychiatrist and got the order for 1:1 monitoring and a referral. The ADON said she did not understand why Resident #1 was always attacking Resident #2 because Resident #2 was not a problem resident. The ADON said there was no way to effectively track and trend behaviors if the staff were not doing incident/accident reports on them. She said they did not know to do a short-term care plan on the resident so those were not getting done, and they did not identify the pattern that Resident #1 was always targeting Resident #2. Interview on 6/20/24 at 6:12 p.m., the Administrator said she did not remember if there was a history between Resident #1 and Resident #2 or not when she did the report to the state agency. She said she just knew of what was on Resident #1's care plan. The Administrator said Resident #2 thought Resident #1 was her sister-in-law but that would not explain why Resident #1 was always hurting Resident #2. RESIDENT #3 Review of Resident #3's Admission Record, dated 6/19/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Dementia, psychotic disorder with delusions due to known physiological condition, anxiety, and mood disorder with depressive features. He was on the men's secured unit. Review of Resident #3's Annual MDS Assessment, dated 4/4/24, revealed: He scored a 9 of 15 on his mental status exam (indicating moderate cognitive impairment). He had 10 of 27 self-reported indicators for depression (indicating possible depression). No behaviors were indicated in the seven days prior to the assessment. He walked independently. He reported no pain. He was on no psychotropic medications. Review of Resident #3's Care Plan revealed: (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Revised 3/11/24: Resident #3 had the potential to demonstrate physical behaviors related to dementia, poor impulse control, attempts to hit others, flips residents off. Resident took Divalproex Sodium for psychotic disorder. The identified goal was: Resident #3 will demonstrate effective coping skills through the review date. Identified interventions included: analyze key times, places, circumstances, triggers and what de-escalates behavior and document; assess and address for contributing sensory deficits; if he has physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance. Initiated 6/16/23: Resident #3 had a history of making false accusations. The identified goal was: Resident #3: reductions of absence of false accusations. Identified interventions included: Document any behaviors, separate residents if altercations ensue and notify Administrator/DON immediately; notify Administrator/DON/doctor/ and responsible party of any accusations made by resident. Review of Resident #3's Order Summary, dated 6/19/24 documented orders: Dated 4/13/23 for the mood stabilizer for Divalproex Sodium Sprinkles 250 mg three times a day. Review of the electronic record revealed: Behavior Note, dated 3/8/24 at 7:55 p.m.: Resident attempting to pick a fight with another resident, walking by and giving the resident a middle finger and calling him a motherfucker, telling him he would punch him. Resident went into other resident's room and other resident held him in bear hug. No injuries at this time. Called resident's responsible party, she spoke to resident about behavior, resident went back to his room. Behavior Note, dated 4/19/24 at 8:02 p.m. documented: CNA reports the resident instigates an argument and attempts to hit that resident, resident assessed, skin assessment complete, no injuries notes, resident denies pain or discomfort, education on safety complete. No incident/accident reports were completed for the corresponding dates. Interview on 6/21/24 at 12:30 p.m. the Administrator and Regional Director reviewed electronic notes with surveyor. They read the 3/8/24 behavior note. The Regional Director stated the 3/8/24 behavior note was physical contact, and an incident/accident report should have been completed. The Regional Director stated the 4/19/24 Behavior note would only trigger an incident/accident report if there was a pattern of behavior or history. When asked how the Regional Director would know if there was at pattern of behavior or history if there was no tracking know he said that was why the facility needed consistent staff. RESIDENT #4 Review of Resident #4's Admission Record, dated 6/21/24, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a type of dementia); depression, pain, psychotic disorder with delusions with known phsysiological condition, anxiety, and personality change due to known physiological condition. He lived on the men's secured unit. Review Resident #4's Annual MDS Assessment, dated 5/1/24 revealed: (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He scored an 8 of 15 on his mental status exam (indicating moderate cognitive impairment). He had 11 of 27 self-reported indicators of depression (indicating a possible diagnosis of depression). He displayed verbal behaviors director towards others 1 -3 days in 7 prior to the assessment. He was independently ambulatory. He occasionally experienced pain and rated it as an 8 of 10 when he did experience it. He was on an antidepressant. Review of Resident #4's Care Plan revealed: Revised 5/1/24: Resident #4 Has potential to demonstrate physical behaviors Anger, dementia, attempts to hit staff and throw snacks when requesting a cigarette before smoke break, potential to yell/curse at other residets. The identified goal was: Resident #5 will not harm self or others through the review date. Identified approaches included: analyze key times, places, circumstances, triggers, and what de-escalates behavior and document; notify the charge nurse of any physcially abusive behaviors; psychiatric consult as needed. Review of Resident #4's Order Summary, dated 6/21/24, revealed: Order dated 5/22/23 for mood stabelizer Divalproex Sodium 250mg twice a day. Order dated 5/9/22 for the antidepressant Venlafaxine. Review of Resident #4's electronic notes revealed: Behavior note dated 2/12/24 at 10:08 a.m.: Resident putting his hands on other residents and causing the resident at risk for falling and being angry, which can lead into an altercation. Education has been given to the resident and family. ADON aware of the behavior. Behavior note dated 4/15/24 at 7:16 p.m.:Resident noted by this nurse going behind wheelchairs of other residents and shaking chairs making other residents upset. This nurse advised resident not to do so as others don't like it. Residents states he was just playing and I advised him to not play like that. Resident did it again after speaking with him about not doing it. Will continue to do it. No incident/accident reports were completed corresponding to the above dates. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/20/24 at 10:20 a.m. the Administrator and ADON stated the facility tracked behavior by discussing it in the morning meeting. They stated nurses would document behaviors and it would show up on the 24-hour report and it would be discussed in the morning meeting and a plan of action would be determined. They stated if a pattern of behavior was identified, they would try to do in-services with the staff. They said the social worker would do safety interviews with staff and residents if there was any kind of behavior if the nurses had to intervene. The ADON said there was monitoring done for psychiatric medication and the nurses were good about filling out behavior notes on the secured units, but the independent unit needed reminding. The Administrator stated the facility was always getting new staff or the nurses would seem to forget. The ADON stated under a previous corporation, there was a behavior tracking book but there was nothing under the current corporation that would trend behaviors. The Administrator stated the corporation had hired a behavior consultant and all the department heads were supposed to become certified in addressing behaviors but at that time, all they had was the computer training program the corporation use. Interview on 6/20/24 at 6:12 p.m. the Administrator said the facility had QA meetings quarterly and behaviors were discussed. The Administrator said the facility discussed how many behaviors were going on in the building and how many residents were on medications. The Administrator said she thought they got that information from the incident/accident reports. The Administrator said she thought the Regional Compliance Nurse was supposed to check that the DON was ensuring those were completed but at the moment the corporation did not have one for the region. The Administrator said behaviors were also discussed in morning meetings and in care plan meetings. The Administrator stated the DON was out of the facility for a regional meeting and she had texted her for an answer on how the DON ensured Incident/accident reports were completed on behaviors. In an interview on 6/21/24 at 12:30 p.m. with the Administrator and Regional Director, the Regional Director stated the 4/15/24 incident of Resident #4 shaking wheelchairs would need an incident/accident report. The Administrator stated an incident/accident report was not completed for 2/12/24 when Resident #4 put his hands on other residents, while the Regional Director stated it was vague. Interview on 6/21/24 at 12:26 p.m. the Administrator stated the DON answered her text she said she was able to check through incident reports, progress notes, and behavior notes, that she (the DON) in-services and the nurses knew it (incident/accident reports) needed to be done and some incident/accident reports were still active and had not been closed out yet. The ADON added an incident note would trigger a behavior or fall note but a behavior or fall note would not trigger doing an incident/accident note. At 12:30 p.m. the Regional Corporate Director joined the conversation and stated the expectation was that the nurses completed an incident/accident report in the risk management section about what happened so it could be discussed in the morning meeting and the appropriate monitoring could be completed. The Regional Director stated the outcome to the resident if not done was the possibility of not having interventions and it was the DON's responsibility to see that it was completed. The Regional Director stated he attended QA meeting in person when he could and via the web when he could not because he was part of the governing body. The Regional Director said there was a section in the QA meetings that did address behaviors and incident/accident reports and there was a chart that would determine if there was trending done monthly. Review of the facility's in-services to nurses documented: (continued on next page)

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