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	08/13/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on interviews and record review the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, and administering of controlled medications for 1 of 4 residents (Resident #1) reviewed for pharmaceutical services. The facility failed to accurately receive and store Resident #1's 45 tablets of the anti-anxiety narcotic schedule IV medication Alprazolam. As a result, the 45 tablets of Alprazolam were diverted. The facility failed to accurately receive and store Resident #1's 60 tables of the narcotic scheduled IV pain medication Tramadol. These failures could place residents at risk of misappropriation of property by drug diversion and could result in increased pain and/or anxiety, and poor quality of life. Findings included: Review of Resident #1's Admission Record, dated 8/3/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, hypertension, depression, intermittent explosive disorder (loses his temper without notice), anxiety, hyperlipidemia, and psychotic disorder with delusions. Resident #1 lived on the male secured unit and was on Hospice Services. Review or Resident #1's Quarterly MDS assessment dated [DATE], revealed: He scored a 2 of 15 on his mental status exam (indicating severe cognitive impairment). He showed signs of delirium including continuous inattention. He was ambulatory. He took an anti-anxiety medication in the seven days previous to the assessment. Resident #1 was on Hospice Services. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Care Plan revealed: Revised on 7/4/24 Resident #1 used anti-anxiety medications, adjustment issues related to anxiety, Alprazolam and Buspirone. The identified goal was Resident #1 would show decreased episodes of signs or symptoms of anxiety through the review date. Identified interventions included give anti-anxiety medications ordered by physician; monitor/document side effects and effectiveness. Revised on 4/10/24. Resident #1 had delirium or an acute confusional episode related to acute disease process (dementia) inattention. The identified interventions included: Provide medications to alleviate agitation as ordered by Medical Doctor, monitor/document side effects, and effectiveness. Initiated 5/8/24: Resident #1 had a terminal prognosis and/or was receiving hospice services with [provider]. The identified goal was Resident #1's dignity and autonomy would be maintained at the highest level through the review date. Identified interventions included: observe him closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there was breakthrough pain. Review of Resident #1's Order Summary Report, dated 8/3/24 revealed orders: Alprazolam 0.25 mg give 1 tablet by mouth every 6 hours as needed for agitation related to dementia with other behavioral disturbance beginning 7/22/24. Alprazolam 0.25 mg give 1 tablet by mouth two times a day for Agitation, inability to sleep related to dementia with other behavioral disturbance beginning 7/22/24. Discontinued Order: Alprazolam Tablet 0.25 MG Give 1 tablet by mouth every 6 hours as needed for Agitation (Order Date 5/31/24, Discontinue Date 7/22/24 - order changed by hospice). Tramadol give 50mg by mouth every 8 hours as needed for pain, dated 7/4/24. Review of medications delivered 7/25/24 by the hospice nurse were: Tramadol 50mg Tablet, 60 tablets Potassium 10 meq tablet, 15 tablets Furosemide 20 mg Tablet, 15 tablets Lisinopril 40 mg tablet, 14 tablets Mirtazapine 7.5 mg tablet, 14 tablets Buspirone 5 mg tablet, 45 tablets Alprazolam 0.25mg tablets, 45 tablets. Review of the copy of the Alprazolam card, received 6/21/24, showed Resident #1 had 36 Alprazolam tablets remaining at the time of the diversion. Review of Resident #1's Narcotic sheet for the 6/21/24 Alprazolam also reflected there were 36 tablets remaining. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/3/24 at 1:10 p.m. the Administrator stated the drug diversion was an ongoing investigation. The Administrator said the facility filed a report with the local police department, but it had not been finalized and the facility was hoping it would be finalized 8/5/24 or 8/6/24. The Administrator stated the facility had not discovered a perpetrator in their facility through their investigation. The Administrator said the medication was delivered by a hospice nurse on 7/25/24 and it was the discovered the Alprazolam medication card was missing on 8/1/24. The Administrator stated at that time she called the police and began her investigation. The Administrator stated all staff with access to the medication room where the medication was allegedly left as well as access to the medication carts were drug tested . The Administrator said two staff members tested positive for benzodiazepines but were able to provide prescriptions for the medication. The Administrator stated she got a statement from the Hospice RN who delivered the medication and the nurse who discovered the medication was missing. In an interview on 8/3/24 at 2:45 p.m. the ADON stated she was not in the facility on 7/25/24 but LVN A discovered the missing medication, and LVN A immediately called the ADON to report the missing medication. The ADON stated LVN A said she was cleaning out the medication cart and noticed a bundle of medication for Resident #1 in the bottom of the medication cart, including a card of Tramadol. The ADON stated LVN A checked the receipt for the medications and found a card of Alprazolam was missing. The ADON said it was concerning not only because the Alprazolam was missing but also because the Tramadol was not in locked drawer and there was no narcotic count sheet created for it. The ADON stated the Administrator was notified of the missing Alprazolam immediately after she, the ADON, was notified. In an interview on 8/3/24 at 5:01 p.m. the Administrator stated 45 pills of Alprazolam went missing but not a card of Tramadol. The Administrator said they got the statement from the Hospice RN who identified he gave the medication to the DON. The Administrator said originally the facility thought it was a mix up on residents. In an interview on 8/3/24 at 5:22 p.m. the ADON stated 45 tablets of Alprazolam were missing and the facility did not know what happened. The ADON stated the DON was the last person to see them and there were other medications delivered at the same time. The ADON stated LVN A was cleaning the medication cart or something and found the pile of medications and the delivery slips. The ADON said LVN A texted her (the ADON) at 5 p.m. and she (the ADON) texted back that she was headed to the facility and immediately reported the missing medication to the Administrator. The ADON said she was supposed to get all delivery slips to ensure that medications did, in fact, get delivered. The ADON said the Tramadol was in the cart, but the Alprazolam was nowhere to be found. The ADON said the facility checked every cart including taking the drawers out of the carts to make sure the card was not stuck, dug through the non-narcotic medications, went through the discontinued narcotics, checked the Pixus machine (emergency medications), and tore the medication room apart. The ADON stated all the other medications were where they needed to be. The ADON said she checked, the MDS Coordinator checked, and the Administrator checked for the medications. The ADON said medications were delivered Thursday 7/25/24, and the DON was working 'the back' (the secured units). The ADON explained the hospice company did not require a signature for the medications, but they did now. The ADON said the facility now required the nurse who took the medications to sign for the medications and the hospice got the original and the facility got the copy. The ADON said Resident #1 had a previous prescription for as-needed Alprazolam, so he still had medication remaining and never missed a dose. The ADON said Resident #1's Alprazolam prescription had changed from as-needed only to twice a day scheduled plus an as-needed dose. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/3/24 at 6:55 p.m. revealed all 5 medication carts had been locked with no loose medications found. Narcotic medication count was completed for each cart and no discrepancies were noted. All controlled medications in each cart had a corresponding count sheet in a binder located on the cart. In an interview on 8/4/24 at 1:44 p.m. the MDS Coordinator stated she did not know why anyone would put narcotics in the medication room instead of in the medication cart drawer. The MDS Coordinator stated no one in the facility matched the Hospice RN's description of the other lady. The MDS Coordinator said since the Hospice RN did not get a signature, the facility did not even know if the medications were delivered 7/25/24 or 7/26/24. The MDS Coordinator stated, it sounds like things fell through on both sides. The MDS Coordinator said the Hospice RN brought in a lot of medication for Resident #1 and no one checked with him if even verified the Alprazolam was even there and it made it to the building. In an interview on 8/4/24 at 3:42 p.m. the ADON stated it was not the facility's usual pharmacy that delivered the medication. It was a Hospice nurse who delivered the medication, and the DON was acting as the charge nurse on the unit. The ADON said there was no Medication Aide working that day, so it was just the DON on the units on 7/25/24. The ADON said she did not know who else would take Resident #1's medication, but she did not know if the medication was actually delivered on 7/25/24. The ADON said it could be 4 - 7 days before someone got into the bottom drawer of the medication carts because they were used for overflow medication. The ADON said the Tramadol and Alprazolam should have been put in the narcotic box with a count sheet. The ADON said Resident #1's other medications were in the medication cart. The ADON explained the mirtazapine got put up and were not even in the bottom drawer with the overstock. The ADON explained the tramadol, lisinopril, buspirone, potassium, and furosemide were in the bottom drawer with the delivery slips. The ADON said one problem with how this happened was nurses just don't throw medications in the medication room. The ADON said medications with hospice were supposed to be delivered to the nurse who was supposed to sign for it, put the receipt in her (the ADON's) box, and if it was a narcotic the nurse was supposed to fill out a narcotic count sheet. The ADON said the Hospice nurse was just handing off the medications and not getting signatures. In an interview on 8/4/24 at 6:47 p.m. MA B stated they were sometimes at the facility when hospice dropped off medications. MA B stated they worked on 7/25/24 but they were not sure if they were in the building when the medications were physically delivered. MA B said, normally the hospice nurse would find a facility nurse to hand the medications off to. MA B said they did not know exactly what the procedure was for receiving medications. MA B said that hospice nurses had tried to drop of medications with the Medication Aides in the past. MA B said they refused to accept the medications and told the hospice nurses a facility nurse had to take the medications. MA B said when the facility got a new controlled medications the staff tried to lock them up immediately. MA B stated they saw an unidentified staff a while back place narcotics in the medication room instead of locking the narcotics up. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/4/24 at 7:15 p.m. RN C said it depended on what time the hospice nurse showed up to deliver medication if she (RN C) was in the building or not. RN C said normally the hospice nurse would look for a facility nurse to hand the medications off to. RN C said if there were narcotics, nurses were to create a count sheet and put the medication in the lock box in the medication cart immediately. RN C said she had never seen a hospice nurse deliver medications to a medication aide. RN C stated it depended on the hospice company if they (the facility nurses) signed a paper or electronic delivery confirmation when the facility nurses took possession of the medications. RN C said the facility nurse did not get a copy of the receipt of the medication but thought the DON or ADON did. RN C said it was never appropriate to leave narcotics sitting on the counter in the medication room. RN C said any time narcotics were delivered to the facility when they were working, RN C held onto the narcotics or put it in the locked drawer on the medication cart or gave it to the nurse who took care of the resident so they could put it away. RN C said she never saw Resident #1's Alprazolam on 7/25/24. In an interview on 8/13/24 at 12:54 p.m. the Corporate RN stated the pharmacist was notified of the drug diversion by email. He said, thank you and that was it. Interview on 8/13/24 at 12:58 p.m. the Hospice RN stated he delivered the medications on a Thursday. The Hospice RN said he remembered he initially walked into the women's secured unit to talk with the nurse and drop of medications for another patient. The Hospice RN stated an aide told him the DON was the charge nurse for the day. The Hospice RN said he then left the women's unit came around the corner and saw the DON. The Hospice RN stated the DON was being followed by someone and they were busy and, in a rush, to do something. The Hospice RN said the DON did try to brush him off but the lady said to lock the medication in the medication room. The Hospice RN said he did not physically see the DON put the medications into the medication room. The Hospice RN admitted he did not have the DON sign anything for the medications but since then he had been getting the medications signed for. The Hospice RN said he did get a stack of medications for Resident #1 from the pharmacy but did confirm the Alprazolam was there. The Hospice RN confirmed he was sure it was the DON he gave the medications to. The Hospice RN said the building seemed chaotic that day. Interview on 8/13/24 at 1:28 p.m. the DON stated she worked so many hours that day and she was so tired she did not remember what happened to the medications. The DON said she remembered the Hospice RN coming and she remembered telling him she could not take the medications and he needed to find another nurse. The DON said she did not remember who the nurse was. The DON said she did not remember if he asked her to sign for the medications. The DON said the drugs were never in her hands and she did not know what happened to the medications. The DON said she heard about the drug diversion the day after she started her vacation. The DON said, I really don't remember, I don't know if those pills actually made it into the building. The DON said she had no idea who moved the medications from the medication room to the medication cart. The DON said she remembered working a different hall(s) from the one Resident #1 was on and she thought she was headed down to do wound care. The DON repeated all she remembered was saying she could not take the drugs. The DON said when the Administrator called her and asked her where else she (the DON) would have put the drugs the DON said nowhere because she (the DON) did not take them. The DON said the normal facility procedure for narcotics was to put the narcotics in the locked box, make a narcotic count sheet, and put it in the box. The DON said facility policy was if you received the medications, you put them up. The DON said if this was another nurse, she would probably do some coaching or write the nurse up; she admitted she might terminate the nurse. The DON said there had not been any problems with narcotics missing since she became DON. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Hospice RN Statement, dated 8/2/24, revealed: On 7/25/24 at approximately 2 p.m. the Hospice RN arrived at the facility with refills for two hospice patients that reside there. When he first arrived to the facility, he entered the women's lock down unit looking for the nurse on the hall so he could deliver the medication. A CNA stated that the Director was the nurse in charge and was currently on the other hall. As the Hospice RN exited the women's locked down unit and was turning the corner to find the nurse on the other hall, he saw the Director with some other lady coming out of the men's lock down unit. The Hospice RN attempted to approach to give the medication refills that were needed. The two women acknowledged the Hospice RN and the Director stated she wasn't able to take medication at that time, she was being followed by what the Hospice RN assumed was another staff member. This other staff member suggested locking the medication up, in what the Hospice RN later found out to be the medication room. The lady and the Director proceeded to move the medication into the medication room. This was when the Hospice RN thanked the staff for taking the medication and proceeded to exit the facility. Review of LVN A's statement dated 8/1/24 at 5:00 p.m. revealed: while looking through the cart, LVN A noticed a bundle of medications for Resident #1. While looking at them LVN A saw a card for Tramadol. LVN A then looked at the pharmacy receipt and delivery date of 7/25/24. A card of Alprazolam was on the pharmacy receipt ticket, but the actual medication card for Alprazolam 0.25mg 45 count was missing. LVN A immediately called her ADON to report the issue. LVN A made copies of all pharmacy receipts for that order and looked through the entire medication cart for the missing Alprazolam card and was unable to locate the card. Review of the DON's statement, undated, revealed: the DON did not remember anyone giving her any narcotics. The DON vaguely remember someone wanting to give her (the DON) medications and she was working the floor and asked them to give them to the nurse. The DON was working multiple shifts, doubles, due to staffing shortages. Review of the facility's policy and procedure on Ordering Medications, dated 2003, revealed: Medications and related products are received from the pharmacy supplier on a timely basis. The facility maintains accurate records of medication order and receipt. The nurse that receives a new medication order, should be responsible for the following: Order received is accurate and includes all necessary information. Order must be transcribed accurately to the MAR Sheet unless electronic MARs are used by the facility. MAR contains proper times scheduled. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure on Ordering Controlled Medications, dated 2003, revealed: Medications included in the Drug Enforcement Administration classification as controlled substances and medications classified as controlled substances by state law, are subject to special order, receipt, and record keeping requirements in the facility, in accordance with federal and state laws and regulations. Procedure: The Director of Nursing and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications. Medications listed in Schedules II, III, IV and V are stored under double lock in a locked cabinet or safe designated for that purpose, separate from all other medications. Alternatively, in a unit dose system, Schedule III, IV and V medications may be kept with other medications in the cart however this is at the discretion of the consultant pharmacist and Director of Nursing, due to the possibility of abuse for any of the controlled drug categories. The access key to controlled medications is not the same key giving access to other medications. The medication nurse on duty maintains possession of a key to controlled medications. The Director of Nursing keeps back-up keys to all medication storage areas, including those for controlled medications. Review of the facility's policy and procedure on Storage of Controlled Substance, dated 2003, revealed: Drugs listed in Schedule II, III, and IV or the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 shall not be accessible to other than licensed nursing, pharmacy, and medical personnel designated by the home. The Director of Nurses is designated by the facility to be responsible for the control of such drugs. Controlled substances ordered by the physician shall be sent in easily accountable quantities. All Schedule II, III, and IV controlled substances are to be stored under double lock, separate from all other medications. Drugs shall be stored in an orderly manner in cabinets, drawers, or carts of sufficient size to prevent crowding. All medications and other drugs, including treatment items, shall be stored in a locked cabinet or room, inaccessible to patients and visitors. Drugs shall be accessible only to authorized personnel. Only the authorized personnel will have access to the keys to the medication room and medication carts. The controlled drugs as listed in the Comprehensive Drug Abuse Prevention and Control act of 1970 as well as other drugs subject to abuse will be kept locked in a separate, permanently affixed compartment for the storage of controlled drugs. The facility may at its discretion keep all controlled drugs together stored in the permanently affixed compartment separated from noncontrolled drugs since nurse may not know the different Schedule categories. Review of Drugs.com on 8/15/24 revealed Alprazolam and Tramadol were a federal controlled substance scheduled IV. Review of the Hospice Agreement with the hospice provider, signed 2021, revealed the contract did not outline the process for hospice delivering medications to the facility. Review of the in-service, dated 8/2/24 revealed: As soon as a narcotic is delivered you must write a narcotic sheet (per card) and put it narcotic box, failure to do so can/will result in write up and/or termination. Review of the in-service, undated, revealed: When receiving narcotics/anti-anxiety/ antibiotics you must immediately add count sheet for medications and place medications in locked medication cart.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on interviews and record review, the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to medications for 1 of 4 medication carts reviewed for medication storage. The facility failed to ensure that Resident #1's 60 tablets of Tramadol were secured in a double-locked area. This failure could place residents at risk for harm by not receiving the medications due to misappropriation. The findings included: Review of Resident #1's Admission Record, dated 8/3/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, hypertension, depression, intermittent explosive disorder(loses temper without notice), anxiety, hyperlipidemia, and psychotic disorder with delusions. Resident #1 lived on the male secured unit and was on Hospice Services. Review or Resident #1's Quarterly MDS assessment dated [DATE], revealed: He scored a 2 of 15 on his mental status exam (indicating severe cognitive impairment). He showed signs of delirium including continuous inattention. He was ambulatory. He took an anti-anxiety medication in the seven days previous to the assessment. Resident #1 was on Hospice Services. Review of Resident #1's Care Plan revealed: Initiated 5/8/24: Resident #1 had a terminal prognosis and/or was receiving hospice services with [provider]. The identified goal was Resident #1's dignity and autonomy would be maintained at the highest level through the review date. Identified interventions included: observe him closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. Review of Resident #1's Order Summary Report, dated 8/3/24 revealed orders: Tramadol give 50mg by mouth every 8 hours as needed for pain, dated 7/4/24. Review of medications delivered 7/25/24 by the hospice nurse were Tramadol 50mg Tablet, 60 tablets. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/3/24 at 1:10 p.m. the Administrator stated the drug diversion was an ongoing investigation. The Administrator said the facility filed a report with the local police department, but it had not been finalized and the facility was hoping it would be finalized 8/5/24 or 8/6/24. The Administrator stated the facility had not discovered a perpetrator in their facility through their investigation. The Administrator said the medication was delivered by a hospice nurse on 7/25/24 and the missing Tramadol card was discovered on 8/1/24. The Administrator stated at that time she called the police and began her investigation. The Administrator stated all staff with access to the medication room where the medication was allegedly left as well as access to the medication carts were drug tested . The Administrator stated she got a statement from the Hospice RN who delivered the medication and the nurse who discovered the medication was missing . In an interview on 8/3/24 at 2:45 p.m. the ADON stated she was not in the facility on 7/25/24 but LVN A discovered the missing medication, and she (LVN A) immediately called the ADON to report the missing medication. The ADON stated LVN A said she was cleaning out the medication cart and noticed a bundle of medication for Resident #1 in the bottom of the medication cart, including a card of Tramadol. The ADON said it was concerning because the Tramadol was not in locked drawer and there was no narcotic count sheet created for it. In an interview on 8/3/24 at 5:22 p.m. the ADON stated the DON was the last person to see them and there were other medications delivered at the same time. The ADON stated LVN A was cleaning the medication cart or something and found the pile of medications and the delivery slips. The ADON said LVN A texted her (the ADON) at 5 p.m. and she (the ADON) texted back that she was headed to the facility and immediately reported the missing medication to the Administrator. The ADON said she was supposed to get all delivery slips to ensure that medications did, in fact, get delivered. The ADON said the Tramadol was in the cart bottom drawer of the cart. The ADON said medications were delivered Thursday 7/25/24. The ADON explained the hospice company did not require a signature for the medications, but they did now. Observation on 8/3/24 at 6:55 p.m. revealed all 5 medication carts were locked with no loose medications found. Narcotic medication count was completed for each cart and no discrepancies were noted. All controlled medications in each cart had a corresponding count sheet in a binder located on the cart. In an interview on 8/4/24 at 1:44 p.m. the MDS Coordinator stated she did not know why anyone would put narcotics in the medication room instead of in the medication cart drawer. The MDS Coordinator said since the Hospice RN did not get a signature the facility did not even know if the medications were delivered 7/25/24 or 7/26/24. The MDS Coordinator stated, it sounds like things fell through on both sides. (continued on next page)

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	08/13/2024

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/4/24 at 3:42 p.m. the ADON stated it was not the facility's usual pharmacy that delivered the medication, it was a Hospice nurse who delivered the medication, and the DON was acting as the charge nurse on the unit. The ADON said there was no Medication Aide working that day, so it was just the DON on the units on 7/25/24. The ADON said she did not know who else would take Resident #1's medication, but she did not know if the medication was actually delivered on 7/25/24. The ADON said it could be 4 - 7 days before someone got into the bottom drawer of the medication carts because they were used for overflow medication. The ADON said the Tramadol should have been put in the narcotic box with a count sheet. The ADON explained the tramadol, lisinopril, buspirone, potassium, and furosemide were in the bottom drawer with the delivery slips. The ADON said one problem with how this happened was it was nurses just don't throw medications in the medication room. The ADON said medications with hospice were supposed to be delivered to the nurse who was supposed to sign for it and put the receipt in her (the ADON's) box and if it was a narcotic the nurse was supposed to fill out a narcotic count sheet. The ADON said the Hospice nurse was just handing off the medications and not getting signatures . In an interview on 8/4/24 at 7:15 p.m. RN C said it depended on what time the hospice nurse showed up to deliver medication. RN C said normally the hospice nurse would look for a facility nurse to hand the medications off to. RN C said if there were narcotics, nurses were to create a count sheet and put the medication in the lock box in the cart immediately. RN C stated it depended on the hospice company if they (the facility nurses) signed a paper or electronic delivery confirmation when the facility nurses took possession of the medications. RN C said it was never appropriate to leave narcotics sitting on the counter in the medication room. RN C said any time narcotics were delivered to the facility when they were working, RN C held onto the narcotic or put it in the locked drawer on the medication cart or gave it to the nurse who took care of the resident so they could put it away . In an interview on 8/13/24 at 12:58 p.m. the Hospice RN stated he delivered the medications on a Thursday. The Hospice RN said he remembered he initially walked into the women's secured unit to talk with the nurse and drop of medications for another patient. The Hospice RN stated an aide told him the DON was the charge nurse for the day. The Hospice RN said he then left the women's unit came around the corner and saw the DON. The Hospice RN stated the DON was being followed by someone and she was busy and in a rush to do something. The Hospice RN said the DON did try to brush him off but the lady said to lock the medication in the medication room. The Hospice RN said he did not physically see the DON put the medications into the medication room. The Hospice RN admitted he did not have the DON sign anything for the medications but since then he had been getting the medications signed for. The Hospice RN said he did get a stack of medications for Resident #1 from the pharmacy. The Hospice RN confirmed he was sure it was the DON he gave the medications to. The Hospice RN said the building seemed chaotic that day. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an nterview on 8/13/24 at 1:28 p.m. the DON stated she worked so many hours that and she was so tired she did not remember what happened to the medications. The DON said she remembered the Hospice RN coming and she remembered telling him she could not take the medications and he needed to find another nurse. The DON said she did not remember who the nurse was. The DON said she did not remember if he asked her to sign for the medications. The DON said she had no idea who put the medications from the medication room to the medication cart. The DON said when the Administrator called her and asked her where else she (the DON) would have put the drugs the DON said nowhere because she (the DON) did not take them. The DON said the normal facility procedure for narcotics was to put the narcotics in the locked box, make a narcotic count sheet and put it in the box. The DON said facility policy was if you received the medications, you put them up. The DON said if this was another nurse, she would probably do some coaching or write the nurse up; she admitted she might terminate the nurse. The DON said there had not been any problems with narcotics missing since she became DON . Review of the Hospice RN's Statement, dated 8/2/24, revealed: On 7/25/24 at approximately 2 p.m. the Hospice RN arrived to the facility home with refills for two hospice patients that reside there. When he first arrived to the facility he entered the women's lock down unit looking for the nurse on the hall so he could deliver medication. A CNA stated that the Director was the nurse in charge and was currently on the other hall, as the Hospice RN exited the women's locked down unit and was turning the [NAME] to find the nurse on the other hall he saw the Director with some other lady coming out of the men's lock down unit. The Hospice RN attempted to approach to give the medication refills that were needed. The two women acknowledge the Hospice RN and the Director stated she wasn't able to take medication at that time, she was being followed by what the Hospice RN assumed was another staff member. This other staff member suggested locking the medication up, in what the Hospice RN later found out to be the medication room. The lady and the Director proceeded to moved the medication into the medication room this is when the Hospice RN thanked the staff for taking the medication and proceeded to exit the facility. Review of LVN A's statement dated 8/1/24 at 5:00 p.m. revealed: while looking through the cart, LVN A noticed a bundle of medications for Resident #1. While looking at them LVN A saw a card for Tramadol. LVN A then looked at the pharmacy receipt and delivery date of 7/25/24. A card of Alprazolam was on the pharmacy receipt ticket, but the actual medication card for Alprazolam 0.25mg 45 count was missing. LVN A immediately called the ADON to report the issue. LVN A made copies of all pharmacy receipts for that order and looked through the entire medication cart for the missing Alprazolam card and was unable to locate the card. Review of the DON's statement, undated, revealed: the DON did not remember anyone giving her any narcotics. The DON vaguely remember someone wanting to give her (the DON) medications and she was working the floor and asked them to give them to the nurse. The DON was working multiple shifts, doubles, due to staffing shortages. Review of the Hospice Agreement with the hospice provider, signed 2021, revealed the contract did not outline the process for hospice delivering medications to the facility. Review of the in-service dated 8/2/24 revealed: As soon as a narcotic is delivered you must write a narcotic sheet (per card) and put it narcotic box, failure to do so can/will result in write up and/or termination. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the in-service, undated, revealed: When receiving narcotics/anti-anxiety/ antibiotics you must immediately add count sheet for medications and place medication s in locked medication cart. Review of the facility's policy and procedure on Ordering Medications, dated 2003, revealed: Medications and related products are received from the pharmacy supplier on a timely basis. The facility maintains accurate records of medication order and receipt. The nurse that receives a new medication order, should be responsible for the following: Order received is accurate and includes all necessary information. Order must be transcribed accurately to the MAR Sheet unless electronic MARs are used by the facility. MAR contains proper times scheduled. Review of the facility's policy and procedure on Ordering Controlled Medications, dated 2003, revealed: Medications included in the Drug Enforcement Administration classification as controlled substances and medications classified as controlled substances by state law, are subject to special order, receipt, and record keeping requirements in the facility, in accordance with federal and state laws and regulations. Procedure: The Director of Nursing and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications. Medications listed in Schedules II. III, IV and V are stored under double lock in a locked cabinet or safe designated for that purpose, separate from all other medications. Alternatively, in a unit dose system, Schedule III, IV and V medications may be kept with other medications in the cart however this is at the discretion of the consultant pharmacist and Director of Nursing, due to the possibility of abuse for any of the controlled drug categories. The access key to controlled medications is not the same key giving access to other medications. The medication nurse on duty maintains possession of a key to controlled medications. The Director of Nursing keeps back-up keys to all medication storage areas, including those for controlled medications. Review of the facility's policy and procedure on Storage of Controlled Substance, dated 2003, revealed: Drugs listed in Schedule II, III, and IV or the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 shall not be accessible to other than licensed nursing, pharmacy and medical personnel designated by the home. The Director of Nurses is designated by the facility to be responsible for the control of such drugs. Controlled substances ordered by the physician shall be sent in easily accountable quantities. No medication, which requires a written prescription such as those in Schedule II, shall be delivered until the prescription is in the hands of the pharmacist. All Schedule II, III, and IV controlled substances are to be stored under double lock, separate from all other medications. Drugs shall be stored in an orderly manner in cabinets, drawers, or carts of sufficient size to prevent crowding. All medications and other drugs, including treatment items, shall be stored in a locked cabinet or room, inaccessible to patients and visitors. Drugs shall be accessible only to authorized personnel. Only the authorized personnel will have access to the keys to the medication room and medication carts. The controlled drugs as listed in the Comprehensive Drug Abuse Prevention and Control act of 1970 as well as other drugs subject to abuse will be kept locked in a separate, permanently affixed compartment for the storage of controlled drugs. The facility may at its discretion keep all controlled drugs together stored in the permanently affixed compartment separated from noncontrolled drugs since nurse may not know the different Schedule categories. Review of Drugs.com on 8/15/24 revealed Tramadol was a federal controlled substance scheduled IV.