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	06/24/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect the resident's right to be free from abuse and neglect for 6 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6) of 18 residents reviewed for abuse and neglect. 1. The facility failed to prevent Resident #1 from abusing Resident #3 on Hall 400 (male secured locked unit) that led to an emergency room visit resulting in head laceration requiring 3 staples for Resident #3 on 05/25/2025. 2. The facility failed to ensure Hall 400 (male secured locked unit) had sufficient staffing to prevent Resident #1 from abusing Resident #4 that led to hospitalization of Resident #1 and a fall resulting in a skin tear to Resident #4's left elbow, while Resident #1 was supposed to be on 1:1 monitoring on 05/25/2025. 3. The facility failed ensure Hall 500 (female secured unit) had sufficient staffing to prevent Resident #2 from abusing Resident #5 resulting in a skin tear to her arm for Resident #5 on 06/04/2025. 4. The facility failed ensure Hall 500 (female secured unit) had sufficient staffing to prevent Resident #2 from abusing Resident #5 by slapping her across the face on 06/08/2025. 5. The facility failed ensure Hall 500 (female secured unit) had sufficient staffing to prevent Resident #2 from abusing Resident #6 resulting in a skin tear to the cheek for Resident #6, while Resident #2 was supposed to be on 1:1 monitoring on 06/08/2025. 6. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility failed to ensure Hall 400 (male secured unit) had sufficient staff to provide 1:1 monitoring for Resident #1 on 05/25/2025 from 10:00pm-6:00am. 7. The facility failed to ensure Hall 500 (female secure unit) had sufficient staffing to provide 1:1 monitoring for Resident #2 on 06/04/2024 from 2:00pm-10:00pm, and from 10:00pm-6:00am. 8. The facility failed to ensure Hall 500 (male secure unit) had sufficient staffing to provide 1:1 monitoring for Resident #2 on 06/08/2024 from 2:00pm-10:00pm, and from 10:00pm-6:00am. An Immediate Jeopardy (IJ) situation was identified on 06/22/2025. The IJ template was provided to the facility at 4:05 pm. While the IJ was removed on 06/24/2025 at 10:30 am, the facility remained out of compliance at a scope of pattern with no actual harm with a potential for more than minimal harm at a scope of pattern, due to the facility's need to evaluate the effectiveness of their corrective systems. These failures could place residents at risk for resident-to-resident altercations and serious harm in the event of an emergency, hospitalizations, and even death. Findings included: Resident #1 Review of Resident #1's electronic face sheet revealed a [AGE] year-old male admitted on [DATE] with initial admit date of 12/15/2023, to Hall 400 (male secured locked unit) with diagnoses which included: explosive disorder, heart failure, and alcohol dependence. Review of Resident #1's Quarterly MDS assessment, dated 05/22/2025, revealed a BIMS score of 02 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: behavior not exhibited. Section N: Medications: no antipsychotic, antianxiety, or antidepressant medications. Review of Resident's #1's Care Plan, last review 06/10/2025, revealed in part: Focus: Resident demonstrates physical behaviors hits other residents and staff, revised on 04/14/2025. Goal: Resident will not harm self or others through the review date, revised on 06/10/2025. Interventions: 1:1 supervision as needed, revised on 12/13/2024. Further review of care plan revealed no interventions added since 12/13/2024. Review of Resident #1's progress notes revealed: (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	05/25/2025 10:35 pm, signed by DON: .Resident saw another resident enter his room, he walked to his room and yelled at the other resident. When other resident did not move out fast enough, he punched other resident in the face. Another resident was walking backward, and this resident shoved him causing a fall. No injuries to Resident #1. Stated not in pain. Other resident was sent to the emergency room after hitting head on floor. Initial Treatment/New Orders: skin assessed. 1:1 monitoring, referral to impatient psyc notified: psych center 05/25/2024 at 4:45pm .Interventions 1 on 1 supervision, Redirection. 05/25/2025 10:45 pm, signed by DON: .CMA-A walking into the dining room, heard two residents having a verbal altercation then saw Resident #1 hit another resident in the face. When the other resident was swinging back, he slid out of his chair onto the floor .Initial Treatment/New orders: skin assessed, 1:1 monitoring, send referral to inpatient psych . notified psych center 05/25/2025 at 6:50pm .Interventions 1 on 1 supervision, Redirection. 05/27/2025 at 1:00 pm, signed by ADON: Resident #1 was transferred to a hospital on [DATE] at 1:00 PM related to resident had aggressive behaviors and was sent to psych facility for evaluation and treatment. Resident #3 Review of Resident #3's electronic face sheet revealed an [AGE] year-old male admitted on [DATE] with initial admit date of 02/20/2024, to Hall 400 (male secured locked unit) with diagnoses which included: explosive disorder, depression, and dementia. Review of Resident #3's Quarterly MDS assessment, dated 05/22/2025, revealed a BIMS score of 03 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: behavior not exhibited. E0900. Wandering: behavior not exhibited. Section N: Medications: antidepressant medications. Review of Resident's #3's Care Plan, last review 05/29/2025, revealed in part: Focus: Resident is at risk for wandering, revised on 02/21/2024. Goal: Resident's safety will be maintained through the review date, revised on 05/29/2025. Interventions: Distract him from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, revised on 02/21/2024. Identify pattern of wandering, revised on 02/21/2024. Further review of care plan revealed no interventions regarding wandering added since 02/21/2024. Review of Resident #3's progress notes revealed: 05/25/2025 4:53 pm, signed by RN-B: Resident #3 was transferred to a hospital on [DATE] PM related to resident altercation on another resident. Resident was knocked to the ground and hit his head on the found resident sent out for further Evaluation. 05/25/2025 10:58 pm, signed by DON: .Resident wandered into another resident's room. Other resident came in starting verbal altercation. When this resident did not move fast enough the other resident punched him in the face. The resident was backing up trying to exit room and fell landing on left lateral. 911 was called immediately. Skin assessed and previous left elbow skin tear was bleeding and noted to be bigger in size. No pain .Physician notified on 05/25/2025 6:45 PM . (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Provider Investigation Report, dated 05/31/2025, revealed: on 05/25/2025 at 4:20 pm, Resident #3 went into Resident #1's room. Staff heard yelling and saw Resident #1 hit and push Resident #3. Resident #3 fell to the floor and hit his head on the floor and sent to emergency room to be further evaluated. Resident #3 had laceration to back of heat with hematoma, no bleeding, no signs of infection, closed with 3 staples, measurements 1.5x2x0.5cm, hematoma measures 4x5x0.5cm, hematoma to left side of head measurements 3x3cm, bruises to bilateral upper extremities, reopened skin teas to left elbow with part of skin fold missing, no bleeding, no signs of infection, measurements 2x2.5x0.1cm, no other skin issues noted at this time. Facility initiated one on one monitoring with Resident #1. Contacted psych services. Investigation Findings: Confirmed. Review of the facility daily staff schedule, dated 05/25/2025 at the time of the incident, revealed 2 CNAs (CNA-C and CNA-D) assigned to Hall 400 (male secured locked unit) with a census of 19 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #1 per the facility in-service and DON's interview. Review of 1:1 monitoring sheet for Resident #1 revealed 1:1 monitoring started on 05/25/2025 at 4:45 pm and was signed by the 2 CNA's (CNA-C and CNA-D) assigned to Hall 400 (male secured locked unit) with no evidence of an additional designated CNA for 1:1 monitoring for Resident #1 per the facility in-service and DON's interview. Resident #4 Review of Resident #4's electronic face sheet revealed a [AGE] year-old male admitted on [DATE] with initial admit date of 03/25/2024, to Hall 400 (male secured locked unit) with diagnoses which included: personality change, depression, and dementia. Review of Resident #4's Quarterly MDS assessment, dated 05/30/2025, revealed a BIMS score of 03 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: - Presence and Frequency: 1 physical behavioral symptom directed towards others. Section N: Medications: antidepressant medications. Review of Resident's #4's Care Plan, last review 06/19/2025, revealed in part: Focus: Resident has a potential for trauma that may have a negative impact. The trauma is related to physical altercation, revised on 05/26/2025. Goal: Staff will assist in avoiding triggers through next review date. Interventions: Monitor for escalating anxiety, depression or suicidal thought and report immediate to the nurse. Record review of Resident #4's progress notes revealed: 05/25/2025 11:09 pm, signed by DON: .The fall caused a skin tear to left elbow. Size of the skin tear in cm: 0. 5 x 0.5. New/bleeding, a verbal altercation between this resident and another resident was overheard. CMA-A walked into dining room and saw another resident hit this resident in the face, when Resident #4 tried to swing back he slid out of his chair. Upon assessment a skin tear to the left elbow was noted. Stated it did not hurt . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Provider Investigation Report, dated 05/31/2025, revealed: on 05/25/2025 at 6:30 pm, Resident #1 slapped Resident #4 and when Resident #4 tried to swing back he slid out of his chair. Upon his assessment a skin tear to the left elbow was noted, measurements 0.8x0.7x0.1cm. Facility initiated one on one monitoring with Resident #1. Investigation Findings: Confirmed. Review of the facility daily staff schedule, dated 05/25/2025 at the time of the incident, revealed (2) CNAs (CNA-C and CNA-D) assigned to Hall 400 (male secured locked unit) with a census of 19 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #1 per the facility in-service and DON's interview. Review of 1:1 monitoring sheet for Resident #1 revealed 1:1 monitoring started on 05/25/2025 at 4:45 pm and was signed by the (2) CNA's (CNA-C and CNA-D) assigned to Hall 400 (male secured locked unit) with no evidence of an additional designated CNA for 1:1 monitoring for Resident #1 per the facility in-service and DON's interview. During an interview on 06/19/2025 at 1:35 pm, the DON stated that both secure units were always staffed with 2 CNA's each on all shifts except night shift which had 1 CNA per unit. She stated that if a resident was placed on 1:1 monitoring, an additional staff was added making 3 CNAs or 2 CNAs on 10:00pm-6:00am shift. During an interview on 06/20/2025 at 12:45 pm, CNA- C stated she was on shift on Secure Hall 400 at the time of these incidents with Resident #1. She stated on 05/25/2025, there was only herself and 1 other staff to supervise the 19 residents plus provide 1:1 monitoring with Resident #1 that required the resident to always be within arm's reach. She stated the locked unit was also having issues with the locked doors on the unit not functioning; therefore, they also had to monitor the doors, the residents, and provide 1:1 of Resident #1 within arm's reach. She stated that Resident #1 was placed on 1:1 monitoring but no extra staff was sent. She stated that at the time of the second incident Resident #1 was in the dining room and no staff was present. She stated she worked the secure unit alone often and had never been given extra staff when residents were placed 1:1 monitoring requiring residents to be within arm's reach. During an interview on 06/20/2025 at 8:00 pm, LVN-G stated she was responsible for Secure Hall 400 and Secure Hall 500 on 05/25/2025 from 2pm-10pm. She stated she was on Secure Hall 500 at the time of the first incident. She stated she was back on Secure Hall 500 when the 2nd incident happened. She stated Resident #1 was supposed to be on 1:1 monitoring because of the previous incident, when the 2nd incident happened, and she did not know why he was not. She stated there were only 2 CNAs covering Secure Hall 400 at the time and that there was no way that the LVN could help with 1:1 monitoring because she was responsible for both secure halls. During an interview on 06/20/2025 at 8:15 pm, MA-A stated he was working on 05/25/2025 at time of both incidents and stated that he was in a resident's room during the 1st incident with Resident #3 and did not see that incident, but he knew that he was placed on 1:1 monitoring. He stated that he was walking down the hall, when the 2nd incident happened and heard Resident #1 yelling then he spotted Resident #1 in the dining room with no staff present and saw him slap Resident #4. Resident #2 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #2's electronic face sheet revealed a [AGE] year-old female admitted on [DATE] with initial admit date of 02/09/2024, to Hall 500 (female secured locked unit) with diagnoses which included: traumatic brain injury, anxiety, depression, and dementia. Review of Resident #2's Quarterly MDS assessment, dated 05/20/2025, revealed a BIMS score of 02 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: - Presence and Frequency: 1 other behavioral symptom not directed towards others. Section N: Medications: antianxiety and antidepressant medications. Review of Resident's #2's Care Plan, last review 05/22/2025, revealed in part: Focus: Resident has potential to demonstrate physical behaviors attempts to hit other residents, revised on 04/09/2025. Goal: Resident will not harm self or others through the review date, revised on 05/22/2025. Interventions: When she becomes agitated: 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 11/18/2024. Record review of Resident #2's progress notes revealed: 06/04/2025 11:13 am, signed by LVN-E: .resident started being anxious and agitated. resident grabbed another resident arm causing a skin tear . resident is currently on 1:1 for monitoring .: 06/08/2025 12:19 pm, signed by LVN-F: . nurse was called by resident in hallway, that resident has just slapped another resident across the face. psych facility contacted, and 1:1 supervision. 06/08/2025 1:09 pm, signed by LVN-F . resident was grabbing another female resident by her cheeks and would not let her go, staff intervened but resident would not let other resident go. Resident #5 Review of Resident #5's electronic face sheet revealed a [AGE] year-old female admitted on [DATE] with initial admit date of 06/10/2020, to Hall 500 (female secured locked unit) with diagnoses which included: anxiety, Alzheimer's, and mood disorder. Review of Resident #5's Annual MDS assessment, dated 06/04/2025, revealed a BIMS score of 99 which indicated resident was unable to complete the interview. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: behavior not exhibited. Section N: Medications: antianxiety and antidepressant medications. Review of Resident's #5's Care Plan, last review 04/10/2025, revealed in part: Focus: Resident has a history of trauma that may have a negative impact. The trauma is related to getting scratched, revised on 06/05/2025. Goal: Maintain resident safety and integrity during post trauma episode, using appropriate interventions, revised on 06/05/2025. Interventions: Monitor for escalating anxiety, depression or suicidal thought and report immediately to the nurse, revised on 06/05/2025. Record review of Resident #5's progress notes revealed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	06/05/2025 10:38 am, signed by LVN-E: . resident received a skin tear due to another resident grabbing her arm. Physician notified on 06/04/2025 at 10:10am. 06/08/2025 12:29pm, signed by LVN-F: . Resident voices she was slapped across the face by the other female resident. Review of the Provider Investigation Report, dated 06/11/2025, revealed: On 06/04/2025 at 10:00am, Residents were sitting at the table in dining room when Resident #2 reached over and grabbed Resident #5's arm causing a skin tear. Resident #2 was placed on 1:1 monitoring. Investigation Findings: Confirmed. Review of the facility daily staff schedule, dated 06/04/2025 at the time of the incident, revealed (1) CNA (CNA-J) assigned to Hall 500 (female secured locked unit) with a census of 16 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. Review of the 1:1 monitoring sheet for Resident #2 on 06/04/2025 from 10:15am-2:00pm, was signed by the (1) CNA (CNA-J) assigned to Hall 500 (female secured locked unit) with no evidence of an additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. During an interview on 06/19/2025 at 2:00pm, CNA-J said she was on shift on Secure Hall 500 at the time of this incident with Resident #2 on 06/04/2025. She stated there was supposed to always be 2 CNAs, but she worked many times by herself. She stated that when a resident is placed on 1:1 monitoring the 2 CNAs on shift rotated and monitored them as close as possible. She stated it was very rare that a third CNA was sent. She stated she had worked on the floor multiple times alone with a resident on 1:1 monitoring. She stated when a resident was 1:1 the staff was supposed to be within arm's length of them at all times and must follow them wherever they go. She stated she could not remember specific dates or incidents because there were so many incidents and 1:1 monitoring that she couldn't remember them all. Resident #6 Review of Resident #6's electronic face sheet revealed a [AGE] year-old female admitted on [DATE] to Hall 500 (female secured locked unit) with diagnoses which included: explosive disorder, Alzheimer's, and seizures. Review of Resident #6's Quarterly MDS assessment, dated 05/26/2025, revealed a BIMS score of 03 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms- Presence and Frequency: 1 physical behavioral symptom director towards others. Section N: Medications: no antianxiety, antipsychotic, or antidepressant medications. Review of Resident's #6's Care Plan, last review 05/22/2025, revealed in part: Focus: Resident has potential to demonstrate physical behaviors, revised on 02/16/2024. Goal: Resident will demonstrate effective coping skills through the review date, revised on 05/22/2025. Interventions: Assess and anticipate her needs: food, thirst, toileting needs, comfort level, body positioning, pain, revised on 08/29/2023. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #6's progress notes revealed: 06/08/2025 1:28pm, signed by LVN-F: . Resident was in her wheelchair looking outside, when the other female resident came up to her and grabbed her face and started being combative, nurse/aide intervened but other resident would not let her go. Review of the Provider Investigation Report, dated 06/13/2025, revealed: On 06/08/2025 at 12:00pm, Resident #2 hit Resident #5 with no injuries. She then grabbed Resident #6 by the face causing a very small scratch to her cheek. Resident #2 was placed on 1:1 monitoring. Investigation Findings: Confirmed. Review of the facility daily staff schedule, dated 06/08/2025 at the time of the incident, revealed (1) CNA (CNA-M) and a float CNA (CNA-J) assigned to Hall 500 (female secured locked unit) with a census of 16 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. Review of the 1:1 monitoring sheet for Resident #2 on 06/08/2025 revealed 1:1 monitoring was not initiated until 1:00 pm after the 2nd incident. 1:1 monitoring sheet was signed by RN-B who was assigned as a nurse for Hall 100 and Hall 200. During an interview on 06/21/2025 at 9:00 am, LVN-F stated she was responsible for Secure Hall 500 on 06/08/2025 from 2pm-10pm. She stated that Resident #2 was supposed to have been placed on 1:1 monitoring after the 1st incident but there was no staff available. She stated Resident #1 and Resident #6 were in the dining room alone when she heard Resident #6 screaming. She stated the LVNs cannot provide 1:1 monitoring because they were responsible for multiple halls. Review of the facility daily staff schedule, dated 05/25/2025, revealed during the 10:00pm to 6:00am shift, there was (1) CNA (CNA-H) assigned for Secure Hall 400 and Secure Hall 500 for 36 residents with one (1) of the 36 requiring 1:1 monitoring. Review of the 1:1 monitoring sheet for Resident #1 on 05/25/2025 from 10:00pm-6:00am, revealed it was signed LVN-I who was assigned as the nurse for Secure Hall 500, Secure Hall 400, and hall 100. Review of 1:1 monitoring sheet for Resident #2 on 06/04/2025 from 2:00pm-10:00pm, was signed by one of the CNAs (CNA-K) assigned to Hall 500 (female secured locked unit) with no evidence of an additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. Review of the facility daily staff schedule, dated 06/04/2025, revealed during the 10:00pm to 6:00am shift, there was (1) CNA (CNA-H) assigned for Secure Hall 400 and Secure Hall 500 for 36 residents with (2) of the 36 requiring 1:1 monitoring. Review of 1:1 monitoring sheet for Resident #2 on 06/04/2025 from 10:00pm-6:00am, revealed it was signed by LVN-I who was assigned as the nurse for Secure Hall 500, Secure Hall 400, and hall 100. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility daily staff schedule dated 06/08/2025 from 2:00pm-10:00pm, revealed (2) CNA (CNA-N and CNA-L) assigned to Hall 500 (female secured locked unit) with a census of 16 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #1 per the facility in-service and DON's interview. Review of 1:1 monitoring sheet for Resident #2 on 06/08/2025 from 2:00pm-10:00pm, was signed by one of CNAs (CNA-L) assigned to Hall 500 (female secured locked unit) with no evidence of an additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. Review of the facility daily staff schedule, dated 06/08/2025, revealed during the 10:00pm to 6:00am shift, there was (2) CNA (CNA-O and CNA-P) assigned for Secure Hall 400 and Secure Hall 500 for 36 residents with (2) of the 36 requiring 1:1 monitoring. Review of 1:1 monitoring sheet for Resident #1 on Secure Hall 400 and Resident #2 on Secure Hall 500 on 06/04/2025 from 10:00pm-6:00am, revealed it was signed by LVN-I who was assigned as the nurse for Secure Hall 500, Secure Hall 400, and hall 100. During an interview on 06/20/2025 at 10:15pm, with CNA-O who worked 10pm-6am stated that he worked many shifts alone and he was responsible for covering Secure Hall 400 and Secure Hall 500 at the same time. He stated he also worked alone when residents were on 1:1 monitoring. He stated 1:1 monitoring should be where the staff was within arm's length of the resident, but that was not possible when he was the only CNA and was responsible for both halls. During an interview on 06/20/2025 at 12:30pm, the ADON stated the secured units were supposed to be staffed with 2 CNAs each during the day and 1 CNA each on 10pm-6 am shift. She stated when a resident was placed 1:1 monitoring, and additional staff member was supposed to be designated for that resident. She stated they pull staff from other departments such as dietary and housekeeping to perform 1:1 monitoring. She stated 1:1 meant that 1 staff was with that resident at all times. The ADON stated that on the night shift, if there was only 1 CNA assigned to both secure units, the LVN would stay on the opposite unit and monitor it. She stated resident were usually asleep on that shift, so she felt that 1 person on each unit was enough even when a resident was on 1:1 monitoring. During an interview on 06/20/2025 at 3:30pm, the DON stated that she was not aware of any times that there was not a designated staff for residents on 1:1 monitoring. She stated did not know how Resident # 1 and Resident #2 were able to get into 2nd altercations while on 1:1 monitoring. She stated she felt the facility was doing a good job preventing altercations and injuries. She stated that she did not feel that the facility was short staffed. Review of the facility document dated 05/25/2025 titled In-service training report, reflected: Subject: 1:1 Monitoring. When a resident is on 1:1 monitoring, the person designated to monitor has to be with that resident at all times. Not just with in eyesight. Not in the same room as them. Not having him in an area where all employees can keep an eye out. There needs to be one designated person who will be filling out the monitoring sheet that is within arm's length. This is so we can quickly intervene, if needed. (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	06/24/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of facility policy titled, Abuse/Neglect; not dated, revealed, in part: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the residents medical symptoms . This was determined to be an Immediate Jeopardy (IJ) on 06/22/2025 at 4:05pm. The Regional Compliance Nurse, Director of Nurses, and Assistant Director of Nurses were notified. The Regional Compliance Nurse was provided with the IJ template on 06/22/2022 at 4:05 PM. The following Plan of Removal was accepted on 06/23/2025 at 6:20 PM and included: Interventions: Any resident that resides in the secure unit that has the potential for resident-to-resident altercation can be affected by deficient practices. Alleged perpetrator Resident #2 was interviewed by DON on 06/22/26 @ 6:15pm with no concerns voiced by resident and placed on 15-minute checks for resident safety and the safety of other resident in the secure unit and continued for at least 24 hours. Resident #1 was interviewed on 06/23/25 by DON and voiced no concerns and did not recall being aggressive with any other resident. Resident #7 was interviewed on 06/23/25 by DON and resident did not voice any concerns and could not recall being aggressive with any other resident. Resident #8 is not at the facility for an interview on 06/23/25 and Resident #9 is not at the facility for an interview on 06/23/25. Abuse prevention in-service for all facility staff initiated in house and completed by Admin/DON/Compliance Nurse on 06/22/2025 and for staff that is not present during the in-services will be sent the in-service via staffing application and they be not be allowed to assume duties until in-service prior to them clocking in for their shift and all new staff or agency staff will be in-services on abuse prior to them starting their position. All in services to be completed by 6/23/2025. Immediate psychiatric services on call for residents that trigger through trauma informed assessments on the secure unit completed on 06/22/2025. Referrals sent out by DON and will be followed up by DON for Resident #2 have been sent out to other skilled nursing facility and Behavioral Hospitals. and Resident #8 referral was sent to a facility and accepted and admitted [DATE], Resident #9 referred to a facility and accepted and admitted on [DATE]. Resident #1 referral sent to psych hospital and accepted and admitted 05/2725 and return 06/03/25. All direct care staff that were work at the time of the incident in the secured unit working with Resident #2 have been interviewed by DON on 06/22/25 and no root cause could be determined for her behaviors. Staff was able to state regarding Resident #1 resident is very territorial and does not like resident entering his room and resident was transition to long term community in a private room and have decrease behaviors and for Resident #9 no root cause was determined for his behavior. For Resident #7 no root cause was determined for his behavior. Resident #8 no root cause was determined for his behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Facility will ensure adequate staffing to manage acuity based on the 24-hour report in Point Click Care, Real Time systems monitoring and current census. The administrator will maintain adequate staff for resident safety per acuity. Staffing will be reviewed during stand-up Meetings at 8:30 AM and stand-down meetings at 4PM to ensure there is adequate staffing for the secure units. During both meetings the team will review, and the Administrator/designee will adjust staffing to maintain resident safety based on acuity based on the 24-hour report in PCC, Real Time Systems monitoring and current census. If one on one is required additional staff member will be added and not substituted with the current staff in the units to ensure adequate staffing to protect residents from further incidents. The facility administrator/designee will decide and assure staff are assigned to the 1:1 resident. The Administrator/DON will check in with assigned staff frequently to assure that 1:1 monitoring is ongoing. Resident interviews on the secure units have been completed by DON, compliance, ADON, on 06/22/25. No concerns from residents were voiced. On 6/23/2025 Skin assessments were completed, and no visible signs of physical abuse were noted. We will continue [TRUNCATED]

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to review and revise resident's comprehensive care plans by the interdisciplinary team after each assessment for 3 (Resident #1, Resident #2, and Resident #3) of 18 residents reviewed for comprehensive care plans. The facility failed to update or add interventions to Resident #1's care plan regarding aggressive and physical behaviors towards other residents since 12/13/2024. The facility failed to update or add interventions to Resident #2's care plan regarding physical behaviors towards other residents since 11/18/2024. The facility failed to update or add interventions to Resident #3's care plan regarding wandering since 02/21/2024. These failures could result in residents not receiving the care that they need. Findings included: Resident #1 Review of Resident #1's electronic face sheet revealed a [AGE] year-old male admitted on [DATE] with initial admit date of 12/15/2023, to Hall 400 (male secured locked unit) with diagnoses which included: explosive disorder, heart failure, and alcohol dependence. Review of Resident #1's Quarterly MDS assessment, dated 05/22/2025, revealed a BIMS score of 02 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: behavior not exhibited. Section N: Medications: no antipsychotic, antianxiety, or antidepressant medications. Review of Resident's #1's Care Plan, last review 06/10/2025, revealed in part: Focus: Resident demonstrates physical behaviors hits other residents and staff, revised on 04/14/2025. Goal: Resident will not harm self or others through the review date, revised on 06/10/2025. Interventions: 1:1 supervision as needed, revised on 12/13/2024. Further review of care plan revealed no interventions added since 12/13/2024. Review of Resident #1's progress notes revealed: 05/25/2025 10:35 pm, signed by DON: .Resident saw another resident enter his room, he walked to his room and yelled at the other resident. When other resident did not move out fast enough, he punched other resident in the face. Another resident was walking backward, and this resident shoved him causing a fall. No injuries to Resident #1. Stated not in pain. Other resident was sent to the emergency room after hitting head on floor. Initial Treatment/New Orders: skin assessed. 1:1 monitoring, referral to impatient psyc notified: psych center 05/25/2024 at 4:45pm .Interventions 1 on 1 supervision, Redirection. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/25/2025 10:45 pm, signed by DON: .CMA-A walking into the dining room, heard two residents having a verbal altercation then saw Resident #1 hit another resident in the face. When the other resident was swinging back, he slid out of his chair onto the floor .Initial Treatment/New orders: skin assessed, 1:1 monitoring, send referral to inpatient psych . notified psych center 05/25/2025 at 6:50pm .Interventions 1 on 1 supervision, Redirection. 05/27/2025 at 1:00 pm, signed by ADON: Resident #1 was transferred to a hospital on [DATE] at 1:00 PM related to resident had aggressive behaviors and was sent to psych facility for evaluation and treatment. Resident #2 Review of Resident #2's electronic face sheet revealed a [AGE] year-old female admitted on [DATE] with initial admit date of 02/09/2024, to Hall 500 (female secured locked unit) with diagnoses which included: traumatic brain injury, anxiety, depression, and dementia. Review of Resident #2's Quarterly MDS assessment, dated 05/20/2025, revealed a BIMS score of 02 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: - Presence and Frequency: 1 other behavioral symptom not directed towards others. Section N: Medications: antianxiety and antidepressant medications. Review of Resident's #2's Care Plan, last review 05/22/2025, revealed in part: Focus: Resident has potential to demonstrate physical behaviors attempts to hit other residents, revised on 04/09/2025. Goal: Resident will not harm self or others through the review date, revised on 05/22/2025. Interventions: When she becomes agitated: 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 11/18/2024. Record review of Resident #2's progress notes revealed: 06/04/2025 11:13 am, signed by LVN-E: .resident started being anxious and agitated. resident grabbed another resident arm causing a skin tear . resident is currently on 1:1 for monitoring .: 06/08/2025 12:19 pm, signed by LVN-F: . nurse was called by resident in hallway, that resident has just slapped another resident across the face. psych facility contacted, and 1:1 supervision. 06/08/2025 1:09 pm, signed by LVN-F . resident was grabbing another female resident by her cheeks and would not let her go, staff intervened but resident would not let other resident go. Resident #3 Review of Resident #3's electronic face sheet revealed an [AGE] year-old male admitted on [DATE] with initial admit date of 02/20/2024, to Hall 400 (male secured locked unit) with diagnoses which included: explosive disorder, depression, and dementia. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's Quarterly MDS assessment, dated 05/22/2025, revealed a BIMS score of 03 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: behavior not exhibited. E0900. Wandering: behavior not exhibited. Section N: Medications: antidepressant medications. Review of Resident's #3's Care Plan, last review 05/29/2025, revealed in part: Focus: Resident is at risk for wandering, revised on 02/21/2024. Goal: Resident's safety will be maintained through the review date, revised on 05/29/2025. Interventions: Distract him from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, revised on 02/21/2024. Identify pattern of wandering, revised on 02/21/2024. Further review of care plan revealed no interventions regarding wandering added since 02/21/2024. Review of Resident #3's progress notes revealed: 05/25/2025 4:53 pm, signed by RN-B: Resident #3 was transferred to a hospital on [DATE] PM related to resident altercation on another resident. Resident was knocked to the ground and hit his head on the found resident sent out for further Evaluation. 05/25/2025 10:58 pm, signed by DON: .Resident wandered into another resident's room. Other resident came in starting verbal altercation. When this resident did not move fast enough the other resident punched him in the face. The resident was backing up trying to exit room and fell landing on left lateral. 911 was called immediately. Skin assessed and previous left elbow skin tear was bleeding and noted to be bigger in size. No pain .Physician notified on 05/25/2025 6:45 PM . During an interview on 06/20/2025 at 3:30 pm, the DON stated her, the ADON, and the MDS nurse were responsible for updating the care plans. She stated new interventions should be added to the care plan regarding recurrent resident-to-resident altercations and wandering episodes. She stated she did not know why the interventions have not been updated and no new ones have been added. Review of facility policy titled Comprehensive Care Plans, not dated, revealed in part: .The residents care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences, and needs of the resident and in response to current interventions .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 6 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6) of 18 residents reviewed for resident-to-resident altercations. 1. The facility failed to prevent supervision of Resident #1 from abusing Resident #3 on Hall 400 (male secured locked unit) that led to an emergency room visit resulting in head laceration requiring 3 staples for Resident #3 on 05/25/2025. 2. The facility failed to ensure Hall 400 (male secured locked unit) had sufficient supervising staff to prevent Resident #1 from abusing Resident #4 that led to hospitalization of Resident #1 and a fall resulting in a skin tear to Resident #4's left elbow, while Resident #1 was supposed to be on 1:1 monitoring on 05/25/2025. 3. The facility failed ensure Hall 500 (female secured unit) had sufficient supervising staff to prevent Resident #2 from abusing Resident #5 resulting in a skin tear to her arm for Resident #5 on 06/04/2025. 4. The facility failed ensure Hall 500 (female secured unit) had sufficient supervising staff to prevent Resident #2 from abusing Resident #5 by slapping her across the face on 06/08/2025. 5. The facility failed ensure Hall 500 (female secured unit) had sufficient supervising staff to prevent Resident #2 from abusing Resident #6 resulting in a skin tear to the cheek for Resident #6, while Resident #2 was supposed to be on 1:1 monitoring on 06/08/2025. An Immediate Jeopardy (IJ) situation was identified on 06/22/2025 at 4:05 pm. While the IJ was removed on 06/24/2025 at 10:30 am, the facility remained out of compliance at a scope of pattern with no actual harm with a potential for more than minimal harm at a scope of pattern, due to the facility's need to evaluate the effectiveness of their corrective systems. These failures could place residents at risk for resident-to-resident altercations and serious harm in the event of an emergency, hospitalizations, and even death. Findings included: (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility document dated 05/25/2025 titled In-service training report, reflected: Subject: 1:1 Monitoring. When a resident is on 1:1 monitoring, the person designated to monitor has to be with that resident at all times. Not just with in eyesight. Not in the same room as them. Not having him in an area where all employees can keep an eye out. There needs to be one designated person who will be filling out the monitoring sheet that is within arm's length. This is so we can quickly intervene, if needed. During an interview on 06/19/2025 at 1:35 pm, the DON stated that both secure units were always staffed with 2 CNA's each on all shifts except night shift which had 1 CNA per unit. She stated that if a resident was placed on 1:1 monitoring, an additional staff was added making 3 CNAs or 2 CNAs on 10:00pm-6:00am shift. Resident #1 Review of Resident #1's electronic face sheet revealed a [AGE] year-old male admitted on [DATE] with initial admit date of 12/15/2023, to Hall 400 (male secured locked unit) with diagnoses which included: explosive disorder, heart failure, and alcohol dependence. Review of Resident #1's Quarterly MDS assessment, dated 05/22/2025, revealed a BIMS score of 02 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: behavior not exhibited. Section N: Medications: no antipsychotic, antianxiety, or antidepressant medications. Review of Resident's #1's Care Plan, last review 06/10/2025, revealed in part: Focus: Resident demonstrates physical behaviors hits other residents and staff, revised on 04/14/2025. Goal: Resident will not harm self or others through the review date, revised on 06/10/2025. Interventions: 1:1 supervision as needed, revised on 12/13/2024. Further review of care plan revealed no interventions added since 12/13/2024. Review of Resident #1's progress notes revealed: 05/25/2025 10:35 pm, signed by DON: .Resident saw another resident enter his room, he walked to his room and yelled at the other resident. When other resident did not move out fast enough, he punched other resident in the face. Another resident was walking backward, and this resident shoved him causing a fall. No injuries to Resident #1. Stated not in pain. Other resident was sent to the emergency room after hitting head on floor. Initial Treatment/New Orders: skin assessed. 1:1 monitoring, referral to impatient psyc notified: psych center 05/25/2024 at 4:45pm .Interventions 1 on 1 supervision, Redirection. 05/25/2025 10:45 pm, signed by DON: .CMA-A walking into the dinning room, heard two residents having a verbal altercation then saw Resident #1 hit another resident in the face. When the other resident was swinging back, he slid out of his chair onto the floor .Initial Treatment/New orders: skin assessed, 1:1 monitoring, send referral to inpatient psych . notified psych center 05/25/2025 at 6:50pm .Interventions 1 on 1 supervision, Redirection. 05/27/2025 at 1:00 pm, signed by ADON: Resident #1 was transferred to a hospital on [DATE] at 1:00 PM related to resident had aggressive behaviors and was sent to psych facility for evaluation and treatment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #3 Review of Resident #3's electronic face sheet revealed an [AGE] year-old male admitted on [DATE] with initial admit date of 02/20/2024, to Hall 400 (male secured locked unit) with diagnoses which included: explosive disorder, depression, and dementia. Review of Resident #3's Quarterly MDS assessment, dated 05/22/2025, revealed a BIMS score of 03 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: behavior not exhibited. E0900. Wandering: behavior not exhibited. Section N: Medications: antidepressant medications. Review of Resident's #3's Care Plan, last review 05/29/2025, revealed in part: Focus: Resident is at risk for wandering, revised on 02/21/2024. Goal: Resident's safety will be maintained through the review date, revised on 05/29/2025. Interventions: Distract him from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, revised on 02/21/2024. Identify pattern of wandering, revised on 02/21/2024. Further review of care plan revealed no interventions regarding wandering added since 02/21/2024. Review of Resident #3's progress notes revealed: 05/25/2025 4:53 pm, signed by RN-B: Resident #3 was transferred to a hospital on [DATE] PM related to resident altercation on another resident. Resident was knocked to the ground and hit his head on the found resident sent out for further Evaluation. 05/25/2025 10:58 pm, signed by DON: .Resident wandered into another resident's room. Other resident came in starting verbal altercation. When this resident did not move fast enough the other resident punched him in the face. The resident was backing up trying to exit room and fell landing on left lateral. 911 was called immediately. Skin assessed and previous left elbow skin tear was bleeding and noted to be bigger in size. No pain .Physician notified on 05/25/2025 6:45 PM . Review of Provider Investigation Report, dated 05/31/2025, revealed: on 05/25/2025 at 4:20 pm, Resident #3 went into Resident #1's room. Staff heard yelling and saw Resident #1 hit and push Resident #3. Resident #3 fell to the floor and hit his head on the floor and sent to emergency room to be further evaluated. Resident #3 had laceration to back of heat with hematoma, no bleeding, no signs of infection, closed with 3 staples, measurements 1.5x2x0.5cm, hematoma measures 4x5x0.5cm, hematoma to left side of head measurements 3x3cm, bruises to bilateral upper extremities, reopened skin teas to left elbow with part of skin fold missing, no bleeding, no signs of infection, measurements 2x2.5x0.1cm, no other skin issues noted at this time. Facility initiated one on one monitoring with Resident #1. Contacted psych services. Investigation Findings: Confirmed. Review of the facility daily staff schedule, dated 05/25/2025 at the time of the incident, revealed 2 CNAs (CNA-C and CNA-D) assigned to Hall 400 (male secured locked unit) with a census of 19 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #1 per the facility in-service and DON's interview. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of 1:1 monitoring sheet for Resident #1 revealed 1:1 monitoring started on 05/25/2025 at 4:45 pm and was signed by the 2 CNA's (CNA-C and CNA-D) assigned to Hall 400 (male secured locked unit) with no evidence of an additional designated CNA for 1:1 monitoring for Resident #1 per the facility in-service and DON's interview. Resident #4 Review of Resident #4's electronic face sheet revealed a [AGE] year-old male admitted on [DATE] with initial admit date of 03/25/2024, to Hall 400 (male secured locked unit) with diagnoses which included: personality change, depression, and dementia. Review of Resident #4's Quarterly MDS assessment, dated 05/30/2025, revealed a BIMS score of 03 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: - Presence and Frequency: 1 physical behavioral symptom directed towards others. Section N: Medications: antidepressant medications. Review of Resident's #4's Care Plan, last review 06/19/2025, revealed in part: Focus: Resident has a potential for trauma that may have a negative impact. The trauma is related to physical altercation, revised on 05/26/2025. Goal: Staff will assist in avoiding triggers through next review date. Interventions: Monitor for escalating anxiety, depression or suicidal thought and report immediate to the nurse. Record review of Resident #4's progress notes revealed: 05/25/2025 11:09 pm, signed by DON: .The fall caused a skin tear to left elbow. Size of the skin tear in cm: 0. 5 x 0.5. New/bleeding, a verbal altercation between this resident and another resident was overheard. CMA-A walked into dining room and saw another resident hit this resident in the face, when Resident #4 tried to swing back he slid out of his chair. Upon assessment a skin tear to the left elbow was noted. Stated it did not hurt . Review of Provider Investigation Report, dated 05/31/2025, revealed: on 05/25/2025 at 6:30 pm, Resident ##1 slapped Resident #4 and when Resident #4 tried to swing back he slid out of his chair. Upon his assessment a skin tear to the left elbow was noted, measurements 0.8x0.7x0.1cm. Facility initiated one on one monitoring with Resident #1. Investigation Findings: Confirmed. Review of the facility daily staff schedule, dated 05/25/2025 at the time of the incident, revealed (2) CNAs (CNA-C and CNA-D) assigned to Hall 400 (male secured locked unit) with a census of 19 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #1 per the facility in-service and DON's interview. Review of 1:1 monitoring sheet for Resident #1 revealed 1:1 monitoring started on 05/25/2025 at 4:45 pm and was signed by the (2) CNA's (CNA-C and CNA-D) assigned to Hall 400 (male secured locked unit) with no evidence of an additional designated CNA for 1:1 monitoring for Resident #1 per the facility in-service and DON's interview. (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	06/24/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/20/2025 at 12:45 pm, CNA- C stated she was on shift on Secure Hall 400 at the time of these incidents with Resident #1. She stated on 05/25/2025, there was only herself and 1 other staff to supervise the 19 residents plus provide 1:1 monitoring with Resident #1 that required the resident to always be within arm's reach. She stated the locked unit was also having issues with the locked doors on the unit not functioning; therefore, they also had to monitor the doors, the residents, and provide 1:1 of Resident #1 within arm's reach. She stated that Resident #1 was placed on 1:1 monitoring but no extra staff was sent. She stated that at the time of the second incident Resident #1 was in the dining room and no staff was present. She stated she worked the secure unit alone often and had never been given extra staff when residents were placed 1:1 monitoring requiring residents to be within arm's reach. During an interview on 06/20/2025 at 8:00 pm, LVN-G stated she was responsible for Secure Hall 400 and Secure Hall 500 on 05/25/2025 from 2pm-10pm. She stated she was on Secure Hall 500 at the time of the first incident. She stated she was back on Secure Hall 500 when the 2nd incident happened. She stated Resident #1 was supposed to be on 1:1 monitoring because of the previous incident, when the 2nd incident happened, and she did not know why he was not. She stated there were only 2 CNAs covering Secure Hall 400 at the time and that there was no way that the LVN could help with 1:1 monitoring because she was responsible for both secure halls. During an interview on 06/20/2025 at 8:15 pm, CMA-A stated he was working on 05/25/2025 at time of both incidents and stated that he was in a resident's room during the 1st incident with Resident #3 and did not see that incident, but he knew that he was placed on 1:1 monitoring. He stated that he was walking down the hall, when the 2nd incident happened and heard Resident #1 yelling then he spotted Resident #1 in the dining room with no staff present and saw him slap Resident #4. Resident #2 Review of Resident #2's electronic face sheet revealed a [AGE] year-old female admitted on [DATE] with initial admit date of 02/09/2024, to Hall 500 (female secured locked unit) with diagnoses which included: traumatic brain injury, anxiety, depression, and dementia. Review of Resident #2's Quarterly MDS assessment, dated 05/20/2025, revealed a BIMS score of 02 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: - Presence and Frequency: 1 other behavioral symptom not directed towards others. Section N: Medications: antianxiety and antidepressant medications. Review of Resident's #2's Care Plan, last review 05/22/2025, revealed in part: Focus: Resident has potential to demonstrate physical behaviors attempts to hit other residents, revised on 04/09/2025. Goal: Resident will not harm self or others through the review date, revised on 05/22/2025. Interventions: When she becomes agitated: 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 11/18/2024. Record review of Resident #2's progress notes revealed: 06/04/2025 11:13 am, signed by LVN-E: .resident started being anxious and agitated. resident grabbed another resident arm causing a skin tear . resident is currently on 1:1 for monitoring .: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	06/08/2025 12:19 pm, signed by LVN-F: . nurse was called by resident in hallway, that resident has just slapped another resident across the face. psych facility contacted, and 1:1 supervision. 06/08/2025 1:09 pm, signed by LVN-F . resident was grabbing another female resident by her cheeks and would not let her go, staff intervened but resident would not let other resident go. Resident #5 Review of Resident #5's electronic face sheet revealed a [AGE] year-old female admitted on [DATE] with initial admit date of 06/10/2020, to Hall 500 (female secured locked unit) with diagnoses which included: anxiety, Alzheimer's, and mood disorder. Review of Resident #5's Annual MDS assessment, dated 06/04/2025, revealed a BIMS score of 99 which indicated resident was unable to complete the interview. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: behavior not exhibited. Section N: Medications: antianxiety and antidepressant medications. Review of Resident's #5's Care Plan, last review 04/10/2025, revealed in part: Focus: Resident has a history of trauma that may have a negative impact. The trauma is related to getting scratched, revised on 06/05/2025. Goal: Maintain resident safety and integrity during post trauma episode, using appropriate interventions, revised on 06/05/2025. Interventions: Monitor for escalating anxiety, depression or suicidal thought and report immediately to the nurse, revised on 06/05/2025. Review of the facility daily staff schedule, dated 06/04/2025 at the time of the incident, revealed (1) CNA (CNA-J) assigned to Hall 500 (female secured locked unit) with a census of 16 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. Record review of Resident #5's progress notes revealed: 06/05/2025 10:38 am, signed by LVN-E: . resident received a skin tear due to another resident grabbing her arm. Physician notified on 06/04/2025 at 10:10am. 06/08/2025 12:29pm, signed by LVN-F: . Resident voices she was slapped across the face by the other female resident. Review of Provider Investigation Report, dated 06/11/2025, revealed: On 06/04/2025 at 10:00am, Residents were sitting at the table in dinning room when Resident #2 reached over and grabbed Resident #5's arm causing a skin tear. Resident #2 was placed on 1:1 monitoring. Investigation Findings: Confirmed. Review of the facility daily staff schedule, dated 06/04/2025 at the time of the incident, revealed (1) CNA (CNA-J) assigned to Hall 500 (female secured locked unit) with a census of 16 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of 1:1 monitoring sheet for Resident #2 on 06/04/2025 from 10:15am-2:00pm, was signed by the (1) CNA (CNA-J) assigned to Hall 500 (female secured locked unit) with no evidence of an additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. During an interview on 06/19/2025 at 2:00pm, CNA-J she was on shift on Secure Hall 500 at the time of this incident with Resident #2 on 06/04/2025. She stated there was supposed to always be 2 CNAs, but she worked many times by herself. She stated that when a resident is placed on 1:1 monitoring the 2 CNAs on shift rotated and monitored them as close as possible. She stated it was very rare that a third CNA was sent. She stated she had worked on the floor multiple times alone with a resident on 1:1 monitoring. She stated when a resident was 1:1 the staff was supposed to be within arm's length of them at all times and must follow them wherever they go. She stated she could not remember specific dates or incidents because there were so many incidents and 1:1 monitoring that she couldn't remember them all. Resident #6 Review of Resident #6's electronic face sheet revealed a [AGE] year-old female admitted on [DATE] to Hall 500 (female secured locked unit) with diagnoses which included: explosive disorder, Alzheimer's, and seizures. Review of Resident #6's Quarterly MDS assessment, dated 05/26/2025, revealed a BIMS score of 03 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms- Presence and Frequency: 1 physical behavioral symptom director towards others. Section N: Medications: no antianxiety, antipsychotic, or antidepressant medications. Review of Resident's #6's Care Plan, last review 05/22/2025, revealed in part: Focus: Resident has potential to demonstrate physical behaviors, revised on 02/16/2024. Goal: Resident will demonstrate effective coping skills through the review date, revised on 05/22/2025. Interventions: Assess and anticipate her needs: food, thirst, toileting needs, comfort level, body positioning, pain, revised on 08/29/2023. Record review of Resident #6's progress notes revealed: 06/08/2025 1:28pm, signed by LVN-F: . Resident was in her wheelchair looking outside, when the other female resident came up to her and grabbed her face and started being combative, nurse/aide intervened but other resident would not let her go. Review of Provider Investigation Report, dated 06/13/2025, revealed: On 06/08/2025 at 12:00pm, Resident #2 hit Resident #5 with no injuries. She then grabbed Resident #6 by the face causing a very small scratch to her cheek. Resident #2 was placed on 1:1 monitoring. Investigation Findings: Confirmed. Review of the facility daily staff schedule, dated 06/08/2025 at the time of the incident, revealed (1) CNA (CNA-M) and a float CNA (CNA-J) assigned to Hall 500 (female secured locked unit) with a census of 16 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of 1:1 monitoring sheet for Resident #2 on 06/08/2025 revealed 1:1 monitoring was not initiated until 1:00 pm after the 2nd incident. 1:1 monitoring sheet was signed by RN-B who was assigned as a nurse for Hall 100 and Hall 200. During an interview on 06/21/2025 at 9:00 am, LVN-F stated she was responsible for Secure Hall 500 and Secure Hall 400 on 06/08/2025 from 2pm-10pm. She stated that Resident #2 was supposed to have been placed on 1:1 monitoring after the 1st incident but there was no staff available. She stated Resident #1 and Resident #6 were in the dining room alone when she heard Resident #6 screaming. She stated the LVNs cannot provide 1:1 monitoring because they are responsible for multiple halls. During an interview on 06/20/2025 at 12:30pm, the ADON stated the secured units were supposed to be staffed with 2 CNAs each during the day and 1 CNA each on 10pm-6 am shift. She stated when a resident was placed 1:1 monitoring, and additional staff member was supposed to be designated for that resident. She stated they pull staff from other departments such as dietary and housekeeping to perform 1:1 monitoring. She stated 1:1 means that 1 staff is with that resident at all times. The ADON stated that on the night shift, if there was only 1 CNA assigned to both secure units, the LVN would stay on the opposite unit and monitor it. She stated resident were usually asleep on that shift, so she felt that 1 person on each unit was enough even when a resident was on 1:1 monitoring. During an interview on 06/20/2025 at 3:30pm, the DON stated that she was not aware of any times that there was not a designated staff for residents on 1:1 monitoring. She stated did not know how Resident # 1 and Resident #2 were able to get into 2nd altercations while on 1:1 monitoring. She stated she felt the facility was doing a good job preventing altercations and injuries. She stated that she did not feel that the facility was short staffed. During an interview on 06/23/2025 at 8:00pm, the ADO stated the facility did not have a policy regarding accidents and hazards. This was determined to be an Immediate Jeopardy (IJ) on 06/22/2025 at 4:05pm. The Regional Compliance Nurse, Director of Nurses, and Assistant Director of Nurses were notified. The Regional Compliance Nurse was provided with the IJ template on 06/22/2022 at 4:05 PM. The following Plan of Removal was accepted on 06/23/2025 at 6:20 PM and included: Interventions: Any resident that resides in the secure unit that has the potential for resident-to-resident altercation can be affected by deficient practices. Alleged perpetrator Resident #2 was interviewed by DON on 06/22/26 @ 6:15pm with no concerns voiced by resident and placed on 15-minute checks for resident safety and the safety of other resident in the secure unit and continued for at least 24 hours. Resident #1 was interviewed on 06/23/25 by DON and voiced no concerns and did not recall being aggressive with any other resident. Resident #7 was interviewed on 06/23/25 by DON and resident did not voice any concerns and could not recall being aggressive with any other resident. Resident #8 is not at the facility for an interview on 06/23/25 and Resident #9 is not at the facility for an interview on 06/23/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Abuse prevention in-service for all facility staff initiated in house and completed by Admin/DON/Compliance Nurse on 06/22/2025 and for staff that is not present during the in-services will be sent the in-service via staffing application and they be not be allowed to assume duties until in-service prior to them clocking in for their shift and all new staff or agency staff will be in-services on abuse prior to them starting their position. All in services to be completed by 6/23/2025. Immediate psychiatric services on call for residents that trigger through trauma informed assessments on the secure unit completed on 06/22/2025. Referrals sent out by DON and will be followed up by DON for Resident #2 have been sent out to other skilled nursing facility and Behavioral Hospitals. and Resident #8 referral was sent to a facility and accepted and admitted [DATE], Resident #9 referred to a facility and accepted and admitted on [DATE]. Resident #1 referral sent to psych hospital and accepted and admitted 05/2725 and return 06/03/25. All direct care staff that were work at the time of the incident in the secured unit working with Resident #2 have been interviewed by DON on 06/22/25 and no root cause could be determined for her behaviors. Staff was able to state regarding Resident #1 resident is very territorial and does not like resident entering his room and resident was transition to long term community in a private room and have decrease behaviors and for Resident #9 no root cause was determined for his behavior. For Resident #7 no root cause was determined for his behavior. Resident #8 no root cause was determined for his behaviors. Facility will ensure adequate staffing to manage acuity based on the 24-hour report in Point Click Care, Real Time systems monitoring and current census. The administrator will maintain adequate staff for resident safety per acuity. Staffing will be reviewed during stand-up Meetings at 8:30 AM and stand-down meetings at 4PM to ensure there is adequate staffing for the secure units. During both meetings the team will review, and the Administrator/designee will adjust staffing to maintain resident safety based on acuity based on the 24-hour report in PCC, Real Time Systems monitoring and current census. If one on one is required additional staff member will be added and not substituted with the current staff in the units to ensure adequate staffing to protect residents from further incidents. The facility administrator/designee will decide and assure staff are assigned to the 1:1 resident. The Administrator/DON will check in with assigned staff frequently to assure that 1:1 monitoring is ongoing. Resident interviews on the secure units have been completed by DON, compliance, ADON, on 06/22/25. No concerns from residents were voiced. On 6/23/2025 Skin assessments were completed, and no visible signs of physical abuse were noted. We will continue to monitor with random interviews and weekly skin assessments, and address if issues are identified. Primary contact for each resident on the secure unit to be contacted on 6/23/2025 by the DON/Compliance Nurse to inquire about any concerns related to resident safety/abuse. These will be reviewed by the DON/Facility Administrator, Regional Compliance Nurse, and ADO for follow up and to address concerns identified. All resident responsible party contacts will be initiated/completed by 6/23/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Trauma informed assessment (to determine historical or present trauma based on resident perspective) completed by Compliance, DON and ADON on residents in the secured unit with history of physical aggression and assessment were completed on 06/22/2025. No trauma was identified during these assessments. On 6/23/2025, skin assessments were completed by DON and Compliance Nurse to assess for signs of physical trauma. Off cycle QAPI done with Dr. medical director via telephone on 06/22/25 by facility DON. No recommendation made by the medical director at this time. The following in-services were initiated by Facility DON on 06/22/25. Any staff member who is not present during the in-service will not be allowed to assume their duties until in-service. All in-services sent via staffing application to all staff on 06/22/25. o All Staff Abuse/Neglect Abuse/Neglect Reporting Who to Report Abuse/Neglect to Management of aggressive behavior One-to-one monitoring Prevention of Resident-to-Resident physical Abuse On 6/23/2025, 1:1 in-service for Administrator by ADO regarding staffing adjustment as needed based on acuity to maintain resident safety. After receiving education, a handout is given to the staff members to have on their person in case a question arises and random interviews with staff members are ongoing to assess understanding. These will be completed by DON/Compliance team/ADO. Monitoring of facilities Plan of Removal through observations, interviews, and record reviews from 06/23/2022 at 7:00 PM through 06/24/2022 at 10:30 AM revealed: Review of facility documents revealed written interviews by the DON with Resident #2, Resident #1, and Resident #7, with no concerns voiced. Review of facility fax receipts revealed referrals were faxed on 06/21/2025 to 6 different facilities for Resident #2. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of facility documents revealed 9 staff were interviewed by DON for Resident #2, 5 staff were interviewed for Resident #7, 4 staff were interviewed for Resident #1, and 2 staff were interviewed for Resident #9. The questions asked where: Are you aware of any triggers for resident? What time of day are her behaviors worst? Is there anything they like? Are there any recommendations to improve care? And are there any co[TRUNCATED]

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident and determined by considering the number, acuity, and diagnoses of the facility's resident population with accordance with 5 (Resident #1, Resident #2, Resident #4, Resident #5, and Resident #6) of 18 residents reviewed for sufficient staffing related resident-to-resident altercations and 1:1 monitoring. 1. The facility failed to ensure Hall 400 (male secured locked unit) had sufficient staffing to prevent Resident #1 from abusing Resident #4 that led to hospitalization of Resident #1 and a fall resulting in a skin tear to Resident #4's left elbow, while Resident #1 was supposed to be on 1:1 monitoring from a previous altercation on 05/25/2025. 2. The facility failed ensure Hall 500 (female secured unit) had sufficient staffing to prevent Resident #2 from abusing Resident #5 resulting in a skin tear to her arm for Resident #5 on 06/04/2025. 3. The facility failed ensure Hall 500 (female secured unit) had sufficient staffing to prevent Resident #2 from abusing Resident #5 by slapping her across the face on 06/08/2025. 4. The facility failed ensure Hall 500 (female secured unit) had sufficient staffing to prevent Resident #2 from abusing Resident #6 resulting in a skin tear to the cheek for Resident #6, while Resident #2 was supposed to be on 1:1 monitoring on 06/08/2025. 5. The facility failed to ensure Hall 400 (male secured unit) had sufficient staff to provide 1:1 monitoring for Resident #1 on 05/25/2025 from 10:00pm-6:00am. 6. The facility failed to ensure Hall 500 (female secure unit) had sufficient staffing to provide 1:1 monitoring for Resident #2 on 06/04/2024 from 2:00pm-10:00pm, and from 10:00pm-6:00am. 7. The facility failed to ensure Hall 500 (male secure unit) had sufficient staffing to provide 1:1 monitoring for Resident #2 on 06/08/2024 from 2:00pm-10:00pm, and from 10:00pm-6:00am. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Immediate Jeopardy (IJ) situation was identified on 06/22/2025 at 4:05 pm. While the IJ was removed on 06/24/2025 at 10:30 am, the facility remained out of compliance at a scope of pattern with no actual harm with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of their corrective systems. These failures could place residents at risk for resident-to-resident altercations and serious harm in the event of an emergency, hospitalizations, and even death. Findings included: Review of the facility document dated 05/25/2025 titled In-service training report, reflected: Subject: 1:1 Monitoring. When a resident is on 1:1 monitoring, the person designated to monitor has to be with that resident at all times. Not just with in eyesight. Not in the same room as them. Not having him in an area where all employees can keep an eye out. There needs to be one designated person who will be filling out the monitoring sheet that is within arm's length. This is so we can quickly intervene, if needed. During an interview on 06/19/2025 at 1:35 pm, the DON stated that both secure units were always staffed with 2 CNA's each on all shifts except night shift which had 1 CNA per unit. She stated that if a resident was placed on 1:1 monitoring, an additional staff was added making 3 CNAs or 2 CNAs on 10:00pm-6:00am shift. Resident #1 Review of Resident #1's electronic face sheet revealed a [AGE] year-old male admitted on [DATE] with initial admit date of 12/15/2023, to Hall 400 (male secured locked unit) with diagnoses which included: explosive disorder, heart failure, and alcohol dependence. Review of Resident #1's Quarterly MDS assessment, dated 05/22/2025, revealed a BIMS score of 02 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: behavior not exhibited. Section N: Medications: no antipsychotic, antianxiety, or antidepressant medications. Review of Resident's #1's Care Plan, last review 06/10/2025, revealed in part: Focus: Resident demonstrates physical behaviors hits other residents and staff, revised on 04/14/2025. Goal: Resident will not harm self or others through the review date, revised on 06/10/2025. Interventions: 1:1 supervision as needed, revised on 12/13/2024. Further review of care plan revealed no interventions added since 06/20/2024. Review of Resident #1's progress notes revealed: 05/25/2025 10:45 pm, signed by DON: .CMA-A walking into the dining room, heard two residents having a verbal altercation then saw Resident #1 hit another resident in the face. When the other resident was swinging back, he slid out of his chair onto the floor .Initial Treatment/New orders: skin assessed, 1:1 monitoring, send referral to inpatient psych . notified psych center 05/25/2025 at 6:50pm .Interventions 1 on 1 supervision, Redirection. (continued on next page)

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	675928	A. Building B. Wing	06/24/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	05/27/2025 at 1:00 pm, signed by ADON: Resident #1 was transferred to a hospital on [DATE] at 1:00 PM related to resident had aggressive behaviors and was sent to psych facility for evaluation and treatment. Resident #3 Review of Resident #3's electronic face sheet revealed an [AGE] year-old male admitted on [DATE] with initial admit date of 02/20/2024, to Hall 400 (male secured locked unit) with diagnoses which included: explosive disorder, depression, and dementia. Review of Resident #3's Quarterly MDS assessment, dated 05/22/2025, revealed a BIMS score of 03 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: behavior not exhibited. E0900. Wandering: behavior not exhibited. Section N: Medications: antidepressant medications. Review of Resident's #3's Care Plan, last review 05/29/2025, revealed in part: Focus: Resident is at risk for wandering, revised on 02/21/2024. Goal: Resident's safety will be maintained through the review date, revised on 05/29/2025. Interventions: Distract him from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, revised on 02/21/2024. Identify pattern of wandering, revised on 02/21/2024. Further review of care plan revealed no interventions regarding wandering added since 02/21/2024. Review of Resident #3's progress notes revealed: 05/25/2025 4:53 pm, signed by RN-B: Resident #3 was transferred to a hospital on [DATE] PM related to resident altercation on another resident. Resident was knocked to the ground and hit his head on the found resident sent out for further Evaluation. 05/25/2025 10:58 pm, signed by DON: .Resident wandered into another resident's room. Other resident came in starting verbal altercation. When this resident did not move fast enough the other resident punched him in the face. The resident was backing up trying to exit room and fell landing on left lateral. 911 was called immediately. Skin assessed and previous left elbow skin tear was bleeding and noted to be bigger in size. No pain .Physician notified on 05/25/2025 6:45 PM . Review of Provider Investigation Report, dated 05/31/2025, revealed: on 05/25/2025 at 4:20 pm, Resident #3 went into Resident #1's room. Staff heard yelling and saw Resident #1 hit and push Resident #3. Resident #3 fell to the floor and hit his head on the floor and sent to emergency room to be further evaluated. Resident #3 had laceration to back of heat with hematoma, no bleeding, no signs of infection, closed with 3 staples, measurements 1.5x2x0.5cm, hematoma measures 4x5x0.5cm, hematoma to left side of head measurements 3x3cm, bruises to bilateral upper extremities, reopened skin teas to left elbow with part of skin fold missing, no bleeding, no signs of infection, measurements 2x2.5x0.1cm, no other skin issues noted at this time. Facility initiated one on one monitoring with Resident #1. Contacted psych services. Investigation Findings: Confirmed. Review of the facility daily staff schedule, dated 05/25/2025 at the time of the incident, revealed 2 CNAs (CNA-C and CNA-D) assigned to Hall 400 (male secured locked unit) with a census of 19 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #1 per the facility in-service and DON's interview. (continued on next page)

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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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of 1:1 monitoring sheet for Resident #1 revealed 1:1 monitoring started on 05/25/2025 at 4:45 pm and was signed by the 2 CNA's (CNA-C and CNA-D) assigned to Hall 400 (male secured locked unit) with no evidence of an additional designated CNA for 1:1 monitoring for Resident #1 per the facility in-service and DON's interview. Resident #4 Review of Resident #4's electronic face sheet revealed a [AGE] year-old male admitted on [DATE] with initial admit date of 03/25/2024, to Hall 400 (male secured locked unit) with diagnoses which included: personality change, depression, and dementia. Review of Resident #4's Quarterly MDS assessment, dated 05/30/2025, revealed a BIMS score of 03 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: - Presence and Frequency: 1 physical behavioral symptom directed towards others. Section N: Medications: antidepressant medications. Review of Resident's #4's Care Plan, last review 06/19/2025, revealed in part: Focus: Resident has a potential for trauma that may have a negative impact. The trauma is related to physical altercation, revised on 05/26/2025. Goal: Staff will assist in avoiding triggers through next review date. Interventions: Monitor for escalating anxiety, depression or suicidal thought and report immediate to the nurse. Record review of Resident #4's progress notes revealed: 05/25/2025 11:09 pm, signed by DON: .The fall caused a skin tear to left elbow. Size of the skin tear in cm: 0. 5 x 0.5. New/bleeding, a verbal altercation between this resident and another resident was overheard. CMA-A walked into dining room and saw another resident hit this resident in the face, when Resident #4 tried to swing back he slid out of his chair. Upon assessment a skin tear to the left elbow was noted. Stated it did not hurt . Review of Provider Investigation Report, dated 05/31/2025, revealed: on 05/25/2025 at 6:30 pm, Resident ##1 slapped Resident #4 and when Resident #4 tried to swing back he slid out of his chair. Upon his assessment a skin tear to the left elbow was noted, measurements 0.8x0.7x0.1cm. Facility initiated one on one monitoring with Resident #1. Investigation Findings: Confirmed. Review of the facility daily staff schedule, dated 05/25/2025 at the time of the incident, revealed (2) CNAs (CNA-C and CNA-D) assigned to Hall 400 (male secured locked unit) with a census of 19 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #1 per the facility in-service and DON's interview. Review of 1:1 monitoring sheet for Resident #1 revealed 1:1 monitoring started on 05/25/2025 at 4:45 pm and was signed by the (2) CNA's (CNA-C and CNA-D) assigned to Hall 400 (male secured locked unit) with no evidence of an additional designated CNA for 1:1 monitoring for Resident #1 per the facility in-service and DON's interview. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/20/2025 at 12:45 pm, CNA- C stated she was on shift on Secure Hall 400 at the time of these incidents with Resident #1. She stated on 05/25/2025, there was only herself and 1 other staff to supervise the 19 residents plus provide 1:1 monitoring with Resident #1 that required the resident to always be within arm's reach. She stated the locked unit was also having issues with the locked doors on the unit not functioning; therefore, they also had to monitor the doors, the residents, and provide 1:1 of Resident #1 within arm's reach. She stated that Resident #1 was placed on 1:1 monitoring but no extra staff was sent. She stated that at the time of the second incident Resident #1 was in the dining room and no staff was present. She stated she worked the secure unit alone often and had never been given extra staff when residents were placed 1:1 monitoring requiring residents to be within arm's reach. During an interview on 06/20/2025 at 8:00 pm, LVN-G stated she was responsible for Secure Hall 400 and Secure Hall 500 on 05/25/2025 from 2pm-10pm. She stated she was on Secure Hall 500 at the time of the first incident. She stated she was back on Secure Hall 500 when the 2nd incident happened. She stated Resident #1 was supposed to be on 1:1 monitoring because of the previous incident, when the 2nd incident happened, and she did not know why he was not. She stated there were only 2 CNAs covering Secure Hall 400 at the time and that there was no way that the LVN could help with 1:1 monitoring because she was responsible for both secure halls. During an interview on 06/20/2025 at 8:15 pm, CMA-A stated he was working on 05/25/2025 at time of both incidents and stated that he was in a resident's room during the 1st incident with Resident #3 and did not see that incident but he knew that he was placed on 1:1 monitoring. He stated that he was walking down the hall, when the 2nd incident happened and heard Resident #1 yelling then he spotted Resident #1 in the dining room with no staff present and saw him slap Resident #4. Resident #2 Review of Resident #2's electronic face sheet revealed a [AGE] year-old female admitted on [DATE] with initial admit date of 02/09/2024, to Hall 500 (female secured locked unit) with diagnoses which included: traumatic brain injury, anxiety, depression, and dementia. Review of Resident #2's Quarterly MDS assessment, dated 05/20/2025, revealed a BIMS score of 02 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: - Presence and Frequency: 1 other behavioral symptom not directed towards others. Section N: Medications: antianxiety and antidepressant medications. Review of Resident's #2's Care Plan, last review 05/22/2025, revealed in part: Focus: Resident has potential to demonstrate physical behaviors attempts to hit other residents, revised on 04/09/2025. Goal: Resident will not harm self or others through the review date, revised on 05/22/2025. Interventions: When she becomes agitated: 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 11/18/2024. Record review of Resident #2's progress notes revealed: 06/04/2025 11:13 am, signed by LVN-E: .resident started being anxious and agitated. resident grabbed another resident arm causing a skin tear . resident is currently on 1:1 for monitoring .: (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	06/08/2025 12:19 pm, signed by LVN-F: . nurse was called by resident in hallway, that resident has just slapped another resident across the face. psych facility contacted, and 1:1 supervision. 06/08/2025 1:09 pm, signed by LVN-F . resident was grabbing another female resident by her cheeks and would not let her go, staff intervened but resident would not let other resident go. Resident #5 Review of Resident #5's electronic face sheet revealed a [AGE] year-old female admitted on [DATE] with initial admit date of 06/10/2020, to Hall 500 (female secured locked unit) with diagnoses which included: anxiety, Alzheimer's, and mood disorder. Review of Resident #5's Annual MDS assessment, dated 06/04/2025, revealed a BIMS score of 99 which indicated resident was unable to complete the interview. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms: behavior not exhibited. Section N: Medications: antianxiety and antidepressant medications. Review of Resident's #5's Care Plan, last review 04/10/2025, revealed in part: Focus: Resident has a history of trauma that may have a negative impact. The trauma is related to getting scratched, revised on 06/05/2025. Goal: Maintain resident safety and integrity during post trauma episode, using appropriate interventions, revised on 06/05/2025. Interventions: Monitor for escalating anxiety, depression or suicidal thought and report immediately to the nurse, revised on 06/05/2025. Review of the facility daily staff schedule, dated 06/04/2025 at the time of the incident, revealed (1) CNA (CNA-J) assigned to Hall 500 (female secured locked unit) with a census of 16 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. Record review of Resident #5's progress notes revealed: 06/05/2025 10:38 am, signed by LVN-E: . resident received a skin tear due to another resident grabbing her arm. Physician notified on 06/04/2025 at 10:10am. 06/08/2025 12:29pm, signed by LVN-F: . Resident voices she was slapped across the face by the other female resident. Review of Provider Investigation Report, dated 06/11/2025, revealed: On 06/04/2025 at 10:00am, Residents were sitting at the table in dining room when Resident #2 reached over and grabbed Resident #5's arm causing a skin tear. Resident #2 was placed on 1:1 monitoring. Investigation Findings: Confirmed. Review of the facility daily staff schedule, dated 06/04/2025 at the time of the incident, revealed (1) CNA (CNA-J) assigned to Hall 500 (female secured locked unit) with a census of 16 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of 1:1 monitoring sheet for Resident #2 on 06/04/2025 from 10:15am-2:00pm, was signed by the (1) CNA (CNA-J) assigned to Hall 500 (female secured locked unit) with no evidence of an additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. During an interview on 06/19/2025 at 2:00pm, CNA-J she was on shift on Secure Hall 500 at the time of this incident with Resident #2 on 06/04/2025. She stated there was supposed to always be 2 CNAs, but she worked many times by herself. She stated that when a resident is placed on 1:1 monitoring the 2 CNAs on shift rotated and monitored them as close as possible. She stated it was very rare that a third CNA was sent. She stated she had worked on the floor multiple times alone with a resident on 1:1 monitoring. She stated when a resident was 1:1 the staff was supposed to be within arm's length of them at all times and must follow them wherever they go. She stated she could not remember specific dates or incidents because there were so many incidents and 1:1 monitoring that she couldn't remember them all. Resident #6 Review of Resident #6's electronic face sheet revealed a [AGE] year-old female admitted on [DATE] to Hall 500 (female secured locked unit) with diagnoses which included: explosive disorder, Alzheimer's, and seizures. Review of Resident #6's Quarterly MDS assessment, dated 05/26/2025, revealed a BIMS score of 03 which indicated severe cognitive impairment. Further review of the MDS revealed: Section E: Behavior: E0100 no potential indicators of psychosis. E0200. Behavioral Symptoms- Presence and Frequency: 1 physical behavioral symptom director towards others. Section N: Medications: no antianxiety, antipsychotic, or antidepressant medications. Review of Resident's #6's Care Plan, last review 05/22/2025, revealed in part: Focus: Resident has potential to demonstrate physical behaviors, revised on 02/16/2024. Goal: Resident will demonstrate effective coping skills through the review date, revised on 05/22/2025. Interventions: Assess and anticipate her needs: food, thirst, toileting needs, comfort level, body positioning, pain, revised on 08/29/2023. Record review of Resident #6's progress notes revealed: 06/08/2025 1:28pm, signed by LVN-F: . Resident was in her wheelchair looking outside, when the other female resident came up to her and grabbed her face and started being combative, nurse/aide intervened but other resident would not let her go. Review of Provider Investigation Report, dated 06/13/2025, revealed: On 06/08/2025 at 12:00pm, Resident #2 hit Resident #5 with no injuries. She then grabbed Resident #6 by the face causing a very small scratch to her cheek. Resident #2 was placed on 1:1 monitoring. Investigation Findings: Confirmed. Review of the facility daily staff schedule, dated 06/08/2025 at the time of the incident, revealed (1) CNA (CNA-M) and a float CNA (CNA-J) assigned to Hall 500 (female secured locked unit) with a census of 16 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of 1:1 monitoring sheet for Resident #2 on 06/08/2025 revealed 1:1 monitoring was not initiated until 1:00 pm after the 2nd incident. 1:1 monitoring sheet was signed by RN-B who was assigned as a nurse for Hall 100 and Hall 200. During an interview on 06/21/2025 at 9:00 am, LVN-F stated she was responsible for Secure Hall 500 and Secure Hall 400 on 06/08/2025 from 2pm-10pm. She stated that Resident #2 was supposed to have been placed on 1:1 monitoring after the 1st incident but there was no staff available. She stated Resident #1 and Resident #6 were in the dining room alone when she heard Resident #6 screaming. She stated the LVNs cannot provide 1:1 monitoring because they are responsible for multiple halls. Review of the facility daily staff schedule, dated 05/25/2025, revealed during the 10:00pm to 6:00am shift, there was (1) CNA (CNA-H) assigned for Secure Hall 400 and Secure Hall 500 for 36 residents with one (1) of the 36 requiring 1:1 monitoring. Review of 1:1 monitoring sheet for Resident #1 on 05/25/2025 from 10:00pm-6:00am, revealed it was signed LVN-I who was assigned as the nurse for Secure Hall 500, Secure Hall 400, and hall 100. Review of the facility daily staff schedule dated 06/04/2025 from 2:00pm-10:00pm, revealed (2) CNA (CNA-K and CNA-L) assigned to Hall 500 (female secured locked unit) with a census of 16 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. Review of 1:1 monitoring sheet for Resident #2 on 06/04/2025 from 2:00pm-10:00pm, was signed by one of the CNAs (CNA-K) assigned to Hall 500 (female secured locked unit) with no evidence of an additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. Review of the facility daily staff schedule, dated 06/04/2025, revealed during the 10:00pm to 6:00am shift, there was (1) CNA (CNA-H) assigned for Secure Hall 400 and Secure Hall 500 for 36 residents with (2) of the 36 requiring 1:1 monitoring. Review of 1:1 monitoring sheet for Resident #2 on 06/04/2025 from 10:00pm-6:00am, revealed it was signed by LVN-I who was assigned as the nurse for Secure Hall 500, Secure Hall 400, and hall 100. Review of the facility daily staff schedule dated 06/08/2025 from 2:00pm-10:00pm, revealed (2) CNA (CNA-N and CNA-L) assigned to Hall 500 (female secured locked unit) with a census of 16 residents with known behaviors. Further review of staff schedule revealed no additional designated CNA for 1:1 monitoring for Resident #1 per the facility in-service and DON's interview. Review of 1:1 monitoring sheet for Resident #2 on 06/08/2025 from 2:00pm-10:00pm, was signed by one of CNAs (CNA-L) assigned to Hall 500 (female secured locked unit) with no evidence of an additional designated CNA for 1:1 monitoring for Resident #2 per the facility in-service and DON's interview. Review of the facility daily staff schedule, dated 06/08/2025, revealed during the 10:00pm to 6:00am shift, there was (2) CNA (CNA-O and CNA-P) assigned for Secure Hall 400 and Secure Hall 500 for 36 residents with (2) of the 36 requiring 1:1 monitoring. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of 1:1 monitoring sheet for Resident #1 on Secure Hall 400 and Resident #2 on Secure Hall 500 on 06/04/2025 from 10:00pm-6:00am, revealed it was signed by LVN-I who was assigned as the nurse for Secure Hall 500, Secure Hall 400, and hall 100. During an interview on 06/20/2025 at 10:15pm, with CNA-O who worked 10pm-6am stated that he worked many shifts alone and he was responsible for covering Secure Hall 400 and Secure Hall 500 at the same time. He stated he also worked alone when residents were on 1:1 monitoring. He stated 1:1 monitoring should be where the staff is within arm's length of the resident, but that was not possible when he was the only CNA and was responsible for both halls. During an interview on 06/20/2025 at 12:30pm, the ADON stated the secured units were supposed to be staffed with 2 CNAs each during the day and 1 CNA each on 10pm-6 am shift. She stated when a resident was placed 1:1 monitoring, and additional staff member was supposed to be designated for that resident. She stated they pull staff from other departments such as dietary and housekeeping to perform 1:1 monitoring. She stated 1:1 means that 1 staff is with that resident at all times. The ADON stated that on the night shift, if there was only 1 CNA assigned to both secure units, the LVN would stay on the opposite unit and monitor it. She stated resident were usually asleep on that shift, so she felt that 1 person on each unit was enough even when a resident was on 1:1 monitoring. During an interview on 06/20/2025 at 3:30pm, the DON stated that she was not aware of any times that there was not a designated staff for residents on 1:1 monitoring. She stated did not know how Resident # 1 and Resident #2 were able to get into 2nd altercations while on 1:1 monitoring. She stated she felt the facility was doing a good job preventing altercations and injuries. She stated that she did not feel that the facility was short staffed. During an interview on 06/23/2025 at 8:00pm, the ADO stated the facility did not have a staffing policy. This was determined to be an Immediate Jeopardy (IJ) on 06/22/2025 at 4:05pm. The Regional Compliance Nurse, Director of Nurses, and Assistant Director of Nurses were notified. The Regional Compliance Nurse was provided with the IJ template on 06/22/2022 at 4:05 PM. The following Plan of Removal was accepted on 06/23/2025 at 6:20 PM and included: Interventions: Any resident that resides in the secure unit that has the potential for resident-to-resident altercation can be affected by deficient practices. Alleged perpetrator Resident #2 was interviewed by DON on 06/22/26 @ 6:15pm with no concerns voiced by resident and placed on 15-minute checks for resident safety and the safety of other resident in the secure unit and continued for at least 24 hours. Resident #1 was interviewed on 06/23/25 by DON and voiced no concerns and did not recall being aggressive with any other resident. Resident #7 was interviewed on 06/23/25 by DON and resident did not voice any concerns and could not recall being aggressive with any other resident. Resident #8 is not at the facility for an interview on 06/23/25 and Resident #9 is not at the facility for an interview on 06/23/25. (continued on next page)

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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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Abuse prevention in-service for all facility staff initiated in house and completed by Admin/DON/Compliance Nurse on 06/22/2025 and for staff that is not present during the in-services will be sent the in-service via staffing application and they be not be allowed to assume duties until in-service prior to them clocking in for their shift and all new staff or agency staff will be in-services on abuse prior to them starting their position. All in services to be completed by 6/23/2025. Immediate psychiatric services on call for residents that trigger through trauma informed assessments on the secure unit completed on 06/22/2025. Referrals sent out by DON and will be followed up by DON for Resident #2 have been sent out to other skilled nursing facility and Behavioral Hospitals. and Resident #8 referral was sent to a facility and accepted and admitted [DATE], Resident #9 referred to a facility and accepted and admitted on [DATE]. Resident #1 referral sent to psych hospital and accepted and admitted 05/2725 and return 06/03/25. All direct care staff that were work at the time of the incident in the secured unit working with Resident #2 have been interviewed by DON on 06/22/25 and no root cause could be determined for her behaviors. Staff was able to state regarding Resident #1 resident is very territorial and does not like resident entering his room and resident was transition to long term community in a private room and have decrease behaviors and for Resident #9 no root cause was determined for his behavior. For Resident #7 no root cause was determined for his behavior. Resident #8 no root cause was determined for his behaviors. Facility will ensure adequate staffing to manage acuity based on the 24-hour report in Point Click Care, Real Time systems monitoring and current census. The administrator will maintain adequate staff for resident safety per acuity. Staffing will be reviewed during stand-up Meetings at 8:30 AM and stand-down meetings at 4PM to ensure there is adequate staffing for the secure units. During both meetings the team will review, and the Administrator/designee will adjust staffing to maintain resident safety based on acuity based on the 24-hour report in PCC, Real Time Systems monitoring and current census. If one on one is required additional staff member will be added and not substituted with the current staff in the units to ensure adequate staffing to protect residents from further incidents. The facility administrator/designee will decide and assure staff are assigned to the 1:1 resident. The Administrator/DON will check in with assigned staff frequently to assure that 1:1 monitoring is ongoing. Resident interviews on the secure units have been completed by DON, compliance, ADON, on 06/22/25. No concerns from residents were voiced. On 6/23/2025 Skin assessments were completed, and no visible signs of physical abuse were noted. We will continue to monitor with random interviews and weekly skin assessments, and address if issues are identified. Primary contact for each resident on the secure unit to be contacted on 6/23/2025 by the DON/Compliance Nurse [TRUNCATED]

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	06/24/2025

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure the DON did not serve as a charge nurse when the facility had an average daily occupancy of 60 or more residents for 9 (06/04/25, 06/05/25, 06/06/25, 06/13/25, 06/14/25, 06/15/25, 06/16/25, 06/18/25, 06/19/25) of 20 days reviewed for DON coverage. The facility failed to ensure the DON did not serve as a charge nurse when the facility had an average daily occupancy of 60 or more residents on 06/04/25, 06/05/25, 06/06/25, 06/13/25, 06/14/25, 06/15/25, 06/16/25, 06/18/25, and 06/19/25. This failure leaves residents without the nursing administrative oversight that only the DON can provide. Findings include: Review of the daily staffing schedule revealed DON worked as a charge nurse on 06/04/25, 06/05/25, 06/06/25, 06/13/25, 06/14/25, 06/15/25, 06/16/25, 06/18/25, and 06/19/25. During an interview on 06/20/2025 at 3:30 PM, the DON stated she was responsible for monitoring her staff and ensuring things were done correctly. She stated she had been working night shift as the charge nurse because a night nurse had recently quit. She stated no-one else had been designated to perform her duties while she had not been able to. The DON stated that working the night shifts have not interfered with performing her DON duties. She stated she was not aware of the regulation stating that she could not work the floor. Policy for RN/DON coverage was requested on 06/23/2025 but wasn't provided. Review of document titled, Job Description Director of Nursing dated 2014, revealed: The following is a non-exhaustive criterion that relates to the job of a Director of Nursing, and it is consistent with the business needs of the facility. These are legitimate measures of the qualifications for Director of Nursing. and are related to the functions that are essential to the job of a Director of Nursing. Knowledge Base: Working knowledge of nursing home regulations. Accountable for nursing compliance, excellence, and delivery of resident care services in adherence with The Company, local, state, and federal regulations. Manage nursing staff through appropriate hiring, training, evaluation, assignment, and delegation of duties, within budget and resident census guidelines. Augment floor staffing if needed .