Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675928	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER: Sienna Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status for one (Resident #1) of four residents reviewed for nutrition. The facility failed to ensure Resident #1 maintained acceptable parameters of nutritional status as demonstrated by Resident #1 experiencing a 11.47% weight loss in 80 days. He had an active decline in his weight from 12/1/25 - 02/18/26. This failure could place residents at risk for decreased nutritional status, decline in health, malnutrition, or hospitalization. Findings included: Review of Resident #1's admission record on 2/18/2026 reflected he was a [AGE] year-old female who admitted to the facility on [DATE], with diagnoses including protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), diabetes mellitus (a group of metabolic diseases characterized by high blood sugar levels), dementia (decline in mental ability), anxiety disorder (mental health condition characterized by excessive fear). Review of Resident #1's admission MDS assessment, dated 12/8/26, reflected a BIMS score of 2, indicating severe cognitive impairment. Section GG (Functional Abilities) reflected he required Setup or clean-up assistance with eating. Section K (Swallowing/Nutritional Status) reflected that he was on regular diet. Section K0300 (Weight Loss) reflected that he had no weight loss, and he was not on physician- prescribed weight-loss program. Review of Resident #1's care plan revised 12/4/2026 reflected that Resident#1 was at risk for malnutrition. The interventions included: Determine food preferences as needed, monitor and document amount consumed, monitor weight per facility protocol, serve diet as ordered, notify physician for any negative findings. Review of Resident #1's weights reflected an active decline in his weight from 12/10/25 - 2/18/26. Resident #1 weight on 12/1/25 reflected 191.8 pounds, on 12/10/2026 185.6 pounds, and a weight of 169.80 pounds on 02/18/26. Review of Resident #1's Nutrition Assessment, dated 12/16/2025 and documented by the RD, reflected the following: Height:69.0, Weight: 185.6. Diet order was regular, and texture Order was Regular, and that Residents#1 Food Intake was 25-100%. Review of Resident #1's meal intake for documentation for January and February reflected he consumed 25-100% of his meals. Record review of Resident #1's weight watchers' assessment dated [DATE] revealed resident had a 14.4-pound weight loss. Interventions included red glass initiated and 2 cal supplement with each med pass. Record review of the list of residents on the red cup program (a program in which residents received a red cup at meals to alert staff that they were at risk for weight loss/malnutrition) did not include Resident #1. Record review of Resident #1's order summary for January 2026 revealed no supplement or red glass program in physician orders. Record review of Resident #1's order summary for February 2026 revealed no supplement until 2/13/2026. On 2/13/2026 an order for Boost twice daily was implemented. No red glass program in physician orders. During an observation on 2/18/2026 at 12:35pm during lunch meal Resident#1 only took two bites of his food that was served at lunch and kept leaving the table. Resident#1 declined offer for alternative food from CNA A. Resident #1 accepted a boot (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supplement. During an interview on 2/18/2026 at 3:58 PM with the DM revealed that the DON was responsible for monitoring residents' weight loss, dietary recommendations, and also which residents needed to be on the Red Glass program . The program alerts staff to pay attention to the resident on the program to monitor their intake closely. She stated that if a resident were placed on the red glass program the charge nurse would send a communication slip to dietary. She stated that the DON reports to the dietician and she monitors weight loss and decides if a supplement is needed. DM stated Resident #1 was not on the snack list but kitchen does send extra snacks. DM was not aware of Resident #1's weight loss. During an interview on 2/18/2026 at 4:10pm with the Director of Nursing she stated she recently became aware of Resident #1's weight loss, as she was the individual who entered weights into the electronic charting system. She stated that she has been in this position for a week and did implement a supplement for Resident #1 on 2/13/2026. She stated she felt as though Resident #1 should have weekly weights as well as supplements for extra nutrition. She also stated Resident #1 should have been placed on the facility's Red Glass program. DON stated Resident #1 did not have a decline because of the weight loss. The Director of Nursing stated a negative outcome of weight loss could be impaired skin integrity, decreased nutritional status. During an interview on 2/18/2026 at 4:15pm with RN D she stated Resident #1 has had some weight loss and does not eat well. RN D stated if Resident #1 does not eat they offer alternatives and snacks. RN D stated staff visualize how much residents eat and enter the consumption into electronic health record. RN D stated CNA's notify nursing if someone eats less than they normally do or if a resident doesn't eat at all. RN D stated resident did not have a decline due to weight loss. During an interview on 2/18/2026 at 4:46pm with OTA she stated Resident #1's fine motor skills were intact and he did not require assistive devices while eating. OTA stated Resident #1 has not declined and is still at his prior level of function. During an interview on 2/18/2026 at 4:55pm with ADON she stated she entered a weight watcher assessment for Resident #1 on 1/15/2026 and intended to put interventions in place of red glass program and 2 cal supplement with each med pass. ADON stated that she forgot to enter it into the physician orders to implement these interventions. ADON stated a negative outcome of not implementing physician orders for weight loss could be continued weight loss. ADON stated that they just got a DON and she had been trying to balance completing all the tasks. During an interview 2/19/26 at 11:00 AM with the Dietician (RD), she stated she completed an assessment on Resident #1 on admission [DATE] and recommended house supplements three times daily. RD stated these should have been entered into the electronic health record as a physician order. She stated she receives a monthly report on weight loss and Resident #1 was not on the list she received in January 2026. RD stated interventions for weight loss program include red glass program, weight watchers, fortified food, snacks, and supplements. RD stated effectiveness of interventions are monitored by monitoring weights and sometimes lab work. She stated Resident #1 could definitely be put on a supplement and/or increased weights for additional weight support. She stated she does not necessarily monitor the facility's Red Glass program; she was not sure who monitored this program. RD stated the risk of not carrying out these interventions could be continued weight loss, loss of lean muscle mass, and pressure wounds. RD stated Resident #1 has not had any negative outcomes due to weight loss and was still above his ideal body weight. During an interview on 02/19/2026 at 11:45AM with a CNA C who was assigned to Resident #1's care, she stated she could not tell that Resident #1 had lost weight. CNA C stated that the resident required set up at meals but can feed himself with a lot of encouragement. CNA C stated if residents don't eat, they offer health shakes. She also stated Resident#1 was not on the red cup program and that staff was required to pay extra attention to resident on the Red Cup program. CAN C stated Resident #1 has (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not had a decline in function due to the weight loss. During an observation on 2/19/2026 at 12:10PM during lunch meal Resident #1 would not stay seated at table and kept rolling away despite staff encouragement to eat. Did not observe an alternative or supplement offered at this time. During an interview on 2/19/2026 at 2:07PM with Nurse Practitioner she stated she last assessed Resident #1 on 2/18/2026 and she was unaware of the weigh loss and felt like if he lost that much weight she would have known. NP stated she should have been notified of the weight loss. NP stated they can use appetite stimulants for weight loss. NP stated Resident #1 was still functioning the same and it did not cause him harm as she did not see a decline. She said the risk for harm with weight loss differs for every resident. NP did state that due to dementia and the disease process some weight loss is expected. Review of the Facility' Resident Weight policy reflected that the following assessments and Recognition:Nursing Policy & Procedure Manual undatedAll residents will be weighed by the 10th of the month and their weights documented correctly. Appropriate actions regarding significant changes will be carried out.Procedure:1. Weights shall be obtained and documented at admission, readmission, and monthly unless ordered otherwise by the physician, or unless dictated more frequently by the residents' condition. Factors indicating the need for more frequent weights include significant weight loss, drastic decrease in food consumption, prolonged nausea, vomiting, or diarrhea, significant weight gain, swelling or edema, poor appetite during adjustment period to the facility, recent change from tube feeding to oral intake, or pressure ulcers that are not resolving as expected.The Dietary Profile will be completed upon admission and quarterly thereafter by the dietary manager. The Nutrition Risk Assessment form will be completed by the Registered Dietitian upon admission, annually, and updated if the resident has a significant change. The RD and dietary manager will also chart in the dietary Progress Notes as needed regarding visits, nutritional issues, updates to food preferences, etc.4. All residents must be weighed as indicated, unless otherwise ordered by the attending physician. Pre-medicate resident for pain or discomfort, as per physician's orders, as needed prior to weighting.7. Significant Weight LossThe facility reviews resident weights after monthly weights are obtained, to determine residents with significant weight changes. A significant weight change will be defined as 5% or greater in one month, 7.5% or greater in three months, or 10% or greater in six months. The weight change will be recorded on the appropriate weight watcher's form along with interventions, and follow-up will also be recorded in the designated location. The physician and family will be notified. In addition, an acute care plan for weight loss will be initiated and the clinical record reviewed for possible need of a significant change of condition MDS assessment. Assess the resident for possible reason for weight loss to include:9. All significant weight changes will be referred to the Regional Dietitian on the next visit. The Regional Dietitian will generate a copy of the facility weight report and can review the weight watchers' forms in PCC. The Regional Dietitian will complete an assessment on all significant weight losses. The Regional Dietitian will review all facility interventions, and will make appropriate recommendations, which will be approved by the physician, if necessary.