

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 12/13/2023
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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48593</p> <p>Based on record review and interviews the facility failed to review and revise the comprehensive care plan after assessment of 1 of 5 residents (Resident #70) reviewed for care plan revision.</p> <p>The facility failed to include a care plan for Resident #70's crawling behavior.</p> <p>This failure could place the residents at risk of injury.</p> <p>Findings include:</p> <p>Record Review of Resident #70's face sheet dated 12/13/2023 revealed Resident #70 is a [AGE] year-old female who was admitted on [DATE] with the following diagnoses: Seizures, developmental disorder of speech and language, paranoid schizophrenia, constipation, protein-calorie malnutrition, seasonal allergic rhinitis, excessive and frequent menstruation with regular cycle.</p> <p>Record review of Resident #70's MDS dated [DATE] reveals resident to have memory problems and is severely impaired with Cognitive Skills for Daily Decision Making. Unable to obtain a BIMS score due to Resident #70's cognitive status.</p> <p>Record review of Resident #70's most recent comprehensive care plan dated 12/11/2023 revealed no revisions or interventions for her crawling behavior.</p> <p>Record review of Resident #70's physician orders dated 12/13/2023 revealed the resident to be in low bed with a floor mat at bedside due to poor safety awareness three times a day related to abnormalities of gait and mobility, and schizophrenia.</p> <p>Record review of Resident #70's progress notes revealed nine notes that document Resident #70's crawling behavior starting on 11/26/2022 through 12/07/2023.</p> <p>(continued on next page)</p>

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #70s progress notes revealed no notes detailing the resident crawling on 12/03/2023. A note dated 12/05/2023 at 11:25 am stated Resident noted to have abrasions to Bil (bilateral-both) knees. Areas are scabbed over with no s/s (signs or symptoms) of infection. Resident was noted to be crawling on her knees in her room [ROOM NUMBER] nights ago. No s/s of pain/discomfort. Note dated 12/07/2023 at 05:12 am stated old scrapes to both knees reopened, was bleeding, due to resident woke up and started crawling on the floor. Area cleaned with normal saline, pat dry, dressing applied.</p> <p>Record review of 24-hour report from 12/2/23-12/5/23 revealed a written note attempting to call responsible party two times.</p> <p>Interview with Resident #70's responsible party on 12/12/23 at 11:03 AM revealed Resident #70 has had the crawling behavior at home prior to admission to the facility. The responsible party noted bandages to both of resident's knees. Responsible party states she does not recall if the facility was made aware of behavior on admission. Responsible party states the resident has not had any other injuries or incidents that she can recall. Responsible party states the facility does have Resident #70 in a helmet when she is out of bed to prevent injury.</p> <p>Interview on 12/12/23 at 12:42 p.m. the DON, ADON, and Corporate Compliance Nurse reveals the facility was aware of Resident #70's crawling behavior but were unaware of incident on 12/03/2023 or injuries. ADON states the resident has exhibited the crawling behavior many times in the past but has never injured herself prior. ADON states the resident has a mat next to her bed, but no other interventions have been in place to prevent injury.</p> <p>Observation on 12/13/23 at 08:10 AM with the Administrator and corporate nurse revealed video surveillance of resident crawling, scooting on her knees, and walking in the hallway on 12/03/23 on nightshift at approximately 11:02 pm in a t-shirt and a brief. Resident #70 crawled on her hands and knees for approximately 10 feet. Resident #70 then used handrails to stand and walked down the hallway. Resident #70 then returned to her knees when staff attempted to help resident back to her room, Resident #70 began crawling again. Resident #70 would not allow staff to help her to her feet and became aggressive. Resident #70 crawled back to her room at 11:11 pm. At 11:18 pm, the resident was seen crawling out of room and then stood up and ran down the hallway. Staff were in resident's room from 11:29-11:45. Staff were seen checking on resident periodically and staff stood by her room when not doing rounds on other residents. On 12/07/23, Resident #70 is seen at 4:29 am to be crawling out of her room when staff were in other rooms. When staff noticed Resident #70 in hallway, Resident #70 was taken back to her room at 4:30 am. At 4:48 am, a nurse aide checks on Resident #70 then was seen talking to a nurse. The nurse was seen carrying wound supplies into Resident #70s room.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48593</p> <p>Based on record review and interviews the facility failed to provide assistive devices to prevent injuries of 1 of 5 residents (Resident #70) reviewed for Quality of Care.</p> <p>The facility failed to ensure Resident #70 receives adequate supervision and assistive devices to prevent accidents relating to her crawling behavior.</p> <p>This failure could place the residents at risk of injury.</p> <p>Findings include:</p> <p>Record Review of Resident #70's face sheet dated 12/13/2023 revealed Resident #70 is a [AGE] year-old female who was admitted on [DATE] with the following diagnoses: Seizures, developmental disorder of speech and language, paranoid schizophrenia, constipation, protein-calorie malnutrition, seasonal allergic rhinitis, excessive and frequent menstruation with regular cycle.</p> <p>Record review of Resident #70's MDS dated [DATE] reveals resident to have memory problems and is severely impaired with Cognitive Skills for Daily Decision Making. Unable to obtain a BIMS score due to Resident #70's cognitive status.</p> <p>Record review of Resident #70's most recent comprehensive care plan dated 12/11/2023 revealed no revisions or interventions for her crawling behavior.</p> <p>Record review of Resident #70's physician orders dated 12/13/2023 revealed the resident to be in low bed with a floor mat at bedside due to poor safety awareness three times a day related to abnormalities of gait and mobility, and schizophrenia.</p> <p>Record review of Resident #70's progress notes revealed nine notes that document Resident #70's crawling behavior starting on 11/26/2022 through 12/07/2023.</p> <p>Record review of Resident #70s progress notes revealed no notes detailing the resident crawling on 12/03/2023. A note dated 12/05/2023 at 11:25 am stated Resident noted to have abrasions to Bil (bilateral-both) knees. Areas are scabbed over with no s/s (signs or symptoms) of infection. Resident was noted to be crawling on her knees in her room [ROOM NUMBER] nights ago. No s/s of pain/discomfort. Note dated 12/07/2023 at 05:12 am stated old scrapes to both knees reopened, was bleeding, due to resident woke up and started crawling on the floor. Area cleaned with normal saline, pat dry, dressing applied.</p> <p>Record review of 24-hour report from 12/2/23-12/5/23 revealed a written note attempting to call responsible party two times.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Resident #70's responsible party on 12/12/23 at 11:03 AM revealed Resident #70 has had the crawling behavior at home prior to admission to the facility. The responsible party noted bandages to both of resident's knees. Responsible party states she does not recall if the facility was made aware of behavior on admission. Responsible party states the resident has not had any other injuries or incidents that she can recall. Responsible party states the facility does have Resident #70 in a helmet when she is out of bed to prevent injury.</p> <p>Interview on 12/12/23 at 12:42 p.m. the DON, ADON, and Corporate Compliance Nurse reveals the facility was aware of Resident #70's crawling behavior but were unaware of incident on 12/03/2023 or injuries. ADON states the resident has exhibited the crawling behavior many times in the past but has never injured herself prior. ADON states the resident has a mat next to her bed but no other interventions have been in place to prevent injury.</p> <p>Observation on 12/13/23 at 08:10 AM with the Administrator and corporate nurse revealed video surveillance of resident crawling, scooting on her knees, and walking in the hallway on 12/03/23 on nightshift at approximately 11:02 pm in a t-shirt and a brief. Resident #70 crawled on her hands and knees for approximately 10 feet. Resident #70 then used handrails to stand and walked down the hallway. Resident #70 then returned to her knees when staff attempted to help resident back to her room, Resident #70 began crawling again. Resident #70 would not allow staff to help her to her feet and became aggressive. Resident #70 crawled back to her room at 11:11 pm. At 11:18 pm, the resident was seen crawling out of room and then stood up and ran down the hallway. Staff were in resident's room from 11:29-11:45. Staff were seen checking on resident periodically and staff stood by her room when not doing rounds on other residents. On 12/07/23, Resident #70 is seen at 4:29 am to be crawling out of her room when staff were in other rooms. When staff noticed Resident #70 in hallway, Resident #70 was taken back to her room at 4:30 am. At 4:48 am, a nurse aide checks on Resident #70 then was seen talking to a nurse. The nurse was seen carrying wound supplies into Resident #70s room.</p> <p>Interview with LVN E on 12/12/23 at 04:52 PM who was the nurse on the night shift of 12/03/23 and 12/07/23, states about a week ago Resident #70 was crawling around the hallway and to the nurse's station and refused to allow staff to help her up, LVN E states the resident was acting combative. LVN E stated there were small scrapes to both knees, but she isn't sure if she had contacted the family that night. LVN E stated she had bandaged her knees 'a few days ago' and the wound was bleeding at that time. LVN E states did not contact the family regarding placing bandages on the resident since this was an old wound that had opened from Resident #70 crawling after wound had scabbed.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>45399</p> <p>Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to medications for 1 of 4 medication carts reviewed for label and storage of drugs and biologicals.</p> <p>The facility failed to ensure medication cart #1 was locked when unattended on 12/13/2023.</p> <p>This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm or drug diversions.</p> <p>Findings included:</p> <p>During an observation and interview on 12/13/2023 at 11:10 AM, Medication cart #1 was left unattended and unlocked by RN E. RN E was observed wheeling a resident in his wheelchair and passed the unlocked cart. RN E saw surveyor standing in the hall and turned the wheelchair around and walked by the medication cart and pushed the lock button. RN E stated it was her cart and she left it unlocked. RN E stated that the medication cart should have been locked because there are residents, visitors and staff who should not have access to medications in the cart. Upon observation of the cart, the top drawer contains glucometers, and lancets. The second drawer has over the counter medications including acetaminophen and ibuprofen, bottles of cough syrup, and liquid antacid medication and medication cards. The third drawer has medication cards and sanitizing wipes.</p> <p>During an interview on 12/13/23 at 3:00 PM, the DON stated that her expectation was that all medication carts were locked when unattended.</p> <p>During an interview on 12/13/23 at 3:52 PM, the Administrator stated that her expectation was that all nursing staff would ensure that medication carts were locked when staff was not present.</p> <p>Review of the facility's policy, titled Medication Carts, dated 2003, reflected (in part):</p> <ol style="list-style-type: none"> 1. The medication carts shall be maintained by the facility. 2. The carts are to be locked when not in use or under the direct supervision of the designated nurse. 3. Carts not in use are to be stored in a designated area not blocking egress in the building. 4. Carts must be secured. 5. Carts should be clean. 		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>26221</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for kitchen sanitation, in that:</p> <p>The facility failed to ensure [NAME] A prevented cross contamination while preparing food.</p> <p>The facility failed to throw out food within seven (7) days.</p> <p>The facility did not thaw food within a container causing drips on the floor</p> <p>The facility stored food on the floor of the walk-in refrigerator.</p> <p>The facility failed to ensure Dietary Aides B, C, and D had effective hair restraints.</p> <p>The facility failed to ensure pans and dishes were stored face up and uncovered leaving them exposed to contamination from air born contamination.</p> <p>These deficient practices could place residents who receive meals prepared from the kitchen at risk for food borne illness and cross contamination.</p> <p>The findings included:</p> <p>Observations on 12/11/23 between at 9:40 AM and 9:55 AM of the facility's only kitchen revealed:</p> <p>The facility's walk-in refrigerator revealed:</p> <p>Pudding in a small metal pan dated 12/3/23;</p> <p>Garbanzo beans in a large plastic container dated 11/28/23;</p> <p>Black olives in a large, plastic container dated 11/28/23;</p> <p>Pasteurized eggs in a box stored on the floor;</p> <p>A six-pack of tea stored under the shelf on the floor;</p> <p>A 12-pack of water stored under the shelf on the floor.</p> <p>A tube of ground beef thawing on the bottom shelf of the with no pan, under it was a triangular puddle of blood on the floor.</p> <p>The DM was shown the food on the floor and sighed. She was shown the meat thawing without the pan and the puddle of blood and said ew.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview and observation on 12/11/23 at 9:45 a.m. revealed DA B washed dishes in the dirty dish area. He had a 1/2 inch beard and a hairnet on leaving most of his beard.</p> <p>Observation of the clean dish area revealed the divided plates and pots were face up.</p> <p>Observation of the corn dogs in the upright freezer were open to air and had ice crystals on them. The Dietary Manager tied the bag closed them.</p> <p>Observation of the lunch meal preparation on 12/19/23 between 10:40 a.m. and 11:15 a.m. revealed:</p> <p>Cook A changed gloves 9 times. Each time she took off her gloves, she touched the trash can lid (contaminating her hands) and did not wash her hands or use alcohol gel prior to donning new gloves.</p> <p>The pots were still face up.</p> <p>Observation on 12/12/23 between 3:12 p.m. and 5:15 p.m. of the dinner meal preparation revealed:</p> <p>DA C did not wear an effective hair restraint, half of her hair was uncovered.</p> <p>Cook A wandered around the kitchen holding a bag of potatoes for a few minutes. When she donned gloves, [NAME] A failed to wash her hands or use alcohol gel and began to peel potatoes.</p> <p>The pots and divided plates were still face up.</p> <p>Interview on 12/13/23 at 1:31 PM, the DM stated she was the DM for 1 year. She said the previous night's meal preparation could have gone better. The DM stated leftovers were kept for 7 days. The DM said the olives and garbanzo beans were not cooked so they could have been held for 30 days. The DM said meat should be thawed in a pan on the bottom shelf. The DM stated the divided plates should have been face down. The DM said pots should be face down under the prep table. The DM said hair nets half on were not effective and she was trying to find a more effective brand because the current brand slipped a lot. The DM said the water and tea on the floor were for personal use , but she had no explanation for the eggs on the floor.</p> <p>Interview on 12/13/23 at 2:15 PM, [NAME] A stated every time she touched the garbage lid, she contaminated she hands. She said she did not wash or gel her hands after touching the lid prior to donning gloves .</p> <p>Interview on 12/13/23 at 2:48 PM, the Administrator and Regional Compliance Officer were informed of the food outdated in the refrigerator, the beef not being thawed in a pan, food being stored on the floor, the lack of hand hygiene and possible cross contamination, and the ineffective hair nets. They said they would look to see if they could find anything that could verify the food, once opened could be kept for 30 days if not cooked.</p> <p>Review of the facility's weekly cleaning scheduled revealed the refrigerator was cleaned on 12/10/23.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility's Dietary Services Policy & Procedure Manual dated 2012 on Equipment Sanitation revealed: We will provide clean and sanitized equipment for food preparation. The facility will clean all food service equipment in a sanitary manner.</p> <p>Meats, Poultry, Fish: keep juices of raw meat, poultry, or fish from coming in contact with other raw or uncooked foods.</p> <p>Avoid cross-contamination between raw and cooked foods.</p> <p>Raw (thawing meat) shall be stored on the bottom shelf of the refrigerator.</p> <p>Review of the facility's policy and procedure on Food Storage and Supplies, dated 2012, revealed: All facility storage areas will be maintained in an orderly manner that preserved the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, and insects.</p> <p>Procedures:</p> <p>Storerooms are to be well lighted, ventilated, and temperature controlled.</p> <p>Review of the facility's policy and procedure on Handling of Potentially Hazardous Foods, dated 2012, revealed: we will establish safe and sanitary methods of handling potentially hazardous foods. To prevent food borne illness, all potentially hazardous food shall be cooked and handled in a safe and sanitary manner.</p> <p>Meats, Poultry and Fish: Keep juices of raw meat, poultry, or fish from coming in contact with other raw or uncooked foods.</p> <p>Avoid cross-contamination between raw and cooked foods.</p> <p>Review of the facility's policy and procedure on Food Storage and Supplies, dated 2012, revealed nonperishable items that are refrigerated are dated once and used within 7 days after opening.</p> <p>Review of the facility's policy and procedure on Infection Control, dated 2012, revealed: we will ensure all employees practice infection control in the Food and Nutrition Services Department, and maintain sanitary food preparation. All dietary service employees will follow Infection control Policies as established and approved by the Infection Control committee.</p> <p>Procedure. Clean hair is required. It is to be covered with an effective hair restraint. Facial hair is to be closely trimmed and is to be covered with a hair restraint.</p> <p>Careful hand washing by personnel well be done in the following situations:</p> <p>Between handling of dirty dishes, boxes, or equipment and handling clean food or utensils.</p> <p>Equipment Sanitization:</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>All kitchen ware and food contact used in the preparation and/or serving of food are cleaned and sanitized before use and cleaned after each meal preparation.</p> <p>After cleaning, equipment and utensils are stores so as to prevent contamination.</p> <p>Plastic, disposable gloves are used when handling gloves are sued when handling raw foods or in salad and sandwich preparation. There shall be no bare hand to food contact. However, gloves are not a substitute for thorough and frequent hand washing. When using gloves, always washing hands before touching or putting on new gloves, and single use gloves for one task.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>26221</p> <p>Based on observation and interview, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition in the facility's only kitchen.</p> <p>The facility failed to ensure the oven worked consistently.</p> <p>The facility failed to ensure the garbage disposal worked correctly.</p> <p>The facility failed to ensure milk refrigerator's hinge was not rusted and worked.</p> <p>The facility failed to ensure the milk refrigerator's gasket (seal) was black and did not become detached.</p> <p>These failures placed the residents at risk for not receiving a variety in meals as planned and placed residents at risk for foodborne illness.</p> <p>The findings include:</p> <p>Observation on 12/11/23 at 9:40 a.m. revealed the milk refrigerator hinge was rusted and not working. The gasket (seal) on the refrigerator was coming detached, was black and not sealing. At 9:45 a.m. DA B stated the garbage disposal did not work. The DM acknowledged the garbage disposal did not work.</p> <p>Observation and interview on 12/12/23 beginning at 3:12 p.m. of the dinner meal preparation revealed the only oven did not get up to temperature as the facility tried to cook cookies and corn bread. At that time DA D said she did not know why the oven did not get to temperature.</p> <p>Interview on 12/13/23 at 1:31 p.m., the DM stated the garbage disposal was not working for two weeks and the maintenance director was aware of it. The DM stated the milk refrigerator hinges had been like that since she started a year and half ago. The DM said the gasket (seal) was coming detached for a few months. The DM said she told maintenance that it was coming detached and he said the part was on order. The DM stated she did not think the seal was that hard to get. The DM pointed out the refrigerator could be opened but would go off track The DM stated the staff had problems with the stove intermittently and they had to replace the temperature gauge, and ever since, it sometimes would not get up to the right temperature. The DM said this happened about twice a week. She said she thought maybe the knobs needed to be replaced. The DM stated they were on order and they would see if that would fix that problem.</p> <p>No work orders were provided to support these statements.</p> <p>Interview on 12/13/23 at 2:48 PM the Administrator and Regional Compliance Officer were informed of the garbage disposal, the milk refrigerator, and the oven. The Administrator stated neither the DM nor the Maintenance Director had made her aware of any of these items</p>