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	01/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 26221 Based on observation, interview, and record review the facility failed to treat residents with respect, dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life for 11 of 11 residents in the confidential group interview. Staff used cell phones in residents' presence causing residents to feel disrespected. (11 residents in the Resident Council Meeting) This failure could place residents at risk of a diminished quality of life a loss of self-esteem and increased isolation. The findings included: Observation on 1/21/25 at 11:17 a.m. revealed the Activity Director standing in the main dining room on her cell phone while residents were present. Interview on 1/22/25 at 10:06 a.m. 11 residents in the confidential resident council stated that the staff were frequently on their cell phones. The residents stated sometimes the facility would try to fix it and it would get better but then it would get worse again. The residents said the staff would be on their phones ignoring call lights at the nurse's station. The residents reported the staff were providing care while on their phones, including on video chat. The residents said it made them uncomfortable. The residents said they reported the issue to the Activity Director, but it did no good. The residents said the staff thought the residents were dumb and could not figure out they (the staff) were on the phone. The residents reported the staff were on the phone while passing medications and they worried about medication errors. The residents said it made them feel like the staff did not care about them. The residents reported the staff would talk to anyone and the phone calls were usually about what they were going to do when they got off work. Review of the 11/7/24 Resident Council Minutes revealed 8 residents attended and reported the staff were on their personal cell phones. Review of the 12/12/24 Resident Council Minutes revealed 10 residents attended and reported staff were on their personal cell phones. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 1/2/25 Resident Council Minutes reported 9 residents attended and reported staff were on their personal cell phones. The residents stated one aide talked to her boyfriend on the phone and the things the residents heard were not appropriate. Interview on 1/23/25 at 5:02 p.m. the ADON, DON, and RN Consultant stated the facility expectation was staff was not on the cell phone. The RN Consultant stated the nurses could be on their cell phones if it was for work related issues and the aides could be on their phones during their break but at no time was it acceptable to be on their phone while in a resident's presence. The DON said it was not acceptable to be passing medications while on the phone because there was too much room for error, just one thing at a time. The ADON said she would not feel good if the aides were on the phone while providing care because she would be worried about privacy. All of them seemed shocked when it was relayed the residents reported staff were video chatting on their cell phones. The DON stated it was the resident's right to privacy and HIPAA and broadcasting without their consent. The DON said she would feel depressed if the staff were providing care to her while on the phone. The ADON said she would feel a little depressed and angry because it was demeaning. The ADON said she had recently done an in-service on phone use. The DON said she and the ADON frequently made rounds and if they saw it the staff were told to put it up. The ADON said she saw cell phones often. The ADON said the resident council reported a specific person and they had counseling. Review of the facility's undated policy and procedure on Personal Communication Devices revealed: Use of personal communication devices during scheduled work hours is not permitted at the facility. These devices include but are not limited to cell phones and lap top computers. You may only use your personal communication devices during scheduled break/lunch times. Unauthorized used of communication devices for any reason may be grounds for disciplinary action. The facility prohibits the use of any type of cell phone camera, digital camera, video camera, or other form of image-recording device without the express permission of the facility of each person whose image is recorded. Review of the facility's Inservice, dated 12/2/24, revealed: Absolutely no cell phone use with residents. Review of the facility's Inservice, dated 1/2/25, revealed: Please do make personal phone calls while you are clocked in and working in residents area. No ear buds in ears. Personal phone calls can be made in the break room or out of the building.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48593 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards for 1 of 1 resident (Resident #86) reviewed for intravenous fluids. The facility failed to ensure the dressing on Resident #86's Mid-line intravenous line (a short flexible tube inserted into a vein to administer fluids and medications) was dated and initialed. The failure could affect residents by placing them at risk for infections. Findings included: Record review of Resident #86's admission Record, dated 01/23/2025, revealed the resident was a [AGE] year-old female who admitted to the facility on [DATE]. The resident had diagnoses which included: Chronic Kidney Disease, Type 2 Diabetes and pressure ulcers to the back, buttock and both hips. Record review of Resident #86's MDS admission assessment dated [DATE] revealed Resident #86 was moderately impaired cognitively with a BIMS score of 09. Record review of Resident #86's order report dated 01/23/25 reflected: May inset mid-line ordered on 12/18/2024, Mid-line Line Dressing Change every 3 days one time a day every 3 day(s). Record review of Resident #86's current care plan initiated 11/06/2024 revealed focus Resident #86 has a wound infection. Goal: Resident #86 will be free from complications related to infection. Interventions: Administer antibiotic as per Medical D irectors orders. Observation and interview on 01/21/25 at 03:25 PM, revealed Resident #86 was in her room, lying in her bed. She was observed to have a peripheral intravenous line dressing with no date or initials on the left upper inner arm. The dressing was intact. Resident #86 stated she was unsure the day the Mid-line was inserted or when the last time the dressing was changed. There were no signs or symptoms of infection noted at the site . Record Review of the treatment administration record revealed a documentation of dressing change on 01/19/25. Interview on 01/23/25 at 03:29 PM, the DON revealed she expected the staff to label with initials and to date the dressing. The DON stated dating and initialing the dressing was used to help monitor when the dressing had been changed and to reduce the chance of infections. Record review of the facility's policy titled Dressing changes revealed 7. Cover with transparent dressing. Label the dressing with date, time, and initial.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 30057 Based on observation and interview, the facility failed to permit only authorized personnel to have access to one of one medication room reviewed for drug storage in that: The facility Medical Records staff member had access to the medication room while unauthorized to be in the medication room unattended. These failures could place clients at risk for drug diversion. The findings included: During an observation on 01/22/25 at 04:34 PM revealed the medication room was inspected with the Medical Records staff member present. The medication room door was locked so the Medical Records staff unlocked the room with the use of a code. The medication room was unoccupied by any nursing staff. There were several over the counter and prescribed medications in the cabinets. There was a refrigerator that contained some insulins and other meds such as suppositories. There were other supplies such as blood sugar testing supplies, syringes and other supplies in general in the room. During an interview on 01/23/25 at 10:12 AM the Medical Records staff member said that she usually stocked the medication room with over the counter medications. She said at first there was usually a nurse present in the medication room but at times the nurse would step out and she would be alone in the medication room. The Central Supply staff member acknowledged that she knew the code and at times had been in the room by herself to stock the medication room. During an interview on 01/23/25 at 05:02 PM the DON was made aware of the observation of the Medical Records staff member had entered the medication room unattended. The DON said they would conduct some training and change the medication door code and only allow authorized staff to enter the room or be present with central supply staff from now on. During an interview on 01/23/25 at 05:36 PM the Administrator was made aware of the observation of the central supply staff member entering the medication room by herself. The Administrator said it was expected for someone from nursing to be in the medication room with the central supply staff member at all times and not be left alone. The Administrator said they would take care of the issue and change the door code to the medication room. The Administrator said that from now on they would make sure that only nursing staff or people authorized to enter the medication room had the code. Record review of the facility's document titled Storage of medication dated 2003 indicated in part: The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications. Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications. Medication rooms, carts and medication supplies are locked and attended by persons with authorized access.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51011 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 4 of 7 (Residents #17, #49, #60, and #67) residents reviewed for infection control. The facility failed to ensure CNAs A, B, E and D used PPE during incontinent care for Resident #17 and #60 as the residents were on Enhanced Barrier Precautions (EBP). The facility failed to ensure CNA B changed her gloves after they became contaminated during incontinent care while assisting Resident #17. The facility failed to ensure CNAs C, D, E, and F used PPE during transfers for EBP Residents #49, 60, and #67. These failures could place residents at risk for cross contamination and the spread of infection. The findings included: Resident #17 Record review of Resident #17's MDS dated [DATE] indicated she was admitted to the facility on [DATE]. Diagnoses included dementia, muscle wasting and atrophy, malnutrition, bladder incontinence and bowel incontinence. She was [AGE] years of age. Record review of Resident #17's MDS dated [DATE] indicated in part: BIMS = 99 indicating the resident was not able to complete the assessment. Record review of Resident #17's electronic medical record revealed she was on EBP due to multiple chronic lesions on her body that required wound care. During an observation on 01/22/25 at 04:12 PM on the women's unit revealed CNAs A and B performed incontinent care on Resident #17. CNA B washed her hands, donned (put on) gloves, opened Resident #17's urine-soiled brief, cleaned her vaginal area with wipes, and helped CNA A remove the wet brief. CNA B (while wearing the same gloves) and CNA A put a clean brief on Resident #17 and rearranged her clothing. While wearing the same gloves she performed incontinent care with, CNA B touched Resident #17's chin while speaking to her. Neither CNA A nor B wore gowns. During an interview on 01/23/25 at 05:09 PM with CNA B regarding the lack of changing her gloves and gowns not being worn, CNA B was asked what touching a dirty glove to Resident #17's face was called. CNA B states it is called contamination. CNA B was asked what cross-contamination could cause and CNA B stated infection. CNA B was asked why she did not wear a gown, and she stated she just forgot. Resident #49 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #49's Admission Record, dated 1/23/25, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis including Alzheimer's Disease and Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms (enlarged prostate often leading to problems with urination and urinary tract infections). Resident #49 lived on the male secured unit. Review of Resident #49's Quarterly MDS Assessment, dated 12/29/24, revealed: He had a mental status score of 5 of 15 (indicating severe cognitive impairment). He needed moderate to substantial assistance with all activities of daily living. Review of Resident #49's Care Plan, revised 3/26/24, revealed: Focus: Resident #49 was on enhanced barrier precautions due to a past diagnosis of Extended-spectrum Beta-lactamase (an anti-biotic resistant e-coli bacteria). Goal: There will not be any transmission of infection from or to him. Interventions: Gloves and gown should be donned if any of the following activities are to occur: transfer. Perform hand sanitization before entering the room and prior to leaving the room. Observation and interview on 1/22/25 at 5:54 p.m. revealed CNA C and CNA D washed their hands and put on gloves but not gowns. CNA C helped Resident #49 sit up in his wheelchair, took off his shirt and placed a hospital gown on him. CNA D placed the gait belt on Resident #49. They helped Resident #49 transfer, covered him in a blanket, took off her gloves and [NAME] it away. The Surveyor asked which resident in the room was on enhanced barrier precaution and CNA D said it was Resident #49 but she did not know why. A check of the bathroom and top drawer of Resident #49's dresser and nightstand revealed no PPE. Resident #60 Review of Resident #60's Admission Record, dated 1/23/25, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included osteomyelitis left foot and ankle (bone infection), surgical amputation, Methicillin Resistant Staphylococcus Aureus infection (an antibiotic resistant staph infection). Resident #60 resided on the on male secured unit. Review of Resident #60's quarterly MDS assessment, dated 12/11/24, revealed: He had a mental status score of 3 of 15 (indicating severe cognitive impairment). He needed moderate to substantial assistance with activities of daily living. He needed surgical wound care. Review of Resident #60's Care Plan, updated 3/26/24, revealed: Focus: Resident #60 was on enhanced barrier precautions due to a non-healing wound at left great toe. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goal: There will not be any transmission of infection from or to the resident. Interventions: Gloves and gown should be donned (put on) if any of the following activities are to occur: transfer, toileting/incontinent care. Perform hand sanitization before entering the room and prior to leaving the room. Review of Resident #60's Order Summary Report, dated 1/23/25 revealed orders revealed: 1/16/25 Flush IV line with 5 - 10 ml of normal saline before and after medication. 1/17/25 Ceftaroline Fosamil Intravenous Solution Reconstituted 400 mg every 12 hour for MRSA left foot/ osteomyelitis related to other acute osteomyelitis left ankle and foot. End date 1/26/25. JP Drain (Jackson Pratt Drain - a suction drain) to left foot to be emptied every shift related to encounter for aftercare following surgical aftercare. Observation and interview on 1/21/25 at 3:01 p.m. revealed CNA E and CNA D performing incontinent care and then a transfer on Resident #60 without a gown on. CNA E said she did not know if Resident #60 was on EBP or not even though there was a sign posted on the door. CNA D said she knew Resident #60's roommate was on EBP, but not Resident #60 but you'd think it'd be him. CNA D said she believed staff were supposed to use EBP when a resident had a wound, a catheter (urinary bag), or colostomy (bag attached to bag to the stomach area to collect fecal matter), anything open or infected. CNA D said the point of EBP was so the person performing care did not get the resident infected or contaminate the person performing care. There was not a bin of PPE outside of the room or inside the bathroom. Interview on 1/23/25 at 12:57 p.m. the ADON stated Resident #60 was colonized with ESBL caused by e-coli. The ADON stated everyone was put on barrier precautions with ESBL and the expectation was the staff do all the things like wash their hand, and put on a gown and gloves. Resident #67 Review of Resident #67's Admission Record, dated 1/23/25, revealed he was an [AGE] year-old male admitted to the facility on [DATE]. Resident #67 resided on the male secured unit. Review of Resident #67's Order Summary Report dated 1/23/25 revealed he had a Stage III pressure ulcer to the left great toe beginning 1/9/25. (A stage III ulcer has full tissue loss, but bone, tendon, or muscle is not exposed. Dead tissue may be present, but it does not hide how deep the wound is.) Review of Resident #67's Annual MDS Assessment, dated 1/2/25, revealed: He had a mental status score of 9 of 15 (indicating moderate cognitive impairment). He needed partial to moderate assistance with transfers. He had 1 stage III pressure ulcer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #67's Care Plan, updated 10/21/24, revealed: Focus: Resident #67 was on enhanced barrier precautions. Goal: There will not be any transmission of infection from or to him. Interventions: Gloves and gown should be donned if any of the following activated are to occur: transfer. Perform hand sanitization before entering the room and prior to leaving the room. Observation on 1/22/25 at 5:36 p.m. revealed CNA F left the room. CNA F returned to Resident #67's room with a gait belt, washed her hands, put on gloves, and put the gait belt around Resident #67. CNA F assisted Resident #67 to transfer from the wheelchair to the bed. She covered the resident with a resident with her gloves on. There was a bin of PPE (gowns) in the back corner of the room. CNA F removed her gloves and assisted Resident #67 in finding his television remote. CNA F left the room with the gait belt and did not perform hand hygiene. There was an EBP sign posted outside of Resident #67's room that reflected, wear gloves and a gown for the following high contact resident care activities: transferring. Interview on 1/22/25 at 6:05 p.m. the ADON stated Resident #67 had MRSA in his toes and he did have a stage III pressure ulcer that was healing but was still open. She stated the transfer expectation was that they would gown up because he was on enhanced barrier precautions. The Regional Consultant who was also present stated that any physical contact required enhanced barrier precautions even if the wound was covered. The ADON stated she expected that Resident #67 would have his own gait belt because he was on enhanced barrier precautions. During an interview on 01/22/25 at 4:50 PM with the ADON, she stated an in-service on EBP was conducted on 3/26/24. In a follow up interview on 1/23/25 at 4:05 p.m. the ADON stated she was the Infection Control Preventionist for the facility. The ADON said gloves not worn or changed during incontinent care stated that was cross-contamination with nasty hands. The ADON stated the expectation for EBP transfers was staff gown up, the gait belt was to stay with the resident, the PPE would be in the resident's room. The ADON stated right now, on the secured unit the PPE was held in the shower room so the residents would not rummage through the bin. The ADON said she and the DON were responsible for monitoring that the aides were using the PPE when going into the EBP room. The ADON said she thought the break down on the secured units was they could not have a bin in the front of the room because the residents would rummage, and she and the DON had discussed putting a sign above the resident's bed to make it more obvious the resident needed PPE. The ADON stated the potential for not following EBP precautions was infections. The Regional Consultant who was present stated the whole point was to stop cross contamination in the building to keep it from getting on clothing and keep it from getting into an open area for another resident and get that resident infected. The ADON said the potential for not washing hands after would be cross contamination. The ADON said Obviously I taught them. I can lead a horse to water, I can't make them drink. The ADON said the DON and she did rounds every day in the morning and in the evening. Review of the facility in-service dated 3/26/24 on Enhanced Barrier Protections revealed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	We are using Enhanced Barrier Precautions to help protect our residents from infection. You may notice New signs through the facility. Staff wearing gowns and gloves for high-contact care activities. Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multi-drug resistant organisms in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO. As well as those at risk of MDRO acquisition (e.g. resident with wounds or indwelling medical devices). Record Review of the facility's policy titled Enhanced Barrier Precautions (EBP) dated 04/01/2024 indicated in part: Changing briefs or assisting with toileting requires staff to don gloves and a gown. Review of the facility's Orientation Process on Cross Contamination, revised 3/1/24 revealed: Preventing cross-contamination is a key factor in preventing illness. Cross contamination is the spreading of germs, bacteria and/or disease by carrying them from an infected area to a non-infected area. If a healthcare employee is wearing protective gloves and then comes into contact with the resident's blood, he/she is protected. However, if he/she goes to another task without removing the gloves and handwashing, the task area or object has then been cross-contaminated with blood borne pathogens. If he/she puts on a new pair of gloves, but then picks something off the floor and then touches the resident, the resident has been cross-contaminated with numerous unknown bacteria.