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	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Nursing and Rehabilitation	2510 West 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 observation, the facility failed to designate a registered nurse to serve as the director of nursing on a full-time basis. The facility failed to ensure they employed a full time or interim DON from 02/25/2026 through present date of exit 04/23/2026.This failure could place all residents at risk of not receiving necessary care and services.Findings included:In an interview on 04/23/2026 at 10:24 AM with the Corporate Nurse, he stated he was the Interim DON. He stated he worked 2 days a week, 8-hour shifts, at this Nursing Facility as the DON. He stated he lived close by and was always readily available if needed. He stated he did not believe there was a potential risk for residents not having a full-time DON at the facility. He stated he monitored nurses and residents via online.In an interview on 04/23/2026 at 3:45 PM with the Administrator, he stated the Corporate Nurse was the current DON. He stated he was not aware how many days or hours the DON worked at the facility. He stated he did not believe there was potential risk to residents for not having a full-time DON at the Nursing Facility.In an interview on 04/23/2026 at 10 AM, the Administrator stated the facility did not have a policy for the DON requirement, and the facility followed state regulations.Record review of the Texas State Regulations, it read in part: 483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review the facility failed to ensure the residents right to personal privacy and confidentiality of his or her personal and medical records for 8 of 10 staff (LVN C, LVN M, MA N, MA O, RN H, LVN P, RN Q, RN G). The facility failed to ensure LVN C, LVN M, MA N, MA O, RN H, LVN P, RN Q, and RN G did not use their personal laptops to access residents' medical records and document care provided without any safeguards in place to ensure security of residents' confidential information. This deficient practice placed residents at risk for having their sensitive patient health information disclosed.Findings include: In an observation on 04/21/2026 at 2:57 PM LVN C was observed completing work on her personal computer during medication administration. On 04/23/2026 at 10:19 AM, LVN M was observed completing work on her personal computer. On 04/23/2026 at 10:35 AM, CMA N was observed completing work on her personal computer during medication administration. On 04/23/2026 at 10:43 AM, CMA O was observed completing work on her personal computer during medication administration. On 04/23/2026 at 10:59 AM, RN H was observed completing work on her personal computer. On 04/23/2026 at 2:42 PM, LVN P was observed completing charting on her personal computer. On 04/23/2026 at 4:45 PM, RN Q was observed completing work on her personal computer. On 04/23/2026 at 4:48 PM, RN G was observed completing work on her personal computer. All staff were briefly interviewed and provided verbal confirmation it was their personal computer, all computers varied in models and customizations (stickers). In an interview on 04/21/2026 at 2:57 PM with LVN C stated the laptop on the medication cart was her personal computer. She stated she had not received instruction from her superiors to bring her own laptop to complete work. She stated she was notified by colleagues to bring her own computer to complete work responsibilities. She stated other staff members used their own personal devices for work but was unable to identify which employees used their own personal device. In an interview on 04/23/2026 at 9:09 AM with the Regional HR Coordinator stated the direct care staff was provided the nurse station computers, kiosks and facility owned tablets/laptops. She stated that all the devices were facility owned and staff should only be using these computers for resident records. She stated there was an additional safety measure that the facility's digital medical record had that restricted access to the database without the network Wi-Fi. She stated that staff should not be using their personal devices to be charting and completing tasks related to work. She stated that personal health information was accessible on the facility's digital medical record to include residents': social security numbers, dates of birth, addresses, phone numbers, insurance numbers, etc. She stated that only company issued laptops should be used to access the facility's digital medical record. She stated that facility should make rounds on staff and monitor for personal equipment use. She stated that personal communication devices are prohibited from use in the facility for work related tasks as outlined in the Employee Handbook topic Personal Communication. She stated department supervisors were responsible for ensuring staff adhered to the Employee Handbook. She stated that the facility could not be aware what the staff was doing with the information and there could be unauthorized downloads of resident personal health information. She stated there was potential for the information to be leaked accidentally or intentionally and the facility was not able to monitor for cybersecurity risks. She stated employees are made aware that personal laptops cannot be used for work upon hire. In an interview on 04/23/2026 at 10:19 AM with LVN M stated she was using her personal computer at the moment. She stated the facility provided a laptop but it stopped working and she notified the previous HR coordinator in October 2025. She added that the HR coordinator she notified quit and nothing was done following this notification. She stated she had not brought it up to any supervisor's attention since then. She stated that the facility's laptop was not turning on or charging properly. She stated that no one instructed her to bring her personal computer and added she did not gain permission or authorization to use her own. She stated she did not know if she could use her own personal device for work related tasks. She stated the only (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concern with staff using their personal laptop was a HIPAA issue. She stated the information available on a residents' medical chart included: care, physician orders, medical records, care plan, profiles (name, date of birth , insurance, address, phone numbers, social security numbers), and labs. She stated the information on the medical chart was downloadable for staff. She stated she did not know whose responsibility it was to monitor and ensure that staff was not using their personal devices for work. She stated there was only 1 desktop at the nurses station but it had consistent technical issues like disconnecting from the internet. She stated she would like the facility to do something about the computer and laptop issue because it affected how she completed her job. She stated she needed a laptop to review orders and complete documentation. In an interview on 04/23/2026 at 10:35 AM with CMA N stated that when she first started working at the facility a month ago, she was notified by colleagues that she would have to provide her own computer because there was not enough. She stated these were not instructions from her supervisors but from fellow nurses and medication aides. In an interview on 04/23/2026 at 10:43 AM with CMA O stated she had to buy her own laptop because the facility's issued equipment was either scarce or broken. She added she was not instructed by the facility to provide her own laptop. She stated she reported her concerns about limited functional laptops a year ago. She stated she provided a list of equipment needed to the administrator and to the previous DON about 2 months ago. She stated the facility needed approximately 7 laptops to cover the nurses and medication aides on the floor not including the memory care unit. She stated she does not think the equipment at the nurses station was working which included 2 laptops and 1 desktop. She stated the lack of electronic devices had been ongoing for a year. She stated she had not been notified by the facility that it was not permitted for staff to use their personal laptops for work responsibilities. She stated if she could not use her personal device then it affected the residents she cared for because she would not be able to complete her responsibilities. She stated she needed a laptop to access charts, enter records, and review medication orders. She stated she did not see how it affected residents if staff was only using their laptop for their work obligations. She stated that there was no potential for leaks of information and cybersecurity risks. She stated that personal information was on a resident's medical chart to include social security numbers, diagnosis, dates of birth, phone numbers, and more. She stated she would like the facility to provide an issued computer for her to complete her work responsibilities. She stated with the current laptops and computers she could not complete her tasks. She stated she did not know if she could use her personal computer for work per facility policy. In an interview on 04/23/2026 at 10:59 AM with RN H stated she was using her personal computer for work. In an interview on 04/23/2026 at 2:42 PM with LVN P stated she had worked at the facility for 7 years and had used her own laptop for the past 3 years. She stated none of the facility computers worked except for one, but did not know which one was properly functioning. She stated this had been an ongoing issue and there has only been one computer replaced since the Administrator began working. She stated the new computer was the single desktop that was located in the nursing station and was intended to accommodate potentially 4-5 staff members who needed to document and review orders for 3 hallways. She stated if she did not use her personal computer she would not be able to effectively complete her job. She stated the laptop was her personal and the facility had no monitoring or responsibility to fix it if it broke. She stated she would like to have a laptop issued from the facility to complete her job. She stated the laptops in the facility were not operational, do not turn on, or do not properly charge. She stated it was the facility's responsibility to provide equipment to complete her job. In an interview on 04/23/2026 at 2:54 PM with the ADON stated the facility had always struggled with laptops. She stated the facility sent out 10 laptops for repair when the Administrator began and had not been repaired or returned by the IT department handling the repairs. She stated the facility had not had enough laptops for staff since December 2024. She stated she had never instructed staff to bring their own personal laptop to complete work. She added to her knowledge the previous DON and previous Administrators had never provided instruction for staff to (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bring their personal laptops for work responsibilities. She stated she did not know if there were any firewalls and safeguards for staff who use their personal computer at work. She stated there was a concern for potential to leak resident information if staff were using their personal laptops. She stated to her knowledge there were no information leaks and added she was not sure how it would be monitored. She stated information that could be leaked include medications, diagnosis, social security numbers, dates of birth, addresses, next of kin, phone numbers. She stated it was not permitted per facility policy for staff to use their personal devices for work related responsibilities. She stated she had not instructed any staff member to cease using their personal devices. She stated the alternative was staff would not be able to document and complete responsibilities and tasks. She stated it affected residents by causing potential leak of information. She stated if the facility did not provide equipment it greatly affected the staffs' ability to complete their daily responsibilities and tasks. She stated the Administrator was responsible for creating the work order and ensuring that equipment was working or being fixed. She stated the Administrator created a work order for the 10 laptops sent out in January 2026. In a follow up interview on 04/23/2026 at 4:53 PM, she stated she had a facility issued laptop and desktop in her office. She added she was the only one permitted to access these devices and staff were not permitted to complete work related responsibilities on it. In an interview 04/23/2026 at 3:53 PM with the Administrator stated that staff were using facility issued laptops and could not confirm if there were staff members who used their personal laptops. He stated it was okay based on his interpretation of the employee handbook policy for staff to use their personal computers because it was referring to the laptop being used as a communication device and not as a work related device. He stated that the facility had enough computers for staff to be completing their tasks. He stated there were 3 computers for the direct care nurses, a tablet kiosk, and desktops/laptops for the Social Services and ADONs. He stated he did not know if staff were permitted to use the devices issued to the Social Services and ADONs. He stated the medical database included residents' social security numbers, dates of birth, names, phone numbers, diagnosis, medications, orders. He stated he did not know if there was cyber security monitoring in place for staff members that were completing work tasks on their personal computers. He stated he did not have any work orders or documentation for laptops he sent out in January 2026 and added he did not send out any laptops. In an interview on 04/23/2026 at 4:43 PM with RN Q stated she used her own personal laptop to document and review orders for residents in the men's memory care unit. She stated she was never issued a facility laptop and there was no desktop available to her in the memory care unit. She stated the kiosk behind the nurses station in the memory care unit was for CNAs and did not support the access to the medical portal she needed to complete documentation and review orders. She added the kiosk did not properly work and the CNA had a portable tablet kiosk to complete her work issued by the facility. In an interview on 04/23/2026 at 04:48 PM with RN G stated she used her personal laptop to complete documentation and order review. She stated she did receive a facility issued laptop but left it at the main nurses station for others to use in case they did not have a laptop to chart. She stated this was on her own preference to use her personal laptop. She stated she did not gain permission from leadership to use her personal laptop for documentation. She added there was no other facility issued laptop or desktop in the women's memory care unit for staff to complete documentation. She stated the kiosk for the CNA was properly functioning and her CNA had not notified her otherwise. In an interview on 04/23/2026 at 4:55 PM with ADON B stated she had a facility issued laptop and desktop in her office. She added she was the only one permitted to access these devices and staff were not permitted to complete work related responsibilities on it. In an interview on 04/23/2026 at 4:57 PM with the Social Services Coordinator stated she had a facility issued laptop and desktop in her office. She added she was the only one permitted to access these devices and staff were not permitted to complete work related responsibilities on it. She stated she kept her office locked when not in the room and the desktop had a login only for her to access. Record review of the facility's Employee's Handbook / Policy Review undated, read in part, (General statement) it is the responsibility of the (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	employee to read the Employee Handbook in its entirety and adhere to the instructions found within .Failure to read the handbook is not a reason for not adhering to the policies and will not be allowed as a reason for violating any facility policy (Confidentiality) All information learned while working at the facility is to be kept confidential to each employee when they are not at work, not confidentially speaking with an appropriate employee about the information etc. it is very important to not speak of any information of a resident, co-worker or the facility while out shopping, eating in a restaurant, etc. Facility information should remain in the facility and not the public (Personal Communication) Employees are not permitted to use any form of personal communication devices while at work, unless specified as required use with their job assignment. This includes cell phones, smart phones, laptops, notebooks, notepads, or PDA devices (Computers/ emails / Internet) Employees are not to use the facility computers, internet, or email systems for their own personal entertainment or use. These are intended for business use only

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals for 3 of 3 residents (Resident #58, #68, #77) reviewed for respiratory care. - The facility failed on 04/21/2026 to ensure Resident #68's oxygen concentrator was turned on for 3 and a half hours as per vitals collected at 1:30 PM by LNV C.-The facility failed on 04/21/2026 to ensure Residents #58, #68, and #77 had an oxygen in use signage on the doorway entry. This failure placed residents at risk of not receiving respiratory care or the hazards of machine malfunction or accelerating the spread of fire associated with oxygen usage.Findings included: Resident #58 Record review of Resident #58's admission record dated 04/23/2026 revealed a [AGE] year-old male with an initial admission date 01/28/2026. Record review of Resident #58's comprehensive MDS dated [DATE] revealed the resident had a BIMS score of 99 with the significance being the resident was unable to complete the interview. Under Section O (special treatments) the resident was coded for receiving oxygen therapy. Record review of Resident #58's care plan dated 01/28/2026 revealed the resident had a focus area on chronic obstructive pulmonary disease (a progressive, incurable lung disease) with an intervention to give oxygen therapy as ordered by the physician. Record review of Resident #58's physical and history dated 02/16/2026 revealed the resident was diagnosed with chronic obstructive pulmonary disease (a progressive, incurable lung disease), malignant neoplasm of lung (cancerous growth in the lung tissue or airways). Record review of Resident #58's orders dated 01/29/2026 revealed the resident had an order for oxygen administration of 2-4 Liters per minute, with a frequency of every shift. In an observation on 04/21/2026 at 10:41 AM revealed there was no oxygen in use sign posted on the Resident #58's doorway while there was an oxygen concentrator in her room. Resident #58 was unavailable for an interview despite numerous attempts on 04/21/2026 at 10:41 AM, 11:48 AM, and 4:06 PM. In an observation on 04/23/2026 at 9:37 AM Resident #58 was observed not on portable oxygen and was ambulating with a walker aid. Resident #58 showed no signs of distress, labored breathing, skin discoloration, or faintness. Resident #68 Record review of Resident #68's admission record dated 04/23/2026 revealed a [AGE] year-old Male with an initial admission date on 04/08/2026. Record review of Resident #68's comprehensive MDS dated [DATE] revealed under section C (cognitive patterns) the resident had BIMS score of 99 due to rarely/never being understood during interviews with the significance being severe cognitive impairment. Under Section O (special treatments) the resident was coded for needing continuous oxygen therapy since admission. Record review of Resident #68's care plan dated 04/09/2026 revealed the resident had a care focus area for oxygen therapy with interventions of monitoring for signs and symptoms of respiratory distress (a critical condition indicating difficulty breathing, characterized by rapid, shallow breaths, wheezing, and the use of muscles) and notify the nurse if the oxygen is off the resident. The resident had an additional care focus area for addressing communication problems. Record review of Resident #68's physical and history dated 04/20/2026 revealed the resident was diagnosed with chronic obstructive pulmonary disease (a progressive, incurable lung disease), aphasia following a cerebral infarction (an acquired language disorder caused by a stroke). Orders to monitor Resident #68's oxygen saturation closely were noted in the physical and history. Record review of Resident #68's orders dated 04/08/2026 revealed the resident had an order for oxygen administration of 2-4 LPM, with a frequency of every shift. In an observation on 04/21/2026 at 9:54 AM, Resident #68 was observed lying in bed asleep and not responding to verbal stimuli. Resident #68 had his nasal canula applied properly, but his oxygen concentrator was not on; no vitals had been taken for current oxygen saturation levels per record review of digital health record. Resident #68 did not display any signs of respiratory distress or discoloration in skin. There was no oxygen in use sign posted on Resident (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#68's doorway. A follow-up observation completed at 11:14 AM revealed no change in Resident #68's condition or in the oxygen concentrator. A follow-up observation at 3:21 PM revealed the oxygen was turned on, and Resident #68 had his cannula administered properly with no signs of respiratory distress or discoloration in skin. Record review of Resident #68's vitals revealed his oxygen saturation level measured at 96% on 04/21/2026 at approximately 1:30PM by LVN C. Resident #77 Record review of Resident #77's admission record dated 04/23/2026 revealed an [AGE] year-old female with an original admission date 10/07/2020 and a readmission [DATE]. Record review of Resident #77's quarterly MDS dated [DATE] revealed under section C (cognitive patterns) revealed the resident had a BIMS score of 15 with the significance being the resident was cognitively intact. Record review of Resident #77's care plan dated 03/20/2026 revealed the resident had a care focus area of Emphysema (characterized by damage to the lung's alveoli [air sacs]) with an intervention to ensure the resident will be free of signs and symptoms of respiratory insufficiency. Record review of Resident #77's physical and history dated 04/03/2026 revealed the resident had a diagnosis of acute on chronic respiratory failure with hypoxemia (abnormally low concentration of oxygen in the blood) with an order to continue oxygen therapy and monitor oxygen saturation closely. Record review of Resident #77's orders dated 03/23/2026 revealed the resident had an order for oxygen administration of 2-4 LPM, with a frequency of every shift. In an observation on 04/21/2026 at 10:12 AM revealed there was no oxygen in use sign posted on Resident #77's doorway while there was an oxygen concentrator in her room. In an interview on 04/21/2026 at 11:15 AM with Resident #77 she stated she did have the oxygen concentrator but did not utilize it because she was getting better and did not need it. She stated she was on oxygen previously but was unable to remember the beginning and end of her treatment. She stated she did not have any difficulty breathing, faintness, and did not display skin discoloration. In an interview on 04/21/2026 at 3:09 PM with LVN C stated she checked Resident #68's oxygen saturation and it was in the 80's when she first measured it at approximately 1:20 PM before oxygen administration. She stated a physical therapist notified her that Resident #68 did not have his oxygen on and proceeded to go check the oxygen concentrator because it was not connected. She stated she did not know why she did not document the oxygen saturation being in the 80's but that she documented the 96% level in his vitals after she administered oxygen therapy. She stated signs and symptoms of a resident without oxygen could be labored breathing and discoloration in fingertips. She stated that healthy oxygen saturation was above 95%. She stated she did not know if the resident required continuous oxygen. She stated she completed her assessment of lungs and heart after the discovery of Resident #68's oxygen concentrator was not working for an unknown amount of time. She stated Resident #68 did not display signs or symptoms of respiratory distress. She stated she checked resident oxygen connections and usage during vital checks, which was usually once per shift. She stated that if a resident did not receive oxygen, they could have difficulty breathing, fall unconscious, and die. She stated the nurses were responsible for checking oxygen saturation and ensuring oxygen concentrators were turned on. She stated the Administrator and ADON oversaw the nurses to ensure tasks were completed. She stated the, oxygen in use and no smoking sign should be posted on the residents' doorway to inform others to not smoke or have fire in the room because it was a hazard with the flow of oxygen. She stated that it was Administrator's and direct care staff responsibility to place signage on residents' doorways. In an interview on 04/21/2026 at 4:27 PM with COTA F stated Resident #68 was non-verbal and would not be able to vocalize if he was in pain or discomfort. She stated that he required yes or no questions to respond to staff. She stated she worked with Resident #68 about 4 times a week for 30 minutes at a time. She stated if he reported or displayed any pain or grimacing, she would alert the nurse immediately. She stated she went to talk to LVN C after initial contact with Resident #68 for his occupational therapy session when she noticed Resident #68's oxygen concentrator was not on at 1:20 PM; she stated Resident #68 was on continuous oxygen based on her previous observation with him. She stated the oxygen saturation was 86% when LVN C initially measured it. She stated LVN C then proceeded to (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	power on the oxygen concentrator at approximately 1:25 PM. She stated LVN C remeasured Resident #68's oxygen saturation, and it increased to the 90s a few minutes after oxygen was readministered. She stated she did not know when the oxygen concentrator stopped working. She stated Resident #68 was more lethargic than usual and was not easily aroused by touch and verbal as before. She stated anyone who goes into the room can turn on the oxygen concentrator and connect the cannula to the resident. She stated that a resident could experience shortness of breath, lethargy, discoloration of extremities, if they were deprived of oxygen from a tank or concentrator. She identified that the nursing department was responsible for monitoring oxygen saturation levels and oxygen related equipment. In an interview on 04/23/2026 at 12:47 PM with CNA E stated as a CNA she can correct the nasal canula and turn on residents' oxygen concentrator. She stated if she discovered a resident with oxygen concentrator turned off she would notify the nurse immediately to measure oxygen saturation levels and turn on the machine. She stated oxygen deprivation symptoms include, skin color change, shortness of breath, labored breathing, and body tremors. She stated the nurse needed to be notified immediately because if the resident was on continuous oxygen, there was potential for injury without it. She stated that nurses usually monitor residents' oxygen concentrators and oxygen tanks. She stated that CNAs during rounds review the resident and ensure the oxygen concentrator was on and the cannula was properly applied. She stated that CNAs make rounds every 2 hours. She stated that if a resident did not have oxygen from 9:54 AM to 1:30 PM, it was an issue. She stated the oxygen use and no smoking signs should be on residents rooms that contained oxygen devices. She stated the signage needed to be posted to notify everyone that there was oxygen in use. She stated it affected residents because staff could not know if there was oxygen in use and added it was a safety concern. In an interview on 04/23/2026 at 3:16 PM with ADON D stated residents who needed continuous oxygen needed to have their oxygen concentrator operational to prevent respiratory distress. She stated it was a concern if the resident did not have their oxygen for 3 and a half hours. She stated that if oxygen saturation levels dropped to 86% respiratory treatment needed to be initiated immediately. She added staff needed to notify the physician, leadership, and provide report to the resident's nurse. She stated staff needed to make rounds every 2 hours to ensure oxygen was being administered for residents on continous oxygen. She stated the nurse needed to turn on the oxygen concentrator because other staff members did not hold the credentials to assess respiratory distress. She stated it would be any non-nurse staff members' responsibility to notify the nurse immediately. She stated that if oxygen saturation continued to decrease after the oxygen was administered, then the resident could be experiencing respiratory failure. She stated that the oxygen concentrator and respiratory assessment completed by the nurse needed to be documented on the resident's profile. She stated that the oxygen use and no smoking signs needed to be posted outside the residents' doorway. She stated if a resident had oxygen devices in their room either in use or not in use, then the sign needed to be up as soon as they received the equipment. She stated that any staff member could place the magnet on the residents' doorway. She stated that if it was not in place then some people could not be aware of which residents had oxygen. She identified herself and all staff members were responsible for ensuring signage was in place. In an interview on 04/23/2026 at 3:30 PM with RN G stated if she located a resident with low oxygen saturation levels she would reapply the oxygen source, complete a respiratory assessment and neurochecks. She stated she would have to discover the reason the oxygen concentrator stopped working to identify the source of the failure and ensure it did not occur again. She stated after that she would document the incident and notify all parties to include the physician, ADON, and resident's family and follow any new orders provided. She stated even if the oxygen saturation levels returned back to optimal (95%) she would still notify all parties and provide report to the resident's nurse and incoming shift nurse. She stated this needed to be followed because a lot of things could go wrong if a resident did not receive oxygen. She stated if oxygen dependent residents did not receive ample oxygen source it could result in brain damage, organ failure, perfusion (failure to deliver oxygenated blood to tissues and organs), lethargy, critical (continued on next page)

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	675928	A. Building B. Wing	04/23/2026

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vital signs, and potentially death. She stated the nurses were responsible for tracking and monitoring residents' oxygen levels and ensuring care followed the orders. In an interview on 04/23/2026 at 4:26 PM with the Administrator, he referred to the nursing department for responses regarding oxygen related questions due to limited clinical knowledge on the subject. Record review of the facility's policy titled Oxygen Administration dated 02/13/2007 read in part, Oxygen therapy is also prescribed to ensure oxygenation of all body organs and systems (Goals) The resident will maintain oxygenation with safe and effctive delivery of prescribed oxygen. The resident will maintain an effective breathing pattern with administration of oxygen (Procedures) Become familiar with the type of oxygen administration, medical diagnosis, and reason for oxygen, intermittent or continuous use of oxygen, amount to be delivered Turn on oxygen after properly setting for volume and place device in position Place NO SMOKING signs in area when oxygen is administered and stored Document care Record review of the facility's policy titled, Compressed Gases, Safe Handling of dated 12/10/2015 read in part, When cylinders are used in resident rooms appropriate warning signs are to be placed at the entrace of the resident's room. Record review of the facility's last in-service for respiratory distress and oxygen administration reflected it was dated 04/13/2026 for CNAs and 04/14/2026 for nurses.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature for 2 of 4 items served on a sample tray (cold items) reviewed for food and nutrition services. -The facility failed on 04/22/2026 to provide a pudding dessert and tossed salad below 41 F. This failure places residents at risk of food-borne illnesses, decreased appetite, and overall meal dissatisfaction.Findings include: In an observation completed on 04/22/2026 at 12:31 PM, the facility provided a regular diet sample tray to the survey team to address meal service concerns. The sample tray arrived at the conference room at 12:43 PM, an 11-minute time elapse from the point it left the kitchen steam table. The sides that were intended to be served cold (below 41 F) were measured by the Dietary Manager and read at 53.2 F for a pudding dessert and 69.4 F for a tossed salad. In an interview on 04/22/2026 at 12:35 PM with the Dietary Supervisor I she stated temperatures should be 41 F or below for the cold served items. She stated the salad was in the ice bath and the pudding was in the fridge prior to meal service to maintain the cold serve temperature standard. She stated cold items not held below 41 F could develop bacteria during the resting time. She stated the puddings was stored in the fridge until 10 minutes before serving to residents. She stated she did not know if the puddings were held in the fridge today. She stated the salad was on an ice bath near the steam table before being placed on a resident's tray. She stated the dietary supervisor and manager were responsible for monitoring food temperatures. She stated temperatures were taken daily before meal service to ensure food served was not in the range of 41 F to 140 F. She stated residents could get sick if they received food out of the temperature within the range and could experience an upset stomach. She stated if the food was out of temperature range for a hot item, it should be reheated to 165 F for 15 seconds and for cold items, they should be cooled down to 41 F or below. She stated that cooks and supervisors monitor and measure the temperatures in the daily log daily before meal service;. She provided a record of meal temperatures captured before meal service on 04/22/2026 at 2:00 PM. Record review of the facility's temperature log for lunch on 04/22/2026 revealed the tossed salad measured at 40.8 F and pudding dessert measured at 40.1 F before meal service began. In an interview on 04/23/2026 at 11:31 AM with [NAME] J he stated the temperature danger zone for food was from 43 F to 145 F. He stated that food could develop pathogens and could become spoiled if it was in this range for too long. He stated that hot foods need to be served between 155 F to 175 F. He stated cold foods needed to be served between 31 F to 41 F. He stated the temperatures for the cold items from the lunch sample were not acceptable. He stated he monitored the temperatures before serving on the tray line before every meal service. He stated if food was not in the temperature range, it needed to be heated up or cooled down before being served. He stated cooks and supervisors were responsible for completing temperature logs every day before every meal. He stated if a resident was served food not within the acceptable hot and cold food temperature range they could be served late or they could get sick. He stated he could not remember the last in- service for safe food temperature but suspected it was 2 months ago. In an interview on 04/23/2026 at 2:02 PM with Dietary Supervisor K she stated she measured the food temperatures on the steam table before every meal service for hot and cold served items. She stated the food temperature danger zone for food was 45 F to 140 F. She stated food that entered the danger zone could develop bacteria and it could go bad. She stated hot items needed to be served at 140 F and higher she stated cold items needed to be served at 45 F and below. She stated it affected residents by exposing them to food that could have developed bacteria and the palatability of the food. She identified herself and the cooks were the individuals responsible for completing temperature logs and ensuring food was served with these standards in mind. She stated the temperatures of the cold served items from the test tray were unacceptable. She stated she did not recall the last in- service for food temperature monitoring. Record review of the facility's policy titled, Daily Food Temperature Control dated 2012 read in part, We will assure food is (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	served at a safe temperature. Temperatures of all hot and cold food shall be taken prior to every meal service and record on the Temperature Log. This is done to help ensure that food is safe and is served within acceptable ranges (Procedure) Cold foods shall be less than 41 F.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for sanitation and food storage. -The facility failed on 04/21/2026 to ensure a moldy tomato was not stored in the walk-in fridge.- The facility failed on 04/21/2026 to ensure different produce were not stored in the same bag (tomato with green onions).- The facility failed on 04/21/2026 to ensure a bag of green onions, bologna sandwiches, and hardboiled eggs in the walk-in fridge were labeled.- The facility failed on 04/21/2026 to ensure a box of chicken thighs was not leaking fluids, labeled, and was stored to maintain a temperature below 41 F. This failure had the potential to place residents at risk for foodborne illness.Findings included: During an observation and brief interview of the initial tour of the kitchen which began on 04/21/2026 at 8:35 AM with Dietary Supervisor I revealed at 8:41 AM, a tomato that had developed mold was stored in an unlabeled bag and shared the same space with green onions. At 8:45 AM, a bag of hard-boiled eggs with varying age with signs of spoilage, was discovered without a label; a bag of green onions that were showing signs of spoiling (lack of firmness, discoloration, and fluid build-up) was unlabeled; and a bag of bologna sandwiches were unlabeled. At 8:50 AM, a box of chicken thighs was discovered to be leaking in the walk-in fridge and presented with excessive fluid build-up and unlabeled. The Dietary Supervisor I stated she transferred the chicken thighs from the freezer to the walk-in fridge to defrost on 04/17/2026 at approximately 12:00 PM. She added it was her intention to cook them on 04/20/2026. The chicken thighs were removed from the fridge by [NAME] J, and a temperature check was requested of the chicken thighs. At 8:54 AM, 2 different chicken thighs were tested from the box and measured at 45 F by [NAME] J with Dietary Supervisor I and Dietary Supervisor K present during reading and acknowledged of results. Follow up observation of the kitchen on 04/22/2026 at 10:30 AM revealed no additional findings. In an interview on 04/23/2026 at 11:06 AM with Dietary Aide L she stated her responsibilities were to set up the drink area, clean the milk container, and prepare the dessert and beverages for the next day. She stated she goes into the fridge to obtain snacks. She stated if she found moldy, unlabeled, or mixed items she needed to throw them away because it was cross contamination. She stated it was a daily chore for Dietary Supervisor K to review all the ingredients in the kitchen. She stated if this was not completed the residents could get sick or bugs could get in the fridge. She stated she did not know the temperature at which poultry needed to be stored in the fridge. She stated she did not know the range for food temperature danger zone. She stated the last in-service received for sanitary and food storage was in March/April 2026. She stated the dietary staff were responsible for ensuring the kitchen upheld sanitary and safe serving conditions, and the Dietary Supervisors were responsible for ensuring it was being completed by dietary staff. In an interview on 04/23/2026 at 11:23 AM with [NAME] J he stated it was not appropriate for spoiled, unlabeled, and mixed items to be in the walk-in fridge. He stated labels needed to be used to inform staff when the item can last be used. He stated he checked the ingredients in the walk-in fridge every time he entered the fridge. He stated the temperature for the fridge was checked twice a day by cooks and dietary supervisors. He added the Dietary Supervisors were responsible for checking the contents of the fridge. He stated that it was checked at least once a day. He stated that everyone was responsible for ensuring items were labeled in the walk-in fridge. He stated if there was an unlabeled item, staff had to pull it out and label it for 4 days ahead. He stated the temperature of the chicken thighs was 45 F. He stated that the temperature of the chicken thighs needed to be 41 F or below because it could grow bacteria otherwise. He stated the chicken thighs were discarded the same day. He stated that the fluid buildup was a sanitary concern and was a cross-contamination issue for the kitchen. He stated the last in-service he received for food storage and sanitary conditions was on 4/14/2026. He stated that residents could get sick and experience diarrhea if staff (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not adhere to standards. In an interview on 04/23/2026 at 1:25 PM with Dietary Supervisor I she stated the concerning observations from the initial kitchen tour included the chicken thighs temperature while in the walk-in fridge and the box they were stored in was leaking, the storage and labeling of hardboiled eggs, tomatoes, and bologna sandwiches, separate storage of food items, and discarding moldy food immediately. She stated that Dietary Supervisor K was responsible for ensuring the walk in storage was meeting sanitary and storage regulations. She stated the routine was for Dietary Supervisor K to complete a review every morning and ensure it was up to standard. She stated that the walk through was completed before surveyor's arrival at 8:35 AM. She stated cooks and dietary aides were responsible for labeling and dating items. She stated that staff were trained to notify supervisors of ingredient concerns and discard the produce. She stated the last in-service for storage and sanitation was 2 weeks ago. She stated she felt she had enough staff members to complete all kitchen operations and maintain regulation standards. She stated that the kitchen conditions on 04/21/2026 affected residents to include changing the menu on short notice and possibly becoming sick from the food item. She identified all dietary staff were responsible for ensuring food was nutritive, sanitary, and stored in healthy conditions. She stated initial findings were below standards of food and service. She stated the chicken thighs should have been 41 F or below and added anything higher than this temperature was potential for bacterial growth. In an interview on 04/23/2026 at 1:47 PM with Dietary Supervisor K she stated the discrepancies in the kitchen from the initial kitchen tour included the mixed vegetables, chicken thighs conditions and temperature, vegetables quality, unlabeled items, and improper storage practices. She stated these were concerns with cross contamination and could result in the residents developing a food borne illness. She stated her responsibilities were to make meal tickets, monitoring staff to ensure adherence to temperature standards and cooking procedures, washing dishes, and monitoring staff's utilization of protective equipment. She stated she completed a walkthrough of the freezers and fridges every day when she gets to work. She stated she began the walkthrough before the surveyor completed an initial kitchen tour on 04/21/2026 and added she missed the opportunity to address the surveyor's findings in the walk-in fridge at the start of her shift at 6:00 AM. She stated she did not finish the walkthrough due to other responsibilities taking precedence. She stated that all dietary staff were responsible for adhering to storage and safe handling standards. She stated that staff were trained to discard all food that was unlabeled, aged, or spoiled. She stated that it affected residents by not presenting a healthy and safe environment for residents' meals. She stated residents could develop food-borne illnesses. She stated she could not remember the last in-service she provided to her staff for food storage or sanitation. Record review of the facility's policy titled, Food storage and Supplies dated 2012 read in part, All facility storage areas will be maintained in an orderly manner that preserves the conditions of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, and insects (Procedure) Open packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened As the quality may deteriorate after the date passes, the dietary manager should closely inspect any products that are past the best by date to determine if they are still good quality. If in doubt, discard the product If an item does not have a date designated by the manufacturer as an expiration date, then the item should be dated as to when it is received . Any product with a stamped expiration date will be discarded once that date passes On perishable foods, microorganisms such as molds, yeasts, and bacteria can multiply and cause food spoil If food has developed such spoilage characteristics, it should not be eaten If perishable foods are not stored at the proper temperature, spoilage bacteria can grow faster than anticipated bacteria can grow and food becomes spoiled and should not be served However, if possible food spoilage is observed prior to the best by date, the product will be discarded Frozen items that should be thawed before preparation should be stored under refrigeration until thawed, and should be dated with the date removed from the freezer

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interviews and record review, the facility failed to employ a qualified social worker on a full-time basis with a facility of more than 120 beds for 1 of 1 Social Workers reviewed. -The facility failed to ensure social services were directed by a qualified individual on 4/23/26 in a facility with 138 total capacity. This failure placed residents at risk of receiving services from a staff member not qualified to identify as a social worker.Findings included: During record review of personnel files on 04/23/2026 at 8:35 AM, it was revealed the Social Services Coordinator did not complete her bachelor's degree in social work nor did she possess licensure from the Texas State Board of Social Worker Examiners. In an interview on 04/23/2026 at 8:36 AM with the Regional HR Coordinator stated the previous Social Worker passed away in May 2025 and the facility went 8 months without a Social Service department. She stated the facility did not have a policy on Social Services qualifications but followed the regulation for qualifications for a Social Worker. She stated the Social Services Coordinator did not have a social work degree or license but had relevant course work that was adjacent. She stated she was aware that a facility with a capacity of 120 beds or more required a full-time social worker with qualifications. She stated the facility needed to adhere to the state regulation standard which required the Social Services Coordinator to possess a license from the Texas Board of Social Work Examiners. She stated that the Administrator was responsible for hiring decisions and Corporate decides the continuation. She stated it was the divisional HR chain of command and higher ups to monitor and address license concerns with the facility and its employees. She clarified that the facility HR coordinator was only responsible for monitoring and checking for license renewals. She stated that residents have not been affected because the previous 8 months the facility did not have a social services department and added the alternative would be not having a social service department. In an interview on 04/23/2026 at 12:00 PM with the Social Services Coordinator she stated she did not have a license in Social Work. She stated she had her bachelor's degree in human services. She stated that she did not know the State regulation requirements for the Social Worker qualifications in a nursing facility. She stated she had never worked in a nursing facility before. She stated her previous experience was as an advocate related services and completed tasks such as locating in network providers, providing meal service programs, advocating, setting appointments for members, attending meetings, and ensure medication compliance. She stated the Regional HR Coordinator was responsible for adhering to Texas regulation for hiring qualified staff. She stated that it affected residents if the Texas regulation was not adhered to because it was a liability. She stated she was not notified of concerns from corporate personnel regarding qualifications in her role. She stated her responsibilities in her current role were to complete care plans, BIMS, grievances, Patient Healthcare Questionnaire-9s (tool used for screening and measuring depression severity), contact family for concerns, set up appointments for eye exams, dental services, and podiatry appointments. She added that she completed social assessments and managed room changes for residents. She stated that she did not have any concerns about her roles/responsibilities in her position or concerns about being qualified. She addressed her badge displayed the title Social Worker, and clarified it was created by the Regional HR Coordinator. In an interview on 04/23/2026 at 4:15 PM with the Administrator he stated he was aware the Social Services Coordinator did not possess the qualifications to be a licensed Social Worker. He stated the facility was not within compliance of the regulation for the requirement to have a qualified full-time Social Worker for a facility with 138 bed capacity. He stated he was aware of the Social Services Coordinator educational background and credentials before hiring an proceeded with employment offer. He stated the Social Services Coordinator would be enrolling in classes to become a licensed Social Worker. He was provided an image of the Social Services Coordinator badge that read Social Worker and added he was not aware. Record review of the Texas Administration Code Rule S554.703 dated 03/11/2024 read in part, A facility of 120 beds or less must employ or contract with a qualified (continued on next page)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	social worker (or in lieu thereof, a social worker who is licensed by the Texas State Board of Social Worker Examiners A qualified social worker is an individual who is licensed, including a temporary or provisional license, by the Texas State Board of Social Worker Examiners as prescribed by Texas Occupations Code, Chapter 505 Record review of the Texas Occupations Code Chapter 505, Section 505.351. updated 09/01/2019 read in part, (Subchapter G, License Requirements) A person may not use or cause to be used the title ?social worker,' ?licensed baccalaureate social worker,' ?licensed master social worker,' ?licensed clinical social worker,' ?licensed social worker,' or any combination, variation, or abbreviation of those titles, as a professional or business identification, representation, asset, or means of obtaining benefit unless the person holds an appropriate license issued under this chapter .

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 walk-in fridge cooling system and 7 of 10 employees (LVN C, LVN M, MA N, MA O, RN H, LVN P, RN Q) not having access to facility issued laptops and desktops.-The facility failed to ensure water was not pooling under the walk-in fridge cooling system.-The facility failed to ensure laptops intended for nursing staff use were working. This failure placed residents at risk for delay in care and foodborne illnesses.Findings included: During an observation, brief interview, and record review of the initial tour of the kitchen on 04/21/2026 at 8:49 AM with Dietary Supervisor I, it was observed a small puddle of water was developing on the floor directly underneath the cooling system of the walk-in fridge. She stated she could not recall how long the walk-in fridge cooling system had been leaking for and added that she already submitted a work order to maintenance for it. A copy of the work order was requested from Dietary Supervisor I but was not fulfilled due to her not being able to find the work order. Temperature logs for the walk-in fridge did not show any variation of temperature exceeding range above 40 F for the previous 2 weeks. In an interview on 04/23/2026 at 11:15 AM with Dietary Aide L stated walk-in fridge cooling system had been leaking for a couple of weeks. She stated sometimes it leaked and sometimes it stopped. She stated it had never affected the temperature for the walk-in fridge. She stated she notified her manager in March 2026 when she noticed water pooling underneath it. She stated the Maintenance man came and fixed it in March of 2026. She stated that if equipment stopped working, she was trained to notify the supervisor immediately because something could go bad or conditions could get worse. She stated if the equipment was not working then the temperatures could be off then the residents could be served food that was spoiled. In an interview on 04/23/2026 at 11:36 AM with [NAME] J stated that the kitchen equipment worked fine except the walk-in fridge was leaking water from the cooling system. He stated he was made aware of the kitchen leak on 4/21/2026 and prior to that there were no issues. He stated it was not acceptable for the walk-in fridge to have an active leak. He stated it could raise the temperature of the walk-in fridge. He stated the PVC pipe was fixed and insulated by maintenance on 04/21/2026. He stated it affected residents because the food could not be stored in the fridge until it was fixed because of the potential for temperature issues. He stated if he discovered faulty equipment, he would report it to the supervisor immediately to ensure it was fixed. He stated all dietary staff were responsible for reporting equipment issues to the Dietary Supervisors. He stated he did not receive training on reporting broken equipment. In an interview on 04/23/2026 at 1:34 PM with Dietary Supervisor I stated she was made aware of the walk-in fridge leaking from the cooling system about 3 months ago and the previous maintenance man applied foil tape and minimized the leak. She stated that it had been difficult to maintain the fridge temperature below 40 and she noticed that it rose to 41 or 42. She stated she was not aware if this had affected the produce or meat within the walk-in fridge. She stated she was completing on going monitor and suspected that the walk-in door was not being properly closed by dietary staff. She stated the door does close all the way on its own and needed to be pressed hard because of the mechanism on the handle. She stated she believed she told the previous Maintenance worker verbally about the leak thus she did not have a documented workorder to provide. She stated the current maintenance applied the insulation on 04/22/2026. She stated there had been no leaks since 04/21/2026 She stated it was not okay for the walk-in fridge to have a leak due to safety and sanitary issues. She stated that if equipment was properly functioning, it should not be leaking. She stated staff was trained to notify maintenance or supervisor for equipment issues immediately. She stated that if further concerns rose with leaking or temperature, she will notify maintenance. She stated the current Maintenance Supervisor had been working at the facility for a week. In an interview on 4/23/2026 at 4:20 PM, the Administrator stated the copper pipe from the cooling fan in the walk-in fridge was producing condensation and attributed the puddle of water on the floor to it. He stated (continued on next page)

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	675928	A. Building B. Wing	04/23/2026

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

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was no leak in the walk-in fridge and there was nothing wrong with the fridge cooling system. He stated insulation was placed to resolve the water that was dripping from excess condensation. He stated no work order existed for the walk-in fridge cooling system because it did not need repair. Record review of invoice from a local HVAC dated 07/22/2025 read in part, The tech checked all of the AC units and made sure they had freon and were working properly. Record review of a facility generated maintenance review dated 04/16/2026 read in part, Food preparation Equipment: Inspect kitchen small appliances Steps: Conduct safety and operations inspections Visually inspect all appliances for damage. Inspect electric cords and connections. Test functionality of appliance and proper operation of all controls. Lubricate per manufacturer's spec as needed (Notes) ?Had no issue everything was in working condition.' In an observation on 04/21/2026 at 2:57 PM LVN C was observed completing work on her personal computer during medication administration. On 04/23/2026 at 10:19 AM, LVN M was observed completing work on her personal computer. On 04/23/2026 at 10:35 AM, CMA N was observed completing work on her personal computer during medication administration. On 04/23/2026 at 10:43 AM, CMA O was observed completing work on her personal computer during medication administration. On 04/23/2026 at 10:59 AM, RN H was observed completing work on her personal computer. On 04/23/2026 at 2:42 PM, LVN P was observed completing charting on her personal computer. On 04/23/2026 at 4:45 PM, RN Q was observed completing work on her personal computer. All staff were briefly interviewed and provided verbal confirmation it was their personal computer, all computers varied in models and customizations (stickers). In an interview on 04/21/2026 at 2:57 PM with LVN C stated the laptop on the medication cart was her personal computer. She stated she had not received instructions from her superiors to bring her own laptop to complete work. She stated she was notified by colleagues to bring her own computer to complete work responsibilities. She stated other staff members used their own personal devices for work but was unable to identify which employees used their own personal device. In an interview on 04/23/2026 at 9:09 AM with the Regional HR Coordinator stated the direct care staff was provided the nurse station computers, kiosks and a facility owned tablets/laptops. She stated that all the devices were facility owned and staff should only be using these computers for work responsibilities. She stated that staff should not be using their personal devices to be charting and completing tasks related to work. She stated that only company issued laptops should be used to access the facility's digital medical record and facility Wi-Fi. She stated that department heads should make rounds on staff and monitor for personal equipment use. She stated that personal communication devices are prohibited from use in the facility for work related tasks as outlined in the Employee Handbook topic Personal Communication. She stated department supervisors were responsible for ensuring staff adhered to the Employee Handbook. She stated employees are made aware that personal laptops cannot be used for work upon hire. In an interview on 04/23/2026 at 10:19 AM with LVN M stated she was using her personal computer at the moment. She stated the facility provided a laptop but it stopped working and she notified the previous HR coordinator in October 2025. She added that the HR coordinator she notified quit and nothing was done following this notification. She stated she had not brought it up to any supervisor's attention since then. She stated that the facility's laptop was not turning on or charging properly. She stated that no one instructed her to bring her personal computer and added she did not gain permission or authorization to use her own. She stated she did not know if she could use her own personal device for work related tasks. She stated she did not know whose responsibility it was to monitor and ensure that staff was not using their personal devices for work. She stated there was only 1 desktop at the nurses station but it had consistent technical issues like disconnecting from the internet. She stated she would like the facility to do something about the computer and laptop issue because it affected how she completed her job. She stated she needed a laptop to review orders and complete documentation. In an interview on 04/23/2026 on 10:35 AM with CMA N stated that when she first started working at the facility a month ago, she was notified by colleagues that she would have to provide her own computer because (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was not enough facility laptops. She stated these were not instructions from her supervisors but from colleagues. In an interview on 04/23/2026 at 10:43 AM with CMA O stated she had to buy her own laptop because the facility's issued equipment was either scarce or broken. She added she was not instructed by the facility to provide her own laptop. She stated she reported her concerns about limited functional laptops a year ago. She stated she provided a list of equipment needed to the Administrator and to the previous DON about 2 months ago. She stated the facility needed approximately 7 laptops to cover the nurses and medication aides on the floor not including the memory care unit. She stated she does not think the equipment at the nurses station was working which included 2 laptops and 1 desktop. She stated the lack of electronic devices had been ongoing for a year. She stated she had not been notified by the facility that it was not permitted for staff to use their personal laptops for work responsibilities. She stated if she could not use her personal device then it affected the residents she cared for because she would not be able to complete her responsibilities. She stated she needed a laptop to access charts, enter records, and review medication orders. She stated she would like the facility to provide an issued computer for her to complete her work responsibilities. She stated with the current laptops and computers she could not complete her tasks. She stated she did not know if she could use her personal computer for work per facility policy. In an interview on 04/23/2026 at 10:59 AM with RN H stated she was using her personal computer for work. In an interview on 04/23/2026 at 2:42 PM with LVN P stated she had worked at the facility for 7 years and had to use her own laptop for the past 3 years. She stated none of the facility computers worked except for one, but did not know which one was properly functioning. She stated this had been an ongoing issue and there has only been one computer replaced since the Administrator began working in January 2026. She stated the new computer was the single desktop that was located in the nursing station and was intended to accommodate potentially 4-5 staff members who needed to document and review orders for 3 hallways. She stated if she did not use her personal computer she would not be able to effectively complete her job. She stated she would like to have a laptop issued from the facility to complete her job. She stated the laptops in the facility were not operational, do not turn on, or do not properly charge. She stated it was the facility's responsibility to provide equipment for her to complete her job. In an interview on 04/23/2026 at 2:54 PM with ADON D stated the facility had always struggled with laptops. She stated the facility sent out 10 laptops for repair when the Administrator began (January 2026) and had not been repaired or returned by the IT department yet. She stated the facility did not have enough laptops for staff since December 2024. She stated she had never instructed staff to bring their own personal laptop to complete work. She added to her knowledge the previous DON and previous Administrators had never provided instruction for staff to bring their personal laptops for work responsibilities. She stated she had not instructed any staff member to cease using their personal devices. She stated the alternative was staff would not be able to document and complete responsibilities and tasks. She stated if the facility did not provide equipment it greatly affected the staffs' ability to complete their daily responsibilities and tasks and tend to residents' needs. She stated the Administrator was responsible for creating the work order and ensuring that equipment was working or being fixed. She stated the Administrator created a work order for the 10 laptops sent out in January 2026. In a follow up interview on 04/23/2026 at 4:53 PM, she stated she had a facility issued laptop and desktop in her office. She added she was the only one permitted to access these devices and staff were not permitted to complete work related responsibilities on it. In an interview 04/23/2026 at 3:53 PM with the Administrator stated that staff were using facility issued laptops and could not confirm if there were staff members who used their personal laptops. He stated it was okay based on his interpretation of the employee handbook policy for staff to use their personal computers because it was referring to the laptop being used as a communication device and not as a work related device. He stated that the facility had enough computers for staff to be completing their tasks on facility issued laptops instead of personal devices. He stated there were 3 computers for the direct care (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurses, a tablet kiosk, and desktops/laptops for the Social Services and ADONs. He stated he did not know if staff were permitted to use the devices issued to the Social Services and ADONs. He stated he did not have any work orders or documentation for laptops he sent out in January 2026 and added he did not send out any laptops. In an interview on 04/23/2026 at 4:43 PM with RN Q stated she used her own personal laptop to document and review orders for residents in the men's memory care unit. She stated she was never issued a facility laptop and there was no desktop available to her in the memory care unit. She stated the kiosk behind the nurses station in the memory care unit was for CNAs and did not support the access to the medical portal she needed to complete documentation and review orders. She added the kiosk did not properly work and the CNA had a portable tablet kiosk to complete her work issued by the facility. In an interview on 04/23/2026 at 4:55 PM with ADON B stated she had a facility issued laptop and desktop in her office. She added she was the only one permitted to access these devices and staff were not permitted to complete work related responsibilities on it. In an interview on 04/23/2026 at 4:57 PM with the Social Services Coordinator stated she had a facility issued desktop in her office. She added she was the only one permitted to access these devices and staff were not permitted to complete work related responsibilities on it. She stated she kept her office locked when not in the room and the desktop had a login only for her to access. Record review of the facility's Employee's Handbook / Policy Review undated, read in part, (General statement) it is the responsibility of the employee to read the Employee Handbook in its entirety and adhere to the instructions found within .Failure to read the handbook is not a reason for not adhering to the policies and will not be allowed as a reason for violating any facility policy (Personal Communication) Employees are not permitted to use any form of personal communication devices while at work, unless specified as required use with their job assignment. This includes cell phones, smart phones, laptops, notebooks, notepads, or PDA devices (Computers/ emails / Internet) Employees are not to use the facility computers, internet, or email systems for their own personal entertainment or use. These are intended for business use only Record review of the facility policy titled Dietary Preventive Maintenance dated 2003 read in part, The Maintenance Supervisor is responsible for ensuring mechanical and electrical operations of the kitchen. The dietary personnel will be responsible for advising the Maintenance Supervisor in writing of needed repairs. The Maintenance Supervisor will complete the dietary Preventative Maintenance log on a monthly basis to ensure maintenance of dietary equipment. Written documentation will be maintained by the facility of preventative maintenance and corrective actions.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to immediately inform the resident's physician and their representative when there was a significant change in the resident's physical, mental or psychosocial status for 1 of 3 residents (Resident #68 reviewed for change in condition. -The facility failed to ensure LVN C reported Resident #68's oxygen being disconnected for unknown number of hours and oxygen saturation of 86% to the physician on 04/21/2026. This failure places residents at risk for experiencing a worsening condition and leaving the resident without appropriate treatment following a change in condition. Findings included: Resident #68 Record review of Resident #68's admission record dated 04/23/2026 revealed a [AGE] year-old Male with an initial admission date on 04/08/2026. Record review of Resident #68's physical and history dated 04/20/2026 revealed the resident was diagnosed with chronic obstructive pulmonary disease (a progressive, incurable lung disease), aphasia following a cerebral infarction (an acquired language disorder caused by a stroke). Orders to monitor Resident #68's oxygen saturation closely were noted in the physical and history. Record review of Resident #68's comprehensive MDS dated [DATE] revealed under section C (cognitive patterns) the resident had BIMS score of 99 due to rarely/never being understood during interviews with the significance being severe cognitive impairment. Under section GG (functional abilities) the resident was coded as dependent on staff for all bed mobilities and transfers. Under Section O (special treatments) the resident was coded for needing continuous oxygen therapy since admission. Record review of Resident #68's care plan dated 04/09/2026 revealed the resident had a care focus area for oxygen therapy with interventions of monitoring for signs and symptoms of respiratory distress (a critical condition indicating difficulty breathing, characterized by rapid, shallow breaths, wheezing, and the use of muscles) and notify the nurse if the oxygen is off the resident. The resident had an additional care focus area for addressing communication problems. Record review of Resident #68's physician order dated 4/8/2026 for oxygen at 2-4 Liters per minute with a frequency of everyday and every shift for diagnosis of chronic obstructive pulmonary disease (a progressive, incurable lung disease). In an observation on 04/21/2026 at 9:54 AM, Resident #68 was observed lying in bed asleep and not responding to verbal stimuli. Resident #68 had his nasal canula applied properly, but his oxygen concentrator was not on; no vitals had been taken for current oxygen saturation levels as per documentation on digital health record. Resident #68 did not display any signs of respiratory distress or discoloration in skin. A follow-up observation completed at 11:14 AM revealed no change in Resident #68's condition or in the oxygen concentrator. A follow-up observation at 3:21 PM revealed the oxygen was turned on and Resident #68 had his cannula administered properly with no signs of respiratory distress or discoloration in skin. Record review of Resident #68's vitals revealed his oxygen saturation level measured at 96% on 04/21/2026 at approximately 1:30PM by LVN C. In an interview on 04/21/2026 at 3:09 PM with LVN C stated she checked Resident #68's oxygen saturation and it was in the 80's when she first measured it at approximately 1:20 PM before oxygen administration. She stated a physical therapist notified her that Resident #68 did not have his oxygen on and proceeded to go check the oxygen concentrator because it was not connected. She stated she did not know why she did not document the oxygen saturation being in the 80's but that she documented the 96% level in his vitals after she administered oxygen therapy. She stated that healthy oxygen saturation was above 95%. She stated she did not know if the resident required continuous oxygen. She stated she completed her assessment of lungs and heart after the discovery of Resident #68 with no signs or symptoms of respiratory distress. She stated she did not report the event to the charge nurse, physician, or the ADON about Resident #68's oxygen saturation. She stated this was because his oxygen levels returned to normal, and assessment showed no findings. She stated she did not know if she had to notify the physician, ADON, or the charge nurse. In an interview (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 04/21/2026 at 4:27 PM with COTA F stated Resident #68 was non-verbal and would not be able to vocalize if he was in pain or discomfort. She stated that he required yes or no questions to respond to staff. She stated she went to talk to LVN C after initial contact with Resident #68 for his occupational therapy session when she noticed Resident #68's oxygen concentrator was not on at approximately 1:20PM; she stated Resident #68 was on continuous oxygen based on her previous observation with him. She stated the oxygen saturation was 86% when LVN C initially measured it. In an interview on 04/23/2026 at 3:16 PM with ADON D stated residents who were dependent on oxygen needed to have it applied to prevent respiratory distress. She stated it was a concern if Resident #68 did not have his oxygen for possibly 4 hours. She stated that if the oxygen drops to 86% saturation, respiratory treatment needed to be made, staff needed to notify the physician, herself, and provide report to the nurse. She stated the physician needed to be notified in case they needed to provide new orders for Resident #68. In an interview on 04/23/2026 at 3:30 PM with RN G She stated she would have to discover the reason the oxygen concentrator stopped working to identify the source of the failure and ensure it did not occur again. She stated after that she would document the incident and notify all parties to include the physician, ADON, and resident's family and follow any new orders provided. She stated even if the oxygen saturation levels returned back to normal levels (95%) she would still notify all parties and provide report to the resident's nurse and incoming shift nurse. She stated this needed to be followed because a lot of things could go wrong if a resident did not receive oxygen. She stated if oxygen dependent residents did not receive ample oxygen source it could result in brain damage, organ failure, perfusion (failure to deliver oxygenated blood to tissues and organs), lethargy, critical vital signs, and potentially death. She stated it was the nurse's responsibility to provide notification to the physician and resident's family with a change in condition. She stated that oxygen being disconnected for an unknown length of time and 86% oxygen saturation was considered a change of condition. Record review of nursing progress notes revealed no respiratory assessment or notification to the physician was completed by LVN C on 04/21/2026. Record review of the facility's policy titled Notifying the Physician of Change in Status dated 03/11/2013 read in part, The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgement deem it necessary for immediate medical attention The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record The nurse is responsible, however, for responding to a change in condition in a timely and effective manner. The nurse will document the time of the call to the physician in the clinical record The nurse will monitor and reassess the resident's status and response to interventions. Physicians should develop a working diagnosis and guide nursing staff in what to monitor Record review of the facility's last in-service for notifying the physician of change in status reflected it was dated 02/13/2026.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview and record review the facility failed to maintain evidence demonstrating the result of all grievances for a period no less than 3 years from the issuance of the grievance decision for 1 of 1 grievance binders reviewed. The facility failed to maintain evidence demonstrating the results of grievances prior to 2/13/2026. This failure could place residents at risk of not having their grievances properly resolved, tracked, and documented for future review.Findings include: An observation made on 04/21/2026 at approximately 1:30 PM revealed that the grievance binder provided did not have any documentation of grievances prior to 2/13/2026. In an interview on 04/23/2026 at 11:48 AM with the Social Services stated she began at the facility in February 2026 and there was no grievance documentation that she located upon taking office. She added that she did not discard anything. She stated she began taking grievances in February 2026 and utilizing a tracking binder. She stated prior to February 2026 she does not know how grievances were being tracked. She stated it was a requirement and facility policy to keep track of the grievances. She stated that grievances needed to be monitored to ensure resolution, follow-up, documentation, and to help track trends. She stated that she did not know how long the grievances needed to be documented for. She identified herself as the individual responsible for tracking and documenting grievances that were completed. She stated that if this was not completed then it affected residents by not addressing their concerns and there could be no change to the issue. She stated she had not provided any in service for reporting or completing grievances for staff or residents. She stated she was not made aware of any grievance handling concerns from residents or staff before she began working on February 2026. She stated the facility's previous Social Worker unexpectedly passed away in the middle of 2025 and was previously the grievance coordinator. In an interview on 04/23/2026 at 12:35 PM with CNA E stated she has worked at the facility for 6 years. She stated the Administrator was the grievance coordinator. She stated that ADON and DON monitored and tracked grievances. She stated that she was not sure if there was a grievance binder where they would be filed. She stated that complaints needed to be tracked and monitored to fix and adjust as the residents identified. She stated it was an issue if the grievances were only documented from February 2026 onward because there was no documentation of concerns or resolutions before then. She stated that all staff were responsible for ensuring they were aware of the grievance system in place and communicating it amongst leadership. In an interview on 04/23/2026 at 1:08 PM with LVN M stated she did not know who monitored and tracked all grievances. She stated that prior to February 2026 the grievances were being completed via paper. She stated either the DON or Administrator would have the binder for grievances prior to February 2026. She stated it was important to track and monitor to ensure it was completed, resolved, and for tracking trends. She stated she does not know how it was being tracked and monitored now. She stated she did not remember the last training/in-service she received for grievances. She stated she did not know how grievances were being handled from June 2025 to January 2026. In an interview on 04/23/2026 at 3:05 PM with the ADON stated she did not play any role on how grievances were handled. She stated the grievances were the responsibility fromof the previous Social Worker who passed away in May 2025. She stated after this, the grievance responsibility transferred to the two Interim Administrators the facility had before January 2026. She added that the grievance coordinator responsibility was then transferred to the current Administrator and now was assigned to the current Social Services. She stated that it was concerning if their furthest back grievance was February 2026 because how does the facility know previous grievances were taken care of. She stated there was no way to determine if previous grievances were resolved or corrected. In an interview on 04/23/2026 at 4:03 PM with the Administrator stated the only documentation of grievances in place was what was provided on 04/21/2026. He stated he did not locate another binder of grievances from his predecessors, nor did the Social Services locate a (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grievance binder from her predecessor. He stated there was a concern for the missing grievance documentation before January 2026. He stated it was important to have the grievances for the past 3 years because it was regulation. He stated that it assisted in trending and tracking residents' concerns. He identified the current grievance coordinator was Social Services. He stated that everyone was responsible for monitoring and tracking grievances. Record review of the facility policy titled Grievances dated 11/2/2016 read in part, The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have (Procedure) The grievance official of this facility is the administrator or their designee. The grievance official will: Oversee the grievance process, receive and track grievances to their conclusion All written grievances will include: the date the greivance was received Maintaining evidence demonstrating the results of all grievances for a period of no less than 3 years from the issuance of the grievance decision .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 3 residents (Resident #12) reviewed for ADL care. -The facility failed on 04/21/2026 to ensure Resident #12's fingernails were trimmed. This failure could place residents who required assistance with ADL's at risk for unmet needs.Findings included: Record review of Resident #12's admission sheet dated 04/23/2026 revealed a [AGE] year-old female with an original admission date on 06/18/2020 and a readmission date on 02/26/2021. Record review of Resident #12's comprehensive MDS dated [DATE] revealed under section C the resident had a BIMS score of 15 with the significance being cognitively intact. Under section GG the resident was coded for needing setup or clean-up assistance for personal hygiene. Record review of Resident #12's care plan dated 04/02/2026 revealed the resident had a focus area for ADL self-care performance deficits with interventions to include assist with personal hygiene as required and to check nail length during bathing and trim on bath day or as necessary. Record review of Resident #12's physical and health dated 04/15/2026 revealed the resident was diagnosed with neuropathy (damage to nerves outside the brain and spinal cord causing numbness, tingling, and stabbing pain in the hands and feet) and reported pain in joints to the physician during visit. In an interview and observation on 04/21/2026 at 3:23 PM with Resident #12 she stated that her nails were long and usually asked the therapy department to cut her nails because she was not diabetic. She stated she received assistance for bathing, and staff had not offered to trim her nails on her most recent shower day. She stated she would like her nails to be cut because they were getting long. She stated she had not scratched or hurt herself while her nails were in their current condition. It was observed that her fingernails were measuring more than 1 inch in length, and added it was not her preference. She was unable to recall when the last time was she had her nails trimmed. In an interview on 04/23/2026 at 12:26 PM with LVN C she stated that CNAs and nurses could cut the nails for residents and added if a resident was diabetic the nurse would have to complete it. She stated nails were reviewed during changing, medication pass, and showers. She stated there was potential for it to be addressed a minimum of 3 times a day. She stated a resident could scratch themselves, hurt others, tear skin, and stated it was an infection control issue. She stated that there was not a nail trimming day or schedule to her knowledge. She stated she did not know how supervisors monitored for the completion of these tasks by CNAs and nurses. She stated it was not appropriate for residents' nails to be an inch and a half long if it was not their preference. She stated she received nail trimming training a week ago. In an interview on 04/23/2026 at 12:41 PM with CNA E she stated CNAs and nurses could provide nail trimming. She stated hygiene related ADLs were reviewed a minimum of 2-3 times a day per staff member during rounds, call light responses, changing, transfers, showers, and medication pass. She stated anyone could notify the CNAs and nurses about a resident's lengthy nails. She stated they do not cut residents' nails very often because some residents refused and the facility was short staffed. She stated shower schedules were not being adhered to. She stated it was hard to complete tasks because of the acuity of residents and the ratio of employees to residents. She stated there were no injuries related to staff shortages. She stated it affected a resident if they had long nails because they could scratch tender skin or develop ingrown nails. She stated an inch and a half of nail length was considered long and needed to be addressed, care planned or serviced. She stated she did not recall the last in- services she received for ADLs. In an interview on 04/23/2026 at 3:10 PM with ADON D she stated that staff provided ADLs with transfer, feeding, nail trimming, changing beds, and incontinences. She stated CNAs and nurses complete fingernail trimming and added it was a monthly routine. She stated staff should cut the nails or offer to cut them for the resident when it was observed the resident had lengthy nails. She stated that it affected the residents because it did not (continued on next page)

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	675928	A. Building B. Wing	04/23/2026

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fulfill their wish to have a nail trim. She stated there was potential to scratch themselves or have skin integrity compromised. She identified herself and ADON B were responsible for ensuring staff were completing ADLs for residents. She stated she did not recall the last in-service or training for ADLs but would look for in-service logs; later provided on 04/23/2026 at 4:55 PM. Record review of the facility's policy titled Nail Care undated read in part, Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity issues, to prevent infection, and injury from scratching by fingernails It includes cleansing, trimming, smoothing, and cuticle are and is usually done during the bath (Goals) nail care will be performed regularly and safely. The resident will be free from abnormal nail conditions Record review of the most recent in-service for nail care was completed on 02/11/2026. Record review of the facility's latest nail care / refusal sheet dated 04/17/2026 revealed that Resident #12 was not on the list for residents who received nail care on the listed date.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan for 1 (Resident #6) of 8 residents reviewed for falls.The facility failed to ensure Resident #6 was assessed by a nurse immediately after her fall on 03/13/2026.This failure could affect residents by placing them at risk of potential medical complications related to changes in condition.Findings include:Record review of Resident #6's admission record dated 04/23/2026 revealed a [AGE] year-old female with initial admission date 12/09/2025, and readmission date 04/04/2026.Record review of Resident #6's health and physical dated 03/13/2026, revealed a medical history of Anxiety (frequent thoughts and feelings of worry or nervousness that affect everyday life tasks), Type 2 Diabetes Mellitus (a condition that happens when the body does not properly use blood sugar), and Schizophrenia (severe mental disorder that affects how the person thinks, feels, and behaves, often leading to hallucinations, or delusions, meaning seeing or hearing things that are not real). The health and physical noted it was a PRN visit for post-fall examination. It was noted Resident #6 was observed with redness and swelling to her chin. Bruises to bi-lateral, or both, knees. It was noted X-rays were ordered for her chin and both knees.Record review of Resident #6's Quarterly MDS dated [DATE] revealed there was no BIMS score as Resident #6 was noted to be never or rarely understood. Under Section GG-Functional Abilities, Resident #6 was noted to be completely dependent with ADLs and mobility, meaning the helper does all the work to complete the task while the resident does none of the effort.Record review of Resident #6's care plan with revision date 04/17/2026, revealed the resident was at risk for falls related to her Dementia diagnosis, wandering, anti-anxiety/antidepressant medication use, and poor safety awareness. Interventions included for staff ensuring a safe environment and educating Resident #6 about safety reminders and what to do if a fall occurs.Record review of Resident #6's Event Nurses' Note- Fall, dated 03/13/2026, it was noted: During AM rounds, resident was noted with redness to bilateral knees, noted with a knot to her right side of forehead and has a red swollen chin. During report, nurse did not get any report of incident. ADON notified, ADON contacted night CNA, he voiced she had a fall and picked her up from the floor, and was on her knees when found and forgot to report it to PM nurse. Vital signs were taken; the Physician and Responsible Party were notified on 03/13/2026.Record review of Resident #6's Patient Report, Mandible (jawbone), partial, dated 03/13/2026, had noted findings with no fracture or loose teeth seen. No acute findings.Record review of Resident #6's Patient Report, Left Knee, dated 03/13/2026, noted no acute findings.Record review of Resident #6's Patient Report, Right Knee, dated 03/13/2026, noted no acute findings.Record review of Resident #6's Neurological assessment dated [DATE], revealed Resident #6 was monitored from 06:30 AM to 2:15 PM, starting with every 15 minutes the first hour, every 30 minutes the second hour, and every 1 hour for four hours. Resident #6 was also noted to be monitored at 10PM-6AM shift, and 6AM-2pm shift the following day. There were no acute findings noted.In an observation on 04/22/2026 at 10:15 AM, Resident #6 was observed in her wheelchair with a dark brown scab on her right-side forehead, no redness, swelling, or bruising observed on her forehead or chin. Resident #6 was unable to answer this State Surveyor's questions coherently. Resident #6 was observed interacting with other residents and staff. Resident #6 did not display physical symptoms of pain, including grimacing or guarding. In an interview on 04/23/2026 at 10:25 AM with the Corporate Nurse, he stated he was not aware of Resident #6's fall incident that happened on 03/13/2026. He stated it was the Nursing Facility expectation for CNAs to remain with the residents if found on the floor and notify the nurse immediately. He stated this was protocol so the nurse could assess the resident before moving them, to prevent further injury.In an interview on 04/23/2026 at 11:57 AM with CNA R, he stated it was approximately 4:45 AM- 5 AM when he found Resident #6 on 03/13/2026. He stated Resident #6 was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unable to state what happened to her. He stated he looked at Resident #6 and she appeared fine. He stated he was unable to locate the assigned nurse, so he moved Resident #6 back into her bed. CNA R stated he was trained and aware he was not to move any residents that experienced a fall until a nurse had assessed the residents. He stated he forgot to report it to the nurse until he was called by the ADON that morning. He stated it was expectation for CNAs to not to move residents after they fall until a nurse assessed them to prevent further injury. He also stated nurses need to assess residents for possible changes in alertness. He stated he was provided a verbal warning and in-service training for falls relating to the incident.In an interview on 04/23/2026 at 2:15 PM with the ADON, she stated she called CNA R on 03/13/2026 after being notified by the morning nurse of Resident #6's observed physical changes such as the redness and swelling of the chin. She stated CNA R reported finding Resident #6 on the floor that morning but failed to notify any of the nurses or nursing supervisors. She stated he had forgotten to report it to the nurse. She stated CNAs were expected to not move any residents after a fall until a nurse assessed the resident. She stated this was expectation because of potential further harm to residents. She stated a 1 to 1 was completed with CNA R, and he was provided a verbal warning and in-service training for falls.In an interview on 04/23/2026 at 3:44 PM with the Administrator, he stated it was expectation for CNAs to wait for the assigned nurse to assess residents after a fall. He stated that was the Nursing Facility's protocol. He stated there was possible risks to residents if CNAs failed to report falls to the assigned nurse or Nursing Supervisor. The Administrator did not want to elaborate on what the possible risks were to residents.Record review of the facility's Fall Policy, with no date, read in part under procedure: In instances where fall risk measures do not prevent a fall, the residents will be assessed immediately for injury. Vital signs and first aid measures will be completed immediately. The Charge Nurse will notify the attending physician and family member as soon as possible after the resident has been stabilized. It continued, The DON or designee will be responsible for investigating all resident falls to attempt to determine the cause and need for new interventions as required.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, 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 1 of 4 residents (Resident #10) reviewed for infection control in that; CNA A failed to change her gloves after they became contaminated during incontinent care while assisting Resident #10. These failures could place resident's at risk for cross contamination and the spread of infection. Finding included: Record review of Resident #10's electronic admission record dated 04/22/2026 indicated he was admitted to the facility on [DATE] with diagnoses of dementia and constipation. He was [AGE] years of age. Review of Resident #10's care plan revised on 10/30/2025 indicated in part: Resident has bowel incontinence. Resident will not have any complications related to bowel incontinence. Check him frequently and assist with toileting as needed. Provide pericare after each incontinent episode. Record review of Resident #10's quarterly MDS assessment dated [DATE] indicated in part: Bladder and bowel: Urinary continence = Always incontinent. Bowel continence = Always incontinent. Observation on 04/21/2026 at 11:54 AM CNA A performed incontinent care for Resident #10. CNA A put on a pair of clean gloves and then undid the resident's brief. The CNA then took some wet wipes and wiped Resident #10's scrotum and penis. CNA A then turned the resident on his side and took some more wipes and wiped the resident's rectal area. The resident had had a bowel movement, so the CNA took some extra wipes and wiped the bowel movements from the resident's bottom. CNA A then removed the soiled brief and while still wearing the same gloves she took a clean brief and fastened it to Resident #10. The CNA then assisted the resident on his back and was done with the care. Interview on 04/21/2026 at 2:28 PM CNA A said that she should have changed her gloves before she took the clean brief and fastened it to the resident. The CNA said that she had gotten nervous when she had performed incontinent care for Resident #10. CNA A said that if she did not change her gloves after they became contaminated it could have led to infections and cross contamination. Interview 04/23/2026 at 2:42 PM the DON said what it was expected for the CNAs to remove their gloves once they became contaminated. The DON said the CNAs were then supposed to sanitize their hands before putting a new pair of gloves on. The DON said if the CNAs did not change their gloves there was a possibility of the spread of fecal matter and the spread of germs. The DON said they monitored staff by conducting periodic training and they also performed proficiencies for CNAs on a yearly basis. Interview on 04/23/2026 at 3:46 PM the Administrator said that he agreed with what the DON had said regarding the expectation of the CNAs changing their gloves after they became contaminated. The Administrator said that he was not a clinical nurse so he would agree with what the DON had said regarding the possible outcomes if the CNA had not changed her gloves. Record review of the facility policy titled Personal/Perineal Care dated 05/11/2022 indicated in part: An incontinent resident of urine and/or bowl should be identified, assessed and provided appropriate treatment and services to restore as much normal bladder/bowel function as possible. This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition. Start: perform hand hygiene - [NAME] (put on) gloves and all other PPE per standard precautions - gently perform perineal care, wiping from clean, urethral area, to dirty, rectal area, to avoid contaminating the urethral area - clean to dirty. Doffing and discarding of gloves are required if visibly soiled. Always perform hand hygiene before and after glove use. Note skin changes and apply moisture barrier cream as directed. Doff (take off) gloves and PPE and perform hand hygiene. Record review of the facility's undated policy titled Infection Control indicated in part: The facility will establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Facility (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment/Infection prevention and control assessment tool for long term care facilities. At least annually and on an as-needed basis the facility will conduct a facility wide assessment to determine the resources needed to maintain an efficient and up to date infection control program. The facility assessment can assist in determining the types of residents being cared for, what is needed to care for those residents, and what education facility staff need.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview the facility failed to ensure the daily nursing staffing was posted as required for 3 of 3 days in that, The facility did not post the daily staffing in a prominent place readily accessible to residents and visitors.This failure could place residents, their families, and facility visitors at risk of not having access to information regarding staffing data and facility census.Findings include:In an observation on 04/22/2026 at 11:25 AM, the staffing schedule and census was posted in the main Nurse's station behind the desk, and by the backwall, not accessible to residents in wheelchairs or residents with visual impairments. The nurse's station area had 2 open walkways located on each side of the desk serving as the Nurse's station, with only Nursing Facility staff walking through and behind the desk. In an interview on 04/22/2026 at 11:29 AM with CMA N, she stated the schedule staffing information was only located in the main nurse's station behind the desk. She stated there was no staffing schedule in either memory care unit. She stated the purpose of the staffing schedule was for residents and staff to be aware of the census and what units staff were assigned to.In an interview on 04/23/2026 at 10 AM with RN S, she stated the staffing schedule was only located behind the main Nurse's station. She stated she did not believe residents were able to observe the schedule information because it was located on the wall behind the Nurse's station. She stated the purpose of the staffing schedule was for staff and residents to see the amount of staffing coverage.In an interview on 04/23/2026 at 10:19 AM with CNA T, she stated the staffing schedule and census information was located at the main Nurse's station, located behind the desk. She stated she did not think residents or visitors were able to observe the information from the nurse's station, and the residents or visitors were not allowed behind the desk. She stated she did not believe it was readable because of the location of the postage being behind the desk of the Nurse's station. In an interview on 04/23/2026 at 3:39 PM with the Administrator, he stated the ADONs currently assisted with posting daily census and staffing schedule. He stated the purpose of the census and staffing schedule being posted was for everyone to be aware of the resident census and staffing census. He stated he believed residents and visitors were able to observed the information and did not see potential risks of not having the information readily visible and accessible.On 04/23/2026 at 9:00 AM, the Administrator stated the facility did not have a policy for scheduled staffing, and the facility followed state regulations.Record review of Texas State Regulations, read in part: 483.35(g)(2) Posting Requirements (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors.

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observation, interview, and record review, the facility failed to post, in a form and manner accessible and understandable to residents and, resident representatives: a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, and the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit for 2 of 5 (400-hall/Male Memory Care Unit, and 500-hall/Female Memory Care Unit) halls reviewed for posting of required information. The facility failed to post a written description of a resident's legal rights in an accessible area for the residents, including information about pertinent state client advocacy groups such as the State Survey Agency and the Ombudsman.This failure could place residents at risk of lack of knowledge of who to contact should they require advocacy, investigation, and not knowing their rights or how to exercise their rights. Findings included:In an observation on 04/22/2026 at 12 PM in the secured female Memory Care Unit, there were no postings regarding Resident Rights and state client advocacy groups.In an observation on 04/22/2026 at 12:10 PM in the secured male Memory Care Unit, there were no postings regarding Resident Rights and state client advocacy groups.In an interview on 04/23/2026 at 10:19 AM with CNA T, she stated there were no postings in the Memory Care Units. She stated the contact information for the Administrator was posted in all the Residents' rooms, and they could contact him for concerns. She stated there was not information in the memory care units regarding contacting the State Agency and/or the Ombudsman.In an interview on 04/23/2026 at 11:33 AM with RN U, she stated the purpose of the postings of the residents' rights and state client advocacy groups was for residents or their families to contact another party to resolve concerns. She stated residents and their families had the right to contact the State Agency or the Ombudsman if they felt the Nursing Facility was not addressing their concerns or attempting to resolve their issues. She stated the potential risk of residents not having contact information to the State Agency, or the Ombudsman included potential neglect.In an interview on 04/23/2026 at 3:41 PM with the Administrator, he stated there were no written postings regarding resident rights including information about the State Agency, or the Ombudsman in the memory care units. He stated his phone number was posted in the residents' rooms, and they were able to contact him for concerns. He stated he did not believe there were no potential risks of not having the posted information in the memory care units for the residents.Record review of the facility's Resident Rights policy, with no date, read in part under Information and Communication: 5. The facility must post, in a form and manner accessible and understandable to residents, and resident representatives: A. A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit.

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review the facility failed to ensure the residents had the right to examine the results of the most recent survey of the facility and the facility failed to post the results of the most recent survey in a place that is readily accessible to residents, family members, legal representatives of residents, and the public for 1 of 1 survey results binder reviewed. -The facility failed to ensure the annual survey results binder was accessible for residents, family members, and staff on 04/22/2026 at 11:30 AM. This failure placed residents, family members, and legal representatives of the residents at risk of not being informed of the facility's survey and investigation results causing.Findings included: During an observation conducted on 04/22/2026 at 11:30 AM, the annual survey results binder was not locatable in an easily accessible area near the entrance or nurse's station. On 04/22/2026 at 11:32 AM, The Administrator obtained the survey results binder from a cabinet located outside his office doorway. There was no sign postage that alerted passersby that the survey results binder was in the cabinet. In an interview on 04/22/2026 at 11:33 AM with The Administrator stated the binder was inside the cabinet by the front entrance with no sign postage or notice of survey results binder. He stated it was accessible because anyone could open the cabinet and locate the survey results binder inside. He stated that there were issues of residents taking it to their rooms and using it as a coloring book when he first began working at the facility in January 2026. He stated that he did not know if the binder needed to be out in the open or if it was fine to be in the cabinet. He stated he would need to review policy and regulation to see if there was placement required for it. He stated he did not see anything wrong with the placement of the survey results binder being inside the cabinet. In a follow-up interview on 04/23/2026 at approximately 3:50 PM the administrator stated there was no facility policy for the annual survey results binder. In an interview on 04/22/2026 at 11:37 AM with CNA stated the binder was located in the front in a basket by administrator's office. She stated it should be on top of the cabinet but there were residents who messed with it and altered the contents. She stated that it was a resident's right to look at it. She stated it was not acceptable for the binder to be tucked away in the cabinet and it needed to be out at all times for the public to access. She stated the contents included compliance with the state survey and investigation results. She stated it was HR or The Administrator's responsibility to update it and to ensure it was accessible at all times. She stated that residents and families would not know where it was and the information it contained if it was not in plain sight. She stated that it was a resident's right to have access and read it without asking for the information. She stated the last in service she received for resident rights was a week ago with education and comprehension evaluation. In a confidential group interview on an undisclosed date and time, 8 of the 10 residents that attended did not know where the survey results binder was located and what the contents of the binder were. In an interview on 04/23/2026 at 10:14 AM with LVN stated she had been a nurse for 7 years and worked at the facility for 3 years. She stated that the survey results binder used to be on the wall near the nurses station but she does not know where it was relocated to. She stated if a resident asked her to help them locate it she would notify her superiors. She stated that the results have to be in the open and accessible for anyone to obtain. She stated it was not acceptable for the binder to be in the cabinet without signage. She stated that everyone had the right to review the survey results binder to include family, residents, and visitors. She stated she did not know who was in charge of updating it or placing it in an open and accessible location. She stated the contents of it included the failures, facility's corrections, and results of the survey. She stated if it was not accessible then the residents and visitors would not have knowledge as to what the survey team's findings were. In an interview on 04/23/2026 at 2:48 PM with The ADON stated the survey results binder was in the front of the building in the basket, but sometimes it has to be placed in the cabinet because residents would take it. She stated it was not acceptable for the binder to be in the (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	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Nursing and Rehabilitation	2510 West 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 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	cabinet without the signage posting for it. She stated it contained the results of the annual survey and investigations and identified The Administrator was responsible for updating it. She stated it was a resident's right to have access to the results. She stated it affected residents and family because they could miss out on findings discovered by the state on the facility. She stated she had not provided an in service or training to staff regarding contents of the binder and where it could be located. Record review of the facility's Resident Rights policy, with no date, under Information and Communications, read in part: 10. The resident had the right to- a. examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. It continued to read, 11. The facility must- a. Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. And, C. Post notice of the availability of such reports in areas of the facility prominent and accessible to the public.