STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365922	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Hills Nursing & Rehabilitation	73841 Pleasant Grove Road Adena, OH 43901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review, review of a facility-reported incident, staff statements, and staff interview, the facility failed to ensure staff treated all residents with respect and dignity. This affected one resident (#10) of three residents reviewed for facility-reported incidents (FRI). The facility census was 33 . Findings include: Record review revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including nontraumatic intracerebral hemorrhage, cerebral infarction, and vascular dementia. Review of a minimum data set (MDS) dated [DATE] revealed Resident #10's cognition was severely impaired. Review of a witness statement by Certified Nursing Assistant (CNA) #300 dated 02/13/25 revealed Resident #10 had asked to go back to her room. CNA #300 and #215 took Resident #10 to her room and when they opened the door, CNA #110 was there and stated, I'm not putting her to f*cking bed, I put her to bed once already. CNA #300 stated this was said in front of Resident #10. CNA #300 & #215 laid Resident #10 down and had not asked CNA #110 for help. Review of a witness statement by CNA #215 dated 02/13/25 revealed she and CNA #300 took Resident #10 to her room because she requested to be laid down. Upon entering the room, CNA #110 stated, I'm not putting her to f*cking bed, I already put her to bed once, in front of Resident #110. CNA #215 and #300 put Resident #10 in bed per her request. The nurse was notified of the situation. Review of a witness statement by Licensed Practical Nurse (LPN) #120 dated 02/13/25 revealed it was reported to her by CNAs #300 and #215 that Resident #10 requested to go to bed and the CNAs took her to her room to lay her down, when CNA #110 stated she would not put Resident #10 to bed because she already did once. Review of a FRI dated 02/14/25 revealed a staff member had a verbal incident with Resident #10. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an undated statement by the Administrator revealed an interview was completed with CNA #110 who denied cussing in front of Resident #10 but did admit to saying Resident #10 just got up and could stay up for a while. CNA #110 was educated on resident choices and preferences via phone interview. Review of a corrective action form dated 02/14/25 revealed CNA #110 was given a first written warning due to cussing in front of a resident. She was educated on company policies and refused to sign the corrective action form stating, I quit. Interview on 04/02/25 at 3:10 P.M. with Director of Nursing (DON) revealed she had not been employed at the facility at the time of the incident, but the information provided in the witness statements was not what she would consider treating residents with dignity and respect. Review of a policy titled Resident Rights dated 12/2016 revealed residents have the right to a dignified existence and to be treated with respect, kindness, and dignity. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number OH00162782.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on observation, review of a service order, review of the facility's grievance/ concern log, review of resident council meeting minutes, resident interview, and staff interview, the facility failed to ensure residents were afforded the right to a comfortable living environment by not maintaining comfortable temperature levels in the facility's shower room while residents were bathing. This had the potential to affect all but three residents (#10, #27, and #33) of the facility's 33 residents, who the facility identified as not having the use of the shared shower room. Findings include: On 04/01/25 at 10:18 A.M., an observation of the facility's only shared shower room located on the 300 hall revealed it did not have a working heater. There was a long heater that was noted to run along the back wall of the shower room that was part of the heat supplied by the facility's boilers. There was no way to turn on the wall unit that was part of the boiler system from inside the shower room. There was another 12 inch by 12 inch heater on a wall that was located to the left side of the shower room. That heater had a knob to turn, but did not function when the knob was turned in any direction. The shower room was slightly cooler than the temperature in the hallway, but staff currently had portable pedestal high velocity shop fan in the shower room that was turned on. Thermostats were checked throughout the facility in the hallways. The thermostat on the 200 hall was a manual thermostat that was behind a metal box on the wall and located about midway down the hall. The metal box was not locked and was able to be raised to access the manual thermostat. It was turned all the way down to 42 degrees Fahrenheit (F.) and was reading 68 degrees F. as the temperature in the hall. The other two halls (100 and 300) had digital thermostats and were reading 69 degrees F. On 04/10/25 at 10:19 A.M., an interview with Certified Nursing Assistant (CNA) #100 and CNA #200 revealed they were the two aides that were working that day. They reported they had already completed their (assigned resident) showers they had scheduled for that day and they included Resident #8, #9, and #28. They denied they had the portable fan on in the shower room when the residents were given their showers. It was not until after the showers had been given that they turned the fans on for their comfort. They were asked about the condition of the heater in the facility's main shower room. CNA #200 reported the smaller fan hanging on the left wall of the shower room had not worked in the past [AGE] years. She denied they were able to get any heat out of the other heating unit that was against the back wall. The CNA's reported it had been a bigger problem during the colder months and they had residents who were refusing to take a shower when scheduled due to it being too cold in the shower room. They would just have to give the residents a complete bed bath instead. She denied it was as much of a problem recently due to it being warmer outside. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/01/25 at 11:10 A.M., an interview with Resident #9 confirmed he was one of the residents that were given showers earlier that morning. He reported the facility has had problems with the shower room not being warm enough when he received his showers. He did not feel the shower room was either warm or cold that morning, but it had been cold in the past. He did get cold that morning when he was wet, but it was not bad in there when he was dry. He was not sure how long it had been that the heater in the shower was not working. He knew the facility had used a space heater in the past, but was told they could not use them. He commented that it would be nice to have some heat in the shower room. On 04/01/25 at 11:20 A.M., an interview with Resident #28 confirmed she had been given a shower earlier that morning. She reported it was cold in the shower room and the heater had been broke. It had been broke ever since she had been there and that had been about two years now. They did have a space heater in there, but was told it was dangerous and they had to take it out. It was really cold in there this past winter. She would take her showers anyway despite her being cold when she received them. She stated she would like it to be warmer in the shower room when she received her showers. On 04/01/25 at 11:25 A.M., an interview with Resident #8 confirmed she too received a shower earlier that morning. She did not have any concerns with the temperature of the shower room that day, but had problems over the winter with the shower room being cold. She confirmed the facility used a portable heater during the winter. She was not sure how long the heater in the shower room had been broken, she just knew it was cold in there. She would like the shower room to be warmer when she received her showers. Review of the facility's resident council meeting minutes for the past three months (01/16/25 to 03/19/25) revealed the meeting minutes for the council meeting held on 02/25/25 indicated one of the residents (Resident #28) attending that meeting stated a heater was needed in the shower room when it was cold outside. The meeting minutes did not include a response to the concern to include who was assigned that concern or what was done about it. Review of the facility's grievance/ concern log from 02/06/25 to present revealed Resident #28 voiced concern on 02/25/25 regarding wanting a heater in the shower room in colder weather. The facility's Social Service Director (SSD) was the staff member assigned to that concern. Findings from investigation revealed the heater had been inspected by an outside boiler company. A plan to restore the boiler use was indicated to be in place. On 04/01/25 at 12:18 P.M., an interview with the Administrator revealed the facility had a company come out and check the facility's heater in the shower room. They were awaiting them to come back to give them an estimate in replacing some radiator units on the 300 hall. She was asked to provide the invoice/ service order to show when the boiler company had been out to check the heating problem in the shower room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the service order from an outside boiler company revealed a technician had been out to the facility on [DATE] at 9:00 A.M. He indicated he checked over the facility's boiler system. He indicated when it was very cold, a few areas in the facility were colder than others. He indicated both the 200 and the 300 hallways and rooms ran off one thermostat located in the 200 hall. A smaller area with more radiators could cause the 300 hall to not be as warm. He also indicated, at the end of the 300 hall entrance area, there were two radiators where the heat from those were no longer in use. He surmised, if that area was heated, it may help the two end rooms on the 300 hall stay warm. Also separate T-stats (thermostats). The technician recommended replacing the heaters at the end of the 300 hallway. He also recommended making two zones instead of one to make the heat more even. They could also add supplement heat in alternate cooling only or add radiator in places if short. He took a couple pictures and indicated another representative would have to come out to look at it. It did not mention anything specific to the lack of heat in the shower room, just addressing the lack of heat on the 300 hall, which is where the shower room was located. There was no documented evidence of the other representative from the boiler company returning to the facility to further address the lack of heating issue. After asking for the boiler company service order, a member of the facility's administrative staff was heard contacting the boiler company to get a representative back to the facility. On 04/01/25 at 1:30 P.M., a representative from the boiler company arrived on site and requested to speak with the facility's Administrator. He identified where he was from and informed the staff of who he was there to see. He was then heard telling the Administrator that he was there to give an estimate on the work that needed to be done to their boiler system. He referenced the service order dated 02/25/25 and informed the Administrator that it indicated a couple units were recommended to be replaced. The issue with a lack of heat in the shower room was not specifically mentioned. He left the facility around 2:05 P.M. and informed the facility's administrator that he would get back to her with their recommendations/ estimates. On 04/01/25 at 2:15 P.M., an interview with the facility's Administrator confirmed the boiler company was contacted by the facility and a representative did come out to check things out to be able to give them an estimate of the work that was needing to be done. She confirmed the facility's boiler system was controlled by a single thermostat on the 200 hall. She acknowledged that the manual thermostat on the 200 hall was noted to be turned all the way down to 42 degrees F. and was reading 68 degrees F. when it was checked during the initial tour on 04/01/25. She suspected that a resident likely turned the thermostat down, which also controlled the temperature on the 300 hall. She confirmed there was talk about replacing a couple radiator units at the end of the 300 hall that they hoped with help with the temperature in the main shower room. This deficiency represents non-compliance investigated under Complaint Number OH00163435 and Complaint Number OH00162782.