

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Villa Serena Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 723 E 9th Street Long Beach, CA 90813	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled resident's (Resident 2) care plan was revised to include interventions to reduce Resident 2's fall risk, such as staff to always provide direct line of sight (unobstructive view) supervision while Resident 2 was awake. The facility also failed to include Resident 2's Responsible Party (RP) in the care planning process during the interdisciplinary Team (IDT-team of healthcare professionals and the resident and/or Resident's RP working together to meet resident's goals) meeting held after Resident 2's sustained fall on 5/15/2024.</p> <p>These deficient practices had the potential to result in future falls for Resident 2 resulting in injury and it violated Resident 2's and Resident 2 RP's rights to be involved in the care planning process.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including overactive bladder (sudden urge to urinate that is hard to control) and major depressive disorder (persistent feeling of sadness which can affect daily activities) with severe psychotic (seeing or hearing things that are not there) symptoms.</p> <p>During a review of Resident 2's Minimum Data Set ([MDS] a standardized assessment and care-screening tool), dated 4/3/2024, the MDS indicated Resident 2's cognitive skills for daily decision-making were severely impaired. The MDS indicated Resident 2 required supervision (helper does less than half the effort.) for chair to bed transfer (ability to transfer to and from bed to chair), toilet transfer, tub/ shower transfer (ability to get on and off the toilet). The MDS indicated Resident 2 required supervision or touching assistance (helper provides verbal cues, and or touching/steadying or contact guard assistant as resident completes activity) to walk 10 feet to 50 feet.</p> <p>During a review of Resident 2's SBAR communication form note, dated 5/14/2024, the note indicated an unidentified resident called for help stating Resident 2 was on the floor and Resident 2 was found on the floor in a sitting position, leaning towards left side near Resident 2's wheelchair. The note indicated Resident 2 sustained an unwitnessed fall on 5/14/2024.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's IDT meeting note, dated 5/15/2024, the IDT note indicated Resident 2 had poor safety awareness and was cognitively impaired. The IDT note indicated on 5/14/2023 during the 3pm-11pm shift, while staff was at the station, a resident (unidentified) called for help stating Resident 2 had fallen to the floor in the dining room. The IDT note indicated Resident 2 was left unattended in the dining room by staff. The IDT note indicated the following fall interventions, starting 5/15/2024, fall precautions using the 4 P's (potty, pain, placement, position), neurological checks (checks to see brain function) for 72 hours, post fall rehabilitation screen (evaluation to be completed by a specialist who helps residents become more independent), monitor for pain and medicate as needed, monitor for redness, swelling, immobility, elevate temperature, pain and report to medical doctor, place resident in well trafficked area for supervision, do not leave resident without supervision, keep resident clean and dry, keep resident busy by giving activities of choice applicable to her mention, in serviced staff regarding supervision and fall management for the resident, will continue to monitor and add interventions as needed. The IDT note did not indicate Resident 2's RP was present during the meeting.</p> <p>During a review of Resident 2's untitled Care Plan initiated 6/30/2023, the Care Plan indicated Resident 2 had an actual fall prior to admission, actual fall on 7/21/2023, actual fall on 9/5/2023, assisted fall on 5/4/2024, and unwitnessed fall on 5/14/2024. The care plan goals indicated to reduce the risk of falls and or injury through appropriate interventions daily thru next review on 8/14/2024, resident will continue with normal activities through next review date on 8/31/2024. The care plan revision for intervention did not indicate all the interventions discussed in the IDT meeting.</p> <p>During an interview on 5/30/2024 at 2:46 p.m., the Infection Preventionist Nurse (IPN) stated she reviewed Resident 2's care plan dated through 5/30/2024 and confirmed Resident 2's care plans were not revised to reflect specific interventions such as Resident 2 always requiring direct line of sight, as discussed in the IDT meeting. The IPN stated the IDT should have revised Resident 2's care plans during each fall incident to include specific interventions in Resident 2's care plans to prevent further falls that could lead to injury and death.</p> <p>During an interview on 5/30/2024 at 3 p.m., Director of Rehabilitation (DOR) stated she Resident 2 was known for frequently attempting to get out of bed or out of her wheelchair without assistance and must always be within direct supervision of staff. The DOR stated Resident 2's required need for supervision was discussed in daily staff huddles and during her post fall IDT meeting on 5/15/2024 but resident 2's care plan was not revised. The DOR stated failure for the IDT team to revise Resident 2's care plan to include direct supervision can lead to Resident 2 sustaining future falls which would lead to decreased mobility and injury.</p> <p>During an interview on 5/30/2024 at 1:30 p.m., the Director of Nursing (DON) stated she reviewed Resident 2's care plans, IDT notes and SBAR /Change of condition (COC)documents from 7/2/2023 through 5/30/2024. The DON stated the documents indicate Resident 2's care plans were not revised to reflect specific interventions discussed in the IDT meeting such as Resident 2 always requiring direct line of sight. The DON stated, the failure to revise Resident 2's care plan led to Resident 2's unwitnessed fall on 5/14/2024 and could lead to further falls, injury and death. The DON stated, the facility staff conducted a post fall IDT on 5/15/2024 but family was not invited. The DON stated the facility should have notified Resident 2's RP of the IDT meeting and provided them the opportunity to attend. The DON stated failing to allow Resident 2's RP to participate in the plan of care is a violation of residents' rights.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy and Procedure (P/P) titled, Fall Risk assessment dated [DATE], the P/P indicated the facility assesses all the residents upon admission and periodically for their risk of falling and uses this information to develop both individualized plans of care.</p> <p>During a review of the facility's P/P titled, Response to Falls dated 2/9/2024, the P/P indicated the IDT team will review fall prevention interventions and modify the plan of care as indicated.</p> <p>During a review of the facility's P/P titled, Care Plan dated 2/9/2024, the P/P indicated the purpose of the policy is to ensure that a comprehensive person-centered care plan was developed for each resident based on their individual assessed needs. The P/P indicated each resident's comprehensive centered care plan will describe the following: services that are to be furnished to attain the resident's highest practicable, physical, mental, and psychosocial well-being. The comprehensive care plan must be prepared by the IDT. The IDT includes the resident and or her family or legal representative. The P/P indicated the resident has right to be informed of changes in the care plan, resident has the right to see the care plan including the right to sign after significant changes are made to the plan of care. The P/P indicated, the facility will invite the resident, if capable and their family to care plan meetings and use its best efforts to schedule care plan meetings at times convenient for the resident and family.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 2) who had a history of multiple falls, was supervised, and monitored while sitting in her wheelchair in the dining room.</p> <p>This deficient practice resulted in Resident 2 sustaining an unwitnessed fall on 5/14/2024 when Certified Nurse Assistant (CNA) 1 left Resident 2 unsupervised in the dining room.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including overactive bladder (sudden urge to urinate that is hard to control) and major depressive disorder (persistent feeling of sadness which can affect daily activities) with severe psychotic (seeing or hearing things that are not there) symptoms.</p> <p>During a review of Resident 2's Minimum Data Set ([MDS] a standardized assessment and care-screening tool), dated 4/3/2024, the MDS indicated Resident 2's cognitive skills for daily decision-making were severely impaired. The MDS indicated Resident 2 required supervision (helper does less than half the effort. Helper lifts, holds, supports trunk or limbs but provides less than half the effort) for chair to bed transfer (ability to transfer to and from bed to chair), toilet transfer, tub/ shower transfer (ability to get on and off the toilet). The MDS indicated Resident 2 required supervision or touching assistance (helper provides verbal cues, and or touching/steadying or contact guard assistant as resident completes activity) to walk 10 feet to 50 feet.</p> <p>During a review of Resident 2's Morse Fall Scale Reports (a method for determining a resident's likelihood of falling which are completed during a resident's admission, quarterly and after each sustained fall), the reports for 6/30/2023 through 5/30/2024, the reports indicated Resident 2 had falls on 7/21/2023, 9/2023, 5/4/2023 and 5/14/2023.</p> <p>During a review of Resident 2's SBAR communication form note, dated 5/14/2024, the note indicated an unidentified resident called for help stating Resident 2 was on the floor and Resident 2 was found on the floor in a sitting position, leaning towards left side near Resident 2's wheelchair. Resident 2 was unable to obtain information as to why Resident 2 got up from wheelchair without assistance. The note indicated Resident 2 sustained an unwitnessed fall on 5/14/2024.</p> <p>During a review of Resident 2's IDT meeting note, dated 5/15/2024, the IDT note indicated Resident 2 had poor safety awareness and was cognitively impaired. The IDT note indicated on 5/14/2023 during the 3pm-11pm shift, while staff was at the station, a resident (unidentified) called for help stating Resident 2 had fallen to the floor in the dining room. The IDT note indicated Resident 2 was left unattended in the dining room by staff.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/30/2024 at 2:46 p.m., the Infection Preventionist Nurse (IPN) stated Resident 2 has history of falls. The IPN stated Resident 2 has poor safety awareness and requires assistance when transferring and ambulating. The IPN stated Resident 2 must be directly always supervised by staff, meaning staff must always have an unobstructive view of Resident 2. The IPN stated Resident 2 cannot be left in a room unattended while awake due to her high risk and history of falling.</p> <p>During an interview on 5/30/2024 at 3 p.m., the Director of Rehabilitation (DOR) stated Resident 2 was known for frequently attempting to get out of bed or out of her wheelchair without assistance and must always be within direct supervision of staff. The DOR stated Resident 2's required need for supervision was discussed in daily staff huddles.</p> <p>During an interview on 5/30/2024 at 3:50 p.m., Registered Nurse (RN) 1 stated on 5/14/2023 at approximately 6:30 p.m., she was notified by CNA 1 that Resident 2 had an unwitnessed fall in the dining room. RN 1 stated Resident 2 was forgetful and needed constant supervision by staff. RN 1 stated Resident 2 frequently attempts to stand up unattended and must be in staff's constant line of sight as she gets up quickly. RN 1 stated the facility does not have a system in place indicating which staff was assigned to supervise Resident 2 to ensure direct supervision while Resident 2 was awake. RN 1 stated failure to have a system in place resulted in staff leaving Resident 2 unattended leading to Resident 2's unwitnessed fall.</p> <p>During an interview on 5/31/2024 at 11:45 a.m., CNA 1 on 5/14/2023 at approximately 6 p.m., she accompanied Resident 2 in the dining room. CNA 1 stated she was called to a huddle at the nurses' station and was later alerted by an identified resident that Resident 2 had fallen to the floor. CNA 1 stated she did not notify other staff that Resident 2 was in the dining room, nor did she endorse Resident 2's care to anyone before leaving her alone in the dining room. CNA 1 stated Resident 2 propels herself in a wheelchair independently and often tries to get out of the wheelchair unassisted. CNA 1 stated Resident 2 needs constant supervision and direct line of sight. CNA 1 stated she should not have left Resident 2 alone in the dining room as she has poor safety awareness and was forgetful.</p> <p>During an interview on 5/30/2024 at 1:30 p.m., the Director of Nursing (DON) stated the facility did not have system in place designating which staff member would be assigned to provide supervision to Resident 2, so the resident was unsupervised. The DON stated Resident 2 must be always supervised by staff while Resident 2 was awake due to Resident 2 poor safety awareness, forgetfulness, and unsteadiness when ambulating.</p> <p>During a review of the facility's Policy and Procedure (P/P) titled, Fall Risk assessment dated [DATE], the P/P indicated the facility will ensure that the resident's environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistant to prevent accidents.</p>		