STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055329	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Serena Healthcare Center	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)
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** 46415 Based on interview and record review, the facility failed to initiate a change of condition (COC) when one of five sampled residents (Resident 1) was found with unknown skin discoloration on his right arm and not doing a pain assessment when Resident 1 was found with a skin tear. This deficient practices placed Resident 1 not being monitored for the COC and had the potential for delay in care. Findings: During a review of Resident 1's Admission record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), muscle wasting and atrophy, and Type 2 (II) Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 1/3/2025 the MDS indicated Resident 1's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were moderately impaired. The MDS indicated Resident 1 required moderate assistance for performing Activities of Daily Living (ADL: bathing, dressing, toileting hygiene, personal hygiene, chair/bed-to-chair transfer, and required supervision for oral hygiene and eating. During a review of the Situation, Background, Assessment, Recommendation (SBAR: structured communication tool used to ensure clear and concise information exchange) Communication Form and progress note dated 3/22/2025 at 9:16a.m., the SBAR indicated Resident 1 was being monitored following an incident where another resident was found on top of Resident 1 with a skin tear on the left arm. The SBAR indicated Resident 1 had a left antecubital skin tear and does not indicate Resident 1's pain status. During a review of Resident 1's progress note dated 3/25/2025, the progress note indicated the Nurse Practitioner 1 (NP) assessed Resident 1. Resident 1's left arm skin tear was reclassified to left forearm skin tear. The skin assessment was done with two other licensed nurses with findings of: left forearm skin tear, left upper arm multiple abrasions, and multiple discolorations on right upper extremity. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/2025 at 11:49a.m. with Treatment Nurse (TXN), TXN stated he did a skin assessment on 3/25/2025 and indicated there was a skin tear on the left arm and discoloration on the right arm and is not sure if the skin discoloration was observed on 3/24/2025 TXN stated when the new skin discoloration was identified, he notified the doctor and updated the care plan. TXN stated the skin assessment is done when there is a change of condition (COC) or at admission TXN stated he wrote a licensed note indicating the doctor was aware but indicated a COC was not done since this was more of a follow up. A COC is done when there are new findings or if the condition has gotten worse. During an interview on 3/28/2025 at 6:12a.m with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated she noticed Resident 1 had a skin tear on his arm when she observed another resident on top of Resident 1 and does not know where it came from LVN 3 stated a COC is done when something is different from the resident's baseline such as a cough. LVN 3 stated a COC will still be completed despite the doctor being onsite when the COC is occurring for documentation purposes and as the resident would need to be on continuous monitoring and would additionally indicate the time the doctor was notified. During an interview on 3/28/2025 at 9:08a.m. with DON, DON stated if there was a division from baseline, the nurses do a COC. DON stated the SBAR specify the COC that was observed, assess, stay at bedside until stable, notify the doctor, provide nursing intervention, notify the family, and carry out doctors' orders. DON stated if the resident is having pain, the pain assessment is initiated. DON stated Resident 1 is prone to discoloration due to his frail skin but does not know what caused the skin discoloration. DON stated if the skin discoloration was observed, an SBAR needs to be initiated. DON stated the TXN admitted he should have done an SBAR the day the skin discoloration was identified. DON stated the COC still needs to be initiated as the nurses need to monitor the resident for 72 hrs to identify any changes . DON stated they should have had a pain assessment when Resident 1 had the skin tear on 3/22/2025. DON stated if a pain assessment was not done, there are no documentation that the pain was addressed at that time and there will be a possibility that the pain will be uncontrolled. During a review of the facility's policy and procedure (P&P) titled, Change of Condition dated 2/9/2024, the P&P indicated the licensed nurse will assess the resident's change of condition and document the observations and symptoms. Notification to the Attending Physician will include a summary of the condition change and an assessment. A licensed nurse will document the following: date, time and pertinent details of the incident and the subsequent assessment in the Nursing Notes. The time the Attending Physician was contacted, the method by which he was contacted, the response time .the time the family/responsible person was contacted. A Licensed Nurse will document each shift for at least seventy-two (72) hours. Documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record and on the 24-hour report. During a review of the P&P titled, Pain Management dated 2/9/2024, the P&P indicated the purpose is to ensure accurate assessment and management of the resident's pain.