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	11/25/2025

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** Based on interview and record review, the facility failed to ensure the legally recognized decisionmaker and physician signed the Physician Orders for Life-Sustaining Treatment ([POLST] form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) form for one of three sampled residents (Resident 1). This deficient practice had the potential to cause Resident 1 to receive treatment or services against their wishes.Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE], and originally admitted to the facility on [DATE], with a diagnosis including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and atherosclerotic heart disease (the buildup for plaque on the artery walls causing reduced blood flow to the tissues and increases risk for a blood clot).During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated [DATE], the MDS indicated Resident 1's cognition (ability to think and reason) was moderately impaired and was fully dependent on staff with toileting hygiene, showering/bathing, and putting on footwear.During a review of Resident 1's History and Physical (H&P) dated [DATE], the H&P indicated Resident 1 did not have capacity to understand and make decisions. The H&P indicated Family Member (FM) 1 was the surrogate decision maker.During a review of Resident 1's POLST dated [DATE], the POLST indicated Resident 1 was designated as Do Not Resuscitate ([DNR] a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating) status and was to receive medical interventions which included comfort-focused treatment (primary goal of maximizing comfort - relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, manual treatment of airway obstruction, and transfer to the hospital only if comfort needs cannot be met) for medical interventions. The POLST form indicated it was signed by Resident 1's physician (MD) 1 on [DATE].During a review of Resident 1's POLST dated [DATE], the POLST indicated Resident 1 was designated as DNR status and was to receive medical interventions which included comfort-focused treatment. The POLST form indicated it was signed by MD 1 on [DATE].During a review of Resident 1's POLST dated [DATE], the POLST indicated Resident 1 was designated as DNR status and was to receive medical interventions which included selective treatment (goal of treating medical conditions while avoiding burdensome measures - in addition to treatment described in Comfort-Focused Treatment, use medical treatment, intravenous ([IV] fluids or medications given directly into the bloodstream) antibiotics, IV fluids as indicated, do not intubate (to insert a tube into a person's airway [usually through the mouth or nose] to help them breathe), may use non-invasive positive airway pressure, and generally avoid intensive care). The POLST indicated there was no signature from Resident 1's legally recognized decisionmaker (FM 1) although it was signed by MD 1 on [DATE].During a review of the 911 Incident Report dated [DATE], the 911 Incident Report indicated facility staff called 911 due to Resident 1 having rapid respirations (abnormally fast breathing greater than 20 breaths per minute) but hypoxia (when the body's tissues don't get enough oxygen) but presented with bilateral expiratory (exhale) wheezing (a high-pitched, whistling sound heard when a person breathes out) and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tachycardia (abnormally fast heart rate greater than 100 beats per minute). The 911 Incident Report indicated paramedics were provided with a POLST for selective treatment that was incomplete and unsigned, and paramedics were unable to get a hold of FM 1 to clarify Resident 1's wishes, and as a result, Resident 1 was transferred to a General Acute Care Hospital (GACH).During an interview on [DATE] at 11:31 a.m., the Director of Nursing (DON) stated it was important for Resident 1's POLST dated [DATE] to be signed because it would be what the paramedics will follow with a change of condition, and since it has changed from comfort measures to selective treatment.During an interview on [DATE] at 12:06 p.m., with the Medical Records Director (MRD), the MRD stated she believed she obtained the signature for Resident 1's POLST dated [DATE] on [DATE], and it was backdated. The MRD stated the POLST form should be signed by the physician as soon as possible, and no later than 72-hours.During an interview on [DATE] at 12:55 p.m., with the Social Services Director (SSD), the SSD stated on [DATE] she spoke to FM 1 regarding her desire to change Resident 1's POLST from comfort measures to selective measures, and it should have been signed that day by the physician to be acted upon, but she was not sure why it was not signed. During review of facility's policy and procedure (P&P) titled Physician Orders for Life Sustaining Treatment (POLST), dated [DATE], the P&P indicated the purpose of the P&P was to help ensure the facility honors residents' treatment wishes concerning resuscitation and life-sustaining treatment. The P&P indicated for the POLST form to be valid, it must be signed by a physician, a nurse practitioner, or a physician assistant acting under the supervision of the physician. The P&P indicated a Licensed Nurse or Social Service Designee must ensure the new POLST form is signed by the physician, and the resident, and the revoked POLST form is voided.