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	04/07/2026

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 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** Based on observation, interview and record review, the facility failed to treat one of four sampled residents (Resident 2) with respect and dignity when Resident 2's family member (FM) while on the phone with Resident 2 overheard CNA 1 speak to Resident 2 using an aggressive and frustrated tone. This deficient practice resulted in Resident 2 crying and responding I'm not stupid to CNA 1 and had the potential for Resident 2 to become afraid of and withdrawn when interacting with facility staff.Findings: During a review of Resident 2's admission Record (Face Sheet) the Face Sheet indicated Resident 2 was admitted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 a diagnosis of hepatic encephalopathy (a reversible, serious neurological condition causing brain dysfunction-including confusion, personality changes, and coma-due to advanced liver disease). During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 1/16/2026, the MDS indicated Resident 2's cognition was intact and she required partial/moderate assistance (helper does less than half the effort) to complete her activities of daily living ([ADLs) activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 2's Licensed Nurses Notes dated 3/27/2026 and timed at 11:41 p.m., the Licensed Nurses Notes indicated LVN 1 received a telephone call (3/27/2026 time unknown) from Resident 2's FM reporting the FM overheard inappropriate words from CNA 1 when CNA 1 was talking to Resident 2. The Licensed Nurses Notes indicated LVN 1 reported the allegation to the Director of Staff Development (DSD) and the Director of Nursing (DON). During a review of the DSD's Statement (Investigation) dated 3/27/2026 and timed at 7:14 p.m., the Investigation indicated the DSD received a telephone call (3/27/2026) from the Administrator (ADM) reporting Resident 2 was crying alleging CNA 1 called her stupid. During a review of a Text Message sent to the DSD from CNA 1 dated 3/27/2026 and timed 8:50 p.m., the Text Message indicated CNA 1 said to Resident 2, if you don't want me to help, you can do it yourself. The Text Message indicated CNA 1 stated it's hard for me to help her (Resident 2) when she wants everything done her way. During a review of a Text Message sent to the DSD from CNA 2 dated 3/30/2026 and timed at 11:24 a.m., the Text Message indicated CNA 2 heard CNA 1 tell Resident 2 you f*ckin bug so much and sh*t what the f*ck do you want now. I'm so f*ckin tired of your sh*t. During an interview on 4/7/2026 at 12:15 p.m., the DSD stated she spoke to Resident 2's FM who told her (DSD) she could not really hear what was said to Resident 2 but from the tone she knew it was inappropriate. During an interview on 4/7/2026 at 12:48 p.m., Resident 2 stated CNA 1 was very bad, and said bad things to her while she (CNA 1) was changing her brief (adult diaper). Resident 2 stated CNA 1 said you can do it yourself which made her (Resident 2) cry. Resident 2 stated CNA 1 treated her like this often, it was her habit. During an interview on 4/7/2026 at 2:27 p.m., CNA 2 stated on the day of the incident (3/27/2026) she passed by Resident 2's room and overheard CNA 1, who was by the entrance of the room, say I f*ckin hate this job and I am tired of this sh*t. During an interview on 4/7/2026 at 2:54 p.m., LVN 1 stated he received a telephone call from Resident 2's FM (3/27/2026) who reported she overheard inappropriate words being said by staff (unknown) to Resident 2. LVN 1 stated after the telephone call, he spoke to Resident 2 who was very emotional and stated she was (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
	055329	A. Building B. Wing	04/07/2026

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Villa Serena Healthcare Center	723 E 9th Street Long Beach, CA 90813

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being rushed while receiving care. LVN 1 stated CNA 1 had an attitude problem and an anger issue and would blow up at him. During an interview on 4/7/2026 at 3:04 p.m., the DON stated CNA 1 would use profanity and curse but would not direct her words at any specific person. The DON stated it was possible for a resident to hear CNA 1 use inappropriate words that were spoken in a elevated tone and think it was directed at them, which could hurt the resident' feelings. The DON stated Resident 2 was emotional and felt rushed while CNA 1 was providing care. During an interview on 4/7/2026 at 3:21 p.m., the ADM stated Resident 2 was upset because she felt she was being rushed during care. The ADM stated CNA 1 was being monitored for negative feelings and behavior of lashing out at staff including the DON. During an interview on 4/7/2026 at 3:45 p.m., Resident 2's FM stated on 3/27/2026 (time unknown) while staff (unknown) was providing care to Resident 2 she (FM) was on the phone with Resident 2 and overheard staff (unknown) speak to Resident 2 in a frustrated and aggressive voice. The FM stated she could not hear what was being said to Resident 2 but Resident 2 was crying and said, I'm not stupid. Resident 2's FM stated Resident 2 told her this was not the first time CNA 1 treated her that way. During a review of the facility's Policy and Procedure (P&P) titled Resident Rights dated 2/9/2024, the P&P indicated the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to report an allegation of verbal abuse for one of four sampled residents (Resident 2) when Resident 2's Family Member (FM) reported to Licensed Vocational Nurse (LVN 1) that Certified Nursing Assistant (CNA) used inappropriate words in an aggressive and frustrated tone when providing care to Resident 2. This deficient practice resulted in the inability of the California Department of Public Health (CDPH) to conduct a timely investigation and had the potential for information to be lost and/or forgotten.Findings: 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 a diagnosis of hepatic encephalopathy (a reversible, serious neurological condition causing brain dysfunction-including confusion, personality changes, and coma-due to advanced liver disease). During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 1/16/2026, the MDS indicated Resident 2's cognition was intact and she required partial/moderate assistance (helper does less than half the effort) to complete her activities of daily living ([ADLs) activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 2's Licensed Nurses Notes dated 3/27/2026 and timed at 11:41 p.m., the Licensed Nurses Notes indicated LVN 1 received a telephone call (3/27/2026 time unknown) from Resident 2's FM reporting the FM overheard inappropriate words from CNA 1 when CNA 1 was talking to Resident 2. The Licensed Nurses Notes indicated LVN 1 reported the allegation to the Director of Staff Development (DSD) and the Director of Nursing (DON). During a review of the DSD's Statement (Investigation) dated 3/27/2026 and timed at 7:14 p.m., the Investigation indicated the DSD received a telephone call (3/27/2026) from the Administrator (ADM) reporting Resident 2 was crying alleging CNA 1 called her stupid. During a review of a Text Message sent to the DSD from CNA 2 dated 3/30/2026 and timed at 11:24 a.m., the Text Message indicated CNA 2 heard CNA 1 tell Resident 2 you f*ckin bug so much and sh*t what the f*ck do you want now. I'm so f*ckin tired of your sh*t. During an interview on 4/7/2026 at 3:04 p.m., the DON stated the incident was not reported to the CDPH because the FM could not hear what was said by CNA 1 and CNA 1 denied saying inappropriate words to Resident 2. During an interview on 4/7/2026 at 3:21 p.m., the ADM stated the incident was not reported to the CDPH because Resident 2 reported she felt rushed during care so there was no need for the incident to be reported. The ADM stated they could not prove what actually happened, the FM could not make out the actual words said by CNA 1, and CNA 1 denied saying anything wrong. During an interview on 4/7/2026 at 3:45 p.m., Resident 2's FM stated on 3/27/2026 (time unknown) while staff (unknown) was providing care to Resident 2 she (FM) was on the phone with Resident 2 and overheard staff (unknown) speak to Resident 2 in a frustrated and aggressive voice. The FM stated she could not hear what was being said to Resident 2 but Resident 2 was crying and said, I'm not stupid. Resident 2's FM stated Resident 2 told her this was not the first time CNA 1 treated her that way. During a review of the facility's Policy and Procedure (P&P) titled Abuse Prevention and Prohibition Program dated 2/9/2024, the P & P indicated facility employees are obligated by the Elder Justice Act and the California Elder Abuse and Dependent Adult Civil Protection Act to report known or suspected instances of abuse of elder or dependent adult. The facility will report allegations of abuse, neglect, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify as a crime.