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	04/29/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise the care plan for one of three sampled residents (Resident 2) when Resident 2 experienced a change of condition on 4/5/2026 and 4/9/2026.This had the potential to result in not meeting Resident 2's needs, poor resident outcomes, or risk of serious injury.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (any damage or disease that affects the brain), dysphagia (difficulty swallowing), and chronic bronchitis (inflammation of airways in the lungs.)During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 1/27/2026, the MDS indicated Resident 2 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required supervision when eating, for oral and personal hygiene, and upper body dressing, required moderate assistance (helper does less than half the effort) for toileting and lower body dressing, and required maximal assistance (helper does more than half the effort) for bathing.During a concurrent interview and record review on 4/28/2026 at 1:34 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's change of condition (COC) dated 4/5/2026 and COC dated 4/9/2026 were reviewed. LVN 1 stated the COC on 4/5/2026 indicated Resident 2 was coughing while drinking liquids. LVN 1 stated the COC on 4/9/2026 indicated Resident 2 was pocketing food (storing food in the mouth instead of chewing and swallowing it).During a concurrent interview and record review on 4/28/2026 at 3:26 p.m. with the MDS Coordinator (MDSC), Resident 2's COC dated 4/5/2026, 4/15/2026 and care plans were reviewed. The MDSC stated Resident 2's care plan tilted Resident 2 is at risk for impaired nutritional and hydration status was not revised to reflect Resident 2's COC episodes of coughing while drinking liquids on 4/5/2026 and pocketing food on 4/9/2026. The MDSC stated the care plan should have been revised at the time of the COC's on 4/5/2026 and 4/29/2026. The MDSC stated if care plans are not revised right away, there is a risk for resident decline, not meeting the resident's needs, or risk of serious injury.During an interview on 4/29/2026 at 2:18 p.m. with the Director of Nursing (DON), the DON stated Resident 2's care plans should have been revised on 4/5/2026 and 4/9/2026 when the COC's were identified to ensure the appropriate interventions were implemented.During a review of the facility's policy and procedure (P&P), titled Care Planning, dated 2/9/2024, the P&P indicated a licensed nurse will initiated the care plan, and the plan will be finalized in accordance with OBRA/MDS guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by the clinical assessment and judgment on an as needed basis.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet professional standards of quality for one of three sampled residents (Resident 2) by failing to communicate Resident 2's change of condition and indication for the Speech Language Pathologist (SLP - profession that identifies, assesses, and treats speech, language, cognitive communication and swallowing disorders) evaluation. This had the potential to result in a delay of care or treatment for Resident 2.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (any damage or disease that affects the brain), dysphagia (difficulty swallowing), and chronic bronchitis (inflammation of airways in the lungs.)During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 1/27/2026, the MDS indicated Resident 2 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required supervision when eating, for oral and personal hygiene, and upper body dressing, required moderate assistance (helper does less than half the effort) for toileting and lower body dressing, and required maximal assistance (helper does more than half the effort) for bathing.During a concurrent interview and record review on 4/28/2026 at 1:34 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's change of condition (COC) dated 4/5/2026, COC dated 4/9/2026, orders, and facility communication notes were reviewed. LVN 1 stated the COC on 4/5/2026 indicated Resident 2 was coughing while drinking liquids. LVN 1 stated the COC on 4/9/2026 indicated Resident 2 was pocketing food (storing food in the mouth instead of chewing and swallowing it). LVN 1 stated the physician ordered a SLP evaluation on 4/9/2026. LVN 1 stated there was no documentation in the nursing notes, SLP notes, communication orders, or change to the order indicating the SLP evaluation had taken place. LVN 1 stated when a SLP evaluation had been completed by the SLP, the SLP either documents the new recommendations in the communication orders and/or modifies the SLP evaluation order to indicate the evaluation had been completed. LVN 1 stated when an SLP evaluation is ordered, nursing prints the order and provides it to the director of rehabilitation services.During a concurrent interview and record review on 4/28/2026 at 2:35 p.m. with the Director of Rehabilitation Services (DOR), Resident 2's comprehensive rehab screen dated 4/15/2026 and orders were reviewed. The DOR stated Resident 2's comprehensive rehab screen dated 4/15/2026 indicated Resident 2's reason for screening was because patient was referred for ST due to family request for diet upgrade. The DOR stated the rehab screen did not indicate the SLP was aware that Resident 2 had episodes of coughing while drinking liquids or was pocketing food. The DOR stated the SLP evaluation order on 4/9/2025 did not indicate the reason for referral. The DOR stated when there is a speech evaluation ordered, nursing provides the printed order and verbalizes resident concerns to the DOR.During an interview on 4/28/2026 at 3:00 p.m. with the Speech Language Pathologist (SLP), the SLP stated they (SLP) recently evaluated Resident 2 on 4/15/2026 because Resident 2's responsible party (RP) had requested to upgrade Resident 2's diet. The SLP stated it was not communicated to the SLP that Resident 2 had episodes of coughing while drinking liquids on 4/5/2026 or was pocketing food on 4/9/2026. The SLP stated if the coughing while drinking liquids and pocketing food was communicated as the indication for the SLP evaluation, the SLP would have educated with the staff on precautions and strategies for Resident 2.During an interview on 4/29/2026 at 2:29 p.m. with the Director of Nursing (DON), the DON stated it was important for the LVN to communicate the reason for evaluation to the DOR and the SLP. The DON stated it was important for the SLP to communicate with nursing and review the resident's record for COC's as part of the SLP evaluation and screening.During a review of the facility's policy and procedure (P&P), titled Specialized Rehabilitative Services, dated 2/9/2024, the P&P indicated licensed nursing staff will refer resident's assessed to have a clinical need for rehabilitative therapy for a screening by the appropriate (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discipline.During a review of the facility's job description (JD), titled Licensed Vocational Nurse (LVN), undated, the JD indicated the LVN demonstrated ability to provide appropriate and quality nursing care to residents including ensuring that problems/concerns regarding activities in the facility/department are communicated appropriately and exchanges and communicates resident care information with interdisciplinary team. During a review of the facility's job description (JD), titled Speech and Language Pathologist/Therapist (SLP), undated, the JD indicated the SLP screens and evaluates residents and develops appropriate care plan and communicates patient status and need to the patients, family, caregivers, or other members involved with patient care.