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	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of three of eight sampled residents (Resident 6, 13, and 19) by failing to: a. Assess Resident 6 for the pre (before) and post (after) RASS Assessment (administered tool used to assess a patient's level of agitation or sedation, ranging from +4 (combative) to -5 (unarousable) for administration of narcotic pain medication (powerful drugs used to treat moderate to severe pain) as ordered.This deficient practice had the potential to compromise safe medication administration and increase the risk of adverse outcomes.b. Ensure the gastrostomy (g-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), was flushed before and after medication administration as ordered for Resident 13.This deficient practice had the potential to block the gastrostomy (g-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and create unnecessary complications. c. Administer warfarin (medication used to prevent blood clots) as ordered to Resident 19. The deficient practice had the potential to increase Resident 19's risk for blood clots. Findings: a. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of prostate (slow-growing cancer forming in the prostate glands [gland in the male reproductive system] tissues potentially causing urinary issues (weak flow, frequency), and bone pain), secondary malignant neoplasm of bone (when cancer cells spread from a primary site (prostate) to the bones, causing pain and decreased mobility), and encounter for palliative (focus on relieving pain and stress to enhance quality of life) care. During a review of Resident 6's history and physical (H&P) dated 10/27/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 1/16/2026, the MDS indicated Resident 6 had mild cognitive impairment. The MDS indicated Resident 6 required substantial assistance (Helper does more than half the effort) from staff for toileting hygiene, bathing, taking off footwear, lower body (waist below) dressing, and partial assistance (Helper does less than half the effort) from staff for upper body (above waist) dressing, personal hygiene, oral hygiene, and roll from left to right. The MDS indicated, Resident 6 required supervision from staff for eating. During a record review of Resident 6's medication administration record (MAR), dated 1/1/2026 – 1/31/2026, the MAR indicated facility staff administered oxycodone-acetaminophen (percocet, medication used to treat moderate to severe pain) oral tablet 5-325 milligram (mg, a unit of (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	measurement) 2 tablets by mouth every 8 hours as needed for severe pain (7-10) on 1/17/2026 to 1/24/2026 to Resident 6. The MAR additionally indicated the RASS assessment pre-administration and RASS assessment post-administration was not completed. During a review of Resident 6's order summary report, dated 2/9/2026, the order summary report indicated Resident 6's medications included oxycodone-acetaminophen (Percocet) oral tablet 5-325 mg 2 tablet by mouth every 8 hours as needed for severe pain (7-10), Percocet oral tablet 5-325 (oxycodone w/acetaminophen) 2 tablet by mouth every 8 hrs as needed for moderate pain (4-6), RASS assessment pre-administration to be done pre-administration of narcotic pain medication score as follows + 4=Combative, +3=Very agitated, +@=Agitated, +1=Restless, 0=Alert and calm, -1=Drowsy, -2=Light sedation -3=Moderate sedation, -4=Deep sedation, -5=Unarousable as needed for pre-administration of narcotic pain medication, and RASS assessment post-administration to be done post-administration of narcotic pain medication score as follows + 4=Combative, +3=Very agitated, +@=Agitated, +1=Restless, 0=Alert and calm, -1=Drowsy, -2=Light sedation -3=Moderate sedation, -4=Deep sedation, -5=Unarousable as needed for post-administration of narcotic pain medication. b. During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including g-tube dysphagia (difficulty swallowing), and a history of malignant neoplasm of large intestine (cancer in the large intestine) During a review of Resident 13's H&P dated 11/2/2025, the H&P indicated Resident 13 did not have the capacity to understand and make decisions. During a review of Resident 13's MDS, dated [DATE], the MDS indicated Resident 13 had mild cognitive impairment. The MDS indicated Resident 13 required substantial assistance (Helper does more than half the effort) from staff for toileting hygiene, bathing, taking off footwear, upper (above waist) and lower body (waist below) dressing, roll from left to right and partial assistance (Helper does less than half the effort) from staff for oral and personal hygiene. During an observation on 2/5/2026 at 8:43 a.m., Resident 13's g-tube was clamped with no active feeding running. The Licensed Vocational Nurse 1 (LVN 1) did not flush Resident 13's g-tube prior to administrating the first medication lasix (treat fluid retention and swelling) tablet 40 mg 1 tablet via g-tube one time a day. During an observation on 2/5/2026 at 8:48 a.m., with LVN 1, LVN 1 was observed flushing potassium chloride (mineral supplement to prevent low blood potassium) oral packet 20 milliequivalents (mEq, unit of measure) 1 packet via g-tube one time a day for supplement with 15 milliliter (mL, unit of volume) water. During a concurrent interview and record review on 2/5/2026 at 8:50 a.m., with LVN 1, LVN 1 stated prior to administering mediation she would usually flush the g-tube. LVN 1 stated she would flush the g-tube again before administering the medication to ensure any residue is cleared and the g-tube is patent. LVN 1 stated if the g-tube was not flushed, it could get clogged, medications can get stuck in the tubing and it would be unclear will how much of the medication Resident 13 received. During an interview on 2/9/2026 at 3:00 p.m., with the Director of Nursing (DON), the DON stated there is an order to flush the g-tube prior to mediation administration with 30 mL pre and post medication administration through the g-tube. The DON stated the g-tube is flushed to ensure the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	patency of the tube and ensure the resident received the entire dose of the medication. The DON stated if the g-tube is not flushed, it can get clogged by feeding in the tube, stomach contents or medications. During a concurrent interview and record review on 2/9/2026 at 3:11 p.m., with the DON, the DON stated the pre and post RASS assessments for medication administration should be done if it is the physicians orders. C. During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including chronic thrombosis (blood clot) of deep veins (DVT) of left lower extremity and atrial fibrillation (an irregular, rapid heart rate that may cause symptoms like heart palpitations, fatigue, and shortness of breath and increases risks for blood clots.) During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating and for oral hygiene, required moderate assistance (helper does less than half the effort) for toileting and upper and lower body dressing, and required maximal assistance (helper does more than half the effort) for bathing. During a review of Resident 19's Physician Order Summary, the Order Summary indicated an order for: Warfarin sodium oral tablet 5 milligrams (MG – a unit of measure), 1 tablet to be given in the evening every Tuesday, Wednesday, Thursday, Saturday, and Sunday related to (R/T) chronic DVT of left lower extremity (Start date 1/15/2026) Warfarin sodium oral tablet 7.5 MG, 1 tablet to be given in the evening every Monday R/T chronic DVT of left lower extremity (Start date 1/15/2026) During a review of Resident 19's care plan titled, Ineffective peripheral (upper or lower extremities) tissue perfusion (healthy blood flow) R/T DVT, initiated 1/13/2026, with goals including Resident 19 will report decreased burning, tingling, and numbness in the extremities through the review date. Interventions included the facility would administer medications as prescribed: Warfarin sodium tablet. During an interview on 2/2/2026 at 10:15 a.m., with Resident 19, Resident 19 stated the facility did not give him his scheduled warfarin for 1 or 2 days. During a concurrent interview and record review on 2/6/2026 at 10:40 a.m., with the MDS Coordinator (MDSC), Resident 19's Medication Administration Record (MAR) for January 2025 was reviewed. The MDSC stated the 1/25/2026 warfarin dose on the MAR is blank. The MDSC stated Resident 19's MAR did not indicate that the warfarin dose scheduled on 1/25/2026 was administered or addressed. The MDSC stated not administering the scheduled warfarin dose placed Resident 19 at risk of blood clots. During an interview on 2/6/2026 at 2:34 p.m., with the DON, the DON stated medications should be given according to the doctor's order. The DON stated if there was a scheduled dose, the medication needs to be given. The DON stated there should not be any blanks or unaddressed medication doses on the MAR. If the dose is not addressed or administered, there is a increased risk for Resident 19 developing a blood clot or DVT. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedures (P&P) titled, Enteral Tube Medication Administration, dated 8/2014, the P&P indicated enteral tubes are flushed with at least 15ml of water before administering medications. During a review of the facility's P&P titled, Job Title: Licensed Vocation al Nurse (LVN), undated, the P&P indicated under essential responsibilities and job functions, resident re-assessments: consistently and accurately performs reassessments during each shift and when the resident condition changes, other resident assessments: completes other assessment tools as defined in policy when appropriate (i.e., pain assessment), resident medications: demonstrates ability to provide appropriate nursing medication management including, but not limited to: administering medications as ordered by physician, appropriately transcribing, administering and documenting medications according to policy and process, documentation: demonstrates ability to appropriately document resident care including but not limited to appropriately transcribing, administering, and documenting medications according to P&P, documenting nursing interventions and resident responses including physical and psychological response, ensuring accuracy regarding transcribing of physician orders, ensuring appropriate documentation regarding resident response to medications. During a review of the facility's P&P titled, Physician Orders, dated 2/9/2024, the P&P indicated whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, record review, the facility failed to keep waste contained (trash covered and secure) when two large trash bins in the facility's parking lot were left open.This failure had the potential to allow pests (tiny living things that can make people sick) to enter the area and result in spread of disease.Findings:During an observation on 2/5/2026 at 10:20 a.m. in the facility's parking lot near the rear kitchen entrance, two large trash bins holding garbage and food waste were observed uncovered.During a follow up observation on 2/6/2026 at 9:35 a.m. in the facility's parking lot, the same two trash bins were observed uncovered.During a concurrent observation and interview on 2/6/2026 at 10:20 a.m. with Maintenance Director (MD) 1 in the facility parking lot near the rear kitchen entrance, two large trash bins confining garbage and food waste were observed uncovered. MD 1 stated, outdoor trash bins must remain closed when not in use all the time to prevent pests.During a concurrent interview on 2/6/2026 at 2:18 p.m. with the Infection Preventionist Nurse (IPN), the IPN stated, trash bins must stay closed all the time to prevent pests and germs.During an interview on 2/26/2026 at 11:33 a.m. with the Director of Nursing (DON), the DON stated, residents with low immune systems could get sick easily if pests enter their area.During a review of the facility's policy and procedure (P&P) dated 2/9/2024 indicated, .waste must be placed in covered bins, which are cleaned daily or more frequently if needed.

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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. Based on observation, interview, and record review, the facility failed to promote and maintain dignity for one of three sampled Residents (Resident 40) when the resident's meal tray was placed on a cluttered bedside table. This failure resulted in Resident 40's feeling unimportant during meal service. Findings: During a meal observation on 2/4/2026 at 12:52 p.m., in Resident 40's room, Resident 40 was observed seated upright at the edge of the bed with a lunch tray on a cluttered (too many things in one place) bedside table.During a follow up meal observation on 2/5/2026 at 8:16 a.m., in Resident 40's room, Resident 40 was observed seated upright at the edge of the bed with a breakfast tray on a cluttered bedside table.During a concurrent observation and interview on 2/5/2026 at 8:30 a.m. with Certified Nurse Assistant (CNA) 1 at Resident 40's room, Resident 40 was observed seated upright at the edge of the bed with breakfast tray placed on a cluttered bedside table. CNA1 stated that the requested extra bedside table was not provided.During an interview on 2/5/2026 at 10:01 a.m. with Resident 40, Resident 40 stated she had requested an extra bedside table for meals but had not received one for a month. Resident 40 further stated, I feel like I don't matter.During a review of Resident 40's admission Record (Face Sheet), the admission Record indicated the facility admitted the resident on 11/28/2025, with diagnoses including, diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control) urinary tract infection (UTI- an infection in the bladder/urinary tract), and liver cell carcinoma (a type of cancer that starts in the email cells of the liver.During a review of Resident 40's Minimum Data Set (MDS-an assessment and care screening tool) dated 1/16/2026 indicated the resident was cognitively (ability to think and understand) intact. The MDS indicated the resident was able to feed herself during meals and was dependent on staff for toilet use and transfers, personal hygiene, and with bed mobility.During an interview on 2/6/2026 at 11:36 a.m. with the Director of Nursing (DON), the DON stated, staff must ensure residents receive meals with dignity and provide an extra table as needed for a clean eating space.During a review of the facility's policies and procedures (P&P) titled Privacy and Dignity, dated February 9, 2024, indicated, . the facility promotes independence and dignity during mealtime.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate a care plan to address the resident's risk for aspiration (inhalation of foreign materials) for one of three sampled residents (Resident 33).This deficient practice had the potential to increase Resident 33's risk for aspiration and choking.Findings:During a review of Resident 33's admission Record, the admission Record indicated Resident 33 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 33's diagnoses included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), dysphagia (difficulty swallowing), and dementia (a progressive state of decline in mental abilities).During a review of Resident 33's Minimum Data Set (MDS - a resident assessment tool), dated 10/28/2025, the MDS indicated Resident 33 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required moderate assistance (helper does less than half the effort) for eating, oral hygiene and upper body dressing, and required maximal assistance (helper does more than half the effort) for toileting, bathing, and lower body dressing. During an interview on 2/4/2026 at 9:56 a.m. with Resident 33's Responsible Party (RP), the RP stated they observed staff feeding Resident 33 without seating Resident 33 all the way up multiple times in December 2025. The RP stated when Resident 33 was hospitalized in December 2025, Resident 33 had food and fluid in their lungs.During a concurrent interview and record review on 2/6/2026 at 11:05 a.m. with the MDS Coordinator (MDSC), Resident 33's General Acute Care Hospital (GACH) follow up pulmonary and medicine note dated 12/23/2025, Resident 33's Speech Language Pathologist (SLP) Evaluation, Plan of Treatment Notes dated 12/27/2025, and Resident 33's Care plans were reviewed. The MDSC stated the GACH follow up pulmonary and medicine note dated 12/23/2025 indicated Resident 33 had a diagnosis for acute bronchitis (inflammation of the airways of the lungs)/aspiration pneumonitis (inflammation of lung tissue) and that Resident 33 was a very high risk for aspiration. The MDSC stated the SLP Evaluation and Plan of Treatment Notes dated 12/27/2025 indicated the SLP Resident 33 was referred to the SLP services for dysphagia to minimize risk of aspiration and presented with severe oropharyngeal dysphagia (difficulty moving food from mouth to the throat) and esophageal dysphagia (the sensation of food getting stuck in the chest after swallowing). The MDSC stated care plans are initiated on admission and reviewed and revised quarterly and as needed for changes of resident condition. The MDSC stated the facility reviews GACH discharge summaries, clinicals, and documentation to create or initiate care plans for the Resident 33. The MDSC stated a care plan was not initiated on readmission to address Resident 33's risk for aspiration. The MDSC stated a care plan should have been initiated when Resident 33 was readmitted on [DATE] to address risk of aspiration.During an interview on 2/6/2026 at 2:34 p.m. with the Director of Nursing (DON), the DON stated care plans are important so the facility will know how to take care of Resident 33 based on their diagnosis, medications, and medical problems. The DON stated care plans are initiated on admission and when there is a significant change, change of conditions, quarterly, annually, and as needed. The DON stated if Resident 33, who is at risk for aspiration does not have a care plan to address the risk for aspiration, the staff may not implement appropriate precautions placing the resident at risk of receiving the wrong diet or choking.During a review of the facility's P&P titled, Care Planning, dated 2/9/2024, the P&P indicated the facility will develop a person-centered baseline care plan for each resident within 48 hours of admission. The P&P indicated baseline care plan will be updated to reflect changes in the resident's condition or needs occurring prior to the development of the comprehensive care plan.During a review of the facility's P&P titled, Eating and Swallowing, dated 2/9/2024, the P&P indicated eating activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure one of five employees [Certified Nurse Assistant (CNA) 5] received a performance evaluation annually.This failure had the potential to result in resident injury or decline in level of care because the staff skills are not being evaluated or monitored.Findings:During a concurrent interview and record review on 2/6/2026 at 1:18 p.m. with the Director of Staff Development (DSD), CNA 5's employee files were reviewed. The DSD stated CNA 2 did not receive performance evaluations in the last twelve months. The DSD stated performance evaluations should be completed every year and filed in their employee file. The DSD stated the performance evaluation should have been completed January 2026.During an interview on 2/6/2026 at 2:34 p.m. with the Director of Nursing (DON), the DON stated performance evaluations should be completed annually or every twelve months. The DON stated if performance evaluations are not completed annually, there is a risk of resident injuries and a decline in level of care because the staff skills are not being evaluated or monitored.During a review of the facility's policy and procedure (P&P), titled Performance Evaluations, revised July 2025, the P&P indicated a performance evaluation will be completed on each employee at the at least annually.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure facility staff did not administer medication used to treat sever pain when the resident only had mild pain or no pain to one of four sampled residents (Residents 6). This deficient practice had the potential to result in inconsistent medication administration and Resident 6 receiving unnecessary medication.Findings:During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of prostate (slow-growing cancer forming in the prostate glands [gland in the male reproductive system] tissues potentially causing urinary issues (weak flow, frequency), and bone pain), secondary malignant neoplasm of bone (when cancer cells spread from a primary site (prostate) to the bones, causing pain and decreased mobility), and encounter for palliative care (focus on relieving pain and stress to enhance quality of life). During a review of Resident 6's history and physical (H&P) dated 10/27/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 1/16/2026, the MDS indicated Resident 6 had mild cognitive (ability to make decisions of daily living) impairment. The MDS indicated Resident 6 required substantial assistance (Helper does more than half the effort) from staff for toileting hygiene, bathing, taking off footwear, lower body (waist below) dressing, and partial assistance (Helper does less than half the effort) from staff for upper body (above waist) dressing, personal hygiene, oral hygiene, and roll from left to right. The MDS indicated, Resident 6 required supervision from staff for eating. During a record review of Resident 6's medication administration record (MAR), dated 1/1/2026 - 1/31/2026, the MAR indicated facility staff administered oxycodone-acetaminophen (Percocet, medication to treat moderate and severe pain) oral tablet 5-325 milligram (mg, a unit of measurement) 2 tablets by mouth every 8 hours as needed for severe pain (pain scale used to assess level of pain 1-3 mild pain, 4-6 moderate pain, and 7-10 extreme pain) on 1/9/2026 with a pain level of 5, and on 1/20/2026 with a pain level of 0 to Resident 6. The MAR indicated Resident 6 received Percocet oral tablet 5-325 mg 1 tablet by mouth every 8 hours as needed for moderate pain (4-6) on 1/14/2026 at a pain level of 2. During a review of Resident 6's order summary report, dated 2/9/2026, the order summary report indicated Resident 6's medications included Percocet, medication to treat moderate and severe pain) oral tablet 5-325 mg 2 tablet by mouth every 8 hours as needed for severe pain (7-10) and Percocet oral tablet 5-325 2 tablet by mouth every 8 hrs as needed for moderate pain (4-6). The order summary report indicated Percocet oral tablet 5-325 was not ordered for pain level of 0-3.During a concurrent interview and record review on 2/9/2026 at 3:05 p.m., with the Director of Nursing (DON), the DON stated on 1/9/2026, the order indicated to give Percocet as needed for severe pain (7-10) and indicated if the pain level is 5, there should be another medication that should be given based on the pain level. The DON stated per order, if the pain range is from 7-10, this medication should not have been given for a pain level of 5 or 0. The DON stated Resident 6 received Percocet as needed for pain level of 4-6 when the pain level was 2 on 1/14/2026. The DON stated they would have to check what the doctors' orders are and follow it. The DON stated pain medication would not be given if the resident had no pain. During a review of the facility's policy and procedure (P&P) titled, Job Title: Licensed Vocation al Nurse (LVN), undated, the P&P indicated under essential responsibilities and job functions, resident medications: demonstrates ability to provide appropriate nursing medication management including, but not limited to: administering medications as ordered by physician, appropriately transcribing, administering and documenting medications according to policy and process, documentation: demonstrates ability to appropriately document resident care including but not limited to appropriately transcribing, administering, and documenting medications according to P&P, .ensuring accuracy regarding transcribing of physician orders.During a review of the facility's P&P titled, Physician Orders, dated 2/9/2024, the P&P indicated whenever possible, the Licensed (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse receiving the order will be responsible for documenting and implementing the order. During a review of the facility's P&P titled, Pain Management, dated 2/9/2024, the P&P indicated the licensed nurse will administer pain medication as ordered.

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	02/09/2026

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 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of 19 residents' bedroom rooms (2 and 3) accommodate no more than four residents in each room. This deficient practice had the potential to result in inadequate space to provide nursing care. Findings: During an observation on 2/2/2026 at 12:57 p.m., room [ROOM NUMBER] and 3 were occupied with six residents each. The residents were observed to have no issues moving in and out of rooms and had enough space for wheelchairs, beds, and bedside tables. During a record review of the waiver signed by the administrator dated 3/7/2025 submitted by the Administrator (ADM) indicated resident rooms are permitted to have no more than four beds per room and rooms [ROOM NUMBERS] did not meet the four resident per room requirement by federal regulation. During an interview on 2/9/2025 at 3:51p.m. with the ADM, the ADM stated the residents in room [ROOM NUMBER] and 3 and ensured they are compatible as they have dementia (a progressive state of decline in mental abilities) and the residents have been able to comfort one another.

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	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 17 of 19 resident rooms met the requirements of 80 square feet ([sq. ft.] a unit of area measurement) per residents in multi-bed resident rooms. This deficient practice had the potential to result in an inadequate provision of safe nursing care, and privacy for the residents.Findings: During an observation on 2/2/2026 at 2:02p.m., residents in a three (3) room bedroom were observed having a wheelchair that was not blocking or hindering other residents, had bedside tables, and had enough space going in and out of room. During a review of the Client Accommodations Analysis (identifies approved use ot induvial rooms and approved capacities) dated 2/2/2026, the Client Accommodations Analysis indicated the following: room [ROOM NUMBER] (6 beds) 470 sq. ft. room [ROOM NUMBER] (6 beds) 426 sq. ft.room [ROOM NUMBER] (2 beds) 143 sq. ft.room [ROOM NUMBER] (2 beds) 155 sq. ft.room [ROOM NUMBER] (2 beds) 146 sq. ft.room [ROOM NUMBER] (2 beds) 145 sq. ft.room [ROOM NUMBER] (2 beds) 144 sq. ft.room [ROOM NUMBER] (2 beds) 144 sq. ft.room [ROOM NUMBER] (2 beds) 146 sq. ft.room [ROOM NUMBER] (3 beds) 213 sq. ft.room [ROOM NUMBER] (3 beds) 187 sq. ft.room [ROOM NUMBER] (2 beds) 129 sq. ft.room [ROOM NUMBER] (2 beds) 133 sq. ft.room [ROOM NUMBER] (3 beds) 210 sq. ft.room [ROOM NUMBER] (3 beds) 214 sq. ft.room [ROOM NUMBER] (3 beds) 216 sq. ft. The minimum sq. ft. for two bedrooms is 160 sq. ft. The minimum sq. ft for a three bedroom is 240 sq. ft. The minimum sq. ft. for a six bedroom, is 480 sq. ft. During an interview on 2/9/2026 at 1:03p.m. with the Maintenance Director 1 (MD 1), the MD 1 stated he does not know how many sq. ft. per resident in multi-patient rooms are required and how many residents are supposed to be in one room. The MD 1 stated he does have a room waiver but has not read the room waiver. During a concurrent interview and record review on 2/9/2026 at 3:51p.m. with the Administrator (ADM), the ADM stated they apply for a room waiver every year due to the layout of the facility not meeting the square footage per resident in multi-patient rooms. The ADM stated effort is made to ensure residents are safe, the room is free from clutter as the room size does not meet the 80 sq. ft. per resident. The ADM stated rooms 2 to 9, 11 to 19 are the rooms that do not meet the required footage. The ADM stated the room sq. ft. not meeting the requirement has not affected the care provided to the residents and will be accommodated as needed. During a review of the facility's policy and procedures (P&P) titled, Resident Rooms and Environment, dated 2/9/2024, the P&P indicated the unless a waiver applies, resident rooms must measure at least 80 square feet per resident in multiple resident rooms and 100 square feet in single resident rooms.