STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555070	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southland	11701 Studebaker Road Norwalk, CA 90650

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 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** 44443 Based on interview and record review, the facility failed to ensure a Care Plan was developed for one sampled resident (Resident 1), who had dry eyes. This failure resulted in Resident 1 not receiving Lubricant PM Ophthalmic ointment (an eye lubricant for the temporary relief of burning, irritation, and discomfort due to dryness of the eye) in a timely manner. Findings: During a review of Resident 1 ' s Admission record ([Face Sheet] a document that summarizes a patient ' s personal and medical information), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Transient Ischemic Attack ([TIA] a temporary disruption in the blood supply to part of the brain that results in lack of oxygen to the brain) and anxiety disorder (a mental illness causing persistent fear and worry). During a review of Resident 1 ' s History and Physical (H&P), dated 7/31/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 8/6/2024, indicated Resident 1 had the ability to understand and be understood by others. During a review of Resident 1 ' s Physician Orders, dated 8/28/2024, the Physician Orders indicated Resident 1 was to receive Lubricant PM Ophthalmic Ointment (white Petrolatum- mineral oil) one strip in both eyes at bedtime for dry eyes. During a concurrent interview and record review on 9/5/2024, at 12:22 p.m., with Licensed Vocational Nurse (LVN 1), Resident 1 ' s Clinical Record (Care Plan section) was reviewed. LVN 1 stated, there was no Care Plan developed addressing Resident 1 ' s dry eyes. LVN 1 stated a Care Plan should have been developed which included interventions addressing Resident 1 ' s dry eyes. LVN 1 stated the purpose of the Care Plan is to help guide the nurse on how to care for the resident and if the interventions in place were effective. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P/P) dated 1/2022 and titled, Comprehensive Person-Centered Care Planning, the P/P indicated the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident ' s medical, nursing, mental and psychosocial needs.

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Southland	11701 Studebaker Road Norwalk, CA 90650

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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 - Few	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** 44443 Based on interview and record review, the facility failed to ensure the residents ' ordered medications were available for administration and were administered to residents as prescribed by the physician for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Resident 1 received Lubricant PM Ophthalmic Ointment (an eye lubricant for the temporary relief of burning, irritation, and discomfort due to dryness of the eye) one strip in both eyes at bedtime as ordered for dry eyes. 2. Ensure the licensed nurses followed-up with the pharmacy when Resident 1 ' s medication was not available for administration. This deficient practice resulted in Resident 1 not receiving her prescribed medication as ordered and resulted in Resident 1 having dry eyes and eye pain. Findings: During a review of Resident 1 ' s Admission record ([Face sheet] a document that summarizes a patient ' s personal and medical information), the face sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including Transient Ischemic Attack (a temporary disruption in the blood supply to part of the brain that results in lack of oxygen to the brain) and anxiety disorder (mental illness causing persistent fear and worry). During a review of Resident 1 ' s History and Physical (H&P), dated 7/31/2024, indicated, Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 8/6/2024, the MDS indicated Resident 1 had the ability to understand and be understood by others. During a review of Resident 1 ' s Order Summary Report (Physician Orders), dated 8/28/2024, the Physician Orders indicated an order for Lubricant PM Ophthalmic Ointment (white Petrolatum- mineral oil) one strip in both eyes at bedtime for dry eyes was ordered on 8/28/2024. During an interview on 9/5/2024, at 11 a.m., Resident 1 stated on 8/29/2024 she had reported to the licensed nurses that she was experiencing dry eyes and eye pain and inquired why she hadn ' t received her eye ointment on 8/28/2024. Resident 1 stated the licensed nurses told her it had not arrived from the pharmacy but should be arriving on 8/29/2204. Resident 1 stated the licensed nurses did not administer they eye ointment to her again on 8/29/2024 and she had informed the licensed nurse that her eye pain was getting worse from not receiving her eye drops yet the licensed nurses did not do anything about it and told her that they eye drops had yet to arrive from the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/5/2024, at 12:07 p.m., with Certified Nurse Assistant (CNA 1), stated on 8/28/2024, Resident 1 was complaining of burning and eye pain from not receiving her eye ointment. CNA 1 stated she reported it to the Licensed Vocational Nurse (LVN 1). CNA 1 stated LVN 1 told her they would follow-up with the pharmacy as the eye ointment had not arrived. During an interview on 9/5/2024, at 12:22 p.m., with LVN 1, LVN 1 stated, on 8/28/2024, he faxed the medication order for Lubricant Ointment to the pharmacy but did not follow-up nor did he inform the oncoming shift that the Lubricant Ointment had not arrived from the pharmacy. LVN 1 stated on 8/29/2024, Resident 1 reported to him that she had missed her eye ointment dose on 8/28/2024. LVN 1 stated he followed-up with the pharmacy and endorsed to the oncoming shift that eye medication had not arrived, that pharmacy was called, and the eye medication order was faxed to the pharmacy for the second time. LVN 1 stated LVN 2 notified the Assistant Director of Nursing (ADON) regarding the eye medication not arriving yet and the ADON called the pharmacy around 3 p.m., to follow up for the delivery of the eye medication but the medication was not delivered on 8/30/2024 at 9 p.m. During an interview on 9/5/2024, at 2:33 p.m., the Pharmacy Technician Supervisor stated, there are stat, or emergency runs and scheduled runs. The turnaround time for stat runs is two hours and for scheduled runs, it depends if the medication is in stock or not. For Resident 1, the medication order was received via fax on 8/28/2024 at 11:19 p.m. The wholesaler closes at 7p.m., so any orders received after 7p.m., the medication will be delivered the following business day however the eye ointment was not in stock, so he had to order the medication from the wholesaler which added an additional day in delivering the eye ointment to the facility. The Pharmacy Technician stated the licensed nurses should have informed Resident 1 ' s physician to have an alternative eye ointment ordered so Resident 1 would not have to wait until 8/30/2024 to receive her medication. During an interview on 9/5/2024, at 3:17 p.m., with LVN 2, LVN 2 stated Resident 1 was complaining of eyes feeling dry, inflamed, and had eye pain. LVN 2 stated she followed-up with the pharmacy on 8/29/2024 but the medication was never delivered. During an interview on 9/5/2024, at 4:02 p.m., the Director of Nursing (DON) stated, she was not aware that the eye medication was not available or received. The DON stated if the medication had not been received or available, the doctor and the resident should be notified so additional interventions can be implemented or new orders can be placed for the resident to receive an alternative eye ointment. During a review of the facility ' s policy and procedure (P/P) dated 2010 and titled, Medication Ordering and Receiving from Pharmacy Provider, the P/P indicated if the medication is needed before the next regular delivery, fax/ phone the medication orders to the pharmacy immediately upon receipt and inform the pharmacy of the need for prompt delivery. The P/P indicated timely delivery of new orders is required so that medications administration is not delayed.