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	09/24/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN 1) had the competency skills to care for two of three sampled residents (Residents 1 and 2) by failing to: 1. Provide Cyclosporine Ophthalmic Emulsion 0.05% ([eye drops] medication used to increase tear production in people with dry eyes) to Resident 1 according to the facility ' s policy and procedure (P&P) titled, Medication Administration. 2. Notify Resident 2 ' s physician when Resident 2 had a change of condition (COC) and required oxygen through a non-rebreather mask (a mask that delivers a high concentration of oxygen to a patient in an emergency). 3. Document Resident 2 ' s COC in the medical record. These deficient practices resulted in: 1. Resident 1 receiving her eye medication two hours past the administration time and had the potential for Resident 1 to have eye pain because of the late administration. 2. Resident 2 ' s COC not being reported to the physician and not documented in the medical record. Findings: a. During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated assessment tool) dated 8/5/2024, the MDS indicated Resident 1 ' s cognition (mental process of knowing, learning, and understanding things) was moderately impaired. During a review of Resident 1 ' s Order Summary Report (physician order) dated 9/5/2024, the physicians order indicated Cyclosporine Ophthalmic Emulsion 0.05% one drop in both eyes twice a day for eye pain management was ordered on 9/5/2024. (continued on next page)

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
	555070	A. Building B. Wing	09/24/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Clinical Record (Care Plan section) dated 9/5/2024, the Care Plan indicated Resident 1 had pain in both eyes due to dry eyes. Under this Care Plan, the Care Plan goal indicated Resident 1 ' s pain would be resolved after the administration of medication. The Care Plan ' s interventions included to administer Cyclosporine Ophthalmic Emulsion 0.05% one drop in both eyes twice a day for eye pain management. During an interview on 9/24/2024 at 3:09 p.m., with Resident 1, Resident 1 stated on 9/10/2024 LVN 1 administered the eye drops to her at 11:30 p.m. when the eye drops were due at to be administered at 9 p.m. (over one and a half hours after the scheduled dose). During an interview on 9/24/2024 at 3:47 p.m., with LVN 1, LVN 1 stated Resident 1 ' s eye drops were administered late because he was busy with Resident 2. LVN 1 stated there were no negative outcomes for Resident 1 because of the late administration, since only the eye drops that were late. LVN 1 stated the facility ' s policy is to administer medication one hour before and one hour after the time indicated on the physician order. b. 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 diagnoses including chronic congestive heart failure (CHF - a long term condition which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and pulmonary fibrosis (a serious lung disease that causes the lungs to become scarred, making it difficult to breathe). During a review of Resident 2 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/6/2024, the MDS indicated Resident 1 ' s cognition (mental process of knowing, learning, and understanding things) was moderately impaired. During a review of Resident 2 ' s Order Summary Report (physician order) dated 8/9/2024, the physicians order indicated to administer oxygen 5 liters per minute (LPM) via a nasal cannula (tubing that delivers oxygen to a person through the nose) every shift was ordered on 8/9/2024. During an interview on 9/24/2024 at 3:47 p.m., LVN 1 stated on 9/10/2024, Resident 2 experienced an anxiety attack (an episode of mild to severe worry, distress that may last for hours or days, which is typically preceded by a period of gradually increasing levels of fear and worry), and his blood oxygenation (level of oxygen in the blood) reading was at 80% (normal reading between 95%-100%) while receiving oxygen at 5 LPM through the nasal cannula. LVN 1 stated he provided a non-rebreather mask (a mask that delivers a high concentration of oxygen to a patient in an emergency situation) with oxygen at 5 LPM, encouraged Resident 2 to perform deep breathing exercises, placed him (Resident 2) in the dorsal recumbent position (where the person is laying on their back with their legs bent at the knees and their feet spread out to the sides about shoulder width apart) and elevated the head of the bed. LVN 1 stated he did not document Resident 2 ' s COC nor any of interventions provided because he forgot. LVN 1 stated he did not inform Resident 2 ' s physician of the COC. LVN 1 stated he should have informed the physician to receive any further interventions Resident 2 required. (continued on next page)

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	09/24/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/24/2024 at 4:22 p.m., with the Director of Nursing (DON), the DON stated, LVN 1 should have asked for help from other facility staff such as the Registered Nurse Supervisor (RNS) when Resident 2 had a COC and Resident 1 ' s medication was going to be administered late. The DON stated the stated the facility ' s policy allows one hour before and after ordered time for medication administration and LVN 1 could have asked for help with Resident 2, then he could have proceeded with medication administration or ask another nurse to administer the medication on time. The DON stated LVN 1 should have notified Resident 2 ' s physician to obtain additional orders or provide other interventions. During a review of the facility ' s P&P titled Significant Change of condition, Response, dated 12/2023, the P&P indicated the nurse will perform and document an assessment of the resident and identify the need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident ' s provider using SBAR (situation, background, assessment and recommendation - a structed communication tool that helps share information in a concise and clear way) or similar process to obtain new orders or interventions. During a review of the facility ' s P&P titled Medication Administration, dated 9/2010, the P&P indicated medications should be administered within sixty minutes of the scheduled time. During a review of the facility ' s Licensed Vocational (LVN)/Practical Nurse Job Description, dated 12/17/2021, the Job Description indicated a LVN ' s essential duties and responsibilities include making written and oral reports to the attending physician concerning the status and care of the assigned resident and preparing and administering medications as ordered by the physician. The Job Description indicated a LVN should chart nurses ' notes in a professional and appropriate manner that is timely, accurate and thoroughly reflects the care provided to the resident, as well as the resident ' s response to the care.