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	07/02/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that the resident received treatment and care in accordance with professional standards of practice for one of three sampled residents (Resident 1) by failing to notify the physician and responsible party regarding Resident 1's Computed Tomography (CT- a medical imaging procedure that uses X-rays to create detailed cross-sectional images of the body) scan result which indicated multiple kidney stones (hard objects made of minerals and salts in urine lodged in the kidney, very painful).This failure resulted in a delay in care and treatment to prevent urinary tract infection (UTI- an infection in the bladder/urinary tract) and abdominal pain.During a review of Resident 1's admission Record, the admission Record indicated, Resident 1 was initially admitted to the facility on [DATE] and last re-admission was on 6/25/2024 with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and elevated white blood cell counts (the immune system produced more white blood cells to destroy an infection).During a review of Resident 1's Nurse Practitioner Progress Note, dated 6/28/2024, the Nurse Practitioner Progress Note indicated, Resident 1 had the capacity (ability) to understand and make decisions.During a review of Resident 1's Minimum Data Set ([MDS]-a resident assessment tool), dated 6/15/2025, the MDS indicated Resident 1 required dependent assistance (Helper does all of the effort) from two or more staff for transfer, hygiene, dressing, maximal assistance (Helper does more than half the effort) from one staff for bed mobility, and independent for eating. During an interview on 7/2/2025, at 11:29 a.m., with Resident 1 in Resident 1's room, Resident 1 stated, she had a CT scan in early June, but staff did not inform her of the results. Resident 1 stated, she had abdominal pains frequently and was hospitalized recently for abdominal pain and a UTI. Resident 1 stated, the hospital doctor told her that she had multiple kidney stones that might cause the UTI and pain, but she did not receive any treatment during hospitalization. Resident 1 stated, she would like to know how to treat the kidney stones.During a concurrent interview and record review on 7/2/2025, at 11:51 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 1's Nursing Progress Notes, dated from 6/9/2025 to 7/2/2025 were reviewed. The Nursing Progress indicated, Resident 1 left the facility for a CT scan, but there were no follow up notes and no documentation indicating the facility staff notified the physician and Resident 1's responsible party regarding the CT scan result. RNS 1 stated, any findings from a medical test are considered a change of condition and the physician should be notified, for further treatment orders. RNS 1 stated the facility staff need to update Resident 1's responsible party as well. RNS 1 stated, there was no documentation regarding notification or follow-up.During a phone interview on 7/2/2025, at 12:56 p.m., with Resident 1's Responsible Party (RP)1, RP 1 stated, staff did not inform him regarding CT scan result. RP 1 stated, he found out later that Resident 1's physician and Nurse Practitioner (NP) were not informed about the result until Resident 1 was transferred to the General Acute Care Hospital (GACH) emergency room (ER) on 6/24/2025. RP 1 stated, Resident 1 was getting some pain medication, but it was not effective. RP 1 stated, he was very upset after talking to GACH doctor because Resident 1's UTI and pain were possibly caused by the kidney stones. RP 1 stated, Resident 1's kidney stones were not treated in ER and the GACH sent her back to the facility. RP1 stated, the facility staff did not know why Resident 1 was not treated. RP1 stated, he got frustrated, because the nurses could not tell him the treatment plan. RP 1 stated, he did not want Resident 1 to suffer from UTI and pain again.During a concurrent interview and record review on 7/2/2025, at 1:29 p.m., with Social Service Director (SSD), Resident 1's Grievance Resolution Form, dated 6/24/2025 was reviewed. The Grievance Resolution Form indicated, RP 1 complained Resident 1's CT scan results were not communicated to her attending physician. The SSD stated, the Director of Nursing (DON) spoke to responsible staff including Registered Nurse (RN) 2 regarding the importance of clear communication. The SSD stated, she confirmed that attending physician and NP did not notify Resident 1's physician and Responsible party regarding Resident 1's CT scan results.During an interview on 7/2/2025, at 1:46 p.m., with the Case Manager (CM), the CM stated, she received the CT scan results on 6/12/2025 and handed it to RN 2 with other documents. The CM stated, she flagged the CT scan result and believed this was the nursing responsibility to notify the attending clinician and RP.During an interview on 7/2/2025 at 2:59 p.m., with RN 2, RN 2 stated, the CM gave her a bunch of documents while she was passing the medications. RN 2 stated, the CM did not mention anything about CT scan results. RN 2 stated, the CM only asked her to re-check the appointment date. RN 2 stated, if she knew there were CT scan result, she would notify physician, NP and

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record reviews, the facility failed to ensure effective pain management measures for one of three sampled resident (Resident 1), by failing to ensure Resident 1 had pain medication for moderate pain (pain scale [a tool used to assess pain intensity, with a scale of 0 to 10, where 0 represents no pain and 10 represents the worst pain imaginable] level of 4-7) and routine and breakthrough pain (a transient exacerbation of pain that occurs in individuals who are already experiencing chronic pain).This failure had the potential to result in social isolation and worsening of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and last re-admission was on 6/25/2024 with diagnoses including recurrent major depressive disorder and chronic pain syndrome (persistent pain lasting longer than three months, significantly impacting a person's physical and mental well-being).During a review of Resident 1's Nurse Practitioner Progress Note, dated 6/28/2024, the Nurse Practitioner Progress Note indicated, Resident 1 had the capacity (ability) to understand and make decisions.During a review of Resident 1's Minimum Data Set ([MDS]-a resident assessment tool), dated 6/15/2025, the MDS indicated Resident 1 required dependent assistance (Helper does all of the effort) from two or more staff for transfer, hygiene, dressing, maximal assistance (Helper does more than half the effort) from one staff for bed mobility, and independent for eating.During a concurrent observation and interview on 7/2/2025, at 11:29 a.m., with Resident 1 in Resident 1's room, Resident 1 was grimacing, and her hands were on the mid-section of her abdomen (belly). Resident 1 stated, she was having intermittent pain on her mid abdominal area with a pain level of 10 out of 10. Resident 1 stated, she did not receive pain medication routinely and the pain medication she received was not very effective. Resident 1 stated, she had to get a hold of the nurse to get her pain medication, and her pain level reached eight or nine out of 10 when the nurse brought the pain medication. Resident 1 stated, she had to go to the General Acute Care Hospital (GACH) emergency room (ER) recently for the abdominal pain.During a concurrent interview and record review on 7/2/2025, at 12:34 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 1's Order Summary Report (OSR), dated 7/2/2025 was reviewed. The OSR indicated, an order to give Tylenol (a pain medication to relieve mild pain) 325 milligram(mg) two tablets by mouth every six hours as needed for mild pain (pain scale of 1-3) was ordered on 6/27/2025. The OSR indicated, an order to give Percocet (a pain medication to relieve severe pain) 5-325mg one tablet by mouth every six hours as needed for severe pain (pain scale of 8-10) was ordered on 2/11/2025. There was no pain medication coverage for moderate pain (pain scale of 4-7). LVN 1 stated, she should have asked the physician for moderate pain coverage. LVN 1 stated, last time Percocet was given to Resident 1 was on 7/2/2025, at 1:25 a.m., and did not know that Resident 1 had pain level of eight out of 10. LVN 1 stated, Resident 1's pain level usually stayed at eight or nine and was not very effective. LVN 1 stated, she asked the Nurse Practitioner (NP) who was working with the attending physician regarding the ineffective pain management for Resident 1, but NP declined to change the medication order. LVN 1 stated she should have contacted the Medical Director (MD) to get better coverage for pain management, but she did not.During an interview on 7/2/2025, at 1:29 p.m., with the Social Service Director (SSD), the SSD stated that Resident 1 did not want to participate in group activities and to get out of the bed recently. The SSD stated, during a room visit she asked Resident 1about her pain, and Resident 1 stated that she was in pain constantly and did not feel good enough to get out of bed for activities.During an interview on 7/2/2025, at 3:15 p.m., with the Director of Nursing (DON), the DON stated, effective pain management should cover all levels of pain. The DON stated, if the administer-as-needed pain medication did not relieve the pain, the nursing staff should have asked the attending physician or covering NP for routine and breakthrough pain medications to manage the pain more effectively. The DON stated, if the attending physician or NP did not agree with suggested pain management, the staff could reach out to the Medical Director. The DON stated, Resident 1 was already suffering from depression, chronic pain from multiple previous fractures (broken bones), and kidney stones. The DON stated, if the pain was not controlled effectively, Resident 1 might suffer from insomnia, social isolation, and worsening of depression. During a review of Resident 1's Medication Administration Record (MAR), dated on 7/1/2025 and 7/2/2025, the MAR indicated, Resident 1 received one tablet of Percocet 5-325 mg by mouth for pain level of eight out of ten on 7/1/2025, at 8:32 a.m. The MAR indicated, Resident 1 received one tablet of Percocet 5-325mg by