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	12/12/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 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 they reported an allegation of resident to resident abuse within two hours of being made aware of the allegation for two of two sampled residents (Resident 1 and Resident 2). This deficient practice resulted in the inability for the California Department of Public Health (CDPH) to conduct an immediate investigation of the abuse allegation and had the potential for information to be lost and/or forgotten. Findings: 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 diagnoses that included dementia (a progressive state of decline in mental abilities) and anxiety disorder (persistent and excessive worry that interferes with daily activities). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 8/4/2025, the MDS indicated Resident 1 had severe cognitive (ability to think and process information) impairment (loss). The MDS indicated Resident 1 required supervision (helper provides verbal cues or touching assistance) for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 1 required set up assistance (helper sets up or cleans up and resident completes activity) for eating, oral hygiene, upper body dressing and personal hygiene. During a review of Resident 1's History and Physical (H&P) dated 9/13/2025, the H&P indicated Resident 1 did not have the capacity (ability) to understand and make decisions. During a review of Resident 2's admission Record (Face Sheet), the Face Sheet Resident 2 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had moderate cognitive impairment. The MDS indicated Resident 2 required supervision for eating and oral hygiene. The MDS indicated Resident 2 required moderate assistance (helper does less than half the effort) for upper body dressing. The MDS indicated Resident 2 required substantial assistance (helper does more than half the effort) for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. During a review of Resident 2's H&P dated 10/7/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During an interview on 10/25/2025 at 9:09 a.m., Resident 2 stated she was mad at Resident 1 because Resident 1 called her a bitch, so she pushed her wheelchair. Resident 2 stated staff separated them and moved her room from the third floor to the second floor. During an interview on 10/25/2025 at 9:26 a.m., Licensed Vocational Nurse (LVN) 1 stated Certified Nursing Assistant (CNA) 1 reported to her that on 10/24/2025 Resident 2 was upset with Resident 1 and pushed her (Resident 1) with her (Resident 2) wheelchair. LVN 1 stated Resident 2 was upset because she thought Resident 1 had gone into her room. During an interview on 10/25/2025 at 9:34 a.m., CNA 1 stated she saw Resident 2 rush her wheelchair into Resident 1's wheelchair and then yelled at Resident 1 to get out of her room. CNA 1 stated Resident 2 intentionally bumped into Resident 1's wheelchair twice before she was able separate them. CNA 1 stated this was considered abuse because Resident 1's head went backwards when she was hit by Resident 2's wheelchair. CNA 1 stated she reported what happened to LVN 2. During an interview on 10/25/2025 at 11:09 a.m., LVN 2 stated CNA 1 reported the physical altercation between Resident 1 and Resident 2 to her and she reported it to the Assistant Director of Nursing (ADON). During an interview on 10/25/2025 at 11:23 a.m., the ADON stated LVN 2 reported to her that Resident 2 wheeled herself really fast towards Resident 1 and bumped into her wheelchair. The ADON stated the incident was not considered abuse. ADON stated that if abuse was not reported a resident could get hurt. During an interview on 10/25/2025, at 10:05 a.m., the Administrator (ADM) stated he was notified of the incident between Resident 1 and Resident 2 on 10/24/2025 but he did not report it to CDPH or other departments because he did not consider it abuse. The ADM stated that if abuse was not reported, the abuse could continue causing harm to the resident(s). During a review of the facility's Policy and Procedure (P&P) titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment dated 11/2017, the P&P indicated: 1. If there is an allegation or suspicion of abuse, the facility will make a report to the appropriate agencies as designated by State and Federal laws. 2. Abuse is willful infliction of injury or mental anguish. 3. The facility will ensure all alleged violations involving abuse are reported immediately but not later than 2 hours after the allegation is made if the event involves abuse. 4. The facility will ensure all alleged violations involving abuse are reported to the Administrator of the Facility and The State Survey Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 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 the facility conducted an investigation for two of two sampled residents (Resident 1 and Resident 2) when they were made aware of a physical altercation between the two residents on 10/24/2025. This deficient practice resulted in not determining what the problems were between Resident 1 and Resident. This deficient practice had the potential for an ongoing situation between the two residents to escalate due to no attempted determination of events or resolution of the situation. Findings: 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 diagnoses that included dementia (a progressive state of decline in mental abilities) and anxiety disorder (persistent and excessive worry that interferes with daily activities). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 8/4/2025, the MDS indicated Resident 1 had severe cognitive (ability to think and process information) impairment (loss). The MDS indicated Resident 1 required supervision (helper provides verbal cues or touching assistance) for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 1 required set up assistance (helper sets up or cleans up and resident completes activity) for eating, oral hygiene, upper body dressing and personal hygiene. During a review of Resident 1's History and Physical (H&P) dated 9/13/2025, the H&P indicated Resident 1 did not have the capacity (ability) to understand and make decisions. 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 that included schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had moderate cognitive impairment. The MDS indicated Resident 2 required supervision for eating and oral hygiene. The MDS indicated Resident 2 required moderate assistance (helper does less than half the effort) for upper body dressing. The MDS indicated Resident 2 required substantial assistance (helper does more than half the effort) for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. During a review of Resident 2's H&P dated 10/7/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During an interview on 10/25/2025 at 9:09 a.m., Resident 2 stated she was mad at Resident 1 because Resident 1 called her a bitch, so she pushed her wheelchair. Resident 2 stated staff separated them and moved her room from the third floor to the second floor. During an interview on 10/25/2025 at 9:26 a.m., Licensed Vocational Nurse (LVN) 1 stated Certified Nursing Assistant (CNA) 1 reported to her that on 10/24/2025 Resident 2 was upset with Resident 1 and pushed her (Resident 1) with her (Resident 2) wheelchair. LVN 1 stated Resident 2 was upset because she thought Resident 1 had gone into her room. During an interview on 10/25/2025 at 9:34 a.m., CNA 1 stated she saw Resident 2 rush her wheelchair into Resident 1's wheelchair and then yelled at Resident 1 to get out of her room. 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