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	12/17/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. (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

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	12/17/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation. interview and record review, the facility failed to Implement the facilities procedures and policy (P&P) titled Infection Prevention and Control plan revised 5/2023, indicating standard and transmission-based precautions would be followed to prevent the spread of infections by failing to ensure visitors and staff use Personal Protective Equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) when indicated.These failures had the potential to result in compromised infection control measures resulting in the spread of Covid-19 (a highly contagious respiratory infection caused) infection among residents, staff, and visitors.Findings:A. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including cerebrovascular infarction (CVA-stroke, loss of blood flow to a part of the brain), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and Covid-19 infection.During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 12/1/2025, the MDS indicated Resident 2 required maximal assistance (Helper does more than half the effort) from one staff for shower, moderate assistance (Helper does less than half the effort) from one staff for bed mobility, transfer, toilet hygiene, supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and /or contact guard assistance as resident competes activity) from one staff for dressing, bed mobility and setup or clean-up assistance (Helper sets up or cleans up) from one staff for eating. During an observation on 12/16/2025, at 2:18 p.m., on the first floor near the nursing station, Licensed Vocational Nurse (LVN) 2 was standing next to the medication cart with her Respirator Mask (N-95 mask- a tight-fitting, disposable protective device that filters at least 95% of airborne infectious particles) positioned below her chin.During a concurrent observation and interview on 12/16/2025, at 2:20 p.m., with Certified Nurse Assistant (CNA) 1 in a hallway on the third floor, observed CNA 1, who was wearing N-95 mask went into Resident 2's room without wearing a gown and gloves. CNA 1 came out of Resident 2's room and did not discard her N-95 mask. CNA 1 stated, she was assisting Resident 2 who tested Covid-19 positive. CNA 1 stated, she should have worn a gown and gloves since Resident 2 was on contact (a set of infection control measures, including wearing gowns and gloves, to prevent germs from spreading to others through direct touch or contaminated surfaces) and droplet isolation (a set of infection control steps, including wearing a surgical mask, eye protection, gown, and gloves, used to prevent the spread of germs from patients with respiratory infections spread by coughing, sneezing, or talking) precautions. CNA 1 stated, she did not know that the N-95 was for single use. During a concurrent observation and interview on 12/16/2025, at 2:25 p.m., with CNA 1, CNA 1 was in a hallway near Resident 2's room. Before entering Resident 2's room, CNA 1 put on the gloves first then put on a gown second, when donning (putting on) her PPE. CNA 1 stated, she always dons the gloves first before putting the gown on. CNA 1 stated, she should have donned the gown first and then donned the gloves because it was important to seal the opening of the gown sleeves around the wrist area to prevent contamination and she realized that she donned PPE incorrectly.During a concurrent observation and interview on 12/16/2025, at 2:33 p.m., with Registered Nurse Supervisor (RNS) 3, CNA 2 was standing in front of the elevator on the first floor near the nursing station. CNA 2 was not wearing a mask and was eating a snack (beef jerky). RNS 3 stated, CNA 2 should have worn the N-95 mask when she entered the building due to the current Covid-19 outbreak in the facility. RNS 3 stated, CNA 2 should have protected herself and the vulnerable residents of the facility by wearing the N-95 mask to prevent spreading Covid-19 infection.During an observation on 12/16/2025, at 2:40 p.m., a delivery person from the pharmacy entered from the facility's back door near the parking lot. The delivery person did not wear any mask or perform hand hygiene and continued into the building. There were no infection control supplies such as masks or hand sanitizers near the back door entrance to the building.During an interview on 12/16/2025, at 3:54 p.m., with the infection control nurse (IPN), the IPN stated, all staff should wear an N-95 as soon as they step into the building and wear PPE any time before going into the resident's room if there was signage indicating PPE must be worn to enter the room, to protect themselves and the residents. The IPN stated, the N-95 was for single use and it should be discarded when the staff came out of the resident's room.During a review of the facilities P&P titled Infection prevention and control plan revised on 5/2023, the P&P indicated the elements of the infection prevention and control plan included. Standard and transmission-based precautions to be followed to prevent the spread of infections. Hand Hygiene to be