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	03/13/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an Inventory list (Resident's Clothing and Possessions form) for one of four sampled residents (Resident 1) was created during the admission of Resident 1 to the facility. This deficient practice resulted in the clothing and/or other possessions for Resident 1 not being documented on admission to the facility. This deficient practice had the potential for Resident 1 to have no recourse to recovery clothing or other possessions that could be lost.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]. Resident 1 had a diagnosis of joint replacement surgery aftercare (specialized care, rehabilitation, and lifestyle adjustments needed immediately after surgery to ensure the new joint heal correctly). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 2/19/2026, the MDS indicated Resident 1's cognition (the mental process of acquiring knowledge and understanding through thought, experience and the senses) was intact and she required substantial/maximal assistance (helper does more than half the effort) from facility staff to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Resident's Clothing and Possessions form dated 11/6/2025, the Resident's Clothing and Possessions form was blank. During an interview on 3/12/2026 at 3:18 p.m., Certified Nursing Assistant (CNA) 1 stated Resident 1 had clothing during her admission to the facility. During an interview on 3/12/2026 at 3:59 p.m., the Director of Nursing (DON) stated the Resident?s Clothing and Possessions form should not be left blank, the facility staff should have documented whether the resident had any belongings or not. During a review of the facility's Policy and Procedure (P/P) titled Theft and Loss dated 4/2013, the P/P indicated a written resident personal property inventory must be recorded upon the resident's admission.

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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	555070	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to report an injury of unknown origin for one of four sampled residents (Resident 1) when Resident 1 experienced right hip pain and an X-ray (a medical test that takes black and white pictures of the inside of the body) indicated Resident 1 sustained a dislocation (a traumatic injury where the ends of two connected bones are forced out of their normal positions) to her right hip. This deficient practice resulted in the California Department of Public Health (CDPH) not being aware of Resident 1?s injury causing a delay in their investigation. This deficient practice had the potential for pertinent 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]. Resident 1 had a diagnosis of joint replacement surgery aftercare (specialized care, rehabilitation, and lifestyle adjustments needed immediately after surgery to ensure the new joint heal correctly). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 2/19/2026, the MDS indicated Resident 1's cognition (the mental process of acquiring knowledge and understanding through thought, experience and the senses) was intact and she required substantial/maximal assistance (helper does more than half the effort) from facility staff to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Change of Condition (COC) form dated 11/21/2025, the COC form indicated Resident 1 complained of right hip pain. The COC form indicated Resident 1's skin was intact with slight swelling. During a review of Resident 1's Radiology report dated 11/22/2025, the Radiology report indicated Resident 1 had a femoral head arthroplasty (a prior surgical procedure that replaces only the damaged ball of the hip joint with a implant while preserving the natural socket) with a superior lateral dislocation (when the artificial joint becomes unstable and pops out of the socket toward the top and side) of the right hip. During an interview on 3/12/2026 at 9:53 a.m., the Assistant Director of Nursing (ADON) stated initially there was no explanation for Resident 1's hip pain until Xray (a medical test that take black and white pictures of the inside of the body) results indicated her hip was dislocated. At that point it became an injury of unknown origin. The ADON stated the injury was not reported to the CDPH. During an interview on 3/13/2026 at 3:30 p.m., the Administrator (ADM) stated because there was no reason for Resident 1's hip dislocation, it was considered an injury of unknown origin During an interview on 3/13/2026 at 3:56 p.m., the Director of Nursing (DON) stated she thought Resident 1 had reported hearing a pop while being transferred to her bed, that was why she did not report it as an injury of unknown injury to the CDPH, but she was wrong, there was no report of how the injury occurred. During a review of the facility's Policy and Procedure (P/P) titled Abuse: Prevention of and Prohibition Against dated 4/2025, the P/P indicated the facility will engage in training and orienting its new and existing staff on topics which relate to the delivery of care and service in the post-acute setting. Topics of such training will include, but not be limited to reporting abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources, and to who and when staff and others must report their knowledge.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to thoroughly investigate an injury of unknown origin for one of four sampled residents (Resident 1) when Resident 1 experienced right hip pain and an x-ray (a medical test that take black and white pictures of the inside of the body) indicated Resident 1 sustained a dislocation (a traumatic injury where the ends of two connected bones are forced out of their normal positions) to her right hip. This deficient practice resulted in the facility's inability to determine how the injury occurred and had the potential for abuse and/or neglect to go unrecognized.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]. Resident 1 had a diagnosis of joint replacement surgery aftercare (specialized care, rehabilitation, and lifestyle adjustments needed immediately after surgery to ensure the new joint heal correctly). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 2/19/2026, the MDS indicated Resident 1's cognition (the mental process of acquiring knowledge and understanding through thought, experience and the senses) was intact and she required substantial/maximal assistance (helper does more than half the effort) from facility staff to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Change of Condition (COC) form dated 11/21/2025, the COC form indicated Resident 1 complained of right hip pain. The COC form indicated Resident 1's skin was intact with slight swelling. During a review of Resident 1's Radiology report dated 11/22/2025, the Radiology report indicated Resident 1 had a femoral head arthroplasty (a prior surgical procedure that replaces only the damaged ball of the hip joint with a implant while preserving the natural socket) with a superior lateral dislocation (when the artificial joint becomes unstable and pops out of the socket toward the top and side) of the right hip. During an interview on 3/12/2026 at 9:53 a.m., the Assistant Director of Nursing (ADON) stated the Treatment nurse (TN) and Licensed Vocational Nurse (LVN) 1 were interviewed regarding Resident 1's hip pain but she did not interview Resident 1, any Certified Nursing Assistants (CNAs), or the physical therapist (PT) who worked with Resident 1 on 11/21/2025, to find out if they could provide any information about Resident 1's hip pain and dislocation. During an interview on 3/13/2026 at 3:30 p.m., the Administrator (ADM) stated the incident with Resident 1's hip dislocation was not investigated, and an investigation should have been conducted regarding Resident 1's hip pain. During a review of the facility's Policy and Procedure (P/P) titled Abuse: Prevention of and Prohibition Against dated 4/2025, the P/P indicated all allegations of abuse, neglect, misappropriation of resident property, or exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee.