STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Southland		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44055

Based on observation, interview, and record reviews the facility failed to ensure five of ten sampled residents (Resident 36, 42, 76, and 98) were treated with dignity and respect when the facility failed to ensure:

a) Resident 98's foley catheter bag (medical device that helps drain urine from the bladder) was covered with a dignity bag (a bag used to the cover and hold the catheter drainage/collection bag, so it is not visible).

b) Resident 42 was groomed and was not wearing a hospital gown.

c) Resident 76's teeth were cleaned, and clothes were not soiled with feces.

d) Resident 36 had a dignified dining experience.

e) Resident 33 was assisted to the toilet and not instructed to defecate or void in the adult disposable underwear.

These deficient practices resulted in residents not treated with dignity and respect and does not promote enhancement of quality of life.

Findings:

a) During a review of Resident 98's Admission Record, the Admission Record indicated Resident 98 was admitted to the facility on [DATE] with diagnoses including hydronephrosis (condition of the urinary tract where one or both kidneys swell) with renal and ureteral calculous obstruction (condition where there is blockage caused by kidney stones.

During a review of Resident 98's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 98's cognition (thought process) was intact. The MDS indicated Resident 98 needed substantial assistance (helper does more than half the effort to complete the task) with toileting hygiene, and supervision with personal hygiene.

During a record review of Resident 98's Order summary report, as of 3/12/2025, the report indicated, starting 2/8/2025, Resident 98 had an indwelling catheter.

(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: 555070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 3/10/2025 at 2:19 p.m., with Licensed Vocational Nurse (LVN) 6, Resident 98's catheter drainage bag was not concealed with a dignity bag. LVN 6 stated resident 98 did not have a catheter dignity bag . b) During a review of Resident 42's Admission Record, the Admission Record indicated Resident 42 was originally admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), difficulty walking, and rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility). During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42's cognition was moderately impaired. The MDS indicated Resident 42 needed moderate assistance (helper does less than half the effort to complete task) with eating, oral hygiene, and personal hygiene, needed substantial assistance with upper body dressing, and was dependent (helper does all the effort) on staff with toileting hygiene, showering, lower body dressing, and putting on or taking off footwear. During a concurrent observation and interview on 3/10/2025 at 2:23 p.m., with Resident 42, Resident 42 was wearing a hospital gown, and hair was tangled and unkept. Resident 42 stated Do you think I want to wear this ugly thing? Resident 42 stated she has been wearing a hospital gown for 2 months and preferred to wear personal clothes. Resident 42 stated her hair was unbrushed she doesn't have supplies to brush her hair. During an observation and interview on 3/10/2024 at 2:29 p.m., with the Treatment Nurse (TXN) 1, in Resident 42's room, TXN 1 stated Resident 42's hair was not groomed, Resident 42 was wearing a hospital gown, Resident 42's bedside table had drink stains and was dirty, and Resident 42 needed help with grooming and getting dressed. c) During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (problem in the brain), colostomy status (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body), and bilateral primary osteoarthritis of the knee (a type of arthritis on both knees that occurs when the cartilage on the ends of bones wears down, causing the bones to rub against one another). During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 's cognition was severely impaired. The MDS indicated Resident 76 needed set up assistance when eating, supervision (helper provides verbal cues and assistance may be given during activity) with oral hygiene, upper body dressing, personal hygiene, and moderate assistance with toileting hygiene, showering, lower body dressing, and putting on/taking off footwear. During an interview and record review on 3/12/2025 at 1:30 p.m. with the Social Services Director (SSD), Resident 76's Grievance Resolution Form, dated 12/20/2024 and 1/8/2025, were reviewed and the forms indicated on 12/20/2024 Resident 76 was noted with soiled clothes in the closet. The form indicated Resident 76'd colostomy bag was left opened, and stool spilled over Resident 76's pants. The SSD stated feces were on Resident 76's clothing on several occasions. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 3/12/2025 at 10:30 a.m., in Resident 76's room, with Resident 76 Resident 76 was observed with dirty teeth. Resident 76 stated she was not assisted with toothbrushing this morning. During an observation and interview on 3/12/2025 at 10:30 a.m. with Licensed Vocational Nurse (LVN) 7, in Resident 76's room, Resident 76 was noted with dirty teeth and LVN 7 stated staff should help with resident dental hygiene. During an interview on 3/14/2025 at 11:18 a.m. with the Director of Nursing (DON), the DON stated the residents deserve respect and the facility need to preserve their dignity and treat residents with respect. The DON stated residents should not wear a hospital gown if it was not their preference. The DON stated staff need to ensure residents were groomed and teeth brushed. The DON stated foley drainage bags need to be concealed with a dignity bag. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 2/2023, the P&P indicated residents will be treated with kindness, respect, and dignity. Residents' individual preference will be respected. Residents will be appropriately dressed in clean clothes and will be well groomed. Residents will be treated with a manner that maintains privacy. 50387 45425

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review, the facility failed to involve one of three sampled resident's (Resident 76) in an Interdisciplinary Team (IDT-team of health care professionals that work together toward and prioritize the resident 's needs) care conference. This deficient practice violated Resident 76's rights to be informed and the right to participate in resident's plan of care. Findings: During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (problem in the brain), colostomy status (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body), and bilateral primary osteoarthritis of the knee (a type of arthritis on both knees that occurs when the cartilage on the ends of bones wears down, causing the bones to rub against one another). During a review of Resident 76's Minimum Data Set ({MDS}- a resident assessment), dated 10/30/2024, the MDS indicated Resident 's cognition was severely impaired. The MDS indicated Resident 76 needed set up assistance when eating, supervision (helper provides verbal cues and assistance may be given during activity) with oral hygiene, upper body dressing, personal hygiene, and moderate assistance with toileting hygiene, showering, lower body dressing, and putting on/taking off footwear. During an interview on 3/13/2025 at 3:25 p.m., with Registered Nurse (RN) 3, and record review of Resident 76's Interdisciplinary Team Conference Record, dated 10/15/2024. RN 1 stated according to the IDT record, Nursing, Social Services, and therapist attended the meeting, but the resident or family member was not in attendance during the quarterly IDT care conference. RN 3 stated Resident 76 and the family member should have participated in the IDT care plan meeting. During an interview on 3/14/2025 at 11:18 a.m. with the Director of Nursing (DON), the DON stated IDT care conferences were completed on admission and quarterly. The DON stated the resident, or representative should always be part of the IDT. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 12/2023, the P&P indicated to the extent possible the resident, resident's family and/or responsible party should participate in the development of the care plan. The P&P indicated every effort will be made to schedule care plan meetings to accommodate the availability of the resident and family or responsible party.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on observation, interview and record review, the facility failed to ensure one out of three sampled resident's (Resident 30) would not be allowed to keep medications at the bedside without a physician's order and without being assessed to determine if the resident is capable to self-administer her own medications . This deficient practice had a potential for resident to over or under medicate herself which can lead to further complications. Findings: During a record review of Resident 30's Admission Record (Face Sheet), the Admission Record indicated Resident 30 was originally admitted to the facility on [DATE] then readmitted on [DATE], with diagnoses including unspecified dementia (a decline in cognitive function that cannot be attributed to a specific known cause) unspecified severity, without behavioral disturbance (wide range of changes in behavior like thoughts and mood), During a review of Resident 30's Minimum Data Set ([MDS], a comprehensive assessment and care screening tool]) dated 12/2/2024, the MDS indicated, Resident 30 has the capacity to understand and make decisions. The MDS indicated Resident 30 requires supervision or touching assistance- helper provides verbal cues and or touching /steadying and /or contact guard assistance as resident completes activity with sit to lying , sit to stand, toilet transfer and roll left and right. During a record review of Resident 30's Order Summary Report OSR (OSR), as of 3/11/2025 the OSR indicates as follows : 1.Ketoconazole External Shampoo1% (ketoconazole topical -treats fungal or yeast infections in your skin) apply to head topically one time a day every Monday, Wednesday, Friday for atopic dermatitis (an itchy inflammation of the skin) leave for 3 to 5 minutes then rinse. 2.Fluocinonide External Solution 0.05% (Fluocinonide- a topical corticosteroid medication (a drug used to treat inflammation) used to treat scalp conditions) apply to scalp topically as needed for itching daily . 3.Triamicinolone Acetate External Cream 0.1% a (triamcinolone acetate topical- a corticosteroid medication that treats a variety of skin conditions allergies and certain cancers) apply to both arms and legs topically as needed for itchiness twice daily two weeks on and then 1 week off. 4.Ammonium Lactate External Lotion 12% (Lactic Acid Ammonium Lactate - a class of medication used to treat dry or scaly skin) apply to affected area topically at bedtime for dry, itchy skin apply after bathing while skin is moist. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an initial observation and interview on 3/10/2025 at 10:40 a.m., in Resident 30's room , on the bedside table was one box of Ammonium Lactate cream 12%, one 1-pound jar of Triamcinolone Acetonide Cream 01% , one bottle of Ketoconazole shampoo 2%, two boxes of fluocinonide topical solution 0.05%. During an interview Resident 30 stated the medications on her bedside table were for her dry itchy skin. Resident 30 stated she applies some of the medication creams. During an observation and interview on 3/10/2025 at 2:27 p.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated the medications at Resident 3's bedside are for her dry skin,. LVN 3 stated Resident 3 should have been assessed for the ability to administer her own medications but did not have a self-assessment, she stated the doctor must be called ,it should be care planed and we must monitor the resident while administering the medications. LVN 3 stated Resident 3 should not have been able the have these medications at the bedside because there was no order , she stated the medications must be kept locked in the treatment cart. During an interview and record review with LVN 3 on 3/10/2025 at 2:27 p.m., of Resident 30's clinical record, LVN 3 stated there was no documented evidence the resident was assessed for self-administration of topical medication cream and no doctor's orders indication Resident 30 can administer her medications. During an interview on 3/12/2025 at 9:29 a.m., with the Registered Nurse 1 (RN1), RN 1 stated when a resident wants to have their medications at the bedside there needs to be an assessment done by myself and the doctor to determine if the resident is alert and oriented and capable of administering her medications. RN 1 stated you cannot leave medications at the bedside if there are no doctors order indicating Resident 3 can administer her medications . RN stated the reason we cannot keep medications at the bedside is the resident can use the medication many times and get overdose or could miss a dose. RN 1 stated Resident 3's medications should have been a in a locked treatment cart. During an interview on 3/14/2025 at 11:20 a.m. with the Director of Nursing (DON) , the DON stated an assessment must be done to see if the resident will be safe taking her own medication. DON stated the resident must tell us what the medication is used for, demonstrate how to use the medication and we must also monitor the resident taking the medication. DON stated if a resident does not pass the assessment the medications cannot be left at the bedside, they should be in a medication cart. During a review of the facility's Policy and Procedures (P&P) titled, Self-Administration of Medications Revised 05/2019, the P&P indicates it is the policy of this facility to respect the wishes of alert, competent residents to self-administer prescribed as allowable under state regulations. To determine the ability of alert residents to participate in self-administration of medications. To maintain the safety and accuracy of medication administration. The P &P indicated if a resident desires to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate the resident based on change in the resident's status with the LN-Self Administration of Medications UDA. If the resident is a candidate for self-administration of medications, this will be indicated in the chart. Resident will be instructed regarding proper administration of medication by the nurse.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation, interview and record review, the facility failed to account for one of two resident's (Resident 76) personal belongings. This deficient practice violated Resident 76's rights to retain and use personal possessions and resulted in missing belongings. Findings: During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (problem in the brain), colostomy status (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body), and bilateral primary osteoarthritis of the knee (a type of arthritis on both knees that occurs when the cartilage on the ends of bones wears down, causing the bones to rub against one another). During a review of Resident 76's Minimum Data Set (MDS), a resident assessment tool, dated 10/30/2024, the MDS indicated Resident 76's cognition was severely impaired. The MDS indicated Resident 76 needed set up assistance when eating, supervision (helper provides verbal cues and assistance may be given during activity) with oral hygiene, upper body dressing, personal hygiene, and moderate assistance with toileting hygiene, showering, lower body dressing, and putting on/taking off footwear. During a phone interview with family member 2 (FM 2) on 3/11/2025 12 noon, FM 2 stated Resident 76 has missing articles of clothing and hospital pads. During an interview and record review on 3/12/2025 at 10:23 a.m., with the Licensed Vocational Nurse (LVN) 7, Resident 76's medical records were reviewed and there was no belonging list in the chart. LVN 7 stated there's no tracking of what the resident posses in her room and no way to keep track the belongings. During an interview on 3/14/2025 at 11:18 a.m. with the Director of Nursing (DON), the DON stated all residents need a belonging list to track and ensure there's no loss of personal belongings. During a review of the facility's policy and procedure (P&P) titled, Personal Effects, Inventory of, revised 5/2019, the P&P indicated the facility will take reasonable steps to protect the personal property of residents. The P&P indicated upon readmission the resident's personal effects will be inventoried by a staff member. The inventory should include the recording of all personal clothing, valuable articles and items brought into the facility with the resident and retained by the resident.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 45382 Based on observation, interview, and record review the facility failed to ensure two of four sampled residents (Residents 8 and 58) call lights (device that allows residents to request assistance from nursing staff) were accessible and within reach. This deficient practice resulted in a delay of care and services. Findings: During a review of Resident 8's Admission Record, the Admission Record indicated the facility initially admitted Resident 8 on 6/29/2010 and readmitted Resident 8 on 11/18/210 with diagnoses including urinary tract infection (UTI, an infection in the bladder/urinary tract) and cervical radiculopathy (condition caused by compression and inflammation of nerve roots in the neck which usually leads to pain, numbness, and weakness of the arms). During a review of Resident 8's Minimum Data Set (MDS, a federally mandated assessment tool), dated 11/29/2024, the MDS indicated Resident 8 had moderately impaired cognition (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 8 required supervision/touching assistance for eating, substantial/maximal assistance (helper does more than half the effort) for oral hygiene and rolling to both sides, and was dependent in toileting hygiene, bathing, dressing, and bed mobility. During a review of Resident 8's Fall Risk Evaluation, dated 3/1/2025, the Fall Risk Evaluation indicated Resident 8 received a total score of 13, indicating Resident 8 was a high fall risk. During a review of Resident 58's Admission Record, the Admission Record indicated Resident 58 was admitted to the facility on [DATE] with diagnoses including encephalitis (swelling of the brain) and encephalomyelitis (swelling of brain and spinal cord, end stage renal Disease (ESRD -irreversible kidney failure) , dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed), dementia (a progressive state of decline in mental abilities), and anxiety disorder (a group of mental health conditions characterized by excessive and persistent fear, worry, and nervousness that can interfere with daily life). During a review of Resident 58's MDS, dated [DATE], the MDS indicated Resident 58's cognition was severely impaired. The MDS indicated Resident 58 needed set up assistance with eating, supervision with oral and personal hygiene, and substantial assist with toileting hygiene and showering. During an observation and interview on 3/11/2025 at 9:33 a.m., with Registered Nurse (RN) 5, in Resident 58's room, Resident 58's call light was on the floor close to the back of the bed, which was out of reach. RN 5 stated the call light need to be within the residents' reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/11/2025 at 10:14 a.m., Resident 8 was lying in bed. Resident 8 minimally bent and straightened the right elbow and lifted both arms to less than shoulder height. Resident 8's left elbow was bent, and the left hand was positioned in a fist. Resident 8's call light was on the top right corner of the bed. Resident 8 stated she needed nursing assistance due to pain but was unable to reach the call light because it was placed too high, and her arms were too weak to reach it. During a concurrent interview and observation on 3/11/2025 at 10:24 a.m., Certified Nursing Assistant 5 (CNA 5) confirmed Resident 8's call light was out of reach. CNA 5 stated the call light should always be within Resident 8's reach and should have been clipped to Resident 8's gown or placed in her hand to ensure she was able to obtain nursing assistance when needed. During an interview on 3/14/2025 at 11:18 a.m., with the Director of Nursing (DON), the DON stated all residents must have an accessible call light that is within reach to ensure residents can call for help and verbalize their individual needs. During a review of the facility's policy and procedure (P&P) titled, Call Light/Bell, revised 5/2007, the P&P indicated the facility will provide the residents a means of communication with the nursing staff. The P&P indicated the call light need to be within the residents' reach before the staff leaves the room.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 Based on observation, interview, and record review, the facility failed to ensure the Case Manager (CM) reported one of eleven sampled resident's (Resident 23) continuous refusals for Orthopedic (specialty area in medicine referring to the management of the muscles, bones, and their connective structures) follow up appointments to the physician. This deficient practice resulted in Resident 23 not receiving necessary treatment and services to improve left arm range of motion (ROM, full movement potential of a joint), unnecessary weightbearing restrictions (guidance from a physician limiting the amount of weight a person can put through a specific arm and/or leg after surgery) of the left arm, a delay of therapy and restorative services, and had the potential to result in a decline in Resident 23's overall mobility and physical functioning. Findings: During a review of Resident 23's Admission Record, the Admission Record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses including a displaced fracture of the greater tuberosity of the left humerus (upper arm bone fracture where broken pieces of the bone are out of alignment) and difficulty walking. During a review of Resident 23's Physician History and Physical (H&P), dated 3/29/2024, the H&P indicated Resident 23 initially presented to an outside hospital after sustaining a left humerus fracture, underwent an open reduction internal fixation (ORIF, surgical procedure for repairing broken bones using either plates, screws, or rods) on 3/20/2024 and was transferred to the facility for continued care and rehabilitation with a plan to follow up with orthopedics on 4/3/2024. The H&P indicated Resident 23 was to be non-weight bearing (restriction in which a person is not allowed to put any weight through the operated body part) on the left arm, receive rehabilitation, obtain post-operative care, and follow up with orthopedics on 4/3/2024. During a review of Resident 23's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation and Plan of Treatment (OT Eval), dated 3/28/2024, the OT Eval indicated Resident 23's left arm was not assessed due to Resident 23's diagnosis of a left humerus fracture and non-weightbearing (NWB, restriction in which a person is not allowed to put any weight through the operated body part) restrictions. During a review of Resident 23's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/3/2024, to follow up with orthopedics regarding left humerus. During a review of Resident 23's Progress Notes, dated 4/3/2024, the Nursing Progress Notes indicated Resident 23 left the facility for an orthopedic follow appointment and returned the same day with instruction to follow up with orthopedics in five (5) weeks. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 23's Order Summary Report, the Order Summary report indicated a physician's order, dated 4/3/2024, for Resident 23 to be NWB on the left arm. During a review of Resident 23's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/3/2024, for Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) and Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) to provide ROM exercises to Resident 23's left shoulder and left elbow and keep Resident 23's left arm NWB. During a review of Resident 23's OT Discharge Summary, dated 4/25/2024, the OT Discharge Summary indicated Resident 23 was discharged from OT services per physician or case manager. The OT Discharge Summary indicated Resident 23 showed fluctuating levels of participation in therapy due to pain and fatigue and required maximal cueing for motivation and engagement. During a review of Resident 23's Order Summary Report, the Order Summary Report indicated a physician's order, dated 5/1/2025, for an x-ray (image of the internal body, produced by X-rays being passed through it and being absorbed to different degrees by different materials) of the left humerus for a follow up ortho appointment. During a review of Resident 23's clinical record, the clinical record did not indicate Resident 23 was scheduled for a follow up orthopedics appointment. During a review of Resident 23's Order Summary Report, the Order Summary Report indicated a physician's order, dated 11/21/2024, for Resident 23 to follow up with orthopedics on 12/10/2024 (eight months after consulting physician's recommendations). During a review of Resident 23's Orthopedic Consultation note (Ortho Note), dated 12/10/2024, the Ortho Note indicated Resident 23 presented to the orthopedic appointment to follow up for her left humerus fracture and was last seen in the office on 4/3/2024. The Ortho Note indicated Resident 23's left shoulder had an abnormal strength test in the position of external rotation (rotational movement of the shoulder away from the body), crepitus (sensation or noise when you move a joint), and pain with ROM. The Ortho Note indicated Resident 23 had a complete rotator cuff tear (rip or tear in one of the tendons that stabilize the shoulder joint and allow for joint movement) and received a steroid injection. The Ortho Note indicated Resident 23's left arm could be weightbearing as tolerated (WBAT, a person is medically cleared to place as much weight through the affected arm or leg to the point of comfort or tolerance). During a review of Resident 23's Minimum Data Set (MDS, a resident assessment), dated 1/4/2025, indicated Resident 23 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 23 required set up/clean up assistance for eating and oral hygiene and partial/moderate assistance for toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 23 had functional limitations in range of motion (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm (shoulder, elbow, wrist, hand). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Southland		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/12/2025 at 3:18 pm, the Director of Rehabilitation (DOR) reviewed Resident 23's clinical record. The DOR confirmed Resident 23 was discharged from OT services on 4/25/2024 due to reaching the highest practicable level of function with the left arm NWB restrictions. The DOR confirmed Resident 23 was seen by Orthopedics on 4/3/2024 and 12/10/2024 but was unsure what the recommendations were and why there was a delay in Resident 23's follow-up appointment. The DOR stated the facility should have notified the physician and followed up sooner to determine Resident 23's plan of care for the management of the left arm as it also affected Resident 23's ability to progress in therapy with mobility, ADLs, and ROM. During an observation of an RNA session on 3/13/2025 at 10:38 am, Resident 23 was sitting in a wheelchair. Restorative Nursing Aide 1 (RNA 1) wheeled Resident 23 into the hallway and placed a gait belt (safety device worn around the waist that can be used help safely transfer a person from one surface to another or while walking) around Resident 23's waist. Resident 23 leaned forward and used both arms to push off the wheelchair armrests to stand. RNA 1 held onto Resident 23's right arm while walking and Restorative Nursing Aide 2 (RNA 2) followed behind with a wheelchair. Resident 23 walked about 15 feet and stated she needed to rest. Resident 23 sat down and stood back up again after 30 seconds by leaning forward and pushing up from the wheelchair armrests with both arms. RNA 1 held onto Resident 23's right arm to assist with walking. Resident 23 walked over to the left of the hallway and grabbed onto the left handrail, grabbing and pushing onto the left handrail with the left arm for support while walking for about 15 feet. Resident 23 sat down in the wheelchair after walking exercises and requested to be wheeled back to the room. Resident 23 raised the left arm to shoulder height and the right arm overhead. RNA 2 assisted Resident 23 back to bed. During an interview on 3/13/2024 at 2:06 pm, Restorative Nursing Aide 1 (RNA 1) and Restorative Nursing Aide 2 (RNA 2) stated Resident 23 had limited ROM and fluctuating levels of pain in the left shoulder and required cueing to use the left arm during everyday activities. RNA 1 and RNA 2 stated they notified the DOR directly about Resident 23's left arm ROM limitations, non-compliance with left arm NWB precautions during walking exercises, and progress in RNA, but the DOR stated therapy was waiting for Resident 23 to follow up with Orthopedics to progress Resident 23's RNA or therapy program and did not know if other team members were aware. During a concurrent interview and record review on 3/13/2025 at 3:25 pm, the Case Manager (CM) stated she was responsible for scheduling appointments and arranging transportation for any follow up care the residents needed. The CM stated if a follow up appointment was missed, the CM must attempt to re-schedule the appointment right away, document the reason for missed appointments in the clinical record, notify the physician, and continue to follow up with the resident if a follow up appointment was missed and/or if a resident refused. The CM reviewed Resident 23's clinical record and confirmed Resident 23 was supposed to follow up with Orthopedics five weeks from 4/3/2025 but did not. The CM stated she scheduled a follow up Orthopedic appointment for Resident 23 on 5/8/2025 but Resident 23 refused to go and the CM did not document the refusal in the clinical record. The CM stated she tried to schedule additional follow up Orthopedic appointments multiple times with Resident 23, but Resident 23 refused each time and the CM did not document and/or notify nursing or the physician of Resident 23's continuous refusals. The CM stated it was important the doctor was notified of Resident 23's refusals to follow up with Orthopedics because the doctor could have re-assessed the situation and directed the team in the management of Resident 23's care. (continued on next page)

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Southland	11701 Studebaker Road Norwalk, CA 90650

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/14/2025 at 10:27 am, the CM and MDSN stated Interdisciplinary Team Meetings (IDT, team of health care professionals that work together with the resident and or resident's representative to prioritize the resident 's needs and goals) were conducted upon admission, quarterly, upon discharge, and as needed to discuss a resident's plan of care. The CM and MDSN reviewed Resident 23's clinical record and confirmed the facility had not conducted an IDT for Resident 23 since 4/9/2024. The CM stated Resident 23 should have had quarterly IDTs on 7/2024, 10/2024, and 1/2024 but did not. The CM and MDSN stated an IDT should have been conducted when Resident 23 refused to follow up with orthopedics but was not. The CM and MDSN stated if Resident 23 had IDTs as indicated, the physician would have been notified and the entire team would have been aware of Resident 23's refusals and lack of follow up with orthopedics. During an interview on 3/14/2025 at 1:27 pm, the Director of Nursing (DON) stated any resident refusals for follow up appointments should be documented in the clinical record, care planned, and reported to the physician, nursing, and the resident's family. The DON stated all follow up care or need for clarification of orders should be addressed in IDT meetings which were conducted upon admission, quarterly, and upon a change of condition. The DON stated if IDT meetings were conducted quarterly as indicated, the facility would have been made aware of Resident 23's lack of Orthopedic follow up and constant refusals, notified the physician and family, and addressed the resident's concerns timely. The DON stated if the Orthopedic follow up appointment was done as recommended, Resident 23 would have likely been able to bear weight through the left arm earlier and therapy services could have been re-consulted earlier to progress the resident's function. The DON stated if the physician was not informed of a resident's refusal to follow up with orthopedics, the physician would be unable to follow up with the resident's care potentially resulting in a functional decline and lack of necessary treatment and services. During a review of the facility's Policy and Procedure (P/P) titled, Significant Change of Condition, Response, revied 12/2023, the P/P indicated it was the policy of the facility to ensure each resident received quality of care and services to attain and maintain the highest practicable physical, mental, and psychological well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. The P/P indicated there would be circumstances where immediate attention would be warranted and nursing would be responsible for notifying the appropriate department for evaluation and contact the physician based on the urgency of the situation. The P/P indicated the IDT shall collaborate with the attending physician, resident, and/or resident representative to review risk indicator and the plan of care and document this collaboration in the electronic medical record in the next scheduled Comprehensive Care Plan Meeting or sooner if deemed necessary by the IDT.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to ensure one of two sampled residents (Resident 76) family member (FM) 2's grievance (complaints regarding treatment, care, management of funds, lost clothing, or violation of rights) involving an unidentified Certified Nurse Aide (CNA) was addressed, investigated, and resolved in a timely manner. This deficient practice placed Resident 76's at risk for mistreatment can negatively affect Resident 76. Findings: During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (problem in the brain), colostomy status (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body), and bilateral primary osteoarthritis of the knee (a type of arthritis on both knees that occurs when the cartilage on the ends of bones wears down, causing the bones to rub against one another). During a review of Resident 76's Minimum Data Set (MDS), resident assessment tool, dated 10/30/2024, the MDS indicated Resident 76's cognition was severely impaired. The MDS indicated Resident 76 needed set up assistance when eating, supervision (helper provides verbal cues and assistance may be given during activity) with oral hygiene, upper body dressing, personal hygiene, and moderate assistance with toileting hygiene, showering, lower body dressing, and putting on/taking off footwear. During a review of Resident 76's FM 2's Grievance Resolution Form', dated 11/15/2024, indicated a grievance was made regarding an unnamed CNA taking Resident 76's phone, closing the door on Resident 76, and turning the television loud. During an interview and record review on 3/13/2025 at 11:32 a.m. with the Social Services Director (SSD), FM 2's email correspondence between the Administrator (ADMIN) and FM 2, dated 1/8/2025 indicated FM 2's grievance placed on 11/15/2024 has not been addressed as of 1/8/2024, 54 days after the original grievance was filed. The SSD stated that the SSD was the Grievance official, and she was not made aware of the grievance that was brought to the attention of the ADMIN by the family in 1/2025. The SSD also stated she never got the original grievance on 11/15/2024. The SSD stated policy dictated she need to know status of all grievance so the SSD can follow up appropriately. The SSD stated the grievance filed 11/15/2024 should have been immediately addressed and resolved because it was residents' rights. During an interview on 3/14/2025 at 11:18 a.m., with the Director of Nursing (DON), the DON stated all grievances need to be addressed, investigated, and filed in the log. The DON stated the facility need to ensure there was immediate action and resolution for residents right and safety. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy, and procedure (P/P) titled, Grievances revised 12/2023, the P/P indicated the facility would ensure the grievance process would address resident concerns without fear of discrimination or reprisal. The facility's Grievance Official was responsible for overseeing the grievance process and for receiving and tracking grievances, leading any necessary investigations by the facility, maintaining the confidentiality of all information associated with grievances, issuing a written grievance decisions to the resident if requested, and coordinating with state and federal agencies as necessary. The grievance official evaluates and investigates the concern and takes immediate action to resolve the concern. The grievance official or designee responds to the individual expressing the concern within three working days of the initial concern to acknowledge receipt and describe steps taken toward resolution. The grievance log is maintained by the grievance official and reviewed by the quality assessment and assurance committee and shall not become part of the medical record Cross Reference F600, F609, F610

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44055

Based on interview and record review the facility did not protect one of three sampled residents (Resident 76) from abuse when the facility failed to:

a) Ensure Resident 167, who was only wearing a hospital gown and adult disposable underwear, did not enter Resident 76's room and kiss Resident 76 in the arm without Resident 76's consent on 2/23/2025 at around 7:30 a.m.

b) Ensure Resident 76 was assessed, monitored and provided with emotional support after allegations of abuse were made on 2/23/2025 that Resident 167 entered Resident 76's room and kissed Resident 76's arm without Resident 76's consent.

c) Ensure Resident 76 was assessed, monitored, and provided with emotional support after allegations of abuse were made on 11/15/2024 by Family Member (FM)2 that an unidentified Certified Nurse Assistant (CNA), took Resident 76's cell phone, closed Resident 76's door, and turned the television on loud and Resident 76 felt isolated due to the CNA's actions.

These deficient practices resulted in Resident 76 being subject to a nonconsensual kiss, isolation and had the potential to result in a negative psychosocial wellbeing from re-occurring abuse incidents.

Findings:

During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (change of how brain works due to an underlying condition), colostomy status (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body), and bilateral primary osteoarthritis of the knee (a type of arthritis on both knees that occurs when the cartilage on the ends of bones wears down, causing the bones to rub against one another).

During a review of Resident 76's Minimum Data Set (MDS), resident assessment tool, dated 10/30/2024, the MDS indicated Resident 76's cognition (thought process) was severely impaired. The MDS indicated Resident 76 needed set up assistance when eating, supervision (helper provides verbal cues and assistance may be given during activity) with oral hygiene, upper body dressing, personal hygiene, and moderate assistance (helper does less than half the effort) with toileting hygiene, showering, lower body dressing, and putting on/taking off footwear.

During a review of Resident 167's Admission Record, the Admission record indicated Resident 167 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, cognitive communication deficit, and multiple myeloma (blood cancer).

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 167's MDS, dated [DATE], the MDS indicated Resident 167's cognition was severely impaired. The MDS indicated the resident needed supervision with eating and oral hygiene, moderate assistance with dressing, and maximal assistance (helper does more than half the effort) with toileting hygiene and showering. During a phone interview on 3/11/2025 at 12 p.m., with FM 2, FM 2 stated on 2/23/2025 (no time of day given) a man (Resident 167) was kissing Resident 76's arm. FM2 stated Resident 167 had no pants on. During an interview on 3/11/2025 at 3:34 p.m., with CNA 1, CNA 1 stated CNA 9 informed CNA 1 to watch Resident 167 closely because she heard Resident 167 went into Resident 76's room and gave Resident 76 a kiss. CNA 1 stated she asked Resident 167 what happened and according to CNA 1, Resident 167 told CNA 1 that he (Resident 167) kissed his girlfriend (Resident 76), and they made a big deal about it. During a phone interview on 3/11/2025 at 3:49 p.m., with Registered Nurse (RN)2, RN 2 stated on 2/23/2025 at around 7:30 a.m. Resident 167 was found sitting on a chair inside Resident 76's room just wearing a hospital gown and disposable underwear. RN 2 stated Resident's 76 and 167 were immediately separated. RN 2 stated she was not aware that Resident 167 had just kissed Resident 76 without consent prior to her finding him in Resident 76's room. RN 2 stated one-week later FM 2 informed RN 2 that a man went in Resident 76's room and kissed Resident 76. RN 2 stated RN 2 should have reported the incident to the administrator and Resident 76 should have been assessed, monitored, provided with emotional support, and the physician should have been notified of the allegations of abuse. During an interview on 3/12/2025 at 10:30 a.m., with Resident 76, Resident 76 stated a man (later identified as Resident 167) went in her room held her hand and kissed her arm. Resident 76 stated the man (Resident 167) stated, I finally found you, and then sat down in the chair. Resident 75 stated Resident 167 did not have pants on. During an interview on 3/12/2025 at 12:03 p.m. with the Social Services Director (SSD), the SSD stated the incident should have been reported to the SSD, administrator, or the Director of Nursing. The SSD stated the following interventions should have been implemented: a) SSD would've made room visits to ensure Resident 76 was emotionally and psychosocially stable. b) The Interdisciplinary Team (IDT Resident's health care team consisting of various specialties) would have met and discussed the incident. c) Other residents should have been interviewed to make sure no one else was affected. d) Psychological consult would have been requested for Resident 76. e) The physician should have been notified of the incident. f) The incident should have been reported to state agency, ombudsman, and local law enforcement. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of a document titled, Grievance Resolution Form, dated 11/15/2024, the Grievance Resolution Form completed by Resident 76's FM 2 indicated a grievance was made regarding an unnamed CNA taking Resident 76's phone, closing the door on Resident76, and turning the television in Resident 76's room loud. During an interview on 3/13/2025 at 11:32 a.m., with the Social Services Director (SSD), the SSD stated the grievance filed on 11/15/2024 should have been immediately addressed and resolved because it was residents' rights to be free from abuse. Resident 76 should have been monitored and assessed to make sure the resident was stable as soon as the staff received the allegations of abuse. The CNA's should have been interviewed to see what happened. During an interview on 3/14/2025 at 11:18 a.m., with the Director of Nursing (DON), the DON stated residents have the right to be free from abuse and should be prevented. A thorough investigation should be done to protect the residents. During a review of the facility's policy and procedure (P&P) titled, Abuse, Prevention and Prohibition Against, revised 12/2023, the P&P indicated residents have the right to be free from abuse. The facility has zero tolerance for abuse and staff must not permit anyone to engage in verbal, mental, or physical abuse or mistreatment. The facility was committed to protecting residents from abuse by anyone including other residents. The facility will identify, correct, and intervene in situations which abuse is likely to occur. The facility will establish a safe environment. A licensed nurse will immediately assess the resident upon receiving reports of abuse. Findings of the examination will be recorded in the medical record. The facility will increase supervision of the residents and provide emotional support and counseling to the resident during investigation and as needed. If the allegation of abuse involves an employee the facility will immediately remove the employee from the care of the resident. The care plans will be reviewed and revised because of the allegations of abuse. Cross reference F585, F609, F610

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44055 Based on interview and record review, the facility failed to report allegations of abuse to the California Department of Public Health (CDPH) within the regulated time frame of two hours. a) The facility failed to report to CDPH when an allegation of abuse was made on 11/15/2024 by Family Member (FM)2 that an unidentified Certified Nurse Assistant (CNA) took Resident 76's cell phone, closed Resident 76's door, and turned the television on loud and Resident 76 felt isolated. b) The facility failed to report to CDPH when an allegation of abuse was made, about an incident that occured on 2/23/2025, by FM 2 that a male resident (Resident 167), without pants on, entered Resident 76's room and allegedly kissed Resident 76's arm without Resident 76's consent. This deficient practice resulted in CDPH's inability to investigate the allegation of abuse timely and had the potential for other allegations of abuse to go unreported. Findings: During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was originally admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (change of how brain works due to an underlying condition), colostomy status (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body), and bilateral primary osteoarthritis of the knee (a type of arthritis on both knees that occurs when the cartilage on the ends of bones wears down, causing the bones to rub against one another). During a review of Resident 76's Minimum Data Set (MDS), resident assessment tool, dated 10/30/2024, the MDS indicated Resident 76's cognition (thought process) was severely impaired. The MDS indicated Resident 76 needed set up assistance when eating, supervision (helper provides verbal cues and assistance may be given during activity) with oral hygiene, upper body dressing, personal hygiene, and moderate assistance (helper does less than half the effort) with toileting hygiene, showering, lower body dressing, and putting on/taking off footwear. During a review of Resident 167's Admission Record, the Admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, cognitive communication deficit, and multiple myeloma (blood cancer). During a review of Resident 167's MDS, dated [DATE], the MDS indicated Resident 167's cognition was severely impaired. The MDS indicated the resident needed supervision with eating and oral hygiene, moderate assistance with dressing, and maximal assistance (helper does more than half the effort) with toileting hygiene and showering. During a phone interview on 3/11/2025 at 12 p.m., with FM 2, FM 2 stated on 2/23/2025 (no time of day specified) a man (Resident 167) was kissing Resident 76's arm. FM 21 stated Resident 167 did not have pants on. FM 2 stated she informed Registered Nurse 2 about the incident and CNA 1 knew about the incident. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/11/2025 at 3:34 p.m. with CNA 1, CNA 1 stated, on 2/23/2025, CNA 9 informed CNA 1 to watch Resident 167 closely because she heard Resident 167 went into Resident 76's room and gave Resident 76 a kiss. During a phone interview on 3/11/2025 at 3:49 p.m., with Registered Nurse (RN) 2, RN 2 stated on 2/23/2025 at around 7:30 a.m., Resident 167 was found sitting on a chair inside Resident 76's room just wearing a hospital gown and disposable underwear. RN 2 stated approximately one-week later, FM 2 informed RN 2 that a man (Resident 167) went in Resident 76's room and kissed Resident 76. RN 2 stated that she was not aware of the nonconsensual kiss until FM 2's complaint a week later. RN 2 stated RN 2 should have reported the incident to the administrator. During an interview on 3/12/2025 at 12:03 p.m., with the Social Services Director (SSD), the SSD stated the incident that allegedly occurred on 2/23/2025 should have been reported to the SSD, administrator, or the Director of Nursing. The SSD stated the incident should have been reported to state agency, ombudsman, and local law enforcement. During a review of a document titled, Grievance Resolution Form, dated 11/15/2024, the Grievance Resolution Form completed by Resident 76's FM 2 indicated a grievance was made regarding an unnamed CNA taking Resident 76's phone, closing the door on Resident76, and turning the television in Resident 76's room loud. During an interview on 3/13/2025 at 11:32 a.m., with the Social Services Director (SSD), the SSD stated the grievance filed 11/15/2024 should have been reported to CDPH, ombudsman, and local law enforcement within 2 hours of the incident and investigated thoroughly and reports submitted within 5 days of the incident. The SSD stated the grievance filed 11/15/2024 should have been reported to CDPH, ombudsman, and local law enforcement within 2 hours. During an interview on 3/14/2025 at 11:18 a.m., with the Director of Nursing (DON), the DON stated all allegations of abuse need to re reported to CDPH, ombudsman, and the police. During an interview on 3/14/2025 at 1:44 p.m., with the Administrator (ADMIN), the ADMIN stated all allegations of abuse need to be reported as soon as possible and preventative measures implemented. The investigation needs to be thorough and submitted to the agencies involved. During a review of the facility's policy and procedure (P&P) titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, revised 10/2022, the P&P indicated: 1) All reports of resident abuse and neglect shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. 2) An alleged violation of abuse, neglect, will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025

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 - Some	Cross reference F585, F600, F610

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	03/14/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review, the facility failed to thoroughly investigate and submit the investigation report of all allegations of abuse to the California Department of Public Health (CDPH) within five days of the incident. a) The facility failed to thoroughly investigate and submit investigative reports to CDPH when an allegation of abuse was made on 11/15/2024 by Family Member (FM)2 that an unidentified Certified Nurse Assistant (CNA), unidentified, took Resident 76's cell phone, closed Resident 76's door, and turned the television on loud and Resident 76 felt isolated. b) The facility failed to thoroughly investigate and submit investigative reports to CDPH when an allegation of abuse was made, approximately one week (unspecified date) after an incident that occured on 2/23/2025, by FM 2 that a male resident (Resident 167), who did not have pants on, entered Resident 76's room and allegedly kissed Resident 76's arm without Resident 76's consent. This deficient practice resulted in CDPH's inability to investigate the allegation of abuse timely and had the potential for other allegations of abuse to go unreported. Findings: During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (change of how brain works due to an underlying condition), colostomy status (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body), and bilateral primary osteoarthritis of the knee (a type of arthritis on both knees that occurs when the cartilage on the ends of bones wears down, causing the bones to rub against one another). During a review of Resident 76's Minimum Data Set (MDS), resident assessment tool, dated 10/30/2024, the MDS indicated Resident 76's cognition (thought process) was severely impaired. The MDS indicated Resident 76 needed set up assistance when eating, supervision (helper provides verbal cues and assistance may be given during activity) with oral hygiene, upper body dressing, personal hygiene, and moderate assistance (helper does less than half the effort) with toileting hygiene, showering, lower body dressing, and putting on/taking off footwear. During a review of Resident 167's Admission Record, the Admission record indicated Resident 167 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, cognitive communication deficit, and multiple myeloma (blood cancer). During a review of Resident 167's MDS, dated [DATE], the MDS indicated Resident 167's cognition was severely impaired. The MDS indicated the resident needed supervision with eating and oral hygiene, moderate assistance with dressing, and maximal assistance (helper does more than half the effort) with toileting hygiene and showering. (continued on next page)

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Southland	11701 Studebaker Road Norwalk, CA 90650

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 3/11/2025 at 12 p.m., with FM 2, FM 2 stated on 2/23/2025 (no time of day given) a man (Resident 167) was kissing Resident 76's arm. FM2 stated Resident 167 had no pants on. During an interview on 3/11/2025 at 3:34 p.m. with CNA 1, CNA 1 stated, on 2/23/2025, CNA 9 informed CNA 1 to watch Resident 167 closely because she heard Resident 167 went into Resident 76's room and gave Resident 76 a kiss. During a phone interview on 3/11/2025 at 3:49 p.m., with Registered Nurse (RN)2, RN 2 stated on 2/23/2025 at around 7:30 a.m. Resident 167 was found sitting on a chair inside Resident 76's room just wearing a hospital gown and disposable underwear. RN 2 stated Resident's 76 and 167 were immediately separated. RN 2 stated she was not aware that Resident 167 had just kissed Resident 76 without consent prior to her finding him in Resident 76's room. RN 2 stated one-week later FM 2 informed RN 2 that a man went in Resident 76's room and kissed Resident 76. RN 2 stated RN 2 should have reported the incident to the administrator and Resident 76 should have been assessed, monitored, provided with emotional support, and the physician should have been notified of the allegations of abuse. During an interview on 3/12/2025 at 12:03 p.m., with the Social Services Director (SSD), the SSD stated the incident that allegedly occurred on 2/23/2025 should have been reported to the SSD, administrator, or the Director of Nursing. The SSD stated the incident should have been thoroughly investigated then results submitted to the agencies. During a review of a document titled, Grievance Resolution Form, dated 11/15/2024, the Grievance Resolution Form completed by Resident 76's FM 2 indicated a grievance was made regarding an unnamed CNA taking Resident 76's phone, closing the door on Resident76, and turning the television in Resident 76's room loud. During an interview on 3/13/2025 at 11:32 a.m., with the Social Services Director (SSD), the SSD stated the grievance filed 11/15/2024 should have been reported to CDPH, ombudsman, and local law enforcement within 2 hours of the incident and investigated thoroughly and reports submitted within 5 days of the incident. During an interview on 3/14/2025 at 11:18 a.m., with the Director of Nursing (DON), the DON stated all allegations of abuse need to re reported to CDPH, ombudsman, and the police and thoroughly investigated and submitted to the agencies. During an interview on 3/14/2025 at 1:44 p.m., with the Administrator (ADMIN), the ADMIN stated all allegations of abuse need to be reported as soon as possible and preventative measures implemented. The investigation needs to be thorough and submitted to the agencies involved. During a review of the facility's policy and procedure (P&P) titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, revised 10/2022, the P&P indicated All reports of resident abuse and neglect shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported to the state agency within five working days of the incident. Cross reference F585, F600, F609

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NAME OF PROVIDER OR SUPPLIER Southland		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility did not develop and implement a comprehensive person-centered care plan for two of four sampled residents (Resident 23 and 74) when the facility failed to: 1. Develop a care plan and interventions to improve, prevent, and limit a decline in range of motion (ROM - the extent and direction of movement at a joint or series of joints) for Resident 23 who was identified as having left upper extremity ROM limitations. 2. Develop a comprehensive care plan and conduct interdisciplinary team (IDT, team of health care professionals that work together with the resident and or resident's representative to prioritize the resident 's needs and goals) care conferences for Resident 23 who had a left shoulder fracture (broken bone) and refused multiple times to follow up with orthopedic (branch of surgery concerned with conditions involving the muscles and bones) appointments. 3. Develop and implement a care plan addressing Resident 74's edema (swelling caused by fluid building up in body tissues). These deficient practices had the potential to result in poor quality of care and a delay of care and services. Findings: During a review of Resident 23's Admission Record, the Admission Record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses including a displaced fracture of the greater tuberosity of the left humerus (upper arm bone fracture where broken pieces of the bone are out of alignment) and difficulty walking. During a review of Resident 23's Physician History and Physical (H&P), dated 3/29/2024, the H&P indicated Resident 23 initially presented to an outside hospital after sustaining a left humerus fracture, underwent an open reduction internal fixation (ORIF, surgical procedure for repairing broken bones using either plates, screws, or rods) on 3/20/2024 and was transferred to the facility for continued care and rehabilitation with a plan to follow up with orthopedics on 4/3/2024. The H&P indicated Resident 23 was to be non-weight bearing (restriction in which a person is not allowed to put any weight through the operated body part) on the left arm, receive rehabilitation, obtain post-operative care, and follow up with orthopedics on 4/3/2024. During a review of Resident 23's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation and Plan of Treatment (OT Eval), dated 3/28/2024, the OT Eval indicated Resident 23's left arm was not assessed due to Resident 23's diagnosis of a left humerus fracture and non-weightbearing (NWB, restriction in which a person is not allowed to put any weight through the operated body part) restrictions. (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During a review of Resident 23's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/3/2024, for Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) and Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) to provide range of motion (ROM, movement ability of a joint) exercises to Resident 23's left shoulder and left elbow and keep Resident 23's left arm NWB.

During a review of Resident 23's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/3/2024, to follow up with orthopedics regarding left humerus.

During a review of Resident 23's Progress Notes, dated 4/3/2024, the Nursing Progress Notes indicated Resident 23 left the facility for an orthopedic follow appointment and returned the same day with instruction to follow up with orthopedics in five (5) weeks.

During a review of Resident 23's clinical record, the clinical record did not indicate Resident 23 was scheduled for a follow up orthopedics appointment.

During a review of Resident 23's OT Discharge Summary, dated 4/25/2024, the OT Discharge Summary indicated Resident 23 was discharged from OT services per physician or case manager. The OT Discharge Summary indicated Resident 23 showed fluctuating levels of participation in therapy due to pain and fatigue and required maximal cueing for motivation and engagement.

During a review of Resident 23's Minimum Data Set (MDS, a resident assessment), dated 1/4/2025, indicated Resident 23 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 23 required set up/clean up assistance for eating and oral hygiene and partial/moderate assistance for toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 23 had functional limitations in range of motion (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm (shoulder, elbow, wrist, hand).

During a review of Resident 23's care plan, the care plan did not indicate a care plan addressing Resident 23's left shoulder ROM limitations and NWB status of the left arm.

During a review of Resident 23's care plan, the care plan did not indicate a care plan addressing Resident 23's refusals to follow up with orthopedics for her left shoulder fracture.

During a concurrent interview and record review on 3/13/2025 at 2:31 pm, the Minimum Data Set Nurse (MDSN) reviewed Resident 23's care plan, MDS dated [DATE], RNA orders, and therapy notes. The MDSN stated a comprehensive (inclusive, including everything necessary) care plan was developed for every resident and used as a guideline to ensure proper care was provided for each resident. The MDSN confirmed the facility did not develop a care plan addressing Resident 23's limited left shoulder ROM. The MDSN confirmed no interventions were developed and implemented to maintain and prevent a decline in ROM of Resident 23's left arm since Resident 23 was no longer on skilled therapy services and was on RNA for walking exercises only. The MDSN stated it was important care plans were accurate to ensure goals and interventions were developed to address areas of concern and prevent complications.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/13/2025 at 3:25 pm, the Case Manager (CM) stated she was responsible for scheduling appointments and arranging transportation for any follow up care the residents needed. The CM stated if a follow up appointment was missed, the CM must attempt to re-schedule the appointment right away, document the reason for missed appointments in the clinical record, notify the physician, and continue to follow up with the resident if a follow up appointment was missed and/or if a resident refused. The CM stated she supposed to follow up with Orthopedics five weeks from 4/3/2025 but did not. The CM did not document and/or notify nursing or the physician of Resident 23's continuous refusals. During an observation on 3/13/2025 at 3:58 pm, in Resident 23's room, Resident 23 was lying in bed. Resident 23 stated staff did not assist her with exercises. Resident 23 continuously moved the right arm when asked to move both arms. Resident 23 raised the left arm to less than shoulder height and fully bent and straightened the left elbow, left wrist, and hand. During a concurrent interview and record review on 3/14/2025 at 10:27 am, the CM and MDSN stated IDTs were conducted upon admission, quarterly, upon discharge, and as needed to discuss a resident's plan of care. The CM and MDSN reviewed Resident 23's clinical record and stated the facility had not conducted an IDT for Resident 23 since 4/9/2024. The CM stated Resident 23 should have had quarterly IDTs on 7/2024, 10/2024, and 1/2024 but did not. The CM and MDSN stated if Resident 23 had IDTs as indicated, the physician would have been notified, the care plan would have been updated, and the entire team would have been aware of Resident 23's refusals and lack of follow up with orthopedics. During an interview on 3/14/2025 at 1:27 pm, the Director of Nursing (DON) stated comprehensive care plans were used as a guide to ensure the appropriate care and services were provided for each resident. The DON stated care plans were used to ensure problem areas were accurately identified, goals were created, and interventions were implemented to address a resident's areas of concerns. The DON stated it was important care plans were accurate to ensure the staff was aware of the resident's status and the appropriate care and services were provided. The DON stated fractures, restricted weightbearing statuses, and limited ROM should be care planned to ensure safety measures and the appropriate services were in place to prevent any harm, a functional decline, and contracture (loss of motion of a joint associated with stiffness and joint deformity) development. The DON stated any resident refusals for follow up appointments should be documented in the clinical record, care planned, and reported to the physician, nursing, and the resident's family. The DON stated if IDT meetings were conducted quarterly as indicated, the facility would have been made aware of Resident 23's lack of Orthopedic follow up, constant refusals, and limited ROM, notified the physician and family, and addressed the resident's concerns timely. b. During a review of Resident 74's Admission Record, the admission record indicated Resident 74 was originally admitted to the facility on [DATE] with diagnosis including acute embolism (obstruction of blood vessel) and thrombosis (blood clot) of unspecified deep veins of right lower extremity. During a review of Resident 74's MDS, dated [DATE], the MDS indicated Resident 74's cognition (ability to think and reason) was moderately impaired. The MDS indicated Resident 74 needed supervision with eating, oral hygiene, moderate assistance (helper does less than half the effort) with personal hygiene, and substantial assistance (helper does more than half the effort) with toileting hygiene, and showering. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 3/10/2025 at 3:18 p.m. with Resident 74, Resident 74 was observed with an edematous right leg that was elevated on pillows. Resident 74 stated his only complaint was his right leg has been swollen for 5 months. During an observation and interview on 3/12/2025 at 9:10 a.m. with Registered Nurse (RN) 5, in Resident 74's room, RN 5 stated Resident 74's leg was swollen. During an interview and record review on 3/12/2025 at 9:10 a.m. with RN 5, Resident 74's care plans were reviewed and there was no care plan addressing Resident 74's edema. RN 5 stated Resident 74 should have a care plan addressing edema. During an interview on 3/14/2025 at 11:18 a.m. with the Director of Nursing (DON), the DON stated residents need a care plan for everything addressing all care and services rendered to the resident. care plans were needed for everything to monitor progress, and it guides care rendered. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 12/2023, the P&P indicated the IDT shall develop a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions. 45382

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation, interview, and record reviews the facility failed to ensure one of three sampled resident (Resident 42) was groomed and was not wearing a hospital gown and one of three resident's (Resident 76) teeth were brushed at least twice a day. This deficient practices resulted in residents' poor hygiene which can increase the risk of poor physical and mental wellness. Findings: During a review of Resident 42's Admission Record, the Admission Record indicated Resident 42 was originally admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), difficulty walking, and rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility). During a review of Resident 42's Minimum Data Set (MDS), a resident assessment tool, dated 12/20/2024, the MDS indicated Resident 42's cognition (thought process) was moderately impaired. The MDS indicated Resident 42 needed moderate assistance (helper does less than half the effort to complete task) with eating, oral hygiene, and personal hygiene, needed substantial assistance with upper body dressing, and was dependent (helper does all the effort) on staff with toileting hygiene, showering, lower body dressing, and putting on or taking off footwear. During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (problem in the brain), colostomy status (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body), and bilateral primary osteoarthritis of the knee (a type of arthritis on both knees that occurs when the cartilage on the ends of bones wears down, causing the bones to rub against one another). During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 's cognition was severely impaired. The MDS indicated Resident 76 needed set up assistance when eating, supervision (helper provides verbal cues and assistance may be given during activity) with oral hygiene, upper body dressing, personal hygiene, and moderate assistance with toileting hygiene, showering, lower body dressing, and putting on/taking off footwear. During a concurrent observation and interview on 3/10/2025 at 2:23 p.m., with Resident 42, Resident 42 was wearing a hospital gown, and hair was tangled and unkept. Resident 42 stated Do you think I want to wear this ugly thing? Resident 42 stated she has been wearing a hospital gown for 2 months and preferred to wear personal clothes. Resident 42 stated her hair was unbrushed she doesn't have supplies to brush her hair. During an observation and interview on 3/10/2024 at 2:29 p.m., with the Treatment Nurse (TXN) 1, in Resident 42's room, TXN 1 stated Resident 42's hair was not groomed, Resident 42 was wearing a hospital gown, and Resident 42 needed help with grooming and getting dressed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER: Southland		STREET ADDRESS, CITY, STATE, ZIP CODE: 11701 Studebaker Road Norwalk, CA 90650	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 3/12/2025 at 10:30 a.m., in Resident 76's room, with Resident 76, Resident 76 was observed with dirty teeth. Resident 76 stated she was not assisted with toothbrushing this morning. During an observation and interview on 3/12/2025 at 10:30 a.m. with Licensed Vocational Nurse (LVN) 7, in Resident 76's room, Resident 76 was noted with dirty teeth and LVN 7 stated staff should help the resident with dental hygiene. During an interview and record review on 3/13/2025 with LVN 7, Resident 76's Documentation Survey report for Oral hygiene, 10/2024 to 3/2025 were reviewed. The documentation indicated Resident 76 did not receive oral hygiene twice a day as indicated from 10/2024 to 3/2025. LVN 7 stated if it was not documented it was not done. During an interview on 3/14/2025 at 11:18 a.m. with the Director of Nursing (DON), the DON stated staff need to ensure residents were groomed and teeth brushed daily. During a review of the facility's policy and procedure (P&P) titled, ADL Care, revised 11/2019, the P&P indicated residents who are unable to carry out activities of daily living will receive assistance as needed.

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44055

Based on observation, interview and record review the facility did not provide quality care and services for five out of eight residents (Resident 23, 51, and 74) when:.

a.The facility failed to ensure Resident 51's self-administration of insulin (hormone produced by the pancreas that regulates blood sugar levels) via an insulin pump (a small, wearable device that delivers rapid-acting insulin continuously, mimicking the function of a healthy pancreas (organ that produces hormones which regulate blood sugar levels), and allowing individuals with diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) to manage their blood glucose levels more effectively than with injections) was monitored per facility's policy and procedure, titled Self-Administration of Medications dated 5/2019 which indicated nursing would be responsible for recording self-administration doses of insulin in the resident's medication administration record (MAR).

These deficient practices resulted in Resident 51 experiencing five episodes of hyperglycemia (high blood sugar with a risk of short-term complications like diabetic ketoacidosis [a buildup of harmful substances in the blood] and long-term complications like nerve damage, vision problems, heart and kidney disease), one of those episodes required transfer to the General Acute Care Hospital (GACH) on 2/17/2025, resulting in a diagnosis of diabetic hyperglycemia.

b. The facility failed to follow up with an orthopedic (specialty area in medicine referring to the management of the muscles, bones, and their connective structures) consultation appointment for Resident 23 ' s left humerus (upper arm bone) fracture (broken bone) per consulting physician ' s recommendations.

This deficient practice resulted in a delay of care and had the potential for worsening of the fracture, delayed healing, and a decline in Resident 23 ' s mobility, range of motion (ROM, full movement potential of a joint), physical comfort and psychosocial well-being.

c. The facility failed to monitor and assess Resident 74's edema (swelling caused by fluid building up in body tissues).

The deficient practices had the potential to result in poor quality of care and a delay of care and services.

Findings:

a. During a review of Resident 51's Admission Record, the Admission Record indicated Resident 51 was admitted on [DATE] with diagnoses including Type one diabetes mellitus (pancreas does not produce insulin), end stage renal disease (ESRD -irreversible kidney failure), and dependence on hemodialysis.

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NAME OF PROVIDER OR SUPPLIER Southland		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 51's Minimum Data Set (MDS - a resident assessment tool) dated 2/23/2025, the MDS indicated Resident 51's cognition (ability to make decisions of daily living) was intact, and Resident 51 required partial/ moderate physical assistance (helper does less than half the effort) to complete activities of daily living (ADLs- activities such as bathing, dressing and toileting). During a review of Resident 51's physician order dated 2/16/2025, the physician order indicated Resident 51 was to receive 50 units of Humalog (rapid acting insulin) once a day via insulin pump. During a review of Resident 51's nursing notes dated 2/17/2025 and timed at 8:55 a.m., the nursing note indicated Resident 51 had a physician order dated 2/16/2025 for Humalog 50 units (a quantity of measure of insulin) via pump daily. The nursing notes indicated the pump was unavailable, and the physician was notified, and the Humalog order was discontinued. During a review of Resident 51's nursing note dated 2/17/2025 and timed at 12:06 p.m., the nursing note indicated Resident 51's blood sugar was reading HIGH (severe hyperglycemia exceeding 600 milligrams per deciliter (mg/dl - unit of measurement [reference range of blood sugar 70-99]), the physician was notified, and orders received. The nursing note indicated Resident 51 was transferred to the GACH via emergency medical transportation services due to uncontrolled blood sugar levels, episodes of lethargy (tired and lack of energy), and diaphoresis (excessive sweating due to a secondary condition). During a review of Resident 51's GACH Emergency Department (ED) note dated 2/17/2025, the ED Note indicated Resident 51 was brought into the ED with a complaint of elevated blood sugar levels with a malfunction of an insulin pump. The ED note indicated Resident 51's blood sugar was 549 and he was given 20 units of regular insulin. During a review of Resident 51's nursing note dated 2/17/2025 and timed at 7:03 p.m., the nursing noted indicated Resident 51 returned from the GACH. During a review of Resident 51's nursing noted dated 2/18/2025 and timed at 8:24 a.m., the nursing note indicated Resident 51's blood sugar reading was 426, physician notified, and orders received. During a review of Resident 51's nursing note dated 2/18/2025 and timed at 10 a.m., the nursing note indicated Resident 51's blood sugar was still elevated, and additional units of insulin were ordered by the physician. During a review of Resident 51's nursing note dated 2/18/2025 and timed at 12 p.m., the nursing note indicated Resident 51's blood sugar was still elevated at 450, the physician was notified, and additional units of insulin were ordered. The nursing note indicated; Resident 51 left the facility for his dialysis appointment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 51's untitled care plan dated 2/18/2025, the care plan indicated Resident 51 had diabetes mellitus and was at risk for hypoglycemia and hyperglycemia. The care plan goals were for Resident 51 to be free from any signs and symptoms of hyperglycemia and hypoglycemia (low blood sugar levels that can result in mild symptoms like shakiness and confusion to severe complications like seizures [sudden involuntary movements], coma, and even death), and having no complications related to diabetes through the review date (3/10/2025). The care plan indicated interventions which included diabetes medication as ordered by doctor, monitoring and documenting for side effects and effectiveness. During a review of Resident 51's physician order dated 2/18/2025, the physician order indicated Resident 51 was to have his insulin pump with a basal (continuous supply) rate (the amount of insulin units/hour) with regular insulin on sliding scale ([NAME]- the amount of insulin to be administered changes or slides up or down based on the person's blood sugar). During a review of Resident 51's physician order dated 2/18/2025, the physician order indicated Resident 51's insulin pump was not functional. The physician order indicated to start a high dose insulin sliding scale (ISS) every two hours, see orders for regular insulin sliding scale dosing. During a review of Resident 51's physician order dated 2/20/2025, the physician order indicated Resident 51 may self-administer insulin via insulin pump, refill insulin and change sensor (a small device, typically worn on the body, that measures glucose levels in the fluid between the cells and transmits this data to a connected insulin pump or receiver)/tubing every seven days. During a review of Resident 51's Interdisciplinary Team (IDT-a group of professionals from different disciplines who collaborate to provide comprehensive and coordinated patient care, focusing on shared goals and patient outcomes) note dated 2/19/2025, the IDT note indicated the IDT team discussed Resident 51's use of an insulin pump, how Resident 51 had been managing his insulin pump responsibilities and ordering the refills of insulin and ordering pump supplies. The IDT note indicated; facility staff observed Resident 51 during application of the sensor. The IDT note indicated Resident 51's physician was aware of Resident 51's self-administration of insulin with the insulin pump. During a review of Resident 51's nursing note dated 2/23/2025 and timed at 2:30 p.m., the nursing note indicated Resident 51's blood sugar was 588 at 1:20 p.m., and Resident 51 stated to staff (unknown) that he self-administered 60 units of insulin through his insulin pump. The nursing note indicated Resident 51 informed the facility staff that he ran out of supplies for the sensor that monitors his blood sugar levels. The nursing note indicated at 2:15 p.m., facility staff tested Resident 51's blood sugar level and it was reading HIGH, the physician was notified and ordered to administer 40 units of insulin. During a review of Resident 51's physician order dated 2/23/2025, the physician order indicated Insulin Lispro (rapid acting insulin) 40 units subcutaneously (under the skin) one time only for hyperglycemia for one day. During a review of Resident 51's nursing note dated 2/23/2025 and timed at 3:35 p.m., the nursing note indicated Resident 51's blood sugar was rechecked and still indicated a HIGH reading. The nursing note indicated the physician was notified and additional units of insulin were ordered. (continued on next page)

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Southland	11701 Studebaker Road Norwalk, CA 90650

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 51's physician order dated 2/23/2025, the physician order indicated: Insulin Lispro 30 units inject subcutaneously one time only for hyperglycemia for one day. Humulin 70/30 Insulin (intermediate acting insulin) 50 units inject subcutaneously on time only for hyperglycemia for one day. During a review of Resident 51's nursing note dated 2/24/2025 and timed at 4:52 p.m., the nursing note indicated Resident 51's physician wanted to discontinue the use of his insulin pump while in the facility and he wanted to continue checking blood sugar before meals and at bedtime, Resident 51 and daughter aware. During a review of Resident 51's nursing note dated 2/28/2025 and timed at 4:43 p.m., the nursing note indicated Resident 51's blood sugar was 54, he was diaphoretic, weak and flushed. The nursing note indicated Resident 51 was administered glucose gel (medication used to treat low blood sugar) and blood sugar became 110. During a review of Resident 51's nursing note dated 3/6/2025 and timed at 8:31 a.m., the nursing note indicated Resident 51's blood sugar at 5 a.m. was HIGH, orders were received from physician and carried out. During a review of Resident 51's nursing note dated 3/10/2025 and timed at 12 a.m., the nursing note indicated Resident 51 was hypoglycemic with blood sugar reading at 46. The nursing note indicated Resident 51's physician was notified, and glucose gel was administered. During a review of Resident 51's nursing note dated 3/10/2025 and timed at 1:49 p.m., the nursing note indicated to discontinue Lispro insulin and [NAME] as soon as Resident 51 had insulin pump set up. The nursing note indicated Resident 51 was assisted with pump set up and the order to discontinue insulin administration per [NAME] was verified with the physician. The nursing note indicated to continue monitoring blood glucose and notify physician if Resident 51's blood sugar was above 400. During a review of Resident 51's nursing note dated 3/11/2025 and timed at 7:30 a.m., the nursing note indicated Resident 51's was not wearing his insulin pump was and Resident 51 reported to facility staff and he did not have all the parts to get his pump orking. The nursing note indicated Resident 51's physician was notified and insulin sliding scale was ordered until Resident 51's insulin pump was functioning. During a review of Resident 51's nursing note dated 3/11/2025 and timed at 10:30 a.m., the nursing note indicated Resident 51's blood sugar was 479, physician was notified, and insulin orders were received. During an interview on 3/13/2025 at 1:34 p.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 51 did not use the insulin pump while at the facility. LVN 4 stated Resident 51 told her the insulin pump was incomplete and it was missing parts. LVN 4 stated she did not physically see the resident with the pump. LVN 4 stated the insulin pump would detect if the blood sugar is high and will administer the insulin to the resident. LVN 4 stated if a resident has an insulin pump, the facility staff would monitor the blood sugar and would be checking if the insulin pump is providing the right dose of insulin to the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/2025 at 2:10 p.m., and a subsequent interview on 3/14/2025 at 1:08 p.m., with LVN 7, LVN 7 stated Resident 51 did not have an insulin pump nor did he use one while at the facility. LVN 7 stated during the month of March 2025, there was no administration of insulin from the pump. LVN 7 stated the insulin was never documented to be administered through the insulin pump. LVN 7 stated the facility staff administered insulin through the sliding scale. LVN 7 stated even if the resident is alert enough to work with the insulin pump, the facility staff should be aware of the type of pump used by the resident, assess and monitor the resident on the use of insulin pump. LVN 7 stated monitoring should have been started upon admission. LVN 7 stated Resident 51's noncompliance with his diabetes care, the presence or absence of his insulin pump, and the blood sugars being erratic and Resident 51 being on dialysis, placed Resident 51 at risk of hyperglycemia and hypoglycemia, ketoacidosis, hospitalization and death. During an interview on 3/13/2025 at 4:27 p.m., with the Assistant Director of Nursing (ADON), the ADON stated as long as resident passes the self-administration assessment and they are capable of self-administering medication, the facility staff only monitors the resident for hyperglycemia or hypoglycemia. The ADON stated Resident 51 self-administers the insulin on his own and the insulin pump reads his blood sugar automatically and determines how much insulin he should be getting. The ADON stated after reviewing the facility's policy for self-administration of medication, the facility staff should be documenting the self-administered doses in the resident's administration record. During an interview on 3/14/2025 at 10:11a.m., Resident 51 stated that he has not used the insulin pump since he has been at the facility because it has not been working. Resident 51 stated he knew the pump was not working because the level of the insulin was not going down, the pump was not showing any numbers. Resident 51 stated, and he was unsure when it stopped working. During an interview on 3/14/2025 at 11:05 a.m., Medical Doctor 1 (MD 1) stated if the use of Resident 51's insulin pump is not monitored it could result in bad outcomes such as repeated hospitalization , hyperglycemia and hypoglycemia. MD 1 stated Resident 51's diabetes and dialysis had been difficult for the facility to manage which has resulted in repeated hospitalization s. MD 1 stated Resident 51 was non complaint with his diabetes. During a review of the American Diabetes Association (a non-profit organization dedicated to preventing, curing, and improving the lives of people with diabetes) website titled Insulin Pumps: Relief and Choice, the American Diabetes Association website indicated an insulin pump will warn the user if the pump stops working right or if the insulin infusion set stops working. The American Diabetes Association website indicated if the pump stops working it can cause high blood glucose levels and cause diabetic ketoacidosis (DKA- a serious complication of diabetes that occurs when the body doesn't have enough insulin, leading to a buildup of harmful substances called ketones in the blood) which is very serious and dangerous. https://diabetes.org/about-diabetes/devices-technology/insulin-pumps-relief-and-choice During a review of facility's policy and procedure (P/P) titled Self-Administration of Medications dated 5/2019, the P/P indicated nursing will be responsible for recording self-administration doses in the resident's medication administration record (MAR). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's job description for a Licensed Vocational/ Practical Nurse (LVN) dated 12/2021, the job description indicated one of the essential duties and responsibilities of a LVN included observing medication passes and treatments to ensure quality. b.During a review of Resident 23 ' s Admission Record, the Admission Record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses including a displaced fracture of the greater tuberosity of the left humerus (upper arm bone fracture where broken pieces of the bone are out of alignment) and difficulty walking. During a review of Resident 23 ' s Physician History and Physical (H&P), dated 3/29/2024, the H&P indicated Resident 23 initially presented to an outside hospital after sustaining a left humerus fracture, underwent an open reduction internal fixation (ORIF, surgical procedure for repairing broken bones using either plates, screws, or rods) on 3/20/2024 and was transferred to the facility for continued care and rehabilitation with a plan to follow up with orthopedics on 4/3/2024. The H&P indicated Resident 23 was to be non-weight bearing (restriction in which a person is not allowed to put any weight through the operated body part) on the left arm, receive rehabilitation, obtain post-operative care, and follow up with orthopedics on 4/3/2024. During a review of Resident 23 ' s Occupational Therapy (OT, profession that provides services to increase and/or maintain a person ' s capability to participate in everyday life activities) Evaluation and Plan of Treatment (OT Eval), dated 3/28/2024, the OT Eval indicated Resident 23 ' s left arm was not assessed due to Resident 23 ' s diagnosis of a left humerus fracture and non-weightbearing (NWB, restriction in which a person is not allowed to put any weight through the operated body part) restrictions. During a review of Resident 23 ' s Order Summary Report, the Order Summary Report indicated a physician ' s order, dated 4/3/2024, to follow up with orthopedics regarding left humerus. During a review of Resident 23 ' s Progress Notes, dated 4/3/2024, the Nursing Progress Notes indicated Resident 23 left the facility for an orthopedic follow appointment and returned the same day with instruction to follow up with orthopedics in five (5) weeks. During a review of Resident 23 ' s Order Summary Report, the Order Summary Report indicated a physician ' s order, dated 4/3/2024, for Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) and Occupational Therapy (OT, profession that provides services to increase and/or maintain a person ' s capability to participate in everyday life activities) to provide range of motion (ROM, movement ability of a joint) exercises to Resident 23 ' s left shoulder and left elbow and keep Resident 23 ' s left arm NWB. During a review of Resident 23 ' s OT Discharge Summary, dated 4/25/2024, the OT Discharge Summary indicated Resident 23 was discharged from OT services per physician or case manager. The OT Discharge Summary indicated Resident 23 showed fluctuating levels of participation in therapy due to pain and fatigue and required maximal cueing for motivation and engagement. During a review of Resident 23 ' s Order Summary Report, the Order Summary Report indicated a physician ' s order, dated 5/1/2025, for an x-ray (image of the internal body, produced by X-rays being passed through it and being absorbed to different degrees by different materials) of the left humerus for a follow up ortho appointment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 23 ' s clinical record, the clinical record did not indicate Resident 23 was scheduled for a follow up orthopedics appointment. During a review of Resident 23 ' s Order Summary Report, the Order Summary Report indicated a physician ' s order, dated 11/21/2024, for Resident 23 to follow up with orthopedics on 12/10/2024 (eight months after consulting physician ' s recommendations). During a review of Resident 23 ' s Orthopedic Consultation note (Ortho Note), dated 12/10/2024, the Ortho Note indicated Resident 23 presented to the orthopedic appointment to follow up for her left humerus fracture and was last seen in the office on 4/3/2024. The Ortho Note indicated Resident 23 ' s left shoulder had an abnormal strength test in the position of external rotation (rotational movement of the shoulder away from the body), crepitus (sensation or noise when you move a joint), and pain with ROM. The Ortho Note indicated Resident 23 had a complete rotator cuff tear (rip or tear in one of the tendons that stabilize the shoulder joint and allow for joint movement) and received a steroid injection. The Ortho Note indicated Resident 23 ' s left arm could be weightbearing as tolerated (WBAT, a person is medically cleared to place as much weight through the affected arm or leg to the point of comfort or tolerance). During a review of Resident 23 ' s Minimum Data Set (MDS, a federally mandated assessment), dated 1/4/2025, indicated Resident 23 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 23 required set up/clean up assistance for eating and oral hygiene and partial/moderate assistance for toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 23 had functional limitations in range of motion (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm (shoulder, elbow, wrist, hand). During a concurrent interview and record review on 3/12/2025 at 2:33 pm, Occupational Therapist 1 (OT 1) reviewed Resident 23 ' s clinical record. OT 1 stated Resident 23 was initially evaluated by OT on 3/28/2024 and discharged from OT services on 4/25/2024 due to plateauing (state of little or no change) in therapy with NWB restrictions of the left arm. OT 1 stated OT 1 assisted Resident 23 with ROM of the left arm once cleared by the physician on 4/3/2024. OT 1 stated Resident 23 had limited left shoulder ROM, was very fearful of moving the left arm, had left shoulder pain, and required maximal cueing and encouragement to use the left arm in activities of daily living (ADL, basic activities such as eating, dressing, toileting). OT 1 stated Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain their function and joint mobility) services were not recommended for the left arm at the time because the goal was to focus on walking until the weightbearing status of the left arm was changed by the physician and/or if a decline was noted in ROM on the quarterly JMAs. OT 1 reviewed Resident 23 ' s physician orders, dated 4/3/2024, and confirmed Resident 23 still had active physician orders to remain NWB on the left arm. OT 1 stated he was unsure why Resident 23 was still NWB on the left arm since Resident 23 ' s fracture occurred over one year ago. OT 1 reviewed Resident 1 ' s clinical record and stated he could not locate the orthopedic follow up notes and recommendations from 4/3/2024 and 12/10/2024. OT 1 stated the therapy department was waiting for Resident 23 ' s weightbearing status to be upgraded by the physician during follow up orthopedic appointments to progress Resident 23 functionally in mobility and ADLs but was unsure what happened since Resident 23 ' s weightbearing status never changed and he was unable to determine if and/or when Resident 23 followed up with Orthopedics. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/12/2025 at 3:18 pm, the Director of Rehabilitation (DOR) reviewed Resident 23 ' s clinical record. The DOR confirmed Resident 23 was discharged from OT services on 4/25/2024 due to reaching the highest practicable level of function with the left arm NWB restrictions. The DOR stated the therapy department was waiting for Orthopedics to lift Resident 23 ' s left arm weightbearing restrictions before re-assessing for therapy but was unsure what happened since Resident 23 had been NWB on the left arm for over one year, which was uncommon and a very long length of time to be NWB. The DOR confirmed Resident 23 was seen by Orthopedics on 4/3/2024 and 12/10/2024 but was unsure what the recommendations were and why there was a delay in Resident 23 ' s follow-up appointment. The DOR stated the facility should have followed up sooner to determine Resident 23 ' s plan of care for the management of the left arm. The DOR stated if Orthopedics was consulted earlier for follow up, therapy would have re-assessed and progressed Resident 23 in mobility, ADLs, and ROM. During an observation on 3/13/2025 at 3:58 pm, in Resident 23 ' s room, Resident 23 was lying in bed. Resident 23 stated staff did not assist her with exercises. Resident 23 continuously moved the right arm when asked to move both arms. Resident 23 raised the left arm to less than shoulder height and fully bent and straightened the left elbow, left wrist, and hand. During an observation of an RNA session on 3/13/2025 at 10:38 am, Resident 23 was sitting in a wheelchair. Restorative Nursing Aide 1 (RNA 1) wheeled Resident 23 into the hallway and placed a gait belt (safety device worn around the waist that can be used help safely transfer a person from one surface to another or while walking) around Resident 23 ' s waist. Resident 23 leaned forward and used both arms to push off the wheelchair armrests to stand. RNA 1 held onto Resident 23 ' s right arm while walking and Restorative Nursing Aide 2 (RNA 2) followed behind with a wheelchair. Resident 23 walked about 15 feet and stated she needed to rest. Resident 23 sat down and stood back up again after 30 seconds by leaning forward and pushing up from the wheelchair armrests with both arms. RNA 1 held onto Resident 23 ' s right arm to assist with walking. Resident 23 walked over to the left of the hallway and grabbed onto the left handrail, grabbing and pushing onto the left handrail with the left arm for support while walking for about 15 feet. Resident 23 sat down in the wheelchair after walking exercises and requested to be wheeled back to the room. Resident 23 raised the left arm to shoulder height and the right arm overhead. RNA 2 assisted Resident 23 back to bed. During an interview on 3/13/2024 at 2:06 pm, Restorative Nursing Aide 1 (RNA 1) and Restorative Nursing Aide 2 (RNA 2) stated RNA did not assist Resident 23 with ROM exercises for the arms because there was no RNA order for ROM exercises. RNA 2 stated Resident 23 had limited ROM and fluctuating levels of pain in the left shoulder, required cueing to use the left arm during everyday activities, and was non-compliant with NWB status of the left arm because she pushed through the left arm to stand and to walk. RNA 1 and RNA 2 stated Resident 23 would benefit from ROM exercises to the left arm since she required encouragement to use the left arm functionally and had limited ROM. RNA 1 and RNA 2 stated they notified the DOR directly about Resident 23 ' s left arm ROM limitations, non-compliance with left arm NWB precautions, and progress in RNA, but the DOR stated therapy was waiting for Resident 23 to follow up with Orthopedics to progress Resident 23 ' s RNA or therapy program and did not know if other team members were aware. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/13/2025 at 2:49 pm, the Minimum Data Set Nurse (MDSN) and Licensed Vocational Nurse 2 (LVN 2) stated the charge nurse was responsible for accepting a resident ' s paperwork and implementing new physician orders and recommendations when a resident returned to the facility from a consultation appointment. LVN 2 stated if follow up appointments were recommended by the physician, the charge nurse contacted social services to schedule the follow up appointment based on the physician recommendations and arranged transportation. The MDSN and LVN 2 reviewed Resident 23 ' s clinical record and confirmed Resident 23 was supposed to follow up with Orthopedics five weeks from 4/3/2025 but did not. The MDSN stated Resident 23 was scheduled for a follow up Orthopedic appointment on 5/8/2024, but never went for unknown reasons. The MDSN stated the next follow up Orthopedic appointment was done on 12/10/2024, eight months later, and did not know why there was a delay. The MDSN stated the facility should have followed up with Orthopedics as recommended to determine if Resident 23 ' s left shoulder fracture was healing, if the weightbearing status of the left arm was still appropriate, and if the plan of care needed to be modified. The MDSN stated the lack of Orthopedic follow up as recommended could have potentially resulted in a worsening or non-healing fracture, harm, unnecessary weightbearing restrictions, pain, decline in ADLs, and a delay of necessary treatments and services such as therapy. During a concurrent interview and record review on 3/13/2025 at 3:25 pm, the Case Manager (CM) stated she was responsible for scheduling appointments an arranging transportation for any follow up care the residents needed. The CM stated if a follow up appointment was missed, the CM must attempt to re-schedule the appointment right away, document the reason for missed appointments in the clinical record, notify the physician, and continue to follow up with the resident if a follow up appointment was missed and/or if a resident refused. The CM reviewed Resident 23 ' s clinical record and confirmed Resident 23 was supposed to follow up with Orthopedics five weeks from 4/3/2025 but did not. The CM stated she scheduled a follow up Orthopedic appointment for Resident 23 on 5/8/2025 but Resident 23 refused to go and the CM did not document the refusal in the clinical record. The CM stated she tried to schedule additional follow up Orthopedic appointments multiple times with Resident 23, but Resident 23 refused each time and the CM did not document and/or notify nursing or the physician of Resident 23 ' s continuous refusals. The CM stated Resident 23 refused all follow up appointments because she was uncomfortable riding in the transportation with a stranger and preferred family to accompany her. The CM stated Resident 23 agreed to go to an Orthopedic appointment on 12/10/2024 because Resident 23 ' s family member agreed to accompany or remain on the phone with her during transport. The CM stated the facility could have easily resolved and addressed Resident 23 ' s concerns regarding appointment refusals but did not because she never documented the refusals and did not notify nursing and the physician. The CM stated it was important residents went to follow up appointments as recommended or ordered to ensure the staff was able to provide the appropriate type of care and services the resident needed. During a concurrent interview and record review on 3/14/2025 at 10:27 am, the MDSN and CM stated Interdisciplinary Team meetings (IDT, team of health care professionals that work together with the resident and or resident's representative to prioritize the resident 's needs and goals) were conducted upon admission, quarterly, upon discharge, and as needed to discuss and develop a resident ' s comprehensive plan of care. The MDSN and CM reviewed Resident 23 ' s clinical record and stated no quarterly IDTs were done for Resident 23. The MDSN and CM stated if IDTs were done quarterly, the interdisciplinary staff would have been made aware of Resident 23 ' s lack of Orthopedic follow up and constant refusals, notified the physician and family, and developed a comprehensive care plan to address all areas of concern. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Southland		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/14/2025 at 1:27 pm, the Director of Nursing (DON) stated the charge nurse was responsible for accepting a resident ' s paperwork and implementing new physician orders and recommendations when a resident returned to the facility from a consultation appointment. The DON stated if follow up appointments were recommended by the physician, the charge nurse contacted social services to schedule the follow up appointment based on the physician recommendations and arranged transportation. The DON stated any resident refusals for follow up appointments should be documented in the clinical record, care planned, and reported to the physician, nursing, and the resident ' s family. The DON stated all follow up care or need for clarification of orders should be addressed in IDT me [TRUNCATED]

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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 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45382

Based on observation, interview, and record review, the facility failed to provide treatments and services to one of eleven sampled residents (Resident 23) to improve, prevent and/or limit a decline in joint (where two bones meet) range of motion (ROM, full movement potential of a joint) by failing to:

1. Provide ROM services to improve, maintain, and prevent a decline of Resident 23's left shoulder

2. Ensure Resident 23's Joint Mobility Assessments (JMA, a brief assessment of a resident's ROM in both arms and both legs), dated 7/4/2024 and 10/4/2024, included the assessment of Resident 23's left shoulder ROM

These deficient practices had the potential to cause Resident 23 to have a decline in ROM leading to contracture (loss of motion of a joint associated with stiffness and joint deformity) and have a decline in physical functioning such as the ability to eat, dress, and walk.

Findings:

During a review of Resident 23's Admission Record, the Admission Record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses including a displaced fracture of the greater tuberosity of the left humerus (upper arm bone fracture where broken pieces of the bone are out of alignment) and difficulty walking.

During a review of Resident 23's Physician History and Physical (H&P), dated 3/29/2024, the H&P indicated Resident 23 initially presented to an outside hospital after sustaining a left humerus fracture, underwent an open reduction internal fixation (ORIF, surgical procedure for repairing broken bones using either plates, screws, or rods) on 3/20/2024 and was transferred to the facility for continued care and rehabilitation with a plan to follow up with orthopedics on 4/3/2024. The H&P indicated Resident 23 was to be non-weight bearing (restriction in which a person is not allowed to put any weight through the operated body part) on the left arm, receive rehabilitation, obtain post-operative care, and follow up with orthopedics on 4/3/2024.

During a review of Resident 23's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation and Plan of Treatment (OT Eval), dated 3/28/2024, the OT Eval indicated Resident 23's left arm was not assessed due to Resident 23's diagnosis of a left humerus fracture and non-weightbearing (NWB, restriction in which a person is not allowed to put any weight through the operated body part) restrictions.

During a review of Resident 23's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/3/2024, for Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) and OT to provide ROM exercises to Resident 23's left shoulder and left elbow and keep Resident 23's left arm NWB.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Southland		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 23's OT Discharge Summary, dated 4/25/2024, the OT Discharge Summary indicated Resident 23 was discharged from OT services per physician or case manager. The OT Discharge Summary indicated Resident 23 showed fluctuating levels of participation in therapy due to pain and fatigue and required maximal cueing for motivation and engagement. During a review of Resident 23's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/26/2024 with start date of 4/27/2024, for RNA to assist Resident 23 with walking exercises using a hemi-walker (assistive device that allows a person to lean on one side while walking for support), three times a week. During a review of Resident 23's Quarterly JMA, dated 7/4/2024, the JMA indicated no ROM was assessed for Resident 23's left shoulder. The comment section of the JMA indicated to continue plan of care. During a review of Resident 23's Quarterly JMA, dated 10/4/2024, the JMA indicated no ROM was assessed for Resident 23's left shoulder. The comment section of the JMA indicated to continue Restorative Nursing Aide program ((RNA, nursing aide program that helps residents maintain their function and joint mobility). During a review of Resident 23's Minimum Data Set (MDS, a resident assessment), dated 1/4/2025, indicated Resident 23 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 23 required set up/clean up assistance for eating and oral hygiene and partial/moderate assistance for toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 23 had functional limitations in range of motion (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm (shoulder, elbow, wrist, hand). During a concurrent interview and record review on 3/12/2025 at 2:33 pm, Occupational Therapist 1 (OT 1) reviewed Resident 23's clinical record. OT 1 stated Resident 23 was initially evaluated by OT on 3/28/2024 and discharged from OT services on 4/25/2024 due to plateauing (state of little or no change) in therapy with NWB restrictions of the left arm. OT 1 stated OT 1 assisted Resident 23 with ROM of the left arm once cleared by the physician on 4/3/2024. OT 1 stated Resident 23 had limited left shoulder ROM, was very fearful of moving the left arm, had left shoulder pain, and required maximal cueing and encouragement to use the left arm in activities of daily living (ADL, basic activities such as eating, dressing, toileting). OT 1 stated RNA services were not recommended for the left arm at the time because the goal was to focus on walking until the weightbearing status of the left arm was changed by the physician and/or if a decline was noted in ROM on the quarterly JMAs. OT 1 stated if the JMAs were not done, the therapy department would not know if a resident's ROM changed, improved, or declined. OT 1 stated all residents in the facility would benefit from RNA services for exercises, particularly residents who were identified as having ROM limitations. During an interview on 3/13/2024 at 2:06 pm, Restorative Nursing Aide 1 (RNA 1) and Restorative Nursing Aide 2 (RNA 2) stated RNA did not assist Resident 23 with ROM exercises for the arms because there was no RNA order for ROM exercises. RNA 2 stated Resident 23 had limited ROM and fluctuating levels of pain in the left shoulder and required cueing to use the left arm during everyday activities. RNA 1 and RNA 2 stated Resident 23 would benefit from ROM exercises to the left arm since she required encouragement to use the left arm functionally and had limited ROM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Southland		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/13/2025 at 2:31 pm, the Minimum Data Set Nurse (MDSN) reviewed Resident 23's MDS, dated [DATE], and confirmed Resident 23 was identified as having functional ROM limitations in the left arm. The MDSN stated the facility referred residents identified as having ROM limitations to RNA and/or therapy services to improve, maintain, and prevent declines in ROM. The MDSN reviewed Resident 23's clinical record and confirmed there were no interventions in place to address Resident 23's identified left shoulder ROM limitations. The MDSN stated if residents who required services for ROM maintenance did not receive them, it could lead to medical complications and a functional decline. During an observation on 3/13/2025 at 3:58 pm, in Resident 23's room, Resident 23 was lying in bed. Resident 23 stated staff did not assist her with arm exercises. Resident 23 continuously moved the right arm when asked to move both arms. Resident 23 raised the left arm to less than shoulder height and fully bent and straightened the left elbow, left wrist, and hand. During a concurrent interview and record review on 3/14/2025 at 9:10 am, the DOR stated the facility monitored for changes in a resident's joint ROM by JMAs which were done by the therapy department upon admission, quarterly, annually, and as needed along with any reports from RNA during the routine RNA meetings. The DOR reviewed Resident 23's JMAs, dated 7/4/2024 and 10/4/2024, and confirmed the JMAs did not include an assessment of Resident 23's left shoulder. The DOR stated it was important JMAs were completed quarterly to reflect the resident's current ROM for each joint, to avoid missed declines in ROM, and to ensure the residents received the treatment and services they needed. The DOR stated she not aware Resident 23 had left shoulder ROM limitations, pain, and decreased use of the left arm in ADLs during RNA sessions. The DOR stated if she was aware, she would have contacted the doctor, re-evaluated Resident 23 for therapy services, and/or ordered RNA exercises for the left arm. The DOR stated Resident 23 could have benefitted from RNA or therapy services if she continued to have ROM limitations and was not using the left arm functionally during ADLs. During an interview on 3/14/2025 at 1:27 pm, the Director of Nursing (DON) stated the facility maintained and prevented declines in ROM by providing RNA and/or therapy services. The DON stated JMAs were completed by the therapy department upon admission, quarterly, annually, and as needed to identify any changes in joint ROM. The DON stated it was important JMAs were completed as indicated to ensure the residents were receiving the appropriate services to maintain or improve ROM and to detect any ROM declines. The DON stated if residents who were identified as having ROM limitations were not receiving services to maintain or improve ROM, it could lead to a functional decline. During a review of the facility's Policy and Procedure (P/P) titled, ROM and Contracture Prevention, revised 5/2019, the P/P indicated the facility would ensure that management of resident joint mobility was provided by an interdisciplinary team approach of assessment, care planning, and preventative or rehabilitative measures. The P/P indicated it was the policy of the facility to ensure residents received services, care, and equipment to assure that every resident maintained and/or improved to his/her highest level of ROM and mobility, unless clinically unavoidable. The P/P indicated an interdisciplinary care plan would be developed to maintain or increase joint mobility, and the implementation of the program was carried out by the appropriate personnel in skilled rehab, routine therapy, restorative nursing, or Certified Nursing Assistant staff. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Southland		STREET ADDRESS, CITY, STATE, ZIP CODE: 11701 Studebaker Road, Norwalk, CA 90650	

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P/P titled, Joint Mobility Assessment, revised 2/2023, the P/P indicated JMAs were completed upon admission and at a minimum of every three months thereafter to assess for joint mobility limitations. The P/P indicated the purpose of the JMAs was to determine a resident's ROM for all major joints and to implement plans of care to increase, maintain, or prevent deterioration of joint mobility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 98) who had a foley catheter (device that drains urine into a collection bag) was monitored and assessed for signs and symptoms of a urinary tract infection. The deficient practices had the potential to result in a urinary tract infection. Findings: During a review of Resident 98's Admission Record, the Admission Record indicated Resident 98 was admitted to the facility on [DATE] with diagnoses including hydronephrosis (condition of the urinary tract where one or both kidneys swell) with renal and ureteral calculous obstruction (condition where there is blockage caused by kidney stones. During a review of Resident 98's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 98's cognition (thought process) was intact. The MDS indicated Resident 98 needed substantial assistance (helper does more than half the effort to complete the task) with toileting hygiene, and supervision with personal hygiene. During a record review of Resident 98's Order summary report, as of 3/12/2025, the report indicated, starting 2/8/2025, Resident 98 had an indwelling catheter. During a review of Resident 98's Care plan report, A care plan focused on indwelling catheter, created on 1/10/2025, indicated resident will show no signs and symptoms of urinary infection. A care plan intervention indicated Resident 98 will be monitored / record/ report to the physician for signs and symptoms of urinary tract infection: pain, burning, blood-tinged urine, cloudiness, foul smelling urine. During an interview and record review on 3/12/2025 at 9:59 a.m., with Licensed Vocational Nurse (LVN) 7, Resident 98's medical records were reviewed and there was no documentation of a foley catheter urine assessment and for signs and symptoms of infection. During an interview on 3/14/2025 at 11:18 a.m. with the Director of Nursing (DON), the DON stated residents with a foley catheter need to be monitored and assessed for signs and symptoms of infection. During a review of the facility's Job Description for Registered Nurse, 12/17/2021, the job description indicated the Registered nurse back assists in the development of preliminary and comprehensive assessments of the nursing needs of each residence. During a review of the facility's P&P titled, Catheter, Indwelling Care of, revised 4/2023, the P&P indicated it was the policy of this facility to reduce infection.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to ensure one of one sampled resident (Resident 76) with a colostomy (surgery to create an opening for the colon through the belly) received the correct colostomy bag (pouch that attaches to the stoma [small opening in the abdomen] to collect the waste). This deficient practice resulted in Resident 76's colostomy to leak which had a negative impact in the resident's physical and mental wellbeing. Findings: During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (problem in the brain), colostomy status (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body), and bilateral primary osteoarthritis of the knee (a type of arthritis on both knees that occurs when the cartilage on the ends of bones wears down, causing the bones to rub against one another). During a review of Resident 76's Minimum Data Set (MDS), resident assessment tool, dated 10/30/2024, the MDS indicated Resident 76's cognition was severely impaired. The MDS indicated Resident 76 needed set up assistance when eating, supervision (helper provides verbal cues and assistance may be given during activity) with oral hygiene, upper body dressing, personal hygiene, and moderate assistance with toileting hygiene, showering, lower body dressing, and putting on/taking off footwear. During a review of an email correspondence addressed to the Administrator (ADMIN) and the Director of Nursing (DON) from family member (FM)2, dated 1/29/2025 at 2:59 p.m., the email indicated Resident 76's colostomy bags were not the same ones the Wound Clinic providers ordered. During a review of Resident 76's Wound Clinic Progress notes, dated 3/5/2025 at 3:34 p.m., the progress notes indicated the colostomy bags on 1/28/2025 and 2/12/2025 (as noted with a photograph) were different brand from the ones ordered by the Wound specialist. During a phone interview on 3/11/2025 at 12 noon, with family member (FM) 2, FM 2 stated Resident 76 had the wrong colostomy bag, and the facility waited a long time before ordering the correct one. During an interview on 3/11/2025 at 3:27 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated there was a time the colostomy bag was dripping it was a mess for a couple days then the staff finally ordered the correct ones. During an interview on 3/12/2025 at 1:39 p.m., with the Treatment nurse (TXN)1, TXN 1 stated the colostomy bag should not leak for a couple days. During an interview on 3/14/2025 at 11:18 a.m., with the Director of Nursing (DON), the DON stated the colostomy supplies should be the correct ones so there is no leaking or problems. (continued on next page)

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Colostomy and Ileostomy Care, revised 5/2017, the P&P indicated colostomy care will be provided to residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 45425 Based on observation, interview and record review, the facility failed to ensure three of four hemodialysis ([HD]a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) residents (Resident 58,98, and 103) received dialysis care and services based on professional standards. The facility failed to: a. Ensure Resident 51 received HD as scheduled on Tuesday, Thursday, and Saturday. b. Ensure Resident 58 had a dressing on the site of the dialysis catheter (medical device used to do HD). c. Ensure Resident 98 was assessed prior to sending Resident 98 to HD after Resident 98 returned from the dialysis center. d. Ensure Resident 103 had equipment and supplies necessary to manage emergencies such as bleeding at the bedside. These deficient practices had the potential to result in complications from HD for Residents 58, 98, and 103. The deficient practice of Resident 51 not receiving dialysis resulted in experiencing facial swelling, requiring admission to the GACH, and resulting in the diagnosis of fluid overload (excessive amount of fluid in the body, beyond what is considered normal for a healthy individual) due to a missed hemodialysis session. Findings: a. During a review of Resident 51's Admission Record, the Admission Record indicated Resident 51 was admitted on [DATE] with the diagnosis including Type one diabetes mellitus (pancreas does not produce enough insulin), end stage renal disease (ESRD -irreversible kidney failure), and dependence on renal dialysis (dependent on the dialysis machine to stay alive because the kidneys are no longer able to function adequately). During a review of Resident 51's Minimum Data Set (MDS - a resident assessment tool) dated [DATE], the MDS indicated Resident 51's cognition was intact and required partial/ moderate assistance (helper does less than half the effort) to complete activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 51's physician order dated [DATE], the physician order indicated Resident 51 was to have hemodialysis on Tuesday, Thursday, and Saturday at 9:15 a.m. During a review of Resident 51's physician order dated [DATE], the physician order indicated Resident 51 was to have hemodialysis on Tuesday, Thursday, and Saturday at 12:15 a.m. (continued on next page)

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F 0698

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During a review of Resident 51's care plan dated [DATE] indicated Resident 51 required hemodialysis due to ESRD and Resident 51 was at risk for cardiac overload (too much fluid in the body), edema (swelling caused by a collection of fluid) and congestion (an excessive or abnormal accumulation of blood or other fluid in a body part). The care plan's intervention included hemodialysis Tuesday, Thursday, and Saturday at 12:15 p. m. and resident will be encouraged to go to scheduled dialysis appointment.

During a review of Resident 51's nursing note dated [DATE], the nursing note indicated Resident 51 went to the dialysis center on [DATE] (Friday) and could not receive dialysis that day. The nursing note indicated Resident 51 went to GACH 2 ED due to facial swelling.

During a review of Resident 51's GACH 2 ED note dated [DATE], the ED note indicated Resident 51 chief complaint was facial swelling for one day and Resident 51 stated he missed dialysis yesterday ([DATE]).

During an interview on [DATE] at 9:18 a.m. with LVN 7, LVN 7 stated if a resident misses their scheduled dialysis day and requires dialysis on a different day, the resident should return to their normal schedule. LVN 7 stated Resident 51 received dialysis on [DATE] (Wednesday) and should have maintained his normal schedule of dialysis on [DATE] (Thursday) but there is no documentation regarding Resident 51 going to dialysis on [DATE]. LVN 7 stated if Resident 51 does not maintain his normal dialysis schedule, he is at risk for fluid overload.

During an interview on [DATE] at 9:53 a.m. with the Dialysis Clinical Coordinator (DCC), the DCC stated if the resident misses their normal scheduled day and requires an additional day of dialysis, the resident should return to dialysis on their next scheduled day. The DCC stated Resident 51 missed his normal scheduled dialysis time on [DATE].

During an interview on [DATE] at 2:27 p.m. with the Director of Nursing (DON), the DON stated if a resident misses a scheduled dialysis day, the physician should be called and ask if the dialysis day should be rescheduled. The DON stated Resident 51 is non-complaint and the facility staff should ensure Resident 51 is receiving dialysis on his scheduled days. The DON stated if Resident 51 does not receive dialysis as scheduled, it can result in fluid overload.

b. During a review of Resident 58's Admission Record, the Admission Record indicated Resident 58 was admitted to the facility on [DATE] with diagnoses including encephalitis (swelling of the brain) and encephalomyelitis (swelling of brain and spinal cord, ESRD , dependence on renal dialysis.

During a review of Resident 58's MDS dated [DATE], the MDS indicated Resident 58's cognition was severely impaired. The MDS indicated Resident 58 needed set up assistance with eating, supervision with oral and personal hygiene, and substantial assist with toileting hygiene and showering.

During a review of Resident 58's Physician Order Report: active orders as of [DATE], the report indicated, starting [DATE], dressing on access site right chest Permacath (a catheter inserted into a blood vessel used for dialysis treatment) to be changed at dialysis center and as needed at the facility.

(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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on [DATE] at 9:33 a.m. with Registered Nurse (RN) 5, in Resident 58's room, Resident 58 was noted with a Permacath on the right side of Resident 58's chest and there was no dressing covering the site, RN 5 stated there should be a dressing to cover the site to prevent infection. c. During a review of Resident 98's Admission Record, the Admission Record indicated Resident 98 was admitted to the facility on [DATE] with diagnoses including ESRD and dependence on renal dialysis. During a review of Resident 98's MDS, dated [DATE], the MDS indicated Resident 98's cognition was intact. The MDS indicated Resident 98 needed substantial assistance with toileting hygiene, and supervision with personal hygiene. During a record review of Resident 98's Order summary report, as of [DATE], the report indicated, starting [DATE], HD on Tuesdays, Thursdays, and Saturdays at a dialysis center. During an interview and record review on [DATE] at 9:50 a.m. with the Assistant Director of Nursing (ADON), Resident 98's Dialysis forms, from [DATE] to [DATE] and Resident 98's medical records. The ADON stated although Resident 98 went to dialysis on scheduled days, the pre and post assessment section to be completed by the facility was blank indicating it was not completed for 8 dialysis days. The ADON stated it should have been filled out for continuity of care. The ADON stated it was important to monitor residents for changes and complications of dialysis therapy. d.During a record review of Resident 103's Admission Record, the Admission Record indicated Resident 103 was originally admitted to the facility on [DATE], with diagnoses including chronic kidney disease stage 3 (mild to moderate damage , impacting the ability to filter waste and fluid from the blood), dependence on renal dialysis. During a record review of Resident 103's MDS dated [DATE], the MDS indicated Resident 103's cognition was severely impaired. The MDS indicated Resident 103 needed Partial/moderate assistance. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort with eating , oral hygiene, upper body dressing and substantial/maximal assistance (Helper does MORE THAN HALF the effort). Helper lifts or holds trunk or limbs and provides more than half the effort with toilet hygiene and shower/ bathe self. During a record review of Resident 103's Order Summary Report OSR, the OSR dated [DATE], indicated an order for hemodialysis on Monday, Wednesday Friday chair time (where a resident sits in a dialysis chair for the duration of the treatment) at 1:15 p.m. During a record review of Resident 103's OSR, the OSR dated [DATE] indicated an order to monitor dialysis access site (left upper arm) AV (arteriovenous shunt -a vascular access in patients receiving dialysis) for signs and symptoms of infection, swelling, bleeding every shift. During a record review of resident 103's Care Plan Report (CPR) dated [DATE], the CPR indicated hemodialysis due to end stage disease (kidney disease). The goal will have immediate intervention should any signs or symptoms complications from dialysis occur through the review date . Interventions are dressing on access site to be changed at dialysis center and whenever necessary at the facility and monitor dialysis access site (left upper arteriovenous shunt) for signs and symptoms of infection, swelling, bleeding every shift. (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on [DATE] at 10:40 a.m., with Licensed Vocational Nurse 3, LVN 3 arrived in Resident 103's room and stated Resident 103 did not have a dialysis e-kit at his bedside and stated she did not know where to find one after searching . LVN 3 stated by not having an e-kit at the bedside it becomes difficult for us if the residents left arm shunt becomes dislodged the dressing comes off and the shunt starts to bleed the resident can bleed out and this can bad. During an interview on [DATE] at 3:12 p.m., with the Registered Nurse 1 (RN 1), RN 1 Stated it is important to have an e-kit readily assessable at the bedside in case there is bleeding from a resident's shunt which can be stopped immediately. RN 1 stated by not having an e kit at the beside the outcome can be bad the resident could become hypovolemic (low volume of blood) they may be rushed to the hospital to stop the bleeding. During an interview on [DATE] at 11:18 a.m. with the Director of Nursing (DON), the DON stated staff need to assess the dialysis residents before sending residents to dialysis and the staff need to fill up the form to send to the dialysis center for report, so the dialysis center knows what's going on with the resident. The DON stated the dialysis resident should be assessed post dialysis to make sure there are no complications or problems. The DON stated there should be a dressing on dialysis catheter to prevent infection. The DON stated dialysis residents need an emergency kit at the bedside in case of bleeding it can be fatal. During a review of the facility's policy and procedure (P&P) titled, Dialysis (Renal), Pre- and Post- Care revised ,d+[DATE], the P&P indicated the following: 1. It was the policy of the facility to assist residents in maintaining homeostasis pre and post renal dialysis. 2, The facility will participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. 3. Pre- dialysis a. Assessed the residents' blood pressure prior to being transported to the dialysis unit. b. Any staff concerns. About residents' condition that may influence the dialysis treatment should be addressed prior leaving skilled nursing resident may need to be in an emergency 4. Post dialysis Care a. The dialysis access should be assessed upon return to the facility for patency and any unusual redness or swelling b. Any problems with the resident's access should be addressed immediately. Excessive bleeding from the graft site, redness, swelling, pain or nonfunctioning graft requires medical attention. c. Report any significant change in residence behavior including violent mood swings loss of consciousness or listlessness d. Any significant changes in medical condition should be reported immediately. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Documentation related to pre- and post- dialysis care will be placed in the clinical record which will include residence assessments, interventions and any provided education. Documentation will be completed for assessments of renal dialysis exit site to include presence or absence and quality of a bruit (sound) and thrill (vibratory movement) for residents with an arteriovenous fistula (an abnormal connection between an artery and a vein). Documentation will be done for any communication between facility and the dialysis staff or medical provider period. During a review of the facility's P/P titled Dialysis (Renal), Pre- and Post Care dated ,d+[DATE], the P/P indicated the care of the resident receiving dialysis services will reflect ongoing communication, coordination and collaboration between the nursing home and dialysis staff. 45777

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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 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. 45382 Based on observation, interview, and record review, the facility failed to ensure Restorative Nursing Aide 1 (RNA 1) and Restorative Nursing Aide 2 (RNA 2) were competent in locating personal protective equipment (PPE, equipment worn to minimize exposure to hazards that can cause serious injuries and illnesses) for one of eleven sampled residents (Resident 8) who was on EBP precautions (EBP, infection control intervention using gown and gloves during high contact resident care activities designed to reduce the transmission of multi-drug resistant organisms). This deficient practice had the potential to transmit infectious microorganisms and increase the risk of infection among the residents and staff members. Findings: During a review of Resident 8's Admission Record, the Admission Record indicated the facility initially admitted Resident 8 on 6/29/2010 and readmitted Resident 8 on 11/18/210 with diagnoses including urinary tract infection (UTI, an infection in the bladder/urinary tract) and cervical radiculopathy (condition caused by compression and inflammation of nerve roots in the neck which usually leads to pain, numbness, and weakness of the arms). During a review of Resident 8's Order Summary Report, the Order Summary Report indicated a physician's order, dated 2/25/2025, for Resident 8 to be on EBP precautions due to the presence of a foley catheter (thin, flexible rube inserted into the bladder to drain urine). During a review of RNA 1's Certified Nursing Assistant (CNA) Skills Fair checklist for Donning and Doffing of PPE, dated on 3/6/2025, the CNA Skills Fair Checklist did not include a competency training for location of PPE for residents on EBP precautions. During a review of RNA 2's 2025 Certified Nursing Assistant (CNA) Skills Fair checklist for Donning and Doffing of PPE, dated on 3/6/2025, the CNA Skills Fair Checklist did not include a competency training for location of PPE for residents on EBP precautions. During an observation of a Restorative Nursing Aide program (nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) session on 3/12/2025 at 9:34 am, in Resident 8's room, Resident 8 was lying in bed. RNA 1 and RNA 2 entered Resident 8's room, put on gloves and did not put on isolation gowns. RNA 1 assisted Resident 8 with range of motion (ROM, full movement potential of a joint) exercises to the right arm and RNA 2 assisted Resident 8 with ROM exercises to the left arm. Once RNA 1 and RNA 2 completed exercises to Resident 8's both arms, RNA 1 and RNA 2 removed both gloves, washed hands, and exited the room. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/2025 at 9:43 am, RNA 1 and RNA 2 stated they did not wear isolation gowns while assisting Resident 8 with ROM exercises because they did not know Resident 8 was on EBP precautions. RNA 1 and RNA 2 stated they did not see the sign indicating Resident 8 was on EBP precautions and did not see a PPE storage container upon entrance to Resident 8's room. RNA 1 and RNA 2 stated they thought all PPE for residents on EBP precautions were stored in a container in front of the resident's room and did not know where to locate the PPE if a PPE container was not in front of a resident's room. RNA 1 and RNA 2 stated they were never instructed in where to locate PPE for residents on EBP other than in front of a resident's room in a PPE container. During a concurrent interview and record review on 3/12/2025 at 10:14 am, the IPN stated the PPE for residents on EBP precautions were located inside the resident's closet in the resident's room. The IPN stated the facility used to, but no longer put PPE in a storage container in front of a resident's room. The IPN reviewed RNA 1 and RNA 2's CNA Skills Fair checklist for Donning and Doffing of PPE, dated on 3/6/2025, and confirmed RNA 1 and RNA 2 did not have competency training for location of PPE for residents on EBP. The IPN stated she thought the RNAs were in-serviced about location of PPE for EBP residents but had no documented evidence to support the education provided and stated staff must by in-serviced, retain, and implement the information provided during in-services to be effective. The IPN stated it was important for staff to know where to locate PPE to prevent the spread of infection. During an interview on 3/14/2025 at 1:27 pm, the DON stated it was important staff were competent in infection control protocols and location of PPE to prevent the spread of infection. During a review of the facility's Policy and Procedure (P/P) titled, Nursing Staff Competency, revised 2/2023, the P/P indicated it was the policy of the facility to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychological well-being of each resident. CROSS REFERENCE TO 880

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49130 Based on observation, interview, and record review, the facility failed to clarify and administer medications in accordance with physician orders and manufacturer specifications for two of four sampled residents (Residents 90 and 68) by failing to: 1. Administer Resident 90's Vitamin B12 (a vitamin used to treat low level of vitamin B12 and help with red blood cell formation) and Vitamin B1 (a vitamin used to treat low level of vitamin B1) in accordance with physician orders. This deficient practice failed to provide medications in accordance with the physician's orders or professional standards of practice that can increase the risk to result in medical complications due to choking, constipation and nerve dysfunction for Residents 68 and 90. Findings: 1. During a review of Resident 90's Admission Record (a document containing demographic and diagnostic information), dated 3/11/2025, the admission record indicated, Resident 90 was admitted to facility on 9/5/2024 with diagnoses including, but not limited to, difficulty in walking, abnormal posture and acute respiratory failure (lack of oxygen in body tissues), unspecified with hypoxia (a term used for low levels of oxygen in body tissues) or hypercapnia (a term used to describe too much carbon dioxide in blood). During a review of Resident 90's Minimum Data Set (MDS - a resident assessment), dated 12/13/2024, the MDS indicated, Resident 90 needed supervision assistance from the facility staff in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating and oral hygiene, moderate assistance for upper body dressing, maximal assistance for personal hygiene and dependent on facility staff for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. During a concurrent observation and interview of medication administration on 3/11/2025 at 8:51 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated she prepared 11 medications to be administered for Resident 90 that included, but not limited to, the following: a. One tablet of vitamin B12 500 microgram (mcg - a unit of measurement for mass). LVN 3 did not administer vitamin B1 50 milligram (mg - a unit of measurement for mass) during medication pass observation, per physician order. During a review of Resident 90's Order Summary Report (a document containing a summary of all active physician orders), dated 3/11/2025, the order summary report indicated, but not limited to the following omitted and/or incorrectly administered physician orders: Vitamin B12 oral tablet extended release 1000 mcg (Cyanocobalamin), give 1 tablet by mouth one time a day for supplement, order date 12/19/2024, start date 12/19/2024 (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vitamin B1 oral tablet (thiamine hydrochloride [HCl]), give 50 mg by mouth one time a day for supplement, order date 12/19/2024, start date 12/19/2024 During a concurrent observation and interview on 3/11/2025 at 1:51 p.m. with LVN 3, manufacturer bottles of vitamin B12 500 mcg and vitamin B1 100 mg. LVN 3 stated she gave one tablet of vitamin B12 500 mcg, but physician order indicated to give two tablets of vitamin B12 500 mcg to make up 1000 mcg dose. LVN 3 showed vitamin B1 100 mg bottle and stated, I thought I gave vitamin B1 during med pass and realized that she would have caused a medication error by not administering vitamin B1 50 mg, per physician order. LVN 3 stated it was important to follow physician orders to prevent medication errors and to ensure Resident 90 received proper doses to treat lack of vitamin B12 and vitamin B1. During an interview on 3/12/2025 at 4:31 p.m. with the Director of Nursing (DON), DON stated facility nurses should have checked the eMAR to ensure right dose, right medication name and instructions were followed. DON stated by not providing vitamin B in accordance with physician orders, it increased risk for vitamin B deficiencies. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 09/2010, the P&P indicated, Medications are administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices do so. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions, or if there is the physician orders are checked for the correct dosage schedule. The P&P indicated, Medications are administered in accordance with written orders of the attending physician.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49130

Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5 percent (%) during medication pass for two of four sampled residents (Residents 68 and 90) by failing to:

a. Administer Resident 90's Vitamin B12 (a vitamin used to treat low level of vitamin B12 and help with red blood cell formation) and Vitamin B1 (a vitamin used to treat low level of vitamin B1) in accordance with physician orders.

b. Clarify Resident 68's MiraLAX ([generic name - polyethylene glycol], a medication used to treat constipation) order before administration and failed to administer MiraLAX in accordance with medication label and manufacturer specifications.

These deficient practices of medication administration error rate of 11.54 percent (%) exceeded the five (5) percent (%) threshold.

Findings:

a. During a review of Resident 90's Admission Record (a document containing demographic and diagnostic information), dated 3/11/2025, the admission record indicated, Resident 90 was admitted to facility on 9/5/2024 with diagnoses including, but not limited to, difficulty in walking, abnormal posture and acute respiratory failure (lack of oxygen in body tissues), unspecified with hypoxia (a term used for low level of oxygen in body tissues) or hypercapnia (a term used to describe too much carbon dioxide in blood).

During a review of Resident 90's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/13/2024, the MDS indicated, Resident 90 needed supervision assistance from the facility staff in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating and oral hygiene, moderate assistance for upper body dressing, maximal assistance for personal hygiene and dependent on facility staff for toileting hygiene, showering, lower body dressing and putting on/taking off footwear.

During a concurrent observation and interview of medication administration on 3/11/2025 at 8:51 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated she prepared the following 11 medications to be administered for Resident 90 which did not include vitamin B1:

1. One tablet of hydralazine (a medication used to treat high blood pressure) 100 milligrams (mg - a unit of measurement for mass)

2. One tablet of losartan (a medication used to treat high blood pressure) 50 mg

3. One tablet of clonidine (a medication used to treat high blood pressure) 0.3 mg

4. One tablet of amlodipine (a medication used to treat high blood pressure) 10 mg

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. One tablet of vitamin C (a vitamin used to treat low level of vitamin C) 500 mg 6. Five milliliters (mL - a unit of measurement for volume) of levetiracetam (a medication used to prevent seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) 100 mg/mL 7. One tablet of vitamin B12 500 microgram (mcg - a unit of measurement for mass) 8. Two tablets of senna-plus ([docusate sodium 50 mg plus sennosides 8.6 mg] a combination medication used to treat constipation) 9. Two tablets of magnesium oxide (a medication used to treat low level of magnesium) 400 mg 10. One capsule of vitamin E (a vitamin supplement used to treat low level of vitamin E) 450 mg 11. Two tablets of vitamin B2 50 mg LVN 3 did not administer vitamin B1 50 mg during medication pass observation, per physician order. During a review of Resident 90's Order Summary Report (a document containing a summary of all active physician orders), dated 3/11/2025, the order summary report indicated, but not limited to the following omitted and/or incorrectly administered physician orders: Vitamin B12 oral tablet extended release 1000 mcg (Cyanocobalamin), give 1 tablet by mouth one time a day for supplement, order date 12/19/2024, start date 12/19/2024 Vitamin B1 oral tablet (thiamine hydrochloride [HCl]), give 50 mg by mouth one time a day for supplement, order date 12/19/2024, start date 12/19/2024 During a concurrent observation and interview on 3/11/2025 at 1:51 p.m. with LVN 3, manufacturer bottles of vitamin B12 500 mcg and vitamin B1 100 mg were reviewed. LVN 3 stated she gave one tablet of vitamin B12 500 mcg, but physician order indicated to give two tablets of vitamin B12 500 mcg to make up 1000 mcg dose. LVN 3 showed vitamin B1 100 mg bottle and stated, I thought I gave vitamin B1 during med pass and realized that she would have caused a medication error by not administering vitamin B1 50 mg, per physician order. LVN 3 stated it was important to follow physician orders to prevent medication errors and to ensure Resident 90 received proper doses to treat lack of vitamin B12 and vitamin B1. b. During a review of Resident 68's admission record, dated 3/11/2025, the admission record indicated, Resident 68 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to, atherosclerosis (buildup of fat in and around blood vessels) of coronary artery (major blood vessel supplying blood to the heart) bypass graft(s) without angina pectoris (a medical term used to describe chest pain when heart lacks blood flow and oxygen). (continued on next page)

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F 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During a review of Resident 68's MDS, dated [DATE], the MDS indicated, Resident 68's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was intact. The MDS indicated Resident 68 was independent for ADLs such as eating, oral hygiene and personal hygiene, needed supervision assistance from the facility staff for upper body dressing, moderate assistance for lower body dressing and putting on/taking off footwear, and maximal assistance for toileting and showering.

During a concurrent observation and interview of medication administration on 3/11/2025 at 9:56 a.m. with LVN 4, LVN 4 prepared the following eight medications to be administered for Resident 68. LVN 4 showed the pharmacy label for polyethylene glycol 3350 packets that indicated, Mix one packet with eight-ounce (oz - a unit of measurement for volume) water once daily, hold for loose stool. LVN 4 used the facility's water cup to measure water volume and stated the water was measured to be 240 mL in which she mixed 17 gm polyethylene glycol powder.

1. One tablet of aspirin (a medication used to prevent stroke [a loss of blood flow to a part of the brain]) 81 mg enteric coated

2. One tablet of vitamin C 500 mg

3. One tablet of calcium 600 mg plus vitamin D 10 mcg (400 International units [IU])

4. Two tablets of vitamin D 25 mcg (1000 IU)

5. One tablet of lisinopril (a medication used to treat high blood pressure) 5 mg

6. One tablet of Eliquis (a medication used to prevent stroke and blood clots) 2.5 mg

7. One tablet of levetiracetam (a medication used to prevent seizures) 1000 mg

8. One packet (17 gm) of polyethylene glycol powder mixed with 4 oz of water in the facility's water cup

During a review of Resident 68's order summary report, dated 3/11/2025, the order summary report indicated, but not limited to, the following physician orders:

MiraLAX (generic name - polyethylene glycol) Oral Powder 17 gram (gm - a unit of measurement for mass) per scoop, give 17 grams by mouth one time a day for constipation hold for loose stool, order date 11/7/2024, start date 11/8/2024.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/11/2025 at 2:53 p.m. with LVN 4, LVN 4 measured water in the facility's water cup during medication administration. LVN 4 stated the water volume in facility's water cup was eight oz (240 mL), but the water cup did not have measurements to confirm that. LVN 4 was observed measuring water volume by using small medicine cup to verify the 240 mL volume she thought she used to dissolve polyethylene glycol powder during medication pass. LVN 4 stated the small medicine cup measured one oz (30 mL) and then after measuring water in it five times, LVN 4 confirmed that the facility's water cup could only measure up to five oz (150 mL) of water volume. LVN 4 stated she did not measure the water volume per physician's orders to dissolve polyethylene glycol powder during medication administration. LVN 4 stated it was important to follow physician's orders to prevent medication errors. LVN 4 stated Resident 68 would not get an appropriate dose and would be at risk for constipation. During a concurrent interview and record review on 3/13/2025 at 1:22 p.m. with LVN 4, the physician's order instructions for MiraLAX in electronic medication administration record (eMAR) and instructions on MiraLAX powder packets' pharmacy label were reviewed. The physician's order indicated, MiraLAX Oral Powder 17 gram (gm - a unit of measurement for mass) per scoop, give 17 grams by mouth one time a day for constipation hold for loose stool. The pharmacy label indicated, Polyethylene Glycol Powder 3350, generic for: MiraLAX, mix 1 packet with 8 oz water once daily, hold for loose stool. LVN 4 stated the pharmacy label instructed to dissolve packet's powder in 8 oz water, but the physician order did not instruct to dissolve packet in water and only indicated to take the 17-gm powder by mouth daily. LVN 4 stated the order should have been clarified and ensured that it aligned with pharmacy label to prevent choking, medication errors and hospitalization for Resident 68. During an interview on 3/12/2025 at 4:31 p.m. with the Director of Nursing (DON), DON stated facility nurses should have checked the eMAR to ensure right dose, right medication name and instructions were followed. DON stated by not providing vitamin B in accordance with physician orders, it increased risk for vitamin B deficiencies. DON stated facility nurse should have measured the water volume accurately with the use of small medicine cups to measure eight oz (240 mL) water to dissolve MiraLAX powder. DON stated if MiraLAX powder was not dissolved in appropriate volume of water, it would not help with resident's bowel management, would not treat constipation and increased the risk for aspiration if powder was not properly dissolved. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 09/2010, the P&P indicated, Medications are administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices do so. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions, or if there is the physician orders are checked for the correct dosage schedule. The P&P indicated, Medications are administered in accordance with written orders of the attending physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Southland		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review, the facility failed to administer two of three residents' (Resident 58 and 76) medication as ordered. The facility failed to administer Resident 58's Eliquis (medication used to treat and prevent blood clots) twice a day and Resident 76's Levothyroxine Sodium Oral Tablet (medication to treat hypothyroidism - condition in which the thyroid gland doesn't produce enough thyroid hormone) once a day in the morning. This deficient practice had the potential to result in decreased efficacy of medication treatment which can negatively impact the residents' health and wellbeing. Findings: During a review of Resident 58's Admission Record, the Admission Record indicated Resident 58 was admitted to the facility on [DATE] with diagnoses including encephalitis (swelling of the brain) and encephalomyelitis (swelling of brain and spinal cord, end stage renal Disease (ESRD -irreversible kidney failure) , dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed), dementia (a progressive state of decline in mental abilities), and anxiety disorder(a group of mental health conditions characterized by excessive and persistent fear, worry, and nervousness that can interfere with daily life). During a review of Resident 58's Minimum data Set (MDS), a resident assessment tool, dated 1/28/2025, the MDS indicated Resident 58's cognition was severely impaired. The MDS indicated Resident 58 needed set up assistance with eating, supervision with oral and personal hygiene, and substantial assist (helper does more than half the effort) with toileting hygiene and showering. During a record review of Resident 58's Order Details, the report indicated, start date 9/17/2024, to give Eliquis tablet 2.5 milligrams by mouth two times a day for atrial fibrillation (irregular heartbeat). During an interview and record review on 3/12/2025 at 8:49 a.m., with the Assistant Director of Nursing (ADON), Resident 58's Medication Administration Record for 2/2025 and 3/2025 were reviewed. The MAR indicated the Eliquis was not administered two times a day as ordered; there were seven missed opportunities in February and three missed opportunities in March because the resident went to dialysis. The ADON stated the administration times for Eliquis should have been clarified with the physician on the days Resident 58 went to dialysis to see if it was ok to hold the medication or administer the medication at a different time. During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (problem in the brain), colostomy status (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body), and bilateral primary osteoarthritis of the knee (a type of arthritis on both knees that occurs when the cartilage on the ends of bones wears down, causing the bones to rub against one another). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 76's Minimum Data Set (MDS), resident assessment tool, dated 10/30/2024, the MDS indicated Resident 76's cognition was severely impaired. The MDS indicated Resident 76 needed set up assistance when eating, supervision (helper provides verbal cues and assistance may be given during activity) with oral hygiene, upper body dressing, personal hygiene, and moderate assistance with toileting hygiene, showering, lower body dressing, and putting on/taking off footwear. During an interview and record review on 3/12/2025 at 10:14 a.m., with Licensed Vocational Nurse (LVN) 7, Resident 76's Medication administration record (MAR), 9/2024, was reviewed. The MAR indicated an order to administer Levothyroxine Sodium Oral Tablet 88 micrograms one tablet by mouth, in the morning. LVN 7 stated from 9/13/2024 to 9/18/2025 the levothyroxine was not administered to Resident 76, and it should have been administered. LVN 7 stated medication should be administered so Resident 76's thyroid levels will be normal. During an interview on 3/14/2025 at 11:18 a.m., with the Director of Nursing (DON) the DON stated medications should be administered as ordered to ensure efficacy of treatment. During a review of the facility's P&P titled, Medication Administration - General Guidelines, effective 9/2010, the P&P indicated, medications are administered as prescribed in accordance with manufacturers specifications and good nursing principles and practices.

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45777

Based on observation, interview, and record review, the facility failed to store and label medications in accordance with manufacturer specifications and professional principles in two of three medication carts (Station 1 Medication Cart 2 and Station 3 Medication Cart 3A) and two of two medication rooms (Station 1 Medication Room Refrigerator and Station 2 Medication Room Refrigerator) by failing to:

1. Maintain storage of Resident 18's rectal suppositories separately from Resident 18's eye drops and/or an orally administered medication, per facility's policy and procedure (P&P) titled, Storage of Medication, dated , d+[DATE], and ensure Resident 57's latanoprost ophthalmic solution (a medication in form of eye drops used to treat high pressure in the eyes) were stored and/or labeled in accordance with manufacturer's specifications, affecting two of three inspected medication carts (Station 1 Medication Cart 2 and Station 3 Medication Cart 3A).

2. Ensure medications requiring refrigeration were stored and labeled in accordance with manufacturer specifications and per facility's P&P titled, Storage of Medication, dated ,d+[DATE] at temperatures between 2 Celsius [(C) is a unit of temperature] (36 Fahrenheit [F] is a unit of temperature) and 8 C (46 F), affecting one of two facility's medication room refrigerators (Station 1 Medication Room Refrigerator).

3. Ensure Resident 266's prednisolone eye drops (a medication used to treat eye irritation and redness) found in Station 2 Medication Room Refrigerator was stored in accordance with manufacturer specifications.

These deficient practices had the potential to result in Residents 18, 57, 266 and other facility residents receiving medications that had become expired, ineffective, or toxic due to improper storage and labeling possibly leading to adverse health consequences such as abnormal blood glucose levels, eye complications and hospitalization .

Findings:

1a. During a concurrent inspection and interview on [DATE] at 2:12 p.m. with Licensed Vocational Nurse (LVN) 3 of the Station 1 Medication Cart 2, the following medications were stored in a manner contrary to the facility's P&P:

a. One vial of atropine sulfate ophthalmic solution (a medication in form of eye drops used to treat eye condition) 1 percent (%) for Resident 18 with instructions to use under the tongue, stored with acetaminophen 650 milligram ([mg] a unit of measurement for mass) rectal suppositories in the same bin of the medication cart.

LVN 3 stated the rectal suppositories should have been separated from eye drops or oral medications to prevent infection.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:26 a.m. with LVN 7, LVN 7 stated oral meds, eye drops, and suppositories should be stored separately in their own section, not together, to prevent infection and contamination. 1b. During a concurrent inspection and interview on [DATE] at 3:51 p.m. with LVN 2 of the Station 3 Medication Cart 3A, the following medication was stored in a manner contrary to the manufacturer's requirements or not labeled with an open date as required by their respective manufacturer's specifications: One unopened bottle of latanoprost ophthalmic solution 0.005% for Resident 57 with no label of open date. According to the manufacturer's product labeling, unopened bottle(s) should be stored under refrigeration at 2 C to 8 C (36 F to 46 F) and open or in-use bottle may be stored at room temperature up to 25 C (77 F) for six weeks. LVN 2 stated latanoprost eye drops should have had an open date because it was supposed to be stored in a refrigerator per manufacturer and it was stored in medication cart. LVN 2 stated without an open date on the eye drops, it would not be possible to determine its expiration date and if the medication was safe and effective to be given to the resident. 2. During a concurrent inspection and interview on [DATE] at 10:22 a.m. with Registered Nurse (RN) 1 of the Station 1 Medication Room Refrigerator, the following medications were stored at temperature of 35 F, which was in a manner contrary to its manufacturer's requirements and facility's P&P: a. One Emergency Kit (E-Kit) containing one vial of Humalog (a type of insulin used to treat high blood glucose) and one vial of Humulin (a type of insulin used to treat high blood glucose) b. One bottle of Tubersol ([generic name: tuberculin] a solution to test for infection) house supply c. Three vials of acetylcysteine (a medication used to treat acetaminophen [a medication used to treat pain and fever] overdose and to treat mucus secretions) solution 20% d. Three syringes of Dupixent (a medication used to treat skin problems and breathing difficulty) subcutaneous (under the skin) solution auto-injector 300 mg / 2 milliliters ([mL] a unit of measurement for volume) According to the manufacturer's product labeling, medications requiring refrigeration should be stored in refrigerator at 36 F to 46 F. RN 1 stated the temperature reading on the thermometer inside medication refrigerator was 35 F which was not within the manufacturer recommended temperature range. RN 1 stated the refrigerator had some buildup of ice which was also not appropriate storage conditions for refrigerator medications. RN 1 stated when medications were stored at lower than the manufacturer required temperature requirements, it increased the risk for medications to freeze and they would not be safe or effective to be administered for residents. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent inspection and interview on [DATE] at 11:26 a.m. with LVN 7 of the Station 2 Medication Room Refrigerator, the following medication was found stored in a manner contrary to the manufacturer's requirements: One bottle of prednisolone acetate ophthalmic suspension 1% for Resident 266 stored in refrigerator According to the manufacturer's product labeling, opened and unopened prednisolone acetate ophthalmic suspension 1% should be stored at up to 25 C (77 F) and protect from freezing. LVN 7 stated Resident 266's prednisolone eye drops were not supposed to be stored in refrigerator. LVN 7 stated the prednisolone eye drops would not be safe or effective and increased the risk for eye complications for Resident 266. During an interview on [DATE] at 4:02 p.m. with the Director of Nursing (DON), DON stated the latanoprost eye drops should have been stored in refrigerator if not in use and if outside of refrigerator, it should have been labeled with an open date because the medication would expire at a certain point with the recommended time frame of 28 days after it is opened. DON stated latanoprost would lose its potency and would not be safe to be given to residents. DON stated prednisolone eye drops were not supposed to be stored in refrigerator and would not be effective for the resident's diagnosis and would not be safe for the resident with a possible risk for eye irritation. During an interview on [DATE] at 4:13 p.m. with DON, DON stated the medication refrigerator should not have any buildup of ice, and the temperature range should have been between 36 F and 46 F otherwise the medications stored in refrigerator would not be safe or effective. DON stated the rectal suppositories should have been stored separately from oral medications and eye drops in the medication cart to prevent infection and contamination. During a review of the facility's P&P titled, Medication Storage - Storage of Medication, dated ,d+[DATE], the P&P indicated, Medications and biologicals are stored properly, following manufacturer's recommendations or those of the supplier to maintain their integrity and to support safe administration. The P&P indicated, internally administered medications are kept separate from externally used medications, such as lotions, creams, ointments, and suppositories. 49130

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on observation, interview and record review, the facility failed to: a. dispose of expired Italian dressing, barbeque and caramel sauce. b. properly stores and label coffee creamers and a peanut butter sandwich in the resident's food refrigerator per facility policy. These deficient practices placed the residents at risk for foodborne illness. Findings: a. During an observation on [DATE] at 8:43 a.m. of Refrigerator 2, Italian salad dressing and Barbeque sauce were labeled with a best by date of [DATE], and Caramel sauce was labeled with an open date of [DATE]. The Caramel sauce bottle indicated the sauce should be used within three weeks of opening. During an interview on [DATE] at 8:45 a.m. with the Cook, the [NAME] stated the dressing should not be stored after the best by date and should be thrown away. The [NAME] stated the kitchen staff will follow the instructions on the packaging in regard to expiration date. The [NAME] stated residents are at risk of getting sick if they were to consume food past the expiration date. During an interview on [DATE] at 9:00 a.m. with the Dietary Supervisor (DS), the DS stated expired food or food past the best by date should be thrown away and not stored in the refrigerator. The DS stated residents could get sick if they are served expired food. b. During an observation on [DATE] at 3:35 p.m. of the resident's food refrigerator #2, four bottles of coffee creamer and a peanut butter sandwich were not labeled with resident's name, date and room number. During an interview on [DATE] at 3:35 p.m. with Certified Nursing Assistant 8 (CNA 8), CNA 8 stated the refrigerator is intended for resident's food which should be labeled with the resident's room number. CNA 8 stated the peanut butter sandwich was labeled with a staff member's name and should not be stored in the refrigerator. During an interview on [DATE] at 3:45 p.m. with the Director of Nursing (DON), the DON stated the refrigerators should only be used for storing resident's food which should be labeled with their name, date, and their room number. The DON stated staff food should not be stored in the refrigerator with resident's food. The DON stated without the proper labeling, it is unsure how long the food has been in the refrigerator, and residents may get sick if they eat expired food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P/P) titled Storage of Food and Supplies: Procedure for Refrigerated Storage, dated 2023, the P/P indicated food items should be arranged so that older items will be used first, dates should be placed on packages and containers in order to facilitate this practice. The P/P indicated all refrigerated foods are to be kept the amount of time per the Refrigerated Storage Guidelines. During a review of the facility's P/P titled Foods Brought by Family or Visitor dated [DATE], the P/P indicated resident food shall be stored in the facility in the refrigerators designated for residents. The P/P indicated all food shall be labeled with the resident's name, location and date.

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Southland	11701 Studebaker Road Norwalk, CA 90650

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45382

Based on interview and record review, the facility failed to ensure medical records for one of eleven sampled residents (Resident 23) were accurately documented and readily accessible by failing to:

1. Ensure Resident 23's Joint Mobility Assessment (JMA, a brief assessment of a resident's ROM in both arms and both legs), dated 1/5/2025, was accurately completed to indicate the severity of range of motion (ROM, full movement potential of a joint) loss of Resident 23's left shoulder.

2. Ensure Resident 23's Orthopedic (specialty area in medicine referring to the management of the muscles, bones, and their connective structures) Consultation Progress Note, dated 4/3/2024, was readily accessible.

These deficient practices had the potential to delay and negatively affect the delivery of necessary care and services.

Findings:

During a review of Resident 23's Admission Record, the Admission Record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses including a displaced fracture of the greater tuberosity of the left humerus (upper arm bone fracture where broken pieces of the bone are out of alignment) and difficulty walking.

During a review of Resident 23's Physician History and Physical (H&P), dated 3/29/2024, the H&P indicated Resident 23 initially presented to an outside hospital after sustaining a left humerus fracture, underwent an open reduction internal fixation (ORIF, surgical procedure for repairing broken bones using either plates, screws, or rods) on 3/20/2024 and was transferred to the facility for continued care and rehabilitation with a plan to follow up with orthopedics on 4/3/2024. The H&P indicated Resident 23 was to be non-weight bearing (restriction in which a person is not allowed to put any weight through the operated body part) on the left arm, receive rehabilitation, obtain post-operative care, and follow up with orthopedics on 4/3/2024.

During a review of Resident 23's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/3/2024, to follow up with orthopedics regarding left humerus.

During a review of Resident 23's Progress Notes, dated 4/3/2024, the Progress Notes indicated Resident 23 left the facility for an orthopedic follow appointment and returned the same day with instruction to follow up with orthopedics in five weeks.

During a review of Resident 23's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/3/2024, for Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) and Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) to provide range of motion (ROM, movement ability of a joint) exercises to Resident 23's left shoulder and left elbow and keep Resident 23's left arm NWB.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 23's clinical record and physical chart, there were no Orthopedic Consultation Progress Notes from 4/3/2024. During a review of Resident 23's Minimum Data Set (MDS, a federally mandated assessment), dated 1/4/2025, indicated Resident 23 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 23 required set up/clean up assistance for eating and oral hygiene and partial/moderate assistance for toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 23 had functional limitations in range of motion (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm (shoulder, elbow, wrist, hand). During a review of Resident 23's Quarterly JMA, dated 1/5/2025, the JMA indicated no ROM was observed for Resident 23's left shoulder. The JMA indicated, under the Adjustments to Program section, to continue the Restorative Nursing Aide Program (nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) and indicated Resident 23 actively performed ROM to both arms and both legs. 1. During a concurrent interview and record review on 3/14/2025 at 9:10 am, the Director of Rehabilitation (DOR) stated the facility monitored for changes in a resident's joint ROM by JMAs which were done by the therapy department upon admission, quarterly, and as needed. The DOR stated the front part of the JMA included a diagram of the resident's joints of both arms and both legs and indicated the level of severity of ROM loss for each joint. The DOR stated the back side of the JMA documentation included a section where the evaluating therapist indicated any changes to the joints, adjustments or effectiveness of the current ROM program, and/or any comments observed regarding the JMA. The DOR reviewed Resident 23's JMA, dated 1/5/2025, and physician's orders, dated 4/3/2024, and confirmed the JMA indicated no ROM was observed or assessed for Resident 23's left shoulder despite being cleared for ROM by the physician on 4/3/2024. The DOR stated the illustrated portion of the document was inaccurate because she remembered assessing Resident 23's left shoulder ROM but forgot to change the documentation on the diagram and did not recall the severity of ROM loss since it was not documented. The DOR stated she wrote Resident 23 actively moved both arms and both legs on the back of the JMA but did not and should have indicated the level of severity of ROM loss to determine if there were any changes in ROM since the previous JMA. The DOR stated it was important the JMA was accurately documented to ensure the resident's current ROM was properly documented to avoid missed declines or changes in ROM. 2. During a concurrent interview and record review on 3/13/2025 at 9:49 am, the DOR stated she was not sure why Resident 23 was still NWB on the left arm since 4/3/2024. The DOR stated she checked Resident 23's physical chart and electronic record and was unable to locate the Orthopedic Consultation Progress Note from 4/3/2024. The DOR stated she was unsure why Resident 23 was still NWB on the left arm and did not know the orthopedic recommendations and plan of care because she was unable to locate the Orthopedic Consultation Progress Notes from 4/3/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/2025 at 4:45 pm, the Medical Records Director (MDR) and Medical Records Assistant (MDA) stated they checked Resident 23's physical chart and the electronic clinical record and was unable to locate the Orthopedic Consultation Progress Notes, dated 4/3/2024. The MDR stated all consultation notes should be placed and located in the resident's physical chart under the Progress Note tab. The MDR stated it was important the medical records were readily accessible to ensure all team members were aware of the resident's plan of care. The MDR stated if medical records were not readily accessible, it could lead to missed or delayed care. During an interview on 3/14/2025 at 1:27 pm, the Director of Nursing (DON) stated inaccurate resident assessments and inaccessible medical records could negatively impact a resident's care and result in potential functional declines. During a review of the facility's Policy and Procedure (P/P) titled Resident Assessment and Associated Processes, revised 12/2023, the P/P indicated residents would be assessed and the findings documented in the clinical health record. The P/P indicated these would be comprehensive, accurate, standardized reproducible assessment of each resident and would be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs would be identified. The P/P indicated assessment information would be used to develop, review, and revise the resident's comprehensive care plan and each individual who completed portions of the assessment would electronically sign and certify the accuracy of that portion of the assessment. During a review of the facility's P/P titled Filing of Miscellaneous Papers and Forms, revised 11/2024, the P/P indicated all documents and formed would be timely and currently filed in the resident's health records.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Southland		STREET ADDRESS, CITY, STATE, ZIP CODE 11701 Studebaker Road Norwalk, CA 90650	

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 44055 Based on interview and record review the facility's Quality Assessment and Assurance (QAA) Committee, thereby affecting 114 of 114 residents, failed to identify and implement corrective action to systemic problems identified: a. Ensure infection control program was implemented to mitigate the Coronavirus disease (Covid-19 - contagious disease) outbreak. b. Ensure dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) residents were assessed before departing for dialysis and after residents returned from outpatient dialysis. c. Ensure all allegations of abuse were prevented, reported, and investigated. The deficient practices placed the residents at risk for not receiving the quality treatment necessary to adequately meet their highest practicable well-being. Findings: During an interview on 3/14/2025 at 1:14 p.m., with the Administrator (ADM), the ADM stated the following systemic issues identified were not identified by the QAA committee: a. Ensure infection control program was implemented to mitigate the Covid-19 outbreak. b. Ensure dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) residents are assessed before departing for dialysis and after residents return from outpatient dialysis. c. Ensure any allegations of abuse were prevented, reported, and investigated. During a record review of the facility's policy and procedure (P&P) titled, 2025 Quality assurance performance Improvement (QAPI) Plan, undated, the QAPI plan indicated the facility was committed to providing quality care and services through a collaborative facility wide effort; the facility will proactively identify issues or concerns, openly discuss them, and put together a plan to fix them. The design and scope of the QAPI plan is ongoing and comprehensive its purpose is to correct identified deficiencies in quality of services and put mechanisms in place so that our performance can consistently be improved Cross Reference F600, F609, F610, F698, F880

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 45777 50387 Based on observation, interview, and record review, the facility failed to observe infection control measures on 3 of 5 sampled residents Resident 7, 8, 268 and 7 by failing to: a. Ensure Certified Nursing Assistant 5 (CNA 5) wore an isolation gown (protective apparel used to protect the wearer from the transfer of microorganisms and body fluids) while addressing Resident 8's pain concerns which required direct contact with Resident 8 who was on Enhanced Barrier Precautions (EBP, infection control intervention using gown and gloves during high contact resident care activities designed to reduce the transmission of multi-drug resistant organisms). b. Ensure Restorative Nursing Aide 1 (RNA 1) and Restorative Nursing Aide 2 (RNA 2) wore isolation gowns while providing RNA exercises to Resident 8 who was on EBP precautions. c. ensure Resident 268's, peripheral venous catheter (a thin flexible tube inserted into a vein to provide access for giving medications) hub (the external part of the catheter that allows for infusing medications and fluids) was covered with a pressure cap (a sterile cap placed on the end of an intravenous tubing to minimize the risk of infection entering the blood stream). d. Donning and doffing properly when Certified Nurse Assistant (CNA) 2, CNA 3, CNA 4, Housekeeping staff (HK) 1, HK 3 entered and exited Resident 26's room, a COVID precaution Room (a special room to isolate patients with COVID-19 minimizing the risk of spreading the virus).Wearing proper personal protective equipment (PPE- such as gloves, masks, or safety glasses) while LVN 1 changing the tube feeding (a method of delivering nutrients directly to the digestive system through a tube) for Resident 7 who had Enhanced Standard Precautions (known as Enhanced Barrier Precautions, EBP, are extra infection control measures, like wearing gowns and gloves, used in addition to standard precautions, to reduce the spread of multidrug -resistant organisms). e. Put EBP signage in the entrance door of Resident 7's room. f. Isolate Resident 26 when scabies was identified. These failures had the potential to transmit infectious microorganisms and increase the risk of infection among the residents and staff members. Findings: a. During a review of Resident 8's Admission Record, the Admission Record indicated the facility initially admitted Resident 8 on 6/29/2010 and readmitted Resident 8 on 11/18/210 with diagnoses including urinary tract infection (UTI, an infection in the bladder/urinary tract) and cervical radiculopathy (condition caused by compression and inflammation of nerve roots in the neck which usually leads to pain, numbness, and weakness of the arms). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 8's Order Summary Report, the Order Summary Report indicated a physician's order, dated 2/25/2025, for Resident 8 to be on EBP precautions due to the presence of a foley catheter (thin, flexible rube inserted into the bladder to drain urine). During an observation on 3/11/2025 at 10:14 am, in Resident 8's room, Resident 8 was lying in bed. Resident 8 stated she had pain in the abdominal and buttock area and asked CNA 5 for assistance. CNA 5 put on gloves and did not put on an isolation gown. CNA 5 walked to Resident 8's bed, removed the blankets, touched Resident 8's abdomen and legs, replaced the blankets over Resident 8's body, moved the foley catheter, repositioned Resident 8's call light, removed both gloves, performed hand hygiene, and exited the room. During an interview on 3/11/2025 at 10:24 am, CNA 5 stated she did not wear an isolation gown while providing direct care to Resident 8. CNA 5 stated she should have worn an isolation gown while assisting Resident 8 with care because she had direct contact with Resident 8 who was on EBP precautions. CNA 5 stated it was important to follow infection control protocols to prevent the spread of infection. During an interview on 3/12/2025 at 10:14 am, the Infection Preventionist Nurse (IPN) stated the purpose of EBP was to reduce the transmission of Multi-Drug Resistant Organisms (MRDO, bacteria resistant to many antibiotics). The IPN stated all staff providing direct patient care for residents on EBP precautions must wear the appropriate personal protective equipment (PPE, equipment worn to minimize exposure to hazards that can cause serious injuries and illnesses) which included an isolation gown and gloves to prevent the spread of infection and reduce the transmission of MRDO. During an interview on 3/14/2025 at 1:27 pm, the Director of Nursing (DON) stated it was important all staff followed the proper infection control protocols to prevent the spread of infection. b. During a review of Resident 8's Admission Record, the Admission Record indicated the facility initially admitted Resident 8 on 6/29/2010 and readmitted Resident 8 on 11/18/210 with diagnoses including UTI and cervical radiculopathy. During a review of Resident 8's Order Summary Report, the Order Summary Report indicated a physician's order, dated 2/25/2025, for Resident 8 to be on EBP precautions due to the presence of a foley catheter. During an observation of a Restorative Nursing Aide program (nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) session on 3/12/2025 at 9:34 am, in Resident 8's room, Resident 8 was lying in bed. RNA 1 and RNA 2 entered Resident 8's room, put on gloves and did not put on isolation gowns. RNA 1 assisted Resident 8 with range of motion (ROM, full movement potential of a joint) exercises to the right arm and RNA 2 assisted Resident 8 with ROM exercises to the left arm. Once RNA 1 and RNA 2 completed exercises to Resident 8's both arms, RNA 1 and RNA 2 removed both gloves, washed hands, and exited the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/12/2025 at 9:43 pm, RNA 1 and RNA 2 stated they did not wear isolation gowns while assisting Resident 8 with ROM exercises because they did not know Resident 8 was on EBP precautions. RNA 1 and RNA 2 stated they did not see the sign indicating Resident 8 was on EBP precautions and did not see a PPE storage container upon entrance to Resident 8's room. RNA 1 and RNA 2 stated they should have worn isolation gowns while assisting Resident 8 with ROM exercises to both arms because they had direct contact with Resident 8 who was on EBP precautions. RNA 1 and RNA 2 stated it was important to follow infection control protocols to prevent the spread of infection. During an interview on 3/12/2025 at 10:14 am, the IPN stated the purpose of EBP was to reduce the transmission of MDRO. The IPN stated all staff providing direct patient care for residents on EBP precautions must wear the appropriate PPE which included an isolation gown and gloves to prevent the spread of infection and reduce the transmission of MRDO. During an interview on 3/14/2025 at 1:27 pm, the DON stated it was important all staff followed the proper infection control protocols to prevent the spread of infection. c. During a review of Resident 268's Admission Record (AR), the Admission Record indicated Resident 268 was admitted to the facility on [DATE] with diagnoses including hyperlipidemia (elevated level of fat in the blood), anxiety disorder (feeling of worry anxiety and fear) and difficulty in walking not elsewhere classified. During a review of Resident 268's Minimum data Set (MDS- a resident assessment tool) dated 1/28/2025, the MDS indicated Resident 268's cognition (thought process) was intact. The MDS indicated Resident 268 needs partial/moderate assistance (helper lifts holds or supports trunk or limbs but provides less than half the effort) with sit to lying, roll left to right and lying to sitting on side of bed and substantial /maximum assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with toileting. During a review of Resident 268's Order Summary Report(OSR), the OSR indicated active orders as of 3/4/2025, for a peripheral venous catheter . During an observation and interview on 3/11/2025 at 11:46 a.m., with the Licensed Vocational Nurse 8 (LVN 8) in Resident 268' room , Resident 268 was noted with a peripheral venous catheter on her right hand with no pressure cap covering the hub, LVN 8 stated there should have been a pressure cap to cover the hub of the catheter for infection control preventing pathogens from entering the hub. During an interview on 3/12/2025 at 8:12 a.m., with the Registered Nurse 1 (RN 1) , RN 1 stated peripheral venous catheter needs to have a pressure cap at the end of the hub to prevent infection from going into the hub. During an interview on 3/14/2025 at 11:20 a.m., with Director of Nursing (DON), the DON stated the peripheral venous catheter needs a pressure cap to prevent infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	d. During a review of Resident 26's Admission Record, the Admission Record indicated the facility admitted Resident 26 on 5/13/2022, and readmitted on [DATE] with diagnoses including acute pulmonary edema (a condition where fluid accumulate in the lungs, leading to difficulty breathing) and COVID-19 (a respirator illness caused by a virus, SARS-CoV-2, that spreads through droplets when infected people cough, sneeze, or talk, and can cause symptoms like fever, cough, and trouble breathing) added on 11/26/2024. During a review of Resident 26's MDS dated [DATE], indicated Resident 26 had moderately impaired cognitive (functions your brain uses to think, pay attention, process information, and remember things). The MDS indicated Resident 26 required setup or clean-up assistance (helper assists only prior to or following the activity) with eating, oral hygiene, hygiene, moderate assistance (helper does less than half the effort to complete the task) with toileting hygiene, and showering. During a review of Resident 26's Order Summary Report, orders as of 3/11/2025, the Order Summary Report indicated the resident had diagnosis of COVID-19 again on 3/10/2025 and an order to place the transmission-based precaution (TBP- extra safety measures, used in addition to standard precautions, to prevent the spread of infections that can be transmitted): respiratory (measures taken to prevent the spread of diseases transmitted through the air by using PPE and special ventilation required prior to enter the room, such as a disposable gown, eye protection such as goggles or face shield, fit-tested respirator and gloves), droplet precautions (measures to prevent the spread of germs through tiny droplets released when someone coughs, sneezes, or talks) and contact precautions (measures takes to prevent the spread of germs though direct and indirect contact with a person or their environment) on 3/11/2025. During a concurrent observation and interview on 3/11/2025 at 7:53 a.m. with Housekeeping Staff (HK) 1, at the door of Resident 26's room, observed HK 1 entering the COVID precaution room wearing a mask and gloves but not wearing a gown and eye protection. HK 1 stated that wearing mask without other PPE is acceptable practice while bring supplies in without touching anything inside the COVID precaution room. During a concurrent observation and interview on 3/11/2025 at 8:25 a.m. at the door of Resident 26's room, observed a Certified Nurse Assistant (CNA) 2 entering the room with mask and gloves holding the breakfast tray but not wearing a gown and eye protection. CNA 2 stated that she supposed to wear proper PPE prior to enter the COVID precaution room. During a concurrent observation and interview on 3/12/2025 at 8:04 a.m. by Resident 26's room, observed HK 3 entering the room wearing a mask and gloves, HK 3 was observe touching the curtains inside the room before exiting . HK 3 stated that wearing a mask and gloves without wearing a gown or eye protection was an acceptable practice when entering the Covid precaution room. HK 3 stated that she forgot to sanitize hands prior to entering and leaving the room. During a concurrent observation and interview on 3/12/2025 at 2:12 p.m. inside the Resident 26's room, CNA 3 and CNA 4 observed entering the room without wearing an eye protection. CNA 3 observed leaving the room and walked away from the room without sanitizing hands. CNA 3 stated that she did not sanitize her hand upon leaving the room. CNA 4 observed not changing mask upon leaving the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/13/2025 at 12:43 a.m. with the Director of Nursing (DON), the DON stated that facility place contact, droplet and respiratory precautions upon identifying a COVID-19 resident to prevent the spread of infections. The DON stated that the proper donning (the act of putting on a garment or piece of equipment) PPE included wearing face shield or goggles, gown, gloves, and proper doffing (taking off or removing something, especially clothing or protective gear, like a hat or gloves) PPE included changing the mask upon leaving the room. The DON also stated hand sanitizing required prior to entering and upon leaving the precaution room. e. During a review of Resident 7's Admission Record, the Admission Record indicated the facility admitted Resident 7 on 8/2/2024 , and readmitted on [DATE] with diagnoses including dysphagia (swallowing difficulties), gastrostomy status (having a surgical opening made into the stomach, often to allow for feeding or medication delivery though a tube, known as a gastrostomy tube or G-tube) and chronic viral hepatitis C (a long-term liver infection). During a review of Resident 7's MDS, dated [DATE], indicated Resident 7 had severe impairment cognitive (functions your brain uses to think, pay attention, process information, and remember things). The MDS indicated Resident 7 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, showering, dressings, and required maximal assistance (helper does more than half the effort to complete task) with personal hygiene. During a review of Resident 7's Order Summary Report, orders as of 3/11/2025, the Order Summary Report indicated Enhanced Standard Precautions (know at Enhanced Barrier Precautions), for gastrostomy-tube (G-tube, a feeding tube inserted directly into the stomach) on 2/27/2025. During an observation on 3/10/2025 at 2:26 p.m., in Resident 7's room, observed Licensed Vocational Nurse (LVN) 1 hung new Nepro (therapeutic nutrition) tube feeding at the pole and connecting it to Resident 7's G-tube. LVN 1 was wearing gloves, mask, but not wearing a gown on. During an interview on 3/10/2025 at 2:41 a.m. with LVN 1, LVN 1 stated that she touched Resident 7 and changed the tube feeding without wearing a gown, although she supposed to wear one to prevent the spread of infections. During a concurrent observation and interview on 3/10/2025 at 2:41 p.m. with Licensed Vocational Nurse (LVN) 1, at the door of Resident 7's room, no EBP sign on the door observed. LVN 1 stated that Resident 7 had a G-tube, the EBP sign should be posted but missing. f. During a review of Resident 26's Admission Record, the Admission Record indicated the facility admitted Resident 26 on 5/13/2022 and readmitted on [DATE] with diagnosis including acute pulmonary edema and COVID-19. During a review of Resident 26's MDS dated [DATE], indicated Resident 26 had moderately impaired. The MDS indicated Resident 26 required setup or clean-up with eating, oral hygiene, hygiene, moderate assistance with toileting hygiene, and showering. During a review of Resident 26's Dermatopathology report, dated 2/3/2025, the report indicated that Resident 26' had scabies. The report also indicated the dermatologist will send topical permethrin (a medication used to treat treating scabies and lice). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 26's Order Summary Report, orders as of 3/11/2025, the Order Summary Report indicated there was an order to place contact isolation related to scabies on 2/21/2025. During an interview on 3/12/2025 at 11:50 a.m. with Registered Nurse (RN) 4 at Resident 26's dermatology office, RN 4 stated that Resident 26 had itchiness over her body, so the dermatologist took the sample from the resident on 1/27/2025, got scabies report on 2/3/2025. RN 4 stated that the dermatologist sent a prescription regarding the scabies to the pharmacy on the same day, 2/3/2025. RN 4 also stated that she talked with Licensed Vocational Nurse (LVN) 7 regarding the positive result of scabies on 12/14/2025 to remind the facility. During a review of the facility's pharmacy's prescription history, dated 1/31/2025 through 3/12/2025, the history indicated that the pharmacy dispensed permethrin (on 2/3/2025, 2/20/2025 and 2/26/2025. During a concurrent interview and record review on 3/13/2025 at 9:15 a.m. with LVN 7, Resident 26's progress notes, for the month of January, February, and March were reviewed. The LVN 7 stated that Dermatologist progress note indicated that Resident 26 had rashes on the legs on 1/27/2025, RN 4 informed LVN 7 regarding scabies result on 2/14/2025, and LVN 7 informed the result to the Infection Prevention Nurse (IPN). The LVN 7 stated that scabies are contagious through contact, the facility should had placed the resident on contact isolation on 2/3/2025 when the physician diagnosed the resident with scabies and ordered permethrin to prevent the spread of the disease, not only for the resident but also for the staff, visitors, and anyone who made contact with her or her linens. However, the facility placed the contact insolation on 2/17/2025. During an interview on 3/13/2025 at 12:43 a.m. with the Director of Nursing (DON), the DON stated if scabies identified, it required to put contact isolation on the resident to prevent the spread of infection. g. During a concurrent observation and interview on 3/12/2025 at 3:07 p.m. with the Housekeeping Supervisor (HKS), in clean linen area in the laundry room, multiple non-laundry items found on the shelves. During an interview on 3/14/2025 at 11:18 a.m. with the Director of Nursing (DON), the DON stated that those items should not be there, the laundry area should be clean. During a review of the facility's Policy and Procedure (P/P) titled, IPCP Standard and Transmission-Based Precautions, revised 3/2024, the P/P indicated it was the policy of the facility to implement infection control measures to prevent the spread of communicable diseases and conditions. The P/P indicated the use of gown and gloves for high contact resident care activities for residents on EBP precautions was indicated for residents with wounds and/or indwelling medical devices regardless of known MDRO infection or colonization and MDRO infection or colonization. During a review of the facility's Policy and Procedure (P/P) titled, Dressing change and Care of Central Venous Catheter, undated indicates to reduce the risk of infection to the insertion or exit site and surrounding area of central venous catheters, including [NAME] , Broviac, [NAME] and percutaneous CVA. Quickly remove the old cap and attach the new cap to the catheter hub. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, IPCP standard and transmission-based Precautions (TBP), revised 3/2024, the P&P indicated, the policy was to implement infection control measures to prevent the spread of communicable diseases and conditions. The P&P indicated 1. Standard precautions apply to the care of all residents including hand hygiene, 2. Contact precautions required for patient who has ongoing transmission, staff must wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment, 3. EBP include the use of gown and gloves during high-contact resident care activities, such as device care or use: feeding tube, 4. Droplet Precautions include using PPE appropriately including donning mask (and eye protection if indicated) upon entry into the patient room, 6. Implementation include posting clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to implement the antibiotic stewardship program policy for two of three sampled residents (Resident 53 and 106) by not completing the Mc Geer's Criteria (criteria used to determine appropriate use of antibiotics). This deficient practice had the potential to increase antibiotic resistance and provide antibiotics without justification. Findings: During a review of Resident 53's Admission Record, the Admission record indicated Resident 53 was admitted on [DATE] with the diagnosis of cellulitis (a skin infection that causes swelling and redness) of left lower limb. During a review of Resident 53's Minimum Data Set (MDS - a resident assessment tool) dated 2/17/2025, the MDS indicated Resident 53's cognition was intact, and Resident 53 required partial/moderate assistance (helper does less than half the effort) to complete activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 53's physician order dated 2/10/2025, the physician order indicated Resident 53 was to receive Ceftriaxone (medication used to treat infection) 2 grams (unit of measurement) intravenously (given directly into the blood stream) once a day for bacteremia (the presence of bacteria in the blood) until 3/18/2025. During a review of Resident 53's Infection Surveillance form dated 2/12/2025, the Infection Surveillance form indicated no documentation regarding if the antibiotic order met Mc Geer's Criteria, there were blank spaces in the boxes next to does not meet criteria and meets criteria for infection. During a review of Resident 106's Admission record, the Admission Record indicated Resident 106 was admitted on [DATE] with the diagnosis including sepsis (a life-threatening blood infection) and bacteremia. During a review of Resident 106's MDS dated [DATE], the MDS indicated Resident 106's cognition was intact, and Resident 106 required substantial/maximal assistance (helper does more than half the effort) to complete ADLs. During a review of Resident 106's physician order dated 2/4/2025, the physician order indicated Ceftriaxone 2 gm intravenously every 12 hours for GBS Bacteremia (a serious infection where the bacteria Streptococcus agalactiae (also known as GBS) enters the bloodstream, potentially leading to sepsis, meningitis, or other severe complications) until 3/14/2025. During a review of Resident 106's Infection Surveillance form dated 2/05/2025, the Infection Surveillance form indicated no documentation regarding if the antibiotic order met Mc Geer's Criteria, there were blank spaces in the boxes next to does not meet criteria and meets criteria for infection. (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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/2025 at 4:09 p.m. with the Infection Prevention Nurse (IPN), the IPN stated when there is an order for antibiotics, she will verify if it meets Mc Geer's criteria, and if it does not meet, she will inform the physician. The IPN stated since Residents 53 and 106 had the orders from the hospital, she did not verify if the ordered antibiotics met Mc Geer's criteria. During an interview on 3/14/2025 at 3:50 p.m. with the Director of Nursing (DON), the DON stated Mc Geer's criteria should be considered when verifying the order for antibiotics. The DON stated the purpose of antibiotic stewardship is to decrease the overuse of antibiotics and ensure the antibiotics are prescribed appropriately. During a review of the facility's policy and procedure (P/P) titled Antibiotic Stewardship dated 9/2017, the P/P indicated the Antibiotic Stewardship Team will optimize the use of diagnostic testing and implement an antibiotic review process, also known as an antibiotic time out for all antibiotics prescribed in the facility.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on observation, interview, and record review the facility failed to document education provided regarding the benefits and risks of immunization and administration of the influenza (Flu-a contagious respiratory illness) and pneumonia (PNA -an infection of the lungs) vaccinations (medication to prevent a particular disease) for three of 21 sampled residents (Resident 11, 75 and 93) . This deficient practice had a potential for residents to who are unvaccinated with influenza, pneumonia and no record of being vaccinated. Findings: a. During a record review of Resident 11's Admission Record (Face Sheet), the Admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses including adult failure to thrive (a syndrome of weight loss , decreased appetite and poor nutrition and decreased activity), and personal history of covid 19 . During review of Resident 11's history and physical (H&P), the H&P dated 2/27/2025, indicated Resident 11 has dementia (general term for loss of memory) and aphasic (inability to communicate). During a review of Resident 11's Minimum Data Set ([MDS- a resident assessment) dated 1/15/2025, the MDS indicates Resident 11 is dependent (resident does none of the effort to complete the activity or the assistance of two or more helpers required for the resident to complete the activity) on sit to lying, oral hygiene, upper and lower body dressing. During a record review of Resident 11's medical records (MR), the MR indicated a pneumococcal Vaccine Consent dated October 2/24/2025, was signed by Resident 11's daughter to receive the pneumococcal vaccine. b. During a record review of Resident 75's Admission Record (Face Sheet), the Admission Record indicates Resident 75 was admitted to the facility on [DATE] with a diagnosis including malignant neoplasm (a cancerous tumor), hypertensive heart disease without heart failure (heart issues that develop because of long term high blood pressure) and anemia (low blood volume). During a review of Resident 75's MDS dated [DATE], the MDS indicates Resident 75 has severe cognitive impairment . The MDS indicated Resident 74 required partial/ moderate assistance (helper lifts, holds or supports trunk or limbs and provide less than half the effort) with lower body dressing, toileting hygiene , shower/ bath self. During a record review of Resident 75's medical records the Influenza and Pneumonia Vaccine consent was not found. c. During a record review of Resident 93's Admission Record (Face Sheet), the Admission Record indicates Resident 93 was admitted to the facility on [DATE] with diagnoses including Cerebral infarction unspecified (a condition where blood flow to the brain is interrupted, causing brain cells to die) , muscle weakness and prediabetes (higher than normal blood sugar levels). (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 93's MDS dated [DATE], the MDS indicated Resident 93 has moderate cognitive impairment. The MDS indicated Resident 93 required partial/moderate assistance with toileting hygiene, upper and lower body dressing, and personal hygiene. During a record review of Resident 93's Care Plan (CP) dated 10/5/2025,it indicated that to ensure all immunizations are up to date , follow facility policy and procedures for line listing (used during a disease outbreak to record suspected cases individually) and to summarizing and report infections. During a record review and interview on 3/12/2025 at 11:00 a.m., with the Infection Preventionist Nurse (IP), IP Nurse stated there was a consent signed by Resident 11's daughter giving permission to give the pneumonia vaccine, IP Nurse stated the vaccine was never given. The IP Nurse stated Resident 75's and 93 was not offered the influenza and the pneumonia vaccine and not provided the consent for Influenza and Pneumococcal form to sign. IP Nurse stated when a Resident is admitted to the facility the resident and or family is offered and educated on the risks and benefits of the pneumonia and influenza vaccination . IP Nurse stated Pneumonia Influenza and Covid-19 the form is signed, and the resident is vaccinated immediately. The IP nurse stated the resident is then added to a spread sheet so we can keep track of the resident's immunizations. IP Nurse stated she was not able to provide documented evidence of the vaccinations the residents received or of residents' refusal. IP Nurse stated if there is no way to track vaccinations there is no system in place this is important because residents will miss their vaccinations. During an interview on 3/14/2025 at 11:20 a.m., with the Director of nursing (DON), the DON stated influenza, and pneumonia should be provided and offered all residents. DON stated you must be able to track the ones who want the vaccines and the ones who refused . DON stated staff must document the residents who refused the vaccine. We must keep track to prevent spread of infection. During a review of the facility's policies and procedures (P&P) titled, Immunizations- Residents , revision review dates 6/2021; 1/2022 ; 10/2022 ; 7/2023. The P&P indicated it is the policy of this facility to offer and administer influenza, pneumococcal and Covid -19 immunization to eligible residents after providing education on the risks and potential side effects of the vaccine (S) and obtaining consent . Eligibility to receive the vaccine may include , but is not limited to current vaccine status , season/time of year , medical contra indications , or residents' preference/ choice. Residents will be screened at the time of admission to determine vaccine status and eligibility, using current CDC/ACIP guidelines , to receive the influenza, pneumonia and/ or Covid-19 vaccine(s).Residents will be screened annually during flu season (based on local health department /CDC timeframes) for eligibility to receive annual influenza vaccination.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on observation, interview, and record review the facility failed to document education provided regarding the benefits and risks of immunization and administration of Covid-19 (an infectious respiratory illness) for two of three sampled residents (11 and 74) This deficient practice had a potential for residents to become unvaccinated with Covid and no record of being vaccinated. Findings: During a record review of Resident 11's Admission Record (Face Sheet), the Admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses including adult failure to thrive (a syndrome of weight loss , decreased appetite and poor nutrition and decreased activity), muscle weakness and personal history of covid 19 . During review of Resident 11's history and physical (H&P), the H&P dated 2/27/2025, indicated Resident 11 has dementia (general term for loss of memory) and aphasic (inability to communicate). During a review of Resident 11's Minimum Data Set ([MDS- a resident assessment tool) dated 1/15/2025, the MDS indicates Resident 11 is dependent (resident does none of the effort to complete the activity or the assistance of two or more helpers required for the resident to complete the activity) on sit to lying, oral hygiene, upper and lower body dressing. b. During a record review of Resident 74's Admission Record (Face Sheet), the Admission Record indicates Resident 74 was originally admitted to the facility on [DATE] with diagnoses including Anemia (low blood volume), Hyperlipidemia (Fat in the blood) and hypertensive heart disease (damage or disease in the hearts major blood vessel) without heart failure. During a review of Resident 74's MDS dated [DATE] , the MDS indicated Resident 74 has moderate cognitive impairment requires substantial/ maximal assistance (helper lifts or hold trunk or limbs and provides more than half the effort with toilet hygiene, shower/bath self and lower body dressing . During an interview and record review on 3/13/2025 at 10:45 a.m. with the Infection preventionist Nurse (IP), the IP Nurse stated she did not give Resident 74 his Covid vaccine because the daughter wanted it later. IP nurse stated she had no documentation of daughter wanting the vaccine given later IP Nurse stated it is my fault I should have charted the reason not given. IP nurse stated she did not order the Covid vaccine for the resident. IP Nurse stated it is important to give the Covid vaccine in a timely manner to prevent the spread of infection. During an interview on 3/13/2025 at 12:47 p.m. with the RN 1, RN 1 stated residents are offered the Covid vaccine every year and if a resident wants the vaccine, it should be given. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/14/2025 at 11:20 a.m. with the Director of Nursing (DON), DON stated if resident of family requests the Covid vaccine it should be ordered and given right away to prevent the spread of infection. During a review of the facility's policies and procedures (P&P) titled, Immunizations- Residents , revision review dates 6/2021; 1/2022 ; 10/2022 ; 7/2023. The P&P indicated it is the policy of this facility to offer and administer influenza, pneumococcal and Covid -19 immunization to eligible residents after providing education on the risks and potential side effects of the vaccine (S) and obtaining consent . Eligibility to receive the vaccine may include, but is not limited to current vaccine status, season/time of year, medical contraindications , or residents' preference/ choice. Receipt of vaccination is essential to the health and well-being of long-term care residents. Establishing an immunization program against influenza , pneumococcal disease, and Covid-19 facilitates achievement of this objective. Influenza or Covid-19 outbreaks place both residents and staff at risk of infection. Residents will be screened at the time of admission to determine vaccine status and eligibility, using current CDC/ACIP guidelines, to receive the influenza, pneumonia and/ or Covid-19 vaccine(s).

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to ensure one of two sampled residents (Resident 76) was not in Resident 76's room while workers (unnamed) were sanding and painting a patch on the wall. This deficient practice had the potential to result in an unsafe environment which can negatively affect Resident 76. Findings: During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (problem in the brain), colostomy status (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body), and bilateral primary osteoarthritis of the knee (a type of arthritis on both knees that occurs when the cartilage on the ends of bones wears down, causing the bones to rub against one another). During a review of Resident 76's Minimum Data Set (MDS), resident assessment tool, dated 10/30/2024, the MDS indicated Resident 76's cognition was severely impaired. The MDS indicated Resident 76 needed set up assistance when eating, supervision (helper provides verbal cues and assistance may be given during activity) with oral hygiene, upper body dressing, personal hygiene, and moderate assistance with toileting hygiene, showering, lower body dressing, and putting on/taking off footwear. During a review of an email correspondence between Family Member (FM) 2, the Administrator (ADMIN), and the Director of Nursing (DON), dated 1/22/2025, the email indicated there was painting in Resident 76's room while Resident 76 was in the room. During an interview on 3/12/2025 at 3:48 p.m., with Certified Nurse Assistant (CNA) 6, CNA 6 stated the workers were painting while the Resident 76 was in the room. During an interview on 3/14/2025 at 11:18 a.m., with the Director of Nursing (DON), the DON stated workers should not paint while the residents are in the room for residents' safety and so the residents won't have a problem breathing or be uncomfortable. The DON stated the facility did not have a policy addressing providing residents with a safe homelike environment.

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Southland	11701 Studebaker Road Norwalk, CA 90650

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 50387 Based on observation, interview and record review the facility failed to maintain a pest-free environment when a cockroach appeared in one of one sample resident's room (Resident 48's) . This failure had the potential to compromise the provision of a clean and homelike environment to residents. Findings: During a concurrent observation and interview on 3/10/2025 at 2:15 p.m. with Housekeeping Staff (HS) 2, in Resident 48's room, observed a bug crawling in the room. HS 2 entered and found the bug in the resident's rest room. HS 2 stated that she had observed it before; sometimes it comes from window, and sometimes from the sink. During an interview on 3/12/2025 at 7:45 a.m. with the Administrator (Admin), the Admin stated that the bug was a type of cockroach and it should not be there. During an interview on 3/14/2025 at 11:18 a.m. with the Director of Nursing (DON), the DON stated that no pest should be inside the room, it was not clean or safe environment, residents' room should be kept clean and homelike. During a review of the facility's policy and procedure (P&P) titled, Pest Control, reviewed 7/2023, the P&P indicated, the facility to provide a clean environment and take all reasonable efforts to control pests.