STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555731	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dept of State Hospitals - Metropolitan Snf	11401 South Bloomfield Avenue 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 0600 Level of Harm - Actual harm Residents Affected - Few	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** 47844 Based on observation, interviews and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident for 1 of 3 sampled residents (Resident 1) when Resident 2 assaulted Resident 1. This failure resulted in physical harm to Resident 1 when he sustained multiple facial lacerations, contusions, and a nasal bone fracture. Findings: During a review of Resident 1 (R1)'s Face sheet, (undated), the record indicated that R1 was admitted to the facility on [DATE], with a history of diagnoses that included: unspecified neurocognitive disorder (decreased mental function due to a medical disease other than psychiatric illness), unspecified displaced fracture of second cervical vertebra (break in the second bone of the neck) .with routine healing, aneurysm (a ballooning and weakened area in an artery) of vertebral artery, and tracheostomy (A hole made by surgeons into the throat to help with breathing) status. During a review of R1's Minimum Data Set (MDS - A standardized assessment tool that measures health status), dated [DATE], the MDS indicated that R1 was non-verbal, was rarely able to express ideas and wants, and rarely understood others. The record indicated staff assessed that R1 had short-term memory problems, long-term memory problems and severe cognitive impairment. Record further indicated that R1 had no identifiable behavioral issues. During a review of Treatment Plan, dated [DATE], showed R1 was non-verbal, medically compromised and bed ridden. During a review of Resident 2 (R2)'s Face sheet (undated), the record indicated that R2 was admitted to the facility on [DATE] with a history of diagnoses that included: major neurocognitive disorder due to probable frontotemporal degeneration (brain damage), with behavioral disturbance, hydrocephalus (a build-up of fluid in the cavities of the brain), and unsteadiness on feet. During a review of R2's MDS, dated [DATE], the MDS indicated that R2 had difficulty stating correct year, month, and day of week as well as difficulty with recall. Record further indicated that R2 exhibited physical behavioral symptoms directed towards others that occurred ,d+[DATE] days out of the seven day look back period. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an observation on [DATE] at 10:57 a.m. in R1's room, multiple facial discolorations were observed on R1. A green and yellow discoloration was observed next to R1's right eye and a reddish/purple discoloration underneath R1's right eye. A light reddish/purple discoloration was observed under R1's left eye. A slight greenish/yellow discoloration was observed around the bridge of R1's nose. During an interview on [DATE] at 12:31 p.m. with Clinical Social Worker (CSW), CSW stated that R2 was very impulsive and gets easily irritated. CSW stated that R2 has a history of low frustration, difficulty adjusting to changes and DTO (danger to others). CSW stated that R2 had recently moved rooms and was roomed with R1 due to a Covid quarantine on the unit. During an interview on [DATE] at 11:46 p.m. with RN2, RN2 stated that on [DATE] at approximately 4:00 am, he was doing every 30 minute safety checks and entered the room of R1 and R2. RN2 stated he observed blood all over R1's face and that R1 had multiple facial contusions and lacerations. RN2 further stated he observed R2's hands and blanket covered in blood. RN2 stated that the physician ordered R1 to be transferred to the hospital for evaluation. RN2 stated that R2 has an extensive history of DTO, especially with his peers. RN2 also stated that R2 was very strong, even though he needs a wheelchair for ambulation, he was still able to stand himself up and can shuffle a few steps. RN2 stated that R2's behaviors are unpredictable, he will be calm one moment and aggressive the next. RN2 stated that R1 is not capable of provoking or defending himself as he is non-verbal and non-ambulatory. RN2 stated he would consider this incident to be assault. During a review of Physician's Orders, dated [DATE] at 4:45 a.m., the Physician's Orders indicated, physician ordered R1 to be transferred to the ER via paramedics for evaluation post assault with facial injuries. During a review of Physician Note: Transfer to Outside Facility for Emergency or Other Services, dated [DATE], the record indicated that R1 was being transferred to higher level of care due to s/p (status post) assault c/o (complaint of) facial bleed and bleeding from tracheostomy. Record indicated that R1 was assaulted by other patient and sustained multiple facial injuries and had noticeable bleeding from nose, mouth, eye and tracheostomy site. During a review of Return from Outside hospitalization Note, dated [DATE], the record indicated that upon readmission to facility R1 had .multiple abrasions on face, with bilateral periorbital (surrounding the socket of the eye) edema (swelling) and purplish discoloration. Nasal abrasions noted. The record also indicated that R1 had a CT Maxillofacial (an imaging procedure that uses x-ray and computer to create cross-sectional images of the face, mouth and jaw) scan which showed R1 sustained a comminuted (bone broken in at least two places) nasal bone fracture. During a record review of Interdisciplinary Notes (IDN), dated [DATE] at 8:21 a.m., the IDN indicated that R1 was assaulted by R2 and that it was unwitnessed but R2 was observed to have bloodied hands and blanket. Record further indicated that R2 refused assessment by staff, no PRN (as needed medication) for DTO was given to R2 after the incident. During a review of Treatment Plan, dated [DATE], showed R2's violence risk factor was moderate, decreased from high on [DATE]. The record indicated that R2 had poor impulse control, low frustration tolerance and poor verbal communication resulting in violent behavior towards peers and staff. Record further indicated that R2 had .multiple allegations of threatening and assaulting other patients. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During further review of Treatment Plan, dated [DATE], showed R2 had an active Focus #3.1 for Dangerousness and Impulsivity. The objective was that R2 will practice positive coping skills 2x a day as measured by staff observation and self-report to decrease violent behavior. There were no documented interventions in the treatment plan related to dangerousness and impulsivity for R2. During a review of Physician Progress Notes, dated [DATE] at 5:10 a.m., the record indicated that R2 had a previous incident that occurred the day prior. The record indicated . since unit population is vulnerable patient may harm himself indirectly or may cause further danger to others. During a review of Physician Progress Notes, dated [DATE] at 8:20 a.m., the record indicated that when R2 was asked about the incidents and motive, R2 was not able to recall or provide a motive and stated, I don't know. During a review of IDN, dated [DATE] at 2:54 p.m., it was discovered that R2 had a previous resident-to-resident altercation with another Resident (R3) at approximately 1:55 p.m. on [DATE]. The IDN indicated that R3 reported that she was hit by R2. During an interview on [DATE] at 3:20 p.m. with Unit Supervisor (US), US stated that on [DATE] R2 swung at R3 in the hallway. US stated that after that incident on [DATE] no interventions were ordered for R2. US stated that if a Resident's behaviors are escalating staff would get an order for an as needed (PRN) medication and that the psychiatrist may also order observation, either every 30-minute safety checks or 1-to-1 observation (close observation of resident by staff). During an interview on [DATE] at 10:54 a.m. with Registered Nurse (RN) 1, RN1 stated on the afternoon of [DATE] there was an incident with R2 that involved him hitting R3. RN1 stated that no interventions were implemented following the incident on [DATE]. During a review of the facility's policy and procedure (P&P) titled, Reporting Patient Abuse and Neglect, dated [DATE], the P&P indicated, Abuse or neglect of patients is not condoned and shall not be tolerated . The P&P also indicated that .Physical Abuse: Any of the following: (a) Assault, as defined in Section 240 of the Penal Code. During a review of the facility's P&P titled, Treatment Plan, dated [DATE], the P&P indicated, .3.1 Treatment Plan (TxP) . is developed by an interdisciplinary team . It documents focus of treatment, an intervention plan . The P&P further indicated .5.1 The TxP is: . 5.1.5 Identifies foci of treatment, objectives, and interventions . 5.1.7. Ensures that there are interventions that relate to each objective .