

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555731	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Dept of State Hospitals - Metropolitan Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>50669</p> <p>Based on observation, interview, and record review, the facility failed to ensure interventions were implemented to prevent falls for one of three sampled residents (Resident 1). This failure resulted in Resident 1 experiencing a fracture to the left fifth finger after a fall.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 9/24/24 at 9:52 am with Resident 1, Resident 1 had discoloration to her left fifth finger. Resident 1 stated she did not use her walker while ambulating and fell . Resident 1 further stated she broke her left fifth finger during her fall.</p> <p>During an interview on 9/25/24 at 9:31 am with Registered Nurse (RN) 1, RN 1 stated Resident 1 was sitting at a table in the day room. RN 1 further stated, Resident 1 got up from the table and walked toward him, approximately 10 feet without using her walker. RN 1 confirmed he did not educate Resident 1 to stop and use her walker or assist the resident with ambulating. RN 1 stated, It was close so I did not think she would fall.</p> <p>During an interview on 9/25/24 at 9:58 am with Supervising Registered Nurse (SRN) 1, SRN 1 stated Resident 1 needed to use a walker while ambulating. SRN 1 further stated, RN 1 should have stopped the resident immediately and educated Resident 1 to use the walker.</p> <p>During a review of Resident 1's Interdisciplinary Notes (IDN), dated 9/9/24, the IDN indicated, Resident 1 had a witnessed fall on 9/1/24 which resulted in a fractured left fifth finger.</p> <p>During a review of Resident 1's Minimum Data Set (MDS-an assessment tool), dated 8/1/24, the MDS indicated, Resident 1 used a walker and needed supervision or touching assistance when ambulating.</p> <p>During a review of Resident 1's Treatment Plan, dated 8/26/24, the Treatment Plan indicated, Resident 1 had diagnoses which included unsteadiness on the feet and was at risk for falls. Interventions to prevent falls included ensuring Resident 1 used a walker when ambulating, monitoring for falls and educating Resident 1 to seek staff's assistance.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Fall Prevention/Management Program, dated 4/5/24, the P&P indicated, . Registered Nurses are responsible for the implementation and oversight of fall prevention strategies within a patient's Treatment Plan .</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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