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	10/23/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 50669 Based on observation, interview, and record review, the facility failed to ensure a qualified facility approved interpreter was provided for one of three sampled residents (Resident 2). This failure resulted in Resident 2 being unable to communicate his needs with staff. Findings: During a concurrent observation and interview on 10/22/24 at 11:55 am with Lead Registered Nurse (LRN) 1 on Unit 404, Resident 2 was speaking Spanish to staff. LRN 1, who is not spanish speaking, stated Resident 2 was Spanish speaking and needed an interpreter. LRN 1 stated she was unaware of who the approved interpreters were for the facility. LRN 1 further stated she used either another resident or non-facility approved interpreters to communicate with Resident 2. During an interview on 10/22/24 at 12:16 pm with Registered Nurse (RN) 2, RN 2 stated he called the on-call doctor on 10/18/24 to evaluate Resident 1 when the resident complained of scrotum pain. RN 2 stated Medical Doctor (MD) 1 used Licensed Vocational Nurse (LVN) 1 to translate for Resident 2 during the evaluation. RN 2 stated, after evaluating Resident 2, MD 1 reported that Resident 2 complained a male staff member inappropriately grabbed his scrotum causing him pain. RN 1 stated he did not know if LVN 1 was an approved interpreter for the facility. RN 2 confirmed there was no way to ensure LVN 1's translation was accurate. During an interview on 10/23/24 at 12:11 pm with Resident 2 and RN 3, RN 3 stated he became a facility approved Spanish interpreter after passing a proficiency test. RN 3 translated for Resident 2; Resident 2 stated he reported pain to his scrotum after a staff member assisted him with personal care. Resident 2 further stated police later interviewed him asking if the staff member inappropriately touched him or purposefully harmed him. Resident 2 stated he was confused why police were involved because he did not report a malicious act, just pain. Resident 2 further stated I feel like a bothersome to staff because I want to speak my native language of Spanish and they don't. (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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/23/24 at 12:21 pm with Supervising Registered Nurse (SRN) 1, [facility's name] Bilingual Pay Log dated 10/23/24 was reviewed. The [facility's name] Bilingual Pay Log indicated, LVN 1 was not a facility approved interpreter. SRN 1 confirmed there was no Spanish speaking interpreter available to assist Resident 2 on 10/18/24. The [facility's name] Bilingual Pay Log indicated, there was no Spanish speaking interpreter available during evening shifts. SRN 1 stated she did not know what staff should do when a facility approved interpreter was not available. SRN 1 further stated there was no process in place to ensure facility approved interpreters were available each shift. During an interview on 10/23/24 at 1:46 pm with Social Worker (SW) 1, SW 1 stated, We are limited with translating and it's a flawed system. SW 1 stated she used other staff to translate and confirmed there was no way of knowing if the translation was accurate. During a review of Resident 2's Minimum Data Set (MDS-an assessment tool), dated 8/27/24, the MDS indicated, Resident 2's preferred language was Spanish, and an interpreter was needed for communication. During a review Resident 2's Impaired Verbal Communication Care Plan, dated 8/28/24, the Impaired Verbal Communication Care Plan indicated, . Provide Spanish interpreter as needed, q shift (every shift) . During a review of Resident 2's Treatment Plan, dated 8/26/24, the Treatment Plan indicated, Resident 2 spoke Spanish and a Spanish speaking interpreter should be utilized. During a review of the facility's policy and procedure (P&P) titled, Equal Delivery of Services, dated 8/9/23, the P&P indicated, . Accommodations will be made as necessary from the point of admission through discharge . In order to provide treatment and program services to . the non-English speaking patient, hospital staff can call the telephone operators to obtain the names of employees who . are bilingual in various languages available for interpreting .

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50669 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 fall which resulted in a scalp contusion (bruise). Findings: During a concurrent observation and interview on 10/22/24 at 11:49 am with Resident 1 on Unit 404, Resident 1 had discoloration to left side of his forehead. Resident 1 stated he did not use his wheelchair when standing and fell . Resident 1 further stated he had pain to his head and nausea. During an interview on 10/22/24 at 11:29 am with Registered Nurse (RN) 1, RN 1 stated he observed Resident 1 in his wheelchair in the dayroom, approximately 15 feet from where RN 1 was sitting. RN 1 stated Resident 1 put his hands on the armrests of the wheelchair and stood unassisted, then fell forward. RN 1 confirmed he did not educate Resident 1 to stop and sit down or assist the resident with standing. RN 1 stated, I did not think he would fall. During an interview on 10/23/24 at 12:29 pm with Lead Registered Nurse (LRN) 1, LRN 1 stated Resident 1 was blind and needed moderate assistance for ambulating with his wheelchair and transfers. LRN 1 stated RN 1 should have stopped Resident 1 immediately when he was observed standing without assistance and educated Resident 1 to sit down. During a review of Resident 1's Minimum Data Set (MDS-an assessment tool), dated 9/23/24, the MDS indicated, Resident 1 used a wheelchair and needed moderate assistance when ambulating. During a review Resident 1's Fall Risk Care Plan, dated 10/1/24, the Fall Risk Care Plan indicated, . Prevent injury by educating patient not to transfer or stand unassisted and to seek staff assistance . During a review of Resident 1's Treatment Plan, dated 9/19/24, the Treatment Plan indicated, Resident 1 had a diagnosis of unsteadiness on the feet and was at risk for falls. Interventions to prevent falls included ensuring Resident 1 used a wheelchair and one staff moderate assistance when ambulating and educating Resident 1 to seek staff assistance. During a review of Resident 1's Emergency Department (ED) Summary Report, dated 10/3/24, the ED Summary Report indicated, Resident 1 was seen for a head injury from a witnessed fall on 10/3/24 that resulted in a head contusion. 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 .