

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 03/07/2026
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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse (any intentional act causing injury or trauma to another person through bodily contact) by another resident for one of six sampled residents (Resident 1) when Resident 2 punched Resident 1, in the face while Resident 1 slept. The facility failed to implement adequate supervision, environmental interventions, and behavioral interventions for Resident 2, who the facility had previously identified as a moderate risk for violence against others to prevent foreseeable harm. These failures resulted in Resident 1, a medically fragile resident, sustaining a laceration to his eyebrow requiring medical attention and experiencing a loss of safety and subsequently placed all other residents at risk for potential abuse. The facility census was 53. Cross reference to F607, F609, F610 and F943. Findings: During a review of Resident 1's Quarterly Minimum Data Set (MDS- federally required assessment tool used to guide resident care), dated 11/28/2025, the MDS indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of absence of left eye, tracheostomy (a surgical hole in the throat to help with breathing), gastrostomy tube (a surgical opening into the intestines to administer nutrition and medications via a tube), and need for assistance. MDS further indicated Resident 1 had difficulty communicating his needs and required the use of a wheelchair for ambulation. During a review of Resident 2's Treatment Plan, dated 1/29/2026 the Treatment Plan indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of schizophrenia (chronic, serious brain disorder that causes people to interpret reality abnormally, often resulting in hallucinations, delusions, and disorganized thinking) and a criminal history of assault by means of force likely to produce great bodily injury. The Treatment Plan further indicated Resident 2 was evaluated on 1/22/2026 to be a moderate risk for violence against others. During a concurrent observation and interview on 2/12/2026 at 10:23 a.m. in Resident 1's room, Resident 1 was lying in bed, Resident 1 was without a left eye and had a tracheostomy tube for breathing. Resident 1 had a noticeable laceration above the right eyebrow accompanied by bruising. Resident 1 had to cover his tracheostomy tube with his hand to communicate, spoke in a whisper, and frequently struggled to catch his breath while speaking. Resident 1 stated, He [Resident 2] attacked me in my sleep and it was unprovoked. During an interview on 2/12/2026 at 10:28 a.m. with Resident 2, Resident 2 confirmed he punched Resident 1 in the face. Resident 2 displayed pre-aggression tendencies and RN 1 recommended to stop the interview. During an interview on 2/12/2026 at 11:19 a.m. with Registered Nurse (RN) 1, RN 1 stated he went into Resident 1's room, to take vital signs, and seen dried blood above Resident 1's right eyebrow. RN 1 stated Resident 1 informed him that Resident 2 punched Resident 1 in the face while he was sleeping. RN 1 further stated he interviewed Resident 2 and Resident 2 stated I hit him because he wanted to have sex with me. During an interview on 2/12/2026 at 2:27 p.m. with Registered Nurse Shift Lead (RNSL), RNSL stated Resident 2's medical conditions had drastically improved since admission, and now Resident 2 was highly ambulatory and no longer medically fragile. RNSL stated she was not surprised by this incident because in October 2025, Resident 2 attempted to punch a staff member. RNSL further stated, approximately 10 days prior to (continued on next page)</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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>2/7/2026, Resident 2 punching Resident 1 in the face, Resident 2 removed the footrest from a wheelchair and repeatedly hit the plexiglass window of the nurses' station requiring emergency assistance from multiple staff members to subdue the resident. RNSL stated Resident 2 was scary because he was violent, had aggressive behaviors and was very unpredictable. RNSL stated on 2/9/2026 Resident 2 informed the Psychiatrist (Psych) 1 that he will continue to hit others until he gets out of the facility. During an interview on 2/13/2026 at 11:02 a.m. with the Psychiatrist (Psych) 1, Psych 1 confirmed she was aware of Resident 2 having an aggressive history to include attempting to punch staff, hitting a trash can in the common area and hitting the nurses' station window with a wheelchair footrest, and stated Resident 2 was a high risk for violence against others. Psych 1 further stated on 2/10/2026 Resident 2 informed Psych 1 that he wanted to punch everyone and anyone until he got out of the facility. Psych 1 confirmed with the current treatment plan that there was no care plan in place to address Resident 2's aggressive behaviors toward others or interventions to protect other residents from Resident 2. During an interview on 2/17/2026 at 9:45 a.m. with Unit Supervisor (US), US confirmed with the Violent Risk Assessment completed on 1/22/2026, that the Psychiatrist determined Resident 2 needed to be closely monitored due to aggressive outbursts. US confirmed with the treatment plan completed on 1/29/2026, for 16 days after identifying Resident 2's need to be closely monitored, Resident 2 received the same level of monitoring as all other residents in the facility and was not placed on any enhanced monitoring interventions. US stated there was not a plan of care developed to address Resident 2's aggressive behaviors towards others or interventions implemented to address Resident 2's aggressive outbursts and protect other residents from Resident 2. During a concurrent interview and record review on 2/18/2026 at 10:05 a.m. with SNRL, Resident 2's Treatment Plan, dated 1/29/2026 was reviewed. The Treatment Plan indicated Resident 2 had a documented history of identified violent risk to others and there was no behavioral plan of care to address Resident 2's aggressive behaviors toward others or interventions implemented to safeguard other residents. SNRL stated there should have been a behavioral plan of care with interventions to address Resident 2's violent behaviors. During an interview on 2/19/2026 at 9:49 a.m. with Psych 1, Psych 1 confirmed with the treatment plan, completed on 1/29/2026, there were no mini treatment plan conferences held after Resident 2's episodes of aggression on 10/28/2025 and 1/9/2026. Psych 1 stated there should have been a behavioral plan of care to address Resident 2's aggressive behaviors and implementation of interventions. During an interview on 2/19/2026 at 10:18 a.m. with the Social Worker (SW), SW stated she was concerned for the safety of all residents on the unit with Resident 2 because he is demonstrating such aggressive behaviors and lack of insight. During a review of Resident 2's Special Incident Report (SIR), dated 1/30/2026, the SIR indicated on 10/28/2025 Resident 2 was aggressive towards staff and lunged (sudden, forceful movement forward) at staff with a closed fist, in attempts to punch staff. During a review of Resident 2's Monthly Psychiatric Progress Note, dated 1/31/2026, the Monthly Psychiatric Progress Note indicated Resident 2 was continuously verbally abusive. On 10/23/2025 Resident 2 had worsening behaviors and was verbally abusive to staff, on 10/28/2025 he had an aggressive stance with a closed fist towards staff, and on 1/21/2026 he hit a trash can and then the nurses' station plexiglass window. The Monthly Psychiatric Progress note further indicated Resident 2 has a history of assaulting staff and others, and his risk for violence against others should be carefully monitored. During a review of Resident 2's Interdisciplinary Notes (IDN), dated 1/21/2026, the IDN indicated Resident 2 was banging his fists on the trash can in the common area and staff were unable to redirect Resident 2 and he continued to bang on the trash can. IDN further states Resident 2 walked over to a wheelchair and removed one of the footrests, then walked over to the nurses' station's plexiglass window and repeatedly hit the window with the footrest. During a review of Resident 2's Violence Risk Screening (V-Risk), dated 1/22/2026, the V-Risk indicated Resident 2 was a moderate risk for violence against others due to multiple aggressive incidents such as verbal and physical aggression towards staff and property. The V-Risk further indicated the psychiatrist (continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>recommendations were [Resident 2's name] should be carefully monitored as he has a demonstrated history of violent behaviors. [Resident 2's name]'s risk will be carefully monitored and changed accordingly. During a review of Resident 2's Physician Progress Note, dated 1/23/2026, the Physician Progress Note indicated, He [Resident 2] is telling the staff that he is hearing voices to hurt others, that way he can be out here. During a review of Resident 2's IDN, dated 2/7/2026, the IDN indicated Resident 2 punched Resident 1 in the face while Resident 1 was asleep. The IDN further indicated Resident 1 required wound care as a result of his injuries. During a review of Resident 2's Physician Progress Note, dated 2/9/2026, the Physician Progress Note indicated, I was called by staff to address his [Resident 2] aggressive behaviors. Pt [patient] attacked another peer and caused an injury. He said I will keep doing that till I'm out of here. During a review of Resident 2's Physician Progress Note, dated 2/10/2026, the Physician Progress Note indicated, Yesterday pt [Resident 2] verbalizing he wanted to hit people until he got out of here. During a review of the facility's policy and procedure (P&P) titled, Reporting Patient Abuse and Neglect, dated 5/7/2025, the P&P indicated, Abuse or neglect of patients is not condoned and shall not be tolerated. Physical abuse: Any of the following (a) Assault, as defined in Section 240 of the Penal Code. During a review of California's Penal Code (PC) Section 240, PC Section 240 defines assault as attempt to commit a violent injury on the person of another. During a review of the facility's P&P titled, Treatment Plan, dated 7/10/2024, the P&P indicated, Each patient will have a focused, individualized Treatment Plan, based on the integrated assessment. Treatment shall be designed to address each patient's needs. Mini-Team conferences shall be held after an episode of aggression. The treatment plan shall discuss and document the patient's current mental status, interventions, response to interventions, and any risks. The treatment plan shall address any specific individualized risk(s) of the patient including but not limited to risk of danger to self, danger to others.</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop written policies and procedures (P&P) that clearly defined all forms of abuse to include resident-to-resident abuse. This failure resulted in the facility's inability to recognize and identify three of three sampled incidents involving resident-to-resident physical and alleged sexual assault as abuse when 1. Resident 2 punched Resident 1 in the face while Resident 1 slept and Resident 2 alleged sexual assault and stated he [Resident 1] tried to have sex with me. 2. Resident 3 kicked Resident 4 in the buttocks and Resident 4 punched Resident 3 in the face three times. 3. Resident 5 allegedly punched Resident 6 in the chin after a verbal altercation. Consequently, the facility failed to prevent abuse, protect residents from abuse, conduct abuse investigations, report timely, and accurately train staff. This oversight put 53 of 53 residents at risk of unreported and unmitigated abuse, potentially leading to serious harm and/or psychological trauma. Cross reference to F600, F609, F610 and F943. Findings: 1. During a review of Resident 1's Quarterly Minimum Data Set (MDS- federally required assessment tool used to guide resident care), dated 11/28/2025, the MDS indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of absence of the left eye, tracheostomy (a surgical hole in the throat to help with breathing), gastrostomy tube (a surgical opening into the intestines to administer nutrition and medications via a tube), and need for assistance. MDS further indicated Resident 1 had difficulty communicating his needs and required the use of a wheelchair for ambulation. During a review of Resident 2's Treatment Plan, dated 1/29/2026 the Treatment Plan indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of schizophrenia (chronic, serious brain disorder that causes people to interpret reality abnormally, often resulting in hallucinations, delusions, and disorganized thinking) and a criminal history of assault by means of force likely to produce great bodily injury. The Treatment Plan further indicated Resident 2 was evaluated to be a moderate risk for violence against others. During a concurrent interview and record review on 2/12/2026 at 10 a.m. with Standards Compliance Supervising Registered Nurse (SCSRN), Resident 1's Interdisciplinary Notes (IDN), dated 2/7/2026 was reviewed. The IDN indicated on 2/7/2026, Resident 1 was punched in the face by Resident 2, resulting in a 1.2 cm (centimeter- unit of measurement) laceration to the right upper eyebrow that required medical attention. The IDN further indicated Resident 2 informed staff that I punched him early in the morning because he tried to have sex with me. SCSRN confirmed the incidents were reported to CDPH three days after on 2/10/2026, and stated the facility did not consider resident-to-resident physical or sexual assault to constitute as abuse, therefore the facility did not have to report to CDPH within 2 hours. SCSRN further stated both physical and alleged sexual assault were not investigated due to not meeting the facility's requirement for the definition of abuse. During a concurrent observation and interview on 2/12/2025 at 10:23 a.m. in Resident 1's room, Resident 1 was lying in bed, Resident 1 was without a left eye and had a tracheostomy tube for breathing. Resident 1 had a noticeable laceration above the right eyebrow accompanied by bruising. Resident 1 had to cover his tracheostomy tube with his hand to communicate, spoke in a whisper, and frequently struggled to catch his breath while speaking. Resident 1 stated, He [Resident 2] attacked me in my sleep and it was unprovoked. During an interview on 2/12/2025 at 10:28 a.m. with Resident 2, Resident 2 confirmed he punched Resident 1 in the face. During an interview on 2/12/2026 at 11:19 a.m. with Registered Nurse (RN) 1, RN 1 stated he went into Resident 1's room, to take vital signs, and seen dried blood above Resident 1's right eyebrow. RN 1 stated Resident 1 informed him that Resident 2 punched Resident 1 in the face while he was sleeping. RN 1 further stated he interviewed Resident 2 and Resident 2 stated I hit him because he wanted to have sex with me. RN 1 stated Resident 2 punching Resident 1 in the face was considered a physical altercation and not abuse, and Resident 2 alleging Resident 1 of trying to have sex with him was not considered sexual assault or abuse. During an interview on 2/12/2026 at 11:26 a.m. with Registered Nurse Shift Lead (RNSL), (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>RNSL stated resident to resident physical or sexual assault was not abuse and staff to resident physical or sexual assault was considered abuse. During an interview on 2/12/2026 at 12:09 p.m. with Program 6 Program Director (PD), the PD stated resident on resident physical or sexual assault was not considered abuse and only staff can be a perpetrator (the person who commits a harmful or illegal act such as a crime, wrongdoing or violent act), therefore the incidents between Resident 1 and Resident 2 were not investigated as abuse and a SOC 341 (Form to report Suspected Dependent Adult/Elder Abuse) was not completed. During an interview on 2/12/2026 at 2:27 p.m. with RNSL, RNSL stated she was not surprised by this incident because in October 2025, Resident 2 attempted to punch a staff member. RNSL further stated, approximately 10 days prior to 2/7/2026, Resident 2 punching Resident 1 in the face, Resident 2 removed the footrest from a wheelchair and repeatedly hit the plexiglass window of the nurses' station requiring emergency assistance from multiple staff members to subdue the resident. RNSL stated Resident 2 was scary because he was violent, had aggressive behaviors and was very unpredictable. RNSL stated on 2/9/2026 Resident 2 informed the Psychiatrist (Psych) 1 that he will continue to hit others until he gets out of the facility. During an interview on 2/17/2026 at 2:36 p.m. with Psych 2, Psych 2 stated he was covering the on-call shift on 2/7/2026 and was informed by unit staff of Resident 2 punching Resident 1 in the face. Psych 2 further stated he did not go to the unit to evaluate both residents and was not aware Resident 2 made an allegation of sexual abuse. Psych 2 stated he should have gone and evaluated Resident 1 and Resident 2. During an interview on 2/19/2026 at 10:18 a.m. with the Social Worker (SW), SW stated she was concerned for the safety of all residents on the same unit as Resident 2 due to his aggressive behaviors and lack of insight. SW confirmed with the most recent Treatment Plan dated 1/29/2026, there was no plan of care or intervention in place to prevent Resident 2's aggressive behaviors towards other residents, or to protect other residents from physical harm. 2. During a review of Resident 3's Treatment Plan, the Treatment plan indicated Resident 3 was admitted to the facility on [DATE] with the diagnoses of gastrostomy status (a surgical opening into the intestines to administer nutrition and medications via a tube) and pulmonary fibrosis (chronic lung disease when the tissue becomes thickened, stiff and scarred making it difficult to breathe). The Treatment Plan further indicated Resident 3 required maximum assistance (patient requires significant help/dependency from a caregiver normally a minimum of 2 staff members for helping) for transferring and was a nonfunctional ambulator (an individual is unable to walk). The Treatment Plan further indicated Resident 3 was evaluated to be a high risk for violence against others. During a review of Resident 4's Treatment Plan, the Treatment Plan indicated Resident 4 was admitted to the facility on [DATE] with the diagnoses of unsteadiness on feet, blindness of left eye and fracture of left femur (broken left thigh bone) with routine healing. The Treatment Plan further indicated Resident 4 was evaluated to be a low risk for violence against others but had a history of DTO (danger to others) behaviors in the past. During a review of Resident 3's Interdisciplinary Notes (IDN), dated 2/28/2026, the IDN indicated, On 2/28/2026 at approximately 1205 [Resident 3] was watching TV in the day hall when [Resident 4] was trying to walk in front of him using his front wheel walker. [Resident 3] kicked [Resident 4] on his buttocks area x1. [Resident 4] retaliated, turned around and started punching [Resident 3] with closed right hand fist x3, hitting [Resident 3] on his right side of the face. During a concurrent observation and interview on 3/4/2026 at 3:57 p.m. with Registered Nurse Shift Lead (RNSL) and Standards Compliance Registered Nurse (SCRN) in the day hall, Resident 3 was shouting and yelling out to surveyor. RNSL stated Resident 3 just received a PRN (as needed) antipsychotic medication (drug given to treat psychosis-a disconnection from reality) due to aggression and agitation. RNSL and SCRN recommended not interviewing Resident 3 due to safety concerns. During an interview on 3/4/2026 at 4:30 p.m. with Standards Compliance Director (SCD), SCD confirmed with the facility's abuse P&P that the definitions in the P&P do not include resident-to-resident as a possibility for abuse. SCD stated there is not another P&P for protection and prevention of abuse to include resident-to-resident abuse. SCD further stated the physical (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>altercations between Resident 3 and Resident 4 were not reported to state survey agency (California Department of Public Health-CDPH) until 2 days after the incident on 2/28/2026 and stated it should have been reported within 2 hours. During an interview on 3/5/2026 at 4:15 p.m. with the Social Worker (SW), SW stated she was not aware of Resident 4 receiving any enhanced monitoring after the incident with Resident 3 to prevent further abuse and to protect other residents. SW further stated Resident 4 was transferred to a different unit on 3/4/2026 due to aggressive behaviors and not meeting skilled nursing needs anymore. During an interview on 3/5/2026 at 5:51 p.m. with the Unit Supervisor (US), the US confirmed with Resident 4's medical records, that Resident 4 did not receive a medication change or enhanced monitoring after the physical altercation with Resident 3. The US stated her recommendation would have been to put Resident 4 on enhanced monitoring to protect other residents in case he had another aggressive outburst and confirmed with an IDN that Resident 4 had a second aggressive outburst two days after the physical altercation with Resident 3, on 2/28/2026, with a staff member. 3. During a review of Resident 5's Treatment Plan, the Treatment Plan indicated Resident 5 was admitted to the facility on [DATE] with diagnosis of back fracture and epilepsy (recurrent, unprovoked seizures- abnormal electrical activity in the brain). The Treatment Plan further indicated Resident 5 was evaluated to be a moderate risk for violence against others due to significant history of DTO (danger to others) behaviors towards other residents and staff. During a review of Resident 6's Treatment Plan, the Treatment Plan indicated Resident 6 was admitted to the facility on [DATE] for diagnoses to include. The Treatment Plan further indicated Resident 6 was evaluated to be a moderate risk for violence against others due to verbalizing thoughts of harming another resident. During a review of Resident 6's Interdisciplinary Notes (IDN), dated 2/28/2026, the IDN indicated, At approximately 0900 staff heard yelling coming from the day hall. Staff in the nursing station immediately responded and observed [Resident 5] and [Resident 6] next to each other in the day hall having a verbal altercation when [Resident 5] struck [Resident 6]. When [Resident 6] was asked what happened, patient stated, I don't know. I didn't do anything. [Resident 6] stated [Resident 5] hit him in the chin x1. During an interview on 3/4/2026 at 3:40 p.m. with Resident 5, Resident 5 stated Resident 6 started cursing and yelling at him so with a closed fist Resident 5 touched Resident 6's chin to shut him up. During an interview on 3/4/2026 at 4:30 p.m. with Standards Compliance Director (SCD), SCD confirmed with the facility's abuse P&P that the definitions in the P&P do not include resident-to-resident as a possibility for abuse. SCD stated there is not another P&P for protection and prevention of abuse to include resident-to-resident abuse. SCD further stated the physical altercations between Resident 5 and Resident 6 were not reported to state survey agency (California Department of Public Health-CDPH) until 2 days after the incident on 2/28/2026 and stated it should have been reported within 2 hours. SCD confirmed with SOC 341 (Form to report Suspected Dependent Adult/Elder Abuse), that the SOC 341 was not completed until today, 3/4/2026, and should have been completed by the end of shift on the day of the incident, 2/28/2026. During an interview on 3/6/2026 at 7:59 a.m. with Psychologist (Psych) 3, Psych 3 confirmed she was made aware of the verbal and physical altercation between Resident 5 and Resident 6 when she returned to work on 3/3/2026. Psych 3 stated Resident 6 had an extensive history of verbal aggression towards all residents and staff with two other previous incidents that resulted in alleged physical altercation, and Resident 6 did not have a behavioral care plan and he needed one. Psych 3 further stated Resident 4 had aggressive incidents on his previous unit, and his behavioral care plan had not been updated in over a year. Psych 3 stated Resident 4 informed her that his intent was to harm Resident 3. During a review of the facility's P&P titled, Treatment Plan, dated 7/10/2024, the P&P indicated, Each patient will have a focused, individualized Treatment Plan, based on the integrated assessment. Treatment shall be designed to address each patient's needs. Mini-Team conferences shall be held after an episode of aggression. The treatment plan shall discuss and document the patient's current mental status, interventions, response to interventions, and any risks. The treatment plan shall address any specific individualized risk(s) of the patient including but not limited to risk of danger to self, danger (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>to others. During a review of the facility's P&P titled, Incident Management, dated 5/9/2025, the P&P indicated, . [facility name] will use the definitions of incidents to be reported and investigated listed in the Appendix A. Incidents that Involve Allegations of Abuse or Neglect- When a hospital employee observes suspected patient abuse or receives an allegation of patient abuse from another person, they shall. Refer to AD 3308 [facility's policy and procedure] Reporting Patient Abuse and Neglect for additional information. During a review of the facility's P&P attachment titled, Appendix A- Definitions, undated, the document indicated, Alleged Patient abuse- physical: any intentional interaction or physical contact, motion, or action that is directed toward a patient by someone other than another patient. Alleged Patient Abuse- Psychological: Any act by someone other than another patient that causes or could reasonably be expected to cause mental suffering. Alleged Sexual Abuse: An employee engages in sexual contact with a patient. An employee encourages or allows sexual contact between patients. During a review of the facility's P&P titled, AD 3308: Reporting Patient Abuse and Neglect, dated 1/3/2023, the P&P indicated, .Definitions. Physical abuse: Any of the following: (a) Assault, as defined in Section 240 of the Penal Code. Psychological abuse- any act by someone other than another patient. Verbal abuse- any language by someone other than another patient. Sexual abuse- an employee engages in sexual contact with a patient. An employee encourages or allows sexual contact between patients. Training. What constitutes abuse, neglect and misappropriation of resident property. Prevention. identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. When a hospital employee observes suspected patient abuse, or receives an allegation of patient abuse, they shall immediately . Complete a Form SOC 341 . Immediate supervisor responsibilities . provide protection to the patient in all instances when there is an allegation of abuse. This includes providing the patient with counseling and debriefing . Notify the Patient's Rights Advocate . Standards compliance responsibilities . all alleged violation involving abuse . which occurred in Skilled Nursing units shall be reported by SCD [Standards Compliance Department]/Designee to CDPH [California Department of Public Health] immediately but not later than 2 hours after allegation is made if the events that cause the allegation involve abuse . SCD shall submit to CDPH within 5 working days of the incident the result of investigations and/or a follow up report . Training- all employees are required to complete annual patient abuse prevention training. Train employees through orientation and on-going sessions on issues related to abuse prohibition practices such as: What constitutes abuse. Prevention . Identify, correct, and intervene in situations in which abuse is more likely to occur. This includes an analysis of: The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors . During a review of the facility's power point training titled, Recognizing and Reporting Abuse, Neglect and Suspected Criminal Conduct, dated 12/2/2025, the training indicated, This training is designed to assist you in improving your recognition of, and response to incidents of abuse . The training will cover processes and procedures, definitions . ensure employees understand their ongoing legal and ethical responsibility to recognize and report suspected cases of abuse . Definitions- Physical Abuse- Any interaction or physical contact, motion, or action that is directed toward a patient by someone other than another patient . Psychological abuse- any act by someone other than another patient . verbal abuse- any language by someone other than another patient . sexual abuse- an employee engages in sexual contact with a patient. An employee encourages or allows sexual contact between patients, one of whom is not consenting . When an incident or allegation of abuse, neglect or serious bodily injury has occurred, Recognition is key . On 3/5/2026 at 1:08 p.m., the survey team called an Immediate Jeopardy situation (a situation in which the facility's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident), related to the lack of facility's written policies and procedures for prohibiting and preventing abuse to include resident-to-resident abuse, staff competency in identifying resident-to-resident abuse, preventing, screening, investigating, protecting and reporting abuse, at F (continued on next page)</p>		

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 03/07/2026
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>607 [CFR S 483.12(b)], in the presence of the Director of Nursing, Standards Compliance Director, Nursing Coordinator and Standards Compliance Supervising Registered Nurse. On 3/6/2026 at 4:08 p.m., the Standards Compliance Director provided the team with a Plan of Action which included the following actions to be completed and/or started immediately: a.) Physical altercations, sexual allegations, possible mental, psychological and exploitation in SNF area will be treated as potential abuse allegations. b.) SOC 341 form will be completed for each allegation of abuse incident. Completion of SOC 341 will be verified by RN Health Services Specialist/Supervising Registered Nurse prior to end of shift. c.) The hospital updated its reporting of unusual occurrences practice related to any possible abuse incidents to ensure compliance with the 2-hour reporting requirement. 0700-1630 Program VI management/Unit Shift Lead will notify Standards immediately upon identification of a possible abuse incident to ensure reporting requirements are completed within 2 hours. 1630-0700, on weekends and holidays Program VI manager on call/unit shift lead will notify CNS [Central Nursing Staff] for HSS [Health Service Specialist] to complete reporting within 2 hours. d.) Program Director issued a written memorandum for all SNF nursing staff outlining federal regulatory requirements related to abuse recognition, screening and reporting. The memo references CMS State Operations Manual definition of possible abuse including physical, verbal, possible mental/psychological, sexual, and exploitation and clarifies the resident to resident must be treated as potential abuse. The memo and education includes CMS SOM reference, recognition and identification of potential abuse including resident-to-resident, Screening (VRISK-10), prevention strategies and resident protection measures, including expectations for early intervention and behavioral monitoring for residents at risk, investigation requirements and documentation, reporting requirements, SOC 341 completion. SRN will attest that staff can verbalize understanding. Training will be tracked via tracking log. SRN will provide clarification as needed to ensure staff understand the abuse screening and reporting process. e.) Central Nursing Staff Department/Nursing Administrator issued a written memorandum for all registry nursing staff outlining federal regulatory requirements as listed above in (d). f.) Training via memorandum of the non-nursing clinical staff (psychiatry, psychology, rehabilitation therapy, social work, medical services) and ancillary staff (housekeeping, plant operations, nutrition services) will be directed by each department chief/discipline seniors. The training will include federal regulatory requirements as listed above in (d). g.) Additional staff training to provide directions regarding intervention protocols to enhance behavioral monitoring and interventions strategies for residents identified as high risk for behavioral escalation or aggression. Training will include identification of high-risk residents for behavioral escalation, enhanced monitoring and supervision strategies, early interventions and de-escalation techniques, implementation of individualized behavioral interventions, documentation and communication of behavioral concerns to the interdisciplinary team. h.) Identify, correct and intervene in situations in which possible abuse, neglect and/or misappropriation of resident property is more likely to occur an analysis of the following is conducted: physical environment, sufficient staffing, supervision of staff to identify triggers, the assessment, care planning and monitoring of resident. i.) An update to Administrative Directive 3308 to include resident-to-resident physical and verbal assaults, possible mental/psychological abuse, sexual allegations, and exploitation to be treated as potential abuse. The updated directive will include expectations for abuse screening, investigations and reporting requirements. j.) Program VI management will conduct an ongoing review of all incident reports (IRs) involving resident-to-resident altercations or allegations to ensure: SOC 341 reports are completed, reporting timelines are met. On 3/7/2026 at 5:28 p.m., while onsite and after confirming the facility's implementation of the immediate corrective actions, the team accepted the Plan of Action and removed the Immediate Jeopardy in the presence of Registered Nurse 3.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to identify all forms of abuse to include resident-to-resident abuse for three of three sampled allegations, when:1. Resident 2 punched Resident 1 in the face, alleging that Resident 1 attempted to engage in unwanted sexual activity with Resident 2.2. Resident 3 kicked Resident 4 in the buttocks and in retaliation Resident 4 punched Resident 3 in the face three times.3. Resident 6 reported an allegation that Resident 5 punched him in the chin.These failures resulted in the required authorities, patients' rights advocate (PRA-designated individual that helps patients navigate the healthcare system, ensuring their legal, civil and human rights are upheld) and the state survey agency (CDPH- California Department of Public Health) not being notified immediately, but not later than 2 hours after the allegation was made.Cross reference to F600, F607 and F610.Findings:1.During a review of the facility's Report of Unusual Occurrence, dated 2/10/2026, the report indicated on 2/7/2026, three days prior to notifying State Agency, Resident 1 was punched in the face by Resident 2, which resulted in a laceration above the resident's right eyebrow and Resident 2 alleged Resident 1 attempted to engage in sexual activity with him.During an interview on 2/12/2026 at 10 a.m. with Standards Compliance Supervising Registered Nurse (SCSRN), SCSRN confirmed Resident 1 was punched by Resident 2 on 2/7/2026 and Resident 2 reported an sexual assault allegation against Resident 1. SCSRN stated the department of standards and compliance were not open over the weekend, therefore they would not be able to report abuse within 2 hours. SCSRN further stated she does not consider resident-on-resident physical and/or sexual assault as abuse; therefore, it was not mandated to be reported within 2 hours of incident. During an interview on 2/17/2026 at 1:43 p.m. with the PRA, the PRA stated he had not received any notification of physical and/or sexual assault or abuse from the facility regarding Resident 1 and Resident 2.During a review of the facility's policy and procedure (P&P) titled, Reporting Patient Abuse and Neglect, dated 5/7/2025, the P&P indicated, Abuse of Dependent Adult/Elder: Includes physical. as defined as . Physical abuse: Any of the following: (a) Assault, as defined in Section 240 of the Penal Code. (e) Sexual assault.Standards compliance responsibilities. all alleged violations involving abuse. which occurred in Skilled Nursing units shall be reported by SCD/Designee to CDPH IMMEDIATELY but not later than 2 HOURS after allegation is made.2. During a review of the facility's Report of Unusual Occurrence, dated 3/2/2026, the report indicated on 2/28/2026, two days prior to notifying State Agency, Resident 3 kicked Resident 4 in the buttocks unprovoked and in retaliation Resident 4 punched Resident 3 in the face three times.During an interview on 3/4/2026 at 4:30 p.m. with Standards Compliance Director (SCD), SCD confirmed the physical altercations between Resident 3 and Resident 4 were not reported to CDPH until 2 days after the incident on 2/28/2026 and stated it should have been reported within 2 hours.During an interview on 3/6/2026 at 11:31 a.m. with the PRA, the PRA stated he had not received any notification of physical abuse for Resident 3 and/or Resident 4.During a review of the facility's policy and procedure (P&P) titled, Reporting Patient Abuse and Neglect, dated 5/7/2025, the P&P indicated, Abuse of Dependent Adult/Elder: Includes physical. as defined as . Physical abuse: Any of the following: (a) Assault, as defined in Section 240 of the Penal Code. Standards compliance responsibilities. all alleged violations involving abuse. which occurred in Skilled Nursing units shall be reported by SCD/Designee to CDPH IMMEDIATELY but not later than 2 HOURS after allegation is made.3. During a review of the facility's Report of Unusual Occurrence, dated 3/2/2026, the report indicated on 2/28/2026, two days prior to notifying State Agency, Resident 5 allegedly punched Resident 6 in the chin after a verbal altercation.During an interview on 3/4/2026 at 4:30 p.m. with Standards Compliance Director (SCD), SCD confirmed the alleged physical altercation between Resident 5 and Resident 6 was not reported to CDPH until 2 days after the incident on 2/28/2026 and stated it should have been reported within 2 hours.During an interview on 3/6/2026 at 11:31 a.m. with the PRA, the PRA stated he had not received any</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>notification of a physical abuse allegation for Resident 6. During a review of the facility's policy and procedure (P&P) titled, Reporting Patient Abuse and Neglect, dated 5/7/2025, the P&P indicated, Abuse of Dependent Adult/Elder: Includes physical. as defined as . Physical abuse: Any of the following: (a) Assault, as defined in Section 240 of the Penal Code. Standards compliance responsibilities. all alleged violations involving abuse. which occurred in Skilled Nursing units shall be reported by SCD/Designee to CDPH IMMEDIATELY but not later than 2 HOURS after allegation is made.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations that involved abuse, including alleged sexual assault and physical abuse, were thoroughly investigated for 2 of 6 sampled residents (Resident 1 and Resident 2) when: Resident 2 alleged sexual assault and stated he [Resident 1] tried to have sex with me. Resident 1 was physically assaulted by Resident 2 while he was sleeping. Consequently, the facility failed to report the results of all investigations to the State Survey Agency (SA) within 5 working days of the incident. These failures resulted in the investigations not being conducted and placed Resident 1 and Resident 2 at risk for further harm. Cross reference to F600, F607 and F609. Findings: 1. During a review of Resident 2's Treatment Plan, dated 1/29/2026 the Treatment Plan indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of schizophrenia (chronic, serious brain disorder that causes people to interpret reality abnormally, often resulting in hallucinations, delusions, and disorganized thinking). During a concurrent interview and record review on 2/12/2026 at 10 a.m. with Standards Compliance Supervising Registered Nurse (SCSRN), Resident 1's Interdisciplinary Notes (IDN), dated 2/7/2026 was reviewed. The IDN indicated Resident 1 was punched in the face by Resident 2, resulting in a 1.2 cm (centimeter- unit of measurement) laceration to the right upper eyebrow that required medical attention. The IDN further indicated Resident 2 informed staff that I punched him early in the morning because he tried to have sex with me. SCSRN confirmed the incidents were reported to CDPH three days after 2/7/2026, on 2/10/2026, and stated the facility did not consider resident-to-resident physical or sexual assault to constitute as abuse, therefore the facility did not have to report to CDPH within 2 hours. SCSRN further stated alleged sexual assault was not investigated due to not meeting the facility's requirement for the definition of abuse. During an interview on 2/12/2026 at 10:33 a.m. with Registered Nurse (RN) 2, RN 2 stated he was informed by RN 1 that Resident 2 punched Resident 1 in the face resulting in a laceration to the right upper eyebrow. RN 2 stated he interviewed Resident 2 and Resident 2 informed RN 2 that he hit Resident 1 because he was trying to have sex with me. RN 2 further stated, I didn't ask any further questions. During an interview on 2/12/2026 at 12:09 p.m. with Program 6 Program Director (PD), PD stated she spoke with the nursing staff and treatment team and none of the staff/team believed there was validity to Resident 2's statement of alleged sexual assault, and it was decided from the treatment team the allegation was a delusion. PD further stated alleged sexual assault with the perpetrator being another resident does not constitute as abuse, therefore was not investigated nor completed a SOC 341 (Form to report Suspected Dependent Adult/Elder Abuse). During a concurrent interview and record review on 2/12/2026 at 2:03 p.m. with Standards Compliance Registered Nurse (SCRN), Resident 2's medical records were reviewed. Resident 2's medical record did not include a physician report after Resident 2 made sexual assault allegation against Resident 1 on 2/7/2026. SCRN confirmed there was not a physician report. During an interview on 2/13/2026 at 11:02 a.m. with Psychiatrist (Psych) 1, Psych 1 confirmed she was temporarily the primary psychiatrist for Resident 2 and stated she did not see or evaluate Resident 2 until three days after the incident. Psych 1 further stated she did not address or focus on the sexual assault allegation. During an interview on 2/17/2026 at 1:43 p.m. with the Patients' Rights Advocate (PRA), the PRA stated he was not notified of Resident 2's allegation of sexual assault. During an interview on 2/17/2026 at 2:36 p.m. with Psych 2, Psych 2 stated he was covering the on-call shift on 2/7/2026 and he did not go to the unit to evaluate Resident 2 after the allegation of sexual abuse. During a review of the facility's policy and procedure (P&P) titled, Rape or Sexual Assault of Elder/Dependent Adult (Actual or Alleged), dated 4/1/2025, the P&P indicated, Sexual assault victims (male or female) shall receive immediate medical attention and sensitive supportive counseling from clinical staff as soon as the assault is brought to the attention of hospital staff. Every effort shall be made to ensure the victim's physical and emotional well-being, and to gather evidence. Prompt (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>medical attention is necessary for victims of alleged sexual assaults. Medical attention is required to assess the psychological reaction to the event. Procedures to be implemented immediately upon the discovery of a case of alleged sexual assault. complete Form SOC-341. unit staff/personnel discovering assault. comfort patient. The unit physician or MOD [medical on call doctor] will fill out the Physicians Report section of the Incident Report. During a review of the facility's P&P titled, Reporting Patient Abuse and Neglect, dated 1/3/2023, the P&P indicated, .Definitions. Physical abuse: Any of the following. Sexual abuse- an employee engages in sexual contact with a patient. An employee encourages or allows sexual contact between patients. When a hospital employee observes suspected patient abuse, or receives an allegation of patient abuse, they shall immediately . Complete a Form SOC 341 . Immediate supervisor responsibilities . provide protection to the patient in all instances when there is an allegation of abuse. This includes providing the patient with counseling and debriefing . Notify the Patient's Rights Advocate . Standards compliance responsibilities . all alleged violation involving abuse . which occurred in Skilled Nursing units shall be reported by SCD [Standards Compliance Department] /Designee to CDPH [California Department of Public Health] immediately but not later than 2 hours after allegation is made if the events that cause the allegation involve abuse . SCD shall submit to CDPH within 5 working days of the incident the result of investigations and/or a follow up report . 2. During a review of Resident 1's Quarterly Minimum Data Set (MDS- federally required assessment tool used to guide resident care), dated 11/28/2025, the MDS indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of absence of the left eye, tracheostomy (a surgical hole in the throat to help with breathing), gastrostomy tube (a surgical opening into the intestines to administer nutrition and medications via a tube), and need for assistance. MDS further indicated Resident 1 had difficulty communicating his needs and required the use of a wheelchair for ambulation. During a concurrent interview and record review on 2/12/2026 at 10 a.m. with Standards Compliance Supervising Registered Nurse (SCSRN), Resident 1's Interdisciplinary Notes (IDN), dated 2/7/2026 was reviewed. The IDN indicated Resident 1 was punched in the face by Resident 2, resulting in a 1.2 cm (centimeter- unit of measurement) laceration to the right upper eyebrow that required medical attention. The IDN further indicated Resident 2 informed staff that I punched him early in the morning because he tried to have sex with me. SCSRN confirmed the incidents were reported to CDPH three days after the incident, on 2/10/2026, and stated the facility did not consider resident-to-resident physical or sexual assault to constitute as abuse, therefore the facility did not have to report to CDPH within 2 hours. SCSRN further stated physical assault was not investigated due to not meeting the facility's requirement for the definition of abuse. During an interview on 2/12/2026 at 12:09 p.m. with Program 6 Program Director (PD), the PD stated resident on resident physical assault was not considered abuse and only staff can be a perpetrator (the person who commits a harmful or illegal act such as a crime, wrongdoing or violent act), therefore the incidents between Resident 1 and Resident 2 were not investigated as abuse and a SOC 341 (Form to report Suspected Dependent Adult/Elder Abuse) was not completed. During an interview on 2/13/2026 at 11:02 a.m. with Psychiatrist (Psych) 1, Psych 1 stated she seen Resident 1 four days after the incident, Resident 2 punching Resident 1 in the face while he was asleep, on 2/7/2026. Psych 1 further stated during her visit with Resident 1 she was accompanied by Medical Doctor (MD) and the visit was solely for medical issues regarding his tracheostomy, and not the physical assault. During an interview on 2/17/2026 at 1:43 p.m. with the Patients' Rights Advocate (PRA), the PRA stated he was not notified of Resident 1's physical assault. During an interview on 2/17/2026 at 2:36 p.m. with Psych 2, Psych 2 stated he was covering the on-call shift on 2/7/2026 and was informed by unit staff of Resident 2 punching Resident 1 in the face. Psych 2 further stated he did not go to the unit to evaluate Resident 1 and Resident 2. During a review of the facility's P&P titled, Reporting Patient Abuse and Neglect, dated 1/3/2023, the P&P indicated, .Definitions. Physical abuse: Any of the following: (a) Assault, as defined in Section 240 of the Penal Code. When a hospital employee observes suspected patient abuse, or receives an allegation of patient abuse, they shall (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>immediately . Complete a Form SOC 341 . Immediate supervisor responsibilities . provide protection to the patient in all instances when there is an allegation of abuse. This includes providing the patient with counseling and debriefing . Notify the Patient's Rights Advocate . Standards compliance responsibilities . all alleged violation involving abuse . which occurred in Skilled Nursing units shall be reported by SCD [Standards Compliance Department]/Designee to CDPH [California Department of Public Health] immediately but not later than 2 hours after allegation is made if the events that cause the allegation involve abuse . SCD shall submit to CDPH within 5 working days of the incident the result of investigations and/or a follow up report . Prevention . Identify, correct, and intervene in situations in which abuse is more likely to occur. This includes an analysis of: The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors .</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>Based on interview and record review the facility failed to ensure all staff received adequate training on the recognition, prevention, and reporting of all forms of abuse, including resident-to-resident abuse in accordance with Federal regulations. This failure resulted in staff's inability to recognize incidents involving resident-to-resident physical and alleged sexual assault as abuse for two of six sampled residents (Resident 1 and Resident 2).Cross reference F600, F607, F609 and F610.Findings:During a concurrent interview and record review on 2/12/2026 at 10 a.m. with Standards Compliance Supervising Registered Nurse (SCSRN), Resident 1's Interdisciplinary Notes (IDN), dated 2/7/2026 was reviewed. The IDN indicated Resident 1 was punched in the face by Resident 2, resulting in a 1.2 cm (centimeter- unit of measurement) laceration to the right upper eyebrow that required medical attention. The IDN further indicated Resident 2 informed staff that I punched him early in the morning because he tried to have sex with me. SCSRN stated the facility did not consider resident-to-resident physical or sexual assault to constitute as abuse due to not meeting the facility's requirement for the definition of abuse. During an interview on 2/12/2026 at 10:33 a.m. with Registered Nurse (RN) 2, RN 2 stated he received annual abuse training to include only staff-to-resident abuse, reporting and prevention.During an interview on 2/12/2026 at 11:19 a.m. with RN 1, RN 1 stated he went into Resident 1's room, to take vital signs, and seen dried blood above Resident 1's right eyebrow. RN 1 stated Resident 1 informed him that Resident 2 punched Resident 1 in the face while he was sleeping. RN 1 further stated he interviewed Resident 2 and Resident 2 stated I hit him because he wanted to have sex with me. RN 1 stated Resident 2 punching Resident 1 in the face was considered a physical altercation and not abuse, and Resident 2 alleging Resident 1 of trying to have sex with him was not considered sexual assault or abuse. RN 1 confirmed he received annual abuse training.During an interview on 2/12/2026 at 11:26 a.m. with Registered Nurse Shift Lead (RNSL), RNSL stated resident-to-resident physical or sexual assault was not considered abuse, only staff-to-resident physical or sexual assault was considered abuse. RNSL confirmed she received annual abuse training.During an interview on 2/12/2026 at 12:09 p.m. with Program 6 Program Director (PD), the PD stated resident-to-resident physical or sexual assault was not considered abuse and only staff can be a perpetrator (the person who commits a harmful or illegal act such as a crime, wrongdoing or violent act). PD confirmed she received annual abuse training. During an interview on 2/12/2026 at 12:19 p.m. with Program 6 Nursing Coordinator (NC), NC confirmed he received annual abuse training and stated the incidents with Resident 1 and Resident 2 were not considered abuse because the perpetrator wasn't a staff member.During a review of the facility's power point training titled, Recognizing and Reporting Abuse, Neglect and Suspected Criminal Conduct, dated 12/2/2025, the training indicated, This training is designed to assist you in improving your recognition of, and response to incidents of abuse . The training will cover processes and procedures, definitions . ensure employees understand their ongoing legal and ethical responsibility to recognize and report suspected cases of abuse . Definitions- Physical Abuse- Any interaction or physical contact, motion, or action that is directed toward a patient by someone other than another patient . Psychological abuse- any act by someone other than another patient . verbal abuse- any language by someone other than another patient . sexual abuse- an employee engages in sexual contact with a patient. An employee encourages or allows sexual contact between patients, one of whom is not consenting . When an incident or allegation of abuse, neglect or serious bodily injury has occurred, Recognition is key .During a review of the facility's policy and procedure (P&P) titled, Incident Management, dated 5/9/2025, the P&P indicated, . [facility name] will use the definitions listed in the Appendix A. Incidents that Involve Allegations of Abuse or Neglect- When a hospital employee observes suspected patient abuse or receives an allegation of patient abuse from another person, they shall. Refer to AD 3308 [facility's policy and procedure] Reporting Patient Abuse and Neglect for additional information. (continued on next page)</p>		

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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 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the facility's P&P attachment titled, Appendix A- Definitions, undated, the document indicated, Alleged Patient abuse- physical: any intentional interaction or physical contact, motion, or action that is directed toward a patient by someone other than another patient. Alleged Patient Abuse- Psychological: Any act by someone other than another patient that causes or could reasonably be expected to cause mental suffering. Alleged Sexual Abuse: An employee engages in sexual contact with a patient. An employee encourages or allows sexual contact between patients. During a review of the facility's P&P titled, Reporting Patient Abuse and Neglect, dated 1/3/2023, the P&P indicated, .Definitions. Physical abuse: Any of the following: (a) Assault, as defined in Section 240 of the Penal Code. Psychological abuse- any act by someone other than another patient. Verbal abuse- any language by someone other than another patient. Sexual abuse- an employee engages in sexual contact with a patient. An employee encourages or allows sexual contact between patients. Training. What constitutes abuse, neglect and misappropriation of resident property . Training- all employees are required to complete annual patient abuse prevention training. Train employees through orientation and on-going sessions on issues related to abuse prohibition practices such as: What constitutes abuse .</p>