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	05/06/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interviews and record review, the facility failed to ensure that an alleged violation of neglect was reported within 24 hours to the administrator and that the SOC 341 (Report of Suspected Dependent Adult/Elder Abuse - a mandated California Department of Social Services form used by professionals to report suspected abuse and neglect) was initiated timely when an alleged staff was observed asleep while performing Line of Sight (LOS-a safety intervention requiring continuous direct visual) observation to Resident 1.This failure had the potential to delay the initiation of a timely investigation and implementation of interventions to ensure Resident 1's safety.Findings:During a review of Resident 1's Face Sheet (demographics), dated 4/29/2026, the record indicated Resident 1 was admitted to the facility on [DATE] with a history of diagnoses that included: schizophrenia (a chronic, severe brain disorder that causes individuals to interpret reality abnormally, characterized by symptoms like hallucinations, delusions, and disorganized thinking), other epilepsy - not intractable - without status epilepticus (a seizure disorder that is manageable with medication and does not involve prolonged, continuous seizing) and benign neoplasm of cerebral meninges (a slow growing, noncancerous tumor arising from the protective membranes surrounding the brain).During an interview on 4/29/26 at 9:42 a.m. with Nursing Coordinator (NC), NC stated that on 4/13/26 at approximately 9:00 a.m. he received an email from the Acting after-hours Supervisor Registered Nurse (ASRN) 1 regarding an incident on 4/4/26 alleging the Registry Registered Nurse (RRN) 1 fell asleep while assigned to provide line-of-sight (LOS) observation to Resident 1. NC stated that staff were expected to have reported the incident and should have completed an SOC 341 at time of incident as the incident was considered neglect. NC further stated that SOC 341 was not completed until 4/13/26.During an interview on 4/29/26 at 10:07 a.m. with Supervising Registered Nurse (SRN) 1, SRN 1 stated Resident 1 had been on LOS for danger to self (DTS) behaviors that included throwing herself down to the ground and injuring self.During an interview on 4/29/26 at 8:20 p.m. with ASRN 1, ASRN 1 confirmed he worked the overnight (NOC) shift on 4/3/26. ASRN 1 stated he was contacted in the early morning of 4/4/26 by Registered Nurse (RN) 1, who notified him that RRN 1 fell asleep while assigned to provide LOS observation to Resident 1. ASRN 1 stated this incident would be considered neglect because RRN 1 was asleep and unable to pay attention and watch Resident 1 ?s safety. ASRN 1 confirmed that he did not initiate an SOC 341 at time of the incident.During an interview on 4/30/26 at 6:10 a.m. with RN 1, RN 1 confirmed she worked the NOC shift on 4/3/26. RN 1 stated she went to do her rounds (every 15/30 minute observation of residents) and noticed RRN 1's eyes appeared closed and appeared to be asleep. RN 1 stated she went up to RRN 1 and called out her name with no response and heard what sounded like sleeping sounds. RN 1 stated this was potential neglect because Resident 1 was on LOS observation for safety and RRN 1 was asleep and did not watch Resident 1. RN 1 stated that she notified ASRN 1 but did not know an SOC 341 needed to be completed. RN 1 confirmed an SOC 341 was not initiated at time of incident.During a review of Resident 1's Interdisciplinary Note, dated 4/13/26 at 10:38 a.m., the record indicated that on 4/13/26 at approximately 9:20 a.m. information was obtained that an employee assigned to monitor a patient (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on line of sight (LOS) during 4/3/25 NOC shift was noted sleeping while on the assignment.During a review of Resident 1's Treatment Plan, dated 4/9/26, the record indicated on 4/3/26 Resident 1 had a mini team meeting where it was determined Resident 1 would remain on LOS for DTS. Record indicated that Resident 1 had open focus (care plan - written document outlining a person's specific health needs, goals, and the actions healthcare providers will take to meet them) 3.1 Dangerousness and Impulsivity related to history of aggressive and self-injurious behaviors in response to experience of auditory hallucinations. High risk behaviors include throwing body against the wall and floor, banging head and physical assault of others. Interventions include staff monitor Resident 1 daily for proper use of coping skills that will assist in preventing self-injurious behaviors.During a review of Resident 1's Physician's Orders, dated 4/3/26 at 9:00 a.m., the record indicated that Resident 1's LOS order was renewed for 72 hours.During a review of facility's Report Of Suspected Dependent Adult/Elder Abuse (SOC 341), dated 4/13/26, the report indicated neglect of Resident 1 occurred on 4/4/26 between the times of 0200-0400 and 0600-0700 hours. The record further indicated that the incident was not reported to law enforcement until 4/13/26.During a review of the facility's policy and procedure (P&P) titled, Supervision for High Risk Patients, dated 6/18/2024, the P&P indicated, .It is the policy of [Facility Name] to provide time-limited enhanced observation of patients for the safety of patients. Line of Sight Patients (LOS Patients) shall always be in the field of vision of an assigned staff person who will be able to notice and intervene if a dangerous incident occurs.During a Review of facility's policy and procedure (P&P) titled, Reporting Patient Abuse and Neglect, dated 5/7/2025, the P&P indicated, .Neglect - failure to provide care or service. protection from health and safety hazards. General Rules 5.1 Any mandated reporter who, in their professional capacity, or within the scope of their employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse. or neglect. shall report the known or suspected instance of abuse to the Office of Protected Services (OPS) / Department of Police Services (DPS) local law enforcement agency, by telephone or through a written report immediately or as soon as practicably possible. All staff must report any observed or suspected cases. or who is informed and reasonably believe that an individual has experienced behavior constituting. neglect. 5.3 When a hospital employee observed suspected patient abuse, or receives an allegation of patient abuse from another person, they shall immediately:. 5.3.5 Complete a Report of Suspected Dependent Adult/Elder Abuse (Form SOC 341) and attach the form to the completed incident report by end of shift.9.3 All alleged violations involving abuse, neglect,. which occurred in Skilled Nursing units. do not involve abuse and/or do not result in serious bodily injury, the report should be submitted to CDPH no later than within 24 HOURS.