

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  11/08/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>39605</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and respect for two of 12 sampled residents (Residents 13 and 357) when:</p> <ol style="list-style-type: none"> <li>1. Registered Nurse (RN) 3 was standing while feeding Resident 13 in bed.</li> <li>2. Registered Nurse (RN) 1 was standing while feeding Resident 357 in the dining room.</li> </ol> <p>These failures resulted in Resident 13 and Resident 357 not being provided a respectful and dignified dining experience.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During an observation on 11/4/24 at 1:06 PM in Resident 13's room, Resident 13 was in an enclosure bed with head of bed up. Resident 13 was nonverbal and unable to communicate needs. Resident 13 was being fed by Registered Nurse (RN) 3 while standing. RN 3 was not at Resident 13's eye level. Resident 13's gaze was on the chest level of RN 3.</li> </ol> <p>During an interview on 11/4/24 at 1:24 PM with RN 3, RN 3 stated, I have to have a chair . sitting in front of the patient. RN 3 stated he should be at eye level of Resident 13. RN 3 stated, Standing over [resident] is intimidating. RN 3 stated standing while feeding could have affected resident's dignity.</p> <p>During a review of Resident 13's clinical record titled Treatment Plan, with a conference date of 11/8/24, the treatment plan indicated, . Current Status . [Resident 13] . was admitted . on 6/28/2023 .</p> <p>During an interview on 11/6/24 at 10:50 AM with RN Shift Lead (RNSL) 3, RNSL 3 stated staff were supposed to be sitting while feeding resident and at eye level. RNSL 3 stated, Sitting while feeding conveys respect. RNSL 3 stated standing while feeding a resident could have felt overpowering to the resident. RNSL 3 stated, It could be dignity issue. RNSL 3 stated RN 3 should have gotten a chair and sat while feeding resident. RNSL 3 stated RN 3 should have been at Resident 13's eye-level.</p> <p>(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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/7/24 at 10:27 AM with Supervising RN (SRN) 1, SRN 1 stated the expectation was to be at eye level position while feeding a resident. SRN 1 stated staff could have sat on the chair or raised the bed. SRN 1 stated, It's more a dignity and respect . for resident not to feel the staff is towering over them.</p> <p>During a review of the Policy and Procedure (P&amp;P) titled, 24 - Hour Dining Room Support Plan, dated October 2024, the P&amp;P indicated . Procedure . j) Staff will remain seated and attentive to patient when feeding patients .</p> <p>47844</p> <p>2. During an observation on 11/4/24 at 12:44 PM in the dining hall, observed Resident 357 being assisted by Registered Nurse (RN) 1 during lunch. RN 1 was observed to be standing while he assisted Resident 357 with drinking. Resident 357's neck was observed to be tilted back and Resident 357 started to cough.</p> <p>During an interview on 11/4/24 at 12:45 PM with RN 2, RN 2 stated that staff were supposed to be sitting when they assist Residents with eating.</p> <p>During an interview on 11/4/24 at 12:58 PM with RN 1, RN 1 stated Resident 357 was at risk for choking so he assisted him during lunch. RN 1 further stated he was supposed to sit while assisting a Resident with meals.</p> <p>During a review of Resident 357's Aspiration Risk care plan, dated 10/30/24, the care plan indicated .The patient will display ability to chew and swallow safely, as evidenced by absence of aspiration, no evidence of coughing or choking during eating/drinking.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, 24 - Hour Dining Room Support Plan, dated October 2024, the P&amp;P indicated, .Procedure . j) Staff will remain seated and attentive to patient when feeding patients.</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47844</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure two of 22 sampled residents (Resident 357 and Resident 26) had their call lights within reach.</p> <p>This failure had the potential to result in Resident 357 and Resident 26 not having their needs met.</p> <p>Findings:</p> <p>1. During a review of Resident 357's Clinical Record, the record indicated that Resident 357 was admitted to the facility on [DATE] with a history of diagnoses that included Schizoaffective disorder, Bipolar type (a rare mental health condition that involves both schizophrenia symptoms and bipolar disorder symptoms), and major neurocognitive disorder (a decline in mental function caused by a medical condition, rather than a psychiatric illness) due to traumatic brain injury (Brain dysfunction caused by an outside force, usually a violent blow to the head).</p> <p>During a concurrent observation and interview on 11/4/24 at 1:56 PM with Resident 357, in Resident 357's room, observed Resident 357 laying in a enclosure bed, call light outside enclosure bed dangling by the wall out of Resident's reach. During interview with Resident 357, his thought patterns were scattered and was unable to answer questions or make needs known.</p> <p>During an interview on 11/4/24 at 1:59 PM with Psychiatric Technician (PT) 5, PT 5 stated the call light should be inside Resident 357's enclosure bed. PT 5 then stated she was wrong and Resident 357's call light was not supposed to be in the enclosure bed because it would have to be put through the zipper and the zipper would not be able to zip all the way up.</p> <p>During an interview on 11/4/24 at 2:05 PM with Registered Nurse (RN) 2, RN 2 confirmed call light was outside of Resident 357's enclure bed and stated, The call light should be in the [enclosure brand] bed whenever the resident is in the bed.</p> <p>During a review of Resident 357's ADL Deficit care plan, dated 10/30/24, the care plan indicated .Keep call light within reach when patient is in bed, qshift [every shift].</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Call Light Use, dated February 2024, the P&amp;P indicated .Procedure . 2. Ensure that call light cord is within the reach of the patient.</p> <p>51225</p> <p>2. During a concurrent observation and interview on 11/5/24 at 8:59 AM with Registered Nurse (RN) 4 in Resident 26's room, call light was observed hanging from the wall out of the resident's reach. RN 4 stated Resident 26's call light should have been within the resident's reach.</p> <p>During an observation on 11/6/24 at 8:09 AM and 8:57 AM in Resident 26's room, call light was observed hanging from the wall out of the resident's reach.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/6/24 at 10:07 AM with Supervising Registered Nurse (SRN) 2, SRN 2 stated rounds were conducted every 30 minutes to ensure resident safety which included ensuring call lights within reach of resident.</p> <p>During an observation on 11/6/24 at 10:47 AM in Resident 26's room, call light was observed hanging from the wall, not within Resident 26's reach.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Call Light Use, dated February 2024, P&amp;P indicated, . The purpose of a call light is to enable a patient who is confined to the bed to communicate with staff when assistance is needed . Ensure that call light cord is within the reach of the patient .</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>51225</p> <p>Based on observations, interview, and record review, the facility failed to provide tube feeding (liquid nutrition delivered using a feeding pump directly into the stomach) per the doctor's order for one of two sampled residents (Resident 26).</p> <p>This failure had the potential to result in weight loss and complications of tube feedings for Resident 26.</p> <p>Findings:</p> <p>During an observation on 11/6/24 at 8:57 AM in Resident 26's Room, Resident 26 was observed with a gastrostomy tube (GT - a tube inserted through the skin directly into the stomach for liquid nutrition). Resident 26's tube feeding pump was alarming and not providing tube feeding at that time. The tube feeding was attached to a feeding pump set to deliver 60 milliliters (milliliter (ml) is approximately 2 ounces) of liquid nutrition per hour. The label on the tube feeding bag indicated the feeding was started on 11/6/24 at 12 AM and was to infuse for 22 hours.</p> <p>During a concurrent observation and interview on 11/6/24 at 11:14 AM with Registered Nurse Shift Lead (RNSL) 2 in Resident 26's room, Resident 26's tube feeding pump was alarming and not providing tube feeding at that time. RNSL 2, verified that Resident 26's feeding pump was not delivering the tube feeding. RNSL 2 stated, The pump was probably left on hold after patient care. RNSL 2 stated she was unaware of how long the pump was not infusing and the amount of tube feeding Resident 26 did not receive. RNSL 2 further stated that missing tube feedings could lead to a resident's weight loss.</p> <p>During an interview on 11/6/24 at 11:38 AM with Registered Nurse (RN) 5, RN 5 verified Resident 26 received 470 ml of tube feeding from 11/6/24 at 12 AM through 11:38 AM. RN 5 verified Resident 26 should have received 660 ml [190ml of tube feeding was not given to Resident] of tube feeding during this time.</p> <p>During an interview on 11/7/24 at 9:05 AM with RNSL 2, RNSL 2 verified that Resident 26's tube feeding was off several hours on 11/6/24 and Resident 26 did not receive the correct amount of tube feeding as ordered by the physician.</p> <p>During an interview on 11/7/24 at 10:24 AM with the Registered Dietitian (RD), RD stated if Resident 26 did not receive his ordered tube feeding there was a potential for resident to experience weight loss.</p> <p>During a review of Resident 26's Physician's Orders and Medication, dated 10/28/24, the Physician's Order indicated Resident 26 should receive tube feeding at a rate of 60 ml per hour for 22 hours via the GT.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50852</p> <p>Based on observation, interview, and record review, the facility failed to ensure food service safety and sanitation requirements were met when:</p> <ol style="list-style-type: none"> <li>1. Food trays were observed unclean, chipped and with brownish, yellowish stains.</li> <li>2. Expired foods were found in dry warehouse, freezer and food storage area.</li> <li>3. One dented can was found in dry warehouse.</li> <li>4. One heavily marred chopping board was in the food preparation area.</li> </ol> <p>These failures had the potential to cause food borne illness among vulnerable residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a concurrent observation and interview on [DATE] at 11:58 AM with Dietetics Director (DD) in the clean tray area, 15 gray food trays were observed as unclean with food debris, and one food tray with an old meal ticket still attached. The trays were chipped with brown and yellowish stains. DD stated the unclean, chipped and stained trays should not be in the clean area.</li> </ol> <p>During review of the facility's Policy and Procedure (P&amp;P) titled, Nutrition Policy Manual Policy Number: 3401, dated [DATE], the P&amp;P indicated, . All kitchen and dining room utensils along with food contact surfaces used in the preparation and/or serving of food and drink are cleaned and sanitized before use, after being used and after each meal . Nonfood contact surfaces of equipment are maintained to keep them cleaned and sanitized .</p> <ol style="list-style-type: none"> <li>2. During a concurrent observation and interview on [DATE] at 12:38 PM with Supervising [NAME] (SC) in the Dry Warehouse, a pack of expired sugar was observed. SC stated the expired sugar should not be here.</li> </ol> <p>During a concurrent observation and Interview on [DATE] at 1 PM with Dietetic Director (DD) and SC in the food storage area, 16 boxes of expired coleslaw were found labeled wih Best used by [DATE]. DD stated the coleslaw arrived last Friday [[DATE]] we will toss it. SC stated we go by the best used by date, we should have checked the coleslaw when we received it in the warehouse.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Nutrition Policy Manual Policy Number: 3401.033 dated [DATE], the P&amp;P indicated, . It is the responsibility of all Department of Nutrition Services staff to carefully observe all food item expiration, use by, sell by, delivery dates and open container dates to ensure there are no expired products being used or stored .</p> <ol style="list-style-type: none"> <li>3. During concurrent observation and interview on [DATE] at 12:48 PM with the Dietetic Director (DD) and Supervising [NAME] (SC) in the dry warehouse, one dented can of Vanilla Pudding was found on a storage rack labeled use it first. SC stated, This should have gone in the Dented Cans Area.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During review of the facility's Policy and Procedure (P&amp;P) titled, Nutrition Policy Manual Policy Number 3401.033, dated [DATE], P&amp;P indicated, .Will reject any damaged, moisture soaked, freezer burnt, thaw &amp; refrozen sign on box, leaking containers, visible dented cans, or any other established departmental food or nonfood delivery items at point of delivery .</p> <p>4. During a concurrent observation and interview on [DATE] at 1:07 PM with Supervising [NAME] (SC) and Food Service Technician (FST) in the Cold Prep area, a yellow cutting board was observed marred with deep cut marks on the surface where food was placed to be cut. SC stated the chopping board has the potential for bacterial growth and it needs to be changed.</p> <p>During review of the facility's Policy and Procedure (P&amp;P) titled, Nutrition Policy Manual Policy Number: 3401, dated [DATE], the P&amp;P indicated, . All kitchen and dining room utensils along with food contact surfaces used in the preparation and/or serving of food and drink are cleaned and sanitized before use, after being used and after each meal .</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>50852</p> <p>Based on observation, interview, and record review, the facility failed to keep food storage areas in the warehouse and main kitchen clean from debris and garbage.</p> <p>This failure had the potential to result in food borne illness in vulnerable residents.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 11/4/24 at 12:44 PM with the Dietetics Director (DD) in the warehouse, two cups of grape juice and chipped wood debris were observed on the floor. DD was observed throwing the grape juice cups away in the trash can. DD stated the trash and debris should have been cleaned out.</p> <p>During a concurrent observation and interview on 11/4/24 at 1:02 PM with the Assistant Dietetics Director (ADD) in the walk-in freezer, chipped wood and plastic wrappers were observed on the floor. ADD stated, it should have been cleaned out.</p> <p>During a review of the facility's Policy and Procedure titled, Nutrition Policy Manual Policy Number: 3401, dated July 2018, P&amp;P indicated, .The objective is to control and remove any source of contamination and prevent the growth of bacteria: Garbage is always put into designated disposal units with lids . The storeroom is sweep daily and any debris from deliveries or daily activities of warehouse to supply production and presentation of food and nonfood items will be cleaned up daily</p>

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>47844</p> <p>Based on interview and facility record review, the facility failed to have a written Quality Assurance Performance Improvement (QAPI - a program that enables the facility to evaluate and improve the quality of Resident care and services through data collection, staff input, and other information) plan in place that identified areas of improvement for the Skilled Nursing units.</p> <p>This failure resulted in an ineffective QAPI program that did not identify systemic problems in the Skilled Nursing units related to infection prevention and enhanced barrier precautions (EBP- use of gown and gloves during high contact resident care activities, designed to reduce spread of infections) (cross reference F 880 and F 945).</p> <p>Findings:</p> <p>During an interview on 11/8/24 at 8:49 AM with Supervising Registered Nurse (SRN) 3, SRN 3 stated, when asked for a copy of their QAPI plan, We do not have a QAPI plan.</p> <p>During an interview on 11/8/24 at 9:02 AM with SRN 3, SRN 3 stated there was no QAPI plan for the Skilled Nursing units. SRN 3 stated that they had the capability to track and trend based on program and resident, but they were not currently doing this. SRN 3 stated that the Program (Program 6 - facility's identifier for Skilled Nursing unit) should have taken the initiative.</p> <p>During an interview with SRN 3 on 11/8/24 at 9:38 AM, SRN 3 stated EBP had not been discussed during QAPI. SRN 3 stated there was no QAPI plan for implementing EBP in place.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Quality Assurance, dated 5/3/24, the P&amp;P indicated .The purpose of the Quality Assurance Program is to establish a systemic process that monitors and evaluates various aspects of patient care to ensure that established standards of quality are met and/or maintained. The P&amp;P also indicated .5.3 The Governing Body requires the clinical disciplines at each hospital to implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, identifying opportunities to improve care, identifying solutions to existing clinical problems, and determining if implemented solutions resolved such problems.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>47844</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance (QAA) committee had the required members in attendance.</p> <p>This failure had the potential for quality care improvement activities related to Infection Control to not be evaluated and revised as needed and the potential to negatively impact the quality of resident care.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 11/8/24 at 9:35 AM with the Standards Compliance Director (SCD), the SCD reviewed the Quality Council Minutes from the 9/5/24 meeting. SCD acknowledged the Infection Preventionist/Public Health Nurse II for the Skilled Nursing unit was not in attendance.</p> <p>During a record review of the Quality Council Minutes from 4/23/24, the record indicated that the Infection Preventionist/Public Health Nurse II was not in attendance.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Risk Management, dated 7/8/24, the P&amp;P did not indicate the Infection Preventionist as a required member of Quality Council (QC) under section 4.3.1. 1 Quality Council Membership.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39605</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to help prevent the transmission of communicable diseases and infections for six of 22 sampled residents (Residents 7, 36, 1, 35, 11 and 54) when:</p> <ol style="list-style-type: none"> <li>1. The trash and linen carts were placed outside of Resident 7's isolation room.</li> <li>2. Psychiatric Technician (PT) 2 accepted a pitcher handed by Resident 7, who was on isolation precautions, with bare hands.</li> <li>3. Registered Nurse (RN) 7 performed wound care to Resident 36 wearing gloves as the only personal protective equipment (PPE) used.</li> <li>4. PT 1 performed wound care to Resident 1 wearing gloves as the only PPE used.</li> <li>5. Psychiatric Technician Assistant (PTA) 2 and PTA 3 changed Resident 35's linen and provided personal hygiene without wearing a gown.</li> <li>6. RN 5 and RN Shift Lead (RNSL) 2 performed a dressing change for Resident 11's pressure injury (chronic wound to the skin and underlying tissues) to his left buttock without wearing a gown.</li> <li>7. RN 5 and RNSL 2 performed a dressing change on Resident 54's left heel without wearing a gown.</li> </ol> <p>These failures placed the residents at risk for cross contamination and possible spread of infections.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During an observation on 11/5/24 at 10:15 AM by Resident 7's room, Resident 7 was in the room sitting in her wheelchair listening to the radio. There was a PPE (personal protective equipment) cart outside of the room, with contact (spread of infectious diseases through direct or indirect contact with a person or their environment) and droplet (infectious diseases that are transmitted through respiratory droplets) isolation signage. Trash and linen carts were by the door outside of the room. Psychiatric Technician (PT) 2 wore a gown, gloves and mask and went in Resident 7's room to turn on the radio. PT 2 came out of the room, removed her gown, gloves and mask and threw them in the trash cart by the door, outside of the room. PT 2 stated one cart was for trash and the other cart was for linen.</li> </ol> <p>During an interview on 11/6/24 at 9:39 AM with the Interim Nursing Coordinator (NC) 1, NC 1 stated the trash and linen carts should have been inside Resident 7's room. NC 1 stated keeping the linen and trash cart inside the room contained and limited the spread of infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 11/6/24 at 9:48 AM with Interim Infection Preventionist (IIP), IIP stated Resident 7 was on transmission based, droplet precaution for influenza. IIP stated the linen and trash carts should have been inside the room for infection control. The IIP stated keeping the carts inside the room was a precaution for spread of infection.</p> <p>During an interview on 11/7/24 at 9:25 AM with Registered Nurse Shift Lead (RNSL) 1, RNSL 1 stated Resident 7 was on contact and droplet precaution. RNSL 1 stated, Trash and linen [carts] should be inside the room . To contain the infection and not spread it all over the unit.</p> <p>During a review of the policy and procedure (P&amp;P) titled, Transmission Based Precautions - Contact Precautions Guidelines, dated March 2022, the P&amp;P indicated, . Initiation of Precaution . Place biohazardous [biological or chemical substances that can be dangerous to people, animals or the environment] trash in the patient's room Gowns . Discard the gown in the biohazardous trash before leaving the room .</p> <p>2. During an observation on 11/5/24 at 10:15 AM by the hallway of Resident 7's room, Resident 7 was in the room, sitting in her wheelchair listening to the radio. There was a PPE (personal protective equipment) cart outside of the room, with contact and droplet isolation signage by the door.</p> <p>During a concurrent observation and interview on 11/5/24 at 10:18 AM outside of Resident 7's room, Resident 7 was inside the room by the door. Resident 7 handed her water pitcher to Psychiatric Technician (PT) 2. PT 2 took the water pitcher from Resident 7 with her bare hands.</p> <p>During an interview on 11/5/24 at 10:30 AM with PT 2, PT 2 stated, I should have used gloves . I could get the flu.</p> <p>During an interview on 11/6/24 at 9:39 AM with Interim Nursing Coordinator (NC) 1, NC 1 stated staff (PT 2) should have worn gloves. NC 1 stated, It's contact precaution . risk of staff contacting influenza.</p> <p>During an interview on 11/6/24 at 9:48 AM with Interim Infection Preventionist (IIP), IIP stated Resident 7 was on transmission based and droplet precaution for influenza. IIP stated PT 2 should have worn gloves when receiving items from the isolation room. IIP stated the water pitcher was contaminated and potentially transferred infectious organisms.</p> <p>During a review of the policy and procedure (P&amp;P) titled, Transmission Based Precautions - Contact Precautions Guidelines, dated March 2022, the P&amp;P indicated, . Personal protective equipment . shall be utilized by staff as warranted by the situation for the protection against all hazards . Gloves . Everyone . shall put on gloves .</p> <p>3. During an observation on 11/4/24 at 1:10 PM in the hallway by Resident 36's room, the hallway was clear. There was no enhanced barrier precaution (EBP - use of gown and gloves during high contact resident care activities, designed to reduce spread of infections) signage by the door and no personal protective equipment (PPE) cart.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of Resident 36's clinical record titled Treatment Plan, dated 10/31/24, the treatment plan indicated, . MEDICAL PROBLEMS . 15. Left Buttock Pressure Injury [a localized area of skin damage caused by prolonged pressure on skin] Unstageable [a localized area of skin damage caused by prolonged pressure on skin] . 16. Right Buttock Pressure Injury Unstageable .</p> <p>During an observation on 11/6/24 at 3:05 PM in Resident 36's room, Registered Nurse (RN) 7 was performing a wound dressing change on Resident 36. RN 7 was assisted by Psychiatric Technician (PT) 3. RN 7 and PT 3 had a mask and gloves on, without a gown.</p> <p>During an interview on 11/7/24 at 8:52 AM with PT 3, PT 3 stated she assisted RN 7 with wound care for Resident 36 on 11/6/24. PT 3 stated, We just used mask and gloves . I am not familiar with [EBP] . I never heard about it. PT 3 stated there was no training which she could remember regarding EBP.</p> <p>During an interview on 11/7/24 at 9:03 AM with RN 7, RN 7 stated he performed wound care on Resident 36 on 11/6/24. RN 7 stated, I used gloves and mask. I always use mask when I do wound care. RN 7 stated, I don't know if there was any training done for that [EBP] . I did not get training on EBP.</p> <p>During a review of the All Facilities Letter (AFL- memo issued by the California Department of Public Health) dated 6/13/2024, the AFL indicated skilled nursing facilities should implement EBP per CDC guidance as part of infection control for certified skilled nursing facilities.</p> <p>During a review of a professional reference found in <a href="https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html">https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html</a>, dated 4/2/24, the reference indicated, . Enhanced Barrier Precautions (EBP) are an infection control intervention . that employs targeted gown and glove use during high contact resident care activities . indicated . for residents with . Wounds or indwelling medical devices .</p> <p>47844</p> <p>4. During a review of Resident 1's Clinical Record, the record indicated that Resident 1 was admitted to the facility on [DATE] with a history of diagnoses that included Huntington's disease (a genetic brain disorder that causes nerve cells in the brain to break down and die. It affects movement, thinking, and mood, and worsens over time), depressive disorder, and history of pressure ulcers (a localized area of damaged skin or tissue caused by prolonged pressure on the skin).</p> <p>During a concurrent observation and interview on 11/5/24 at 9:53 AM with Psychiatric Technician (PT) 1 outside Resident 1's room, observed PT 1 prepare to perform wound care for Resident 1's pressure ulcer. PT 1 stated she was going to perform ordered wound care for a pressure ulcer wound on Resident 1's right foot second toe. Observed no enhanced barrier precaution (EBP- an infection control intervention designed to reduce transmission of resistant organisms by utilizing gown and glove use during high contact resident care activities) signage outside Resident 1's room.</p> <p>During a concurrent observation and interview on 11/5/24 at 9:56 AM with Registered Nurse (RN) 3 in Resident 1's room, observed RN 3 enter room, donned clean gloves and prepared to assist PT 1 with positioning Resident 1 for wound care. RN 3 stated Resident 1 currently has one unstageable pressure ulcer on right toe.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on 11/5/24 at 9:58 AM in Resident 1's room, observed PT 1 wheel in treatment cart with prepared supplies. PT 1 doffed dirty gloves, sanitized hands, and then donned clean gloves. PT 1 proceeded with wound care treatment on Resident 1's right second toe. Did not observe PT 1 using gown per EBP guidance during wound care treatment.</p> <p>During an interview on 11/6/24 at 8:05 AM with RN 3, RN 3 stated that Resident 1 was not on EBP.</p> <p>During an interview on 11/6/24 at 2:25 PM with Interim Infection Preventionist (IIP), IIP stated that wound care was standard precautions unless the resident was on contact precautions. IIP was unaware of EBP guidelines and stated they do not have an EBP policy.</p> <p>During a review of Resident 1's Physician's Orders, dated 10/23/24, the Physician's Orders indicated the physician ordered wound treatment for pressure ulcers on Resident 1's right 2nd toe.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled Assessment, Prevention and Treatment of Pressure Injuries and Wounds, dated February 2024, the P&amp;P indicated, .Procedure . Staff are to observe strict aseptic technique when performing wound care and wear appropriate Personal Protective Equipment (PPE) as necessary to control infection.</p> <p>During a review of the All Facilities Letter (AFL- memo issued by the California Department of Public Health) dated 6/13/2024, the AFL indicated skilled nursing facilities should implement EBP per CDC guidance as part of infection control for certified skilled nursing facilities.</p> <p>During a review of a professional reference found in <a href="https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html">https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html</a>, dated 4/2/24, the reference indicated, . Enhanced Barrier Precautions (EBP) are an infection control intervention . that employs targeted gown and glove use during high contact resident care activities . indicated . for residents with . Wounds or indwelling medical devices .</p> <p>51225</p> <p>5. During an observation on 11/6/24 at 8 AM outside Resident 35's room, no signage was present to indicate Resident 35's requirement for enhanced barrier precautions (EBP - a set of infection control measures that requires gowns and gloves during high-contact patient care activities to reduce the spread of multidrug-resistant organisms).</p> <p>During a concurrent observation and interview on 11/6/24 at 3:55 PM in Resident 35's room, Psychiatric Technician Assistant (PTA) 2 and PTA 3 changed Resident 35's linens and provided personal hygiene. Resident 35 had a gastrostomy tube, (GT - tube through the abdomen directly into the stomach), both PTA 2 and PTA 3 did not wear a gown during the observation. PTA 2 and PTA 3 both stated they had never heard of EBP.</p> <p>During a concurrent observation and interview on 11/7/24 at 9:45 AM in Resident 35's room, Registered Nurse (RN) 6 and Licensed Vocational Nurse (LVN), provided personal hygiene and changed linens for Resident 35. RN 6 and LVN did not wear a gown during the observation. Resident 35 displayed an intermittent cough throughout the observation. RN 6 and LVN both stated that they did not know anything about enhanced barrier precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 11/7/24, at 10:14 AM with Registered Nurse Shift Lead (RNSL) 1, RNSL 1 stated a gown was not required when providing personal hygiene and linen changes for Resident 35. RNSL 1 stated that he had not heard of EBP.</p> <p>During a review of Resident 35's Treatment Plan, dated 10/14/24, the Treatment Plan indicated, Resident 35 had a GT. The Treatment Plan further indicated, Resident 35's GT was replaced on 9/28/24 due to cellulitis (infection caused by bacteria) at the insertion point. Resident 35 also tested positive for MRSA (Methicillin-resistant Staphylococcus Aureus - bacterial infection which is resistant to multiple antibiotics) in the nares (nostrils).</p> <p>During a review of Resident 35's MRSA Screen (laboratory test for presence of MRSA), dated 10/7/24, the MRSA Screen indicated Resident 35 was positive for MRSA of the nares.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Duodenostomy [artificial opening into the stomach through the abdominal wall], Gastrostomy, Jejunostomy [artificial opening into the small intestines through the abdominal wall], Enteral Tubes: Feeding and Care, dated June 2022, the P&amp;P indicated, . personal protective equipment (PPE) (e.g. mask, face shield, gown) as clinically indicated .</p> <p>During a review of the All Facilities Letter (AFL- memo issued by the California Department of Public Health) dated 6/13/2024, the AFL indicated skilled nursing facilities should implement EBP per CDC guidance as part of infection control for certified skilled nursing facilities.</p> <p>During a review of CDC recommendations dated 4/2/24, indicated, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities (personal hygiene, linen change, providing medications and treatments such as wound dressing change) for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).</p> <p>6. During an observation on 11/5/24 at 9:29 AM outside of Resident 11's room, no enhanced barrier precautions (EBP - a set of infection control measures that requires gowns and gloves during high-contact patient care activities to reduce the spread of multidrug-resistant organisms) signage was posted.</p> <p>During an observation on 11/6/24 at 8:13 AM in Resident 11's room, Registered Nurse (RN) 5 and Registered Nurse Lead (RNSL) 2 performed a dressing change for Resident 11's pressure injury (chronic wound to the skin and underlying tissues) to his left buttock. RN 5 and RNSL 2 did not wear gowns.</p> <p>During an interview on 11/7/24 at 10 AM with RN 5, RN 5 stated a gown was not needed for a dressing change. When asked about EBP, RN 5 stated, I have never heard of that.</p> <p>During a review of Resident 11's Treatment Plan, dated 9/17/24, the Treatment Plan indicated on 9/16/24, Resident 11 was diagnosed with a pressure injury on his left hip area.</p> <p>During a review of the Medication and Treatment Record, dated 11/6/24, the Medication and Treatment Record indicated Resident 11 had a pressure ulcer on the left hip area which required daily dressing change.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of facility's policy and procedure (P&amp;P) titled, Assessment, Prevention and Treatment of Pressure Injuries and Wounds, dated February 2024, the P&amp;P indicated, . Staff are to observe strict aseptic technique [procedure used by medical staff to prevent spread of infection] when performing wound care and wear appropriate personal protective equipment as necessary to control infection .</p> <p>During a review of the All Facilities Letter (AFL- memo issued by the California Department of Public Health) dated 6/13/2024, the AFL indicated skilled nursing facilities should implement EBP per CDC guidance as part of infection control for certified skilled nursing facilities.</p> <p>During a review of CDC recommendations dated 4/2/24, indicated, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities (personal hygiene, linen change, providing medications and treatments such as wound dressing change) for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).</p> <p>7. During an observation on 11/5/24 at 9:29 AM outside of Resident 54's room, no enhanced barrier precautions (EBP - a set of infection control measures that requires gowns and gloves during high-contact patient care activities to reduce the spread of multidrug-resistant organisms) signage was posted.</p> <p>During an interview on 11/5/24 at 9:29 AM Registered Nurse (RN) 4, RN 4 stated that Resident 54 had a pressure injury on his left heel that required dressing change.</p> <p>During an observation on 11/6/24 at 8:13 AM in Resident 54's room, RN 5 and Registered Nurse Shift Lead (RNSL) 2 performed a dressing change on Resident 54's left heel. RN 5 and RNSL 2 did not wear a gown.</p> <p>During an interview on 11/7/24 at 10 AM with RN 5, RN 5 stated a gown was not needed for a dressing change. When asked about EBP, RN 5 stated, I have never heard of that.</p> <p>During a review of Resident 54's Treatment Plan, dated 9/26/24, the Treatment Plan indicated Resident 54 had a pressure injury to his left heel.</p> <p>During a review of Resident 54's Medication and Treatment Record, dated 11/6/24, the Medication and Treatment Record indicated Resident 54 had a pressure injury on his left heel which required daily dressing change.</p> <p>During a review of facility's policy and procedure (P&amp;P) titled, Assessment, Prevention and Treatment of Pressure Injuries and Wounds, dated February 2024, the P&amp;P indicated, . Staff are to observe strict aseptic technique [procedure used by medical staff to prevent spread of infection] when performing wound care and wear appropriate personal protective equipment as necessary to control infection .</p> <p>During a review of the All Facilities Letter (AFL- memo issued by the California Department of Public Health) dated 6/13/2024, the AFL indicated skilled nursing facilities should implement EBP per CDC guidance as part of infection control for certified skilled nursing facilities.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of CDC recommendations dated 4/2/24, indicated, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities (personal hygiene, linen change, providing medications and treatments such as wound dressing change) for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).</p>		

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<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.</p> <p>39605</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective infection control training program for 94 of 94 staff when the facility did not develop a written policy and training for staff regarding Enhance Barrier Precautions (EBP- use of gown and gloves during high contact resident care activities, designed to reduce spread of infections). (cross reference to F880)</p> <p>This failure had the potential to negatively affect the facility's ability to maintain a safe environment to prevent the spread of infectious diseases among the 54 residents in the facility.</p> <p>Findings:</p> <p>During an observation on 11/4/24 at 1:10 PM in the hallway by Resident 36's room, the hallway was clear. There was no personal protective equipment (PPE) cart or EBP signage by the door.</p> <p>During a review of Resident 36's clinical record titled, Treatment Plan, dated 10/31/24, the treatment plan indicated, . MEDICAL PROBLEMS . 15. Left Buttock Pressure Injury [a localized area of skin damage caused by prolonged pressure on skin] Unstageable [extent of injury cannot be determined] . 16. Right Buttock Pressure Injury Unstageable .</p> <p>During an interview on 11/6/24 at 2:05 PM with Interim Infection Preventionist (IIP), IIP stated, I am not aware of this [EBP] . We are not up to date with EBP. IIP stated EBP was not being practiced in the facility. IIP stated, Our policy does not address EBP.</p> <p>During an observation on 11/6/24 at 3:05 PM in Resident 36's room, Registered Nurse (RN) 7 was performing a wound dressing change on Resident 36. RN 7 was assisted by Psychiatric Technician (PT) 3. RN 7 and PT 3 had mask and gloves on without a gown.</p> <p>During an interview on 11/7/24 at 8:52 AM with PT 3, PT 3 stated she assisted RN 7 with wound care for Resident 36 on 11/6/24. PT 3 stated, We just used mask and gloves . I am not familiar [EBP] . I never heard about it. PT 3 stated there was no training which she could remember regarding EBP.</p> <p>During an interview on 11/7/24 at 9:03 AM with RN 7, RN 7 stated he performed wound care on Resident 36 on 11/6/24. RN 7 stated, I used gloves and mask. I always use mask when I do wound care. RN 7 stated, I don't know if there was any training done for that [EBP] . I did not get training on EBP. RN 7 stated wearing gown and gloves limited the spread of infection.</p> <p>During an interview on 11/7/24 at 9:30 AM with RN Shift Lead (RNSL) 3, RNSL 3 stated She was not aware of EBP. RNSL 3 stated, I just found about it today . We did not have any training [EBP]. RNSL 3 stated gowning and gloving protected the care provider and other residents from cross contamination.</p> <p>(continued on next page)</p>		

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<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 11/7/24 at 10:30 AM with Supervising RN (SRN) 1, SRN 1 stated, I learned about it [EBP] yesterday. My staff don't know what EBP is. SRN 1 stated, We still have to train our staff. SRN 1 stated there were 94 active staff in the facility and all staff did not get training on EBP.</p> <p>During an interview on 11/7/24 at 2:56 PM with Nursing Coordinator (NC) 2, NC 2 stated there was no training for EBP in the facility. NC 2 stated, We were not aware of the information . I knew about it yesterday since it was brought up to my attention by IIP.</p> <p>During a review of the facility's policy and procedure, the facility was unable to provide a policy for EBP.</p> <p>During a review of a professional reference found in <a href="https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html">https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html</a>, dated 4/2/24, the reference indicated, . Enhanced Barrier Precautions (EBP) are an infection control intervention . that employs targeted gown and glove use during high contact resident care activities . indicated . for residents with . Wounds or indwelling medical devices .</p>