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	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dept of State Hospitals - Metropolitan Snf	11401 South Bloomfield Avenue Norwalk, CA 90650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47844 Based on interviews and record review, the facility failed to ensure medical records were complete and accurately documented for one of three sampled residents (Resident 1), when Resident 1's leaking Gastrostomy-tube (G-Tube - feeding tube the provides nutrition to people who cannot eat or swallow safely) assessment was not documented. This failure had the potential to negatively affect Resident 1's care. Findings: During a record review of Resident 1's Treatment Plan, dated 11/26/24, the record indicated Resident 1 was admitted to the facility on [DATE] with a history of diagnoses that included: schizophrenia (chronic mental disorder characterized by significant disruptions in thought processes, perceptions, emotions, and social behaviors), end stage renal disease (medical condition where the kidneys permanently stop functioning), essential (primary) hypertension (high blood pressure with no identifiable cause), heart failure (chronic condition where the heart does not pump blood as well as it should), and type 2 diabetes mellitus (chronic condition in which the body does not produce enough insulin leading to high blood sugar levels). During an interview on 12/18/24 at 12:51 PM with Psychiatric Technician (PT) 1, PT 1 stated that on 11/27/24 she performed a G-tube dressing change for Resident 1 when she returned from dialysis (treatment that removes excess water, solutes and toxin from the blood when the kidneys can no longer perform these functions). PT 1 stated that she observed Resident 1's G-tube gauze dressing to be saturated with clear liquid and that her abdominal binder (a wide elastic/non-elastic belt that wraps around the abdomen to provide support and compression) was also wet. PT 1 stated she notified the registered nurse, and that assessment should have been documented on the treatment record. When asked if she documented her assessment PT 1 stated, I did not document. During a concurrent interview and record review on 12/18/24 at 12:58 PM with Registered Nurse Mentor (RNM), RNM stated that any abnormalities or refusals discovered during G-tube care, feedings, or medication administration, should have been documented on an Interdisciplinary Note (IDN). During a review of Resident 1's medical record, RNM confirmed no IDN or Medication and Treatment Record documentation related to the leaking G-tube was present in Resident 1's medical record. (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

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	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dept of State Hospitals - Metropolitan Snf	11401 South Bloomfield Avenue Norwalk, CA 90650

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1's RN Change in Physical Status Note, dated 11/27/24, the record indicated there was no documentation of a leaking G-tube. During a review of the facility's policy and procedure (P&P) titled, Duodenostomy, Gastrostomy and Jejunostomy Enteral Tubes (D-Tube, G-Tube, J-Tube): Feeding and Care, dated November 2024, the P&P indicated, .Documentation . Interdisciplinary Notes (IDN) - Summarize observational/assessment findings, interventions, notifications and responses .