

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2026
NAME OF PROVIDER OR SUPPLIER North Valley Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7660 Wyngate St Tujunga, CA 91042	
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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to remain free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of four sampled residents (Resident 1), when on 5/22/2026, Resident 2 punched Resident 1 in the face and body several times with a closed fists (a person's hands with the fingers bent inward toward the palms and held tightly closed). This deficient practice resulted in Resident 1 being subjected to physical abuse by Resident 2 while under the care and supervision of the facility. Resident 1 sustained a skin tear (a wound that happens when the layers of skin separate or peel back) on the right forearm (part of the arm between the elbow and the wrist), redness on the left temple (the sunken area on the sides of the head, located just behind the eyes, between the forehead and the ears), and pain on the right side of body, including the face, shoulder and foot. Resident 1 also reported feeling sad and depressed (a mood disorder that causes persistent feeling of sadness and loss of interest and can interfere with daily activities) following the physical altercation (a confrontation that involves physical force or contact between two or more people). During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted the resident (Resident 1) on 10/22/2025 with diagnoses that included intestinal hernia (a condition in which part of the intestine [long, tube-shaped organ in the abdomen {known as belly or stomach}] pushes through a weak area in the abdominal wall, creating a bulge), and osteoarthritis (a degenerative joint [physical point where two or more bones connect] disease where the protective cartilage [strong tissue that protects the joints and bones] that cushions the ends of the bones wears down over time) of right knee. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/27/2026, the MDS indicated Resident 1 had intact cognition (ability to think and make decisions). The MDS further indicated Resident 1 was independent with activities of daily living (ADLs- activities related to personal care such as bathing, dressing and toileting). During a review of Resident 1's History and Physical Examination (H&P - medical evaluation consisting of a detailed resident interview regarding their health history and a structured physical assessment) dated 10/26/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Change in Condition (CIC- any noticeable or significant alteration in a person's physical health, mental status, or functional ability) Evaluation dated 5/22/2026, the CIC Evaluation indicated that on 5/22/2026, Resident 1 received physical aggression (any behavior that intentionally inflicts, or threatens to inflict, physician harm or bodily injury on another person) by Resident 2. The CIC Evaluation form indicated that according to Resident 1, Resident 1 was sitting in a wheelchair near the dining room when Resident 2 suddenly came out of Resident 2's room and struck Resident 1, causing both residents (Resident 1 and Resident 2) to fall to the floor. The CIC Evaluation further indicated that Resident 1 sustained an unsized skin tear to the right forearm and unsized redness to the left temple. During a review of Resident 1's Psychiatric (anything related to diagnosing, treating, and preventing mental, emotional and behavioral disorders) Examination dated 5/26/2026, the Psychiatric Examination indicated that Resident 1 was assessed following a physical (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055146	Facility ID: 055146 If continuation sheet Page 1 of 6

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F 0600 Level of Harm - Actual harm Residents Affected - Few	assault (the intentional use of physical force or violence against another person, resulting in bodily injury or unwanted, offensive contact) by Resident 2 on 5/22/2026. The Psychiatric Examination indicated that the incident occurred in the kitchen area, where Resident 2 repeatedly stared at Resident 1, before grabbing, hitting, pushing, and kicking him (Resident 1). The Psychiatric Examination indicated that as a result of the incident, Resident 1 sustained pain to the head, shoulder, and right foot. The Psychiatric Examination further indicated that Resident 1 experienced sadness, decreased appetite, concerns about safety and emotional well-being, and reported feeling sad and depressed due to both the physical assault and its emotional impact. During a review of Resident 1's CIC Evaluation dated 5/28/2026, the CIC Evaluation indicated that on 5/28/2026, Resident 1 continued to experience pain to the right side of the head, arms, and legs, rated at four on a zero (0) to ten pain scale (zero representing no pain and ten representing the worst possible pain), indicating moderate pain. The CIC Evaluation indicated Resident 1 requested transfer to an acute care hospital, and Resident 1's physician ordered transfer to General Acute Care Hospital 1 (GACH 1). During a review of Resident 1's Nurses' Progress Notes dated 5/29/2026, timed at 3:13 p.m., the Nurses' Progress Notes indicated that Resident 1 returned to the facility from the hospital (GACH 1). During a review of Resident 1's Physician Progress Notes dated 6/3/2026, timed at 11:16 a.m., the Physician Progress Notes indicated a date of service of 6/2/2026. The Physician Progress Notes indicated that Resident 1 was seen for a psychiatric evaluation (a comprehensive mental health assessment conducted by a mental health professional to determine how a specific traumatic event has impacted an individual's psychological [refers to the mind or mental processes], emotional and cognitive functioning) following the assault by another resident (Resident 2) on 5/22/2026 and continued to report ongoing pain related to the incident. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted the resident (Resident 2) on 5/11/2026, with diagnoses that included multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder, (a mood disorder that causes a persistent feeling of sadness and loss of interest in daily activities), and epilepsy (brain disorder in which nerve cells in the brain sometimes send the wrong signals and cause seizures [a sudden burst of electrical activity in the brain that can cause changes in behavior, movements, feelings and levels of consciousness {term used to describe a person's awareness and understanding of what is happening in his or her surroundings})). During a review of Resident 2's MDS dated [DATE], the MDS indicated that Resident 2 had intact cognition. The MDS further indicated Resident 2 required moderate assistance (a resident actively participates in an activity, but requires physical help from a staff) from staff with bed mobility (movement), transfers, and walking. During a review of Resident 2's GACH 2 Physician H&P, updated on 5/8/2026, the Physician H&P indicated the following: The status history of depression was active. The status history of schizophrenia was active. The review of system was positive for anxiety (a feeling of fear, dread, or unease that makes the persons worry about what might happen next) and mood-related concerns. During a review of Resident 2's facility H&P, dated 5/11/2026, the H&P indicated diagnoses that included schizophrenia and major depressive disorder. The H&P further indicated that Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's CIC Evaluation dated 5/22/2026, timed at 8:22 p.m., the CIC Evaluation indicated that on 5/22/2026, Resident 2 initiated physical aggression towards another resident (Resident 1), which was witnessed by Certified Nursing Assistant 2 (CNA 2). When Resident 2 was asked what happened, Resident 2 stated that Resident 1 poked him (Resident 2) in the eye while he (Resident 2) was walking on the patio. The CIC Evaluation indicated that according to Resident 1, he (Resident 1) was sitting in a wheelchair in the hallway near the dining room when Resident 2 suddenly came out of a room and struck him (Resident 1), resulting in both residents (Resident 1 and Resident 2) falling to the floor. The CIC Evaluation further indicated that Resident 2's physician ordered to transfer Resident 2 to GACH 2 for further psychiatric evaluation, which was carried out. During a (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	review of the facility's investigation conclusion letter dated 5/27/2026 regarding the resident-to-resident altercation (refers to physical aggressive conflicts between residents such as hitting, pushing, kicking or biting) involving Resident 1 and Resident 2, the conclusion letter indicated that Resident 2 approached Resident 1 outside the kitchen area and hit Resident 1. The conclusion letter further indicated that the facility concluded that the incident was substantiated (a claim is true by providing solid evidence or facts) because the incident occurred. During an interview on 6/5/2026 at 8:28 a.m., with Resident 1, Resident 1 stated he remembered the incident involving Resident 2. Resident 1 stated that Resident 2 approached and punched him (Resident 1) without warning while he (Resident 1) was sitting in a wheelchair and returning a meal tray to the kitchen after dinner. Resident 1 stated that Resident 2 punched him (Resident 1) multiple times in the face and body with closed fists, causing injuries to the right forearm and face. Resident 1 further stated that he (Resident 1) continued to experience pain on the right side of his face, shoulder, flank areas (the areas on the sides and back of abdomen, between the lower ribs and hips), and leg. Resident 1 stated he (Resident 1) was transferred to the hospital about a week later (5/28/2026) due to unrelieved pain. Resident 1 stated he (Resident 1) reported to staff (did not specify) ongoing emotional distress and low mood related to the incident. Resident 1 stated that the incident involving him (Resident 1) and Resident 2 should not have happened. During a concurrent interview on 6/5/2026 at 1:20 p.m., with Dietary Aide 1 (DA 1) and Licensed Vocational Nurse 2 (LVN 2), assisting with interpretation (translated English to DA 1's own language and translated DA 1's answer to English), DA 1 stated that on 5/22/2026 at around 8 p.m., DA 1 heard noise coming from the hallway outside the kitchen. DA 1 looked through the kitchen door window and saw two residents (referring to Resident 1 and Resident 2) on the floor hitting each other while CNA 2 attempted to separating them. DA 1 stated that he and another dietary staff member (did not specify) sought additional staff assistance. DA 1 described the incident as resident-to-resident physical abuse. During an interview on 6/5/2026 at 2:02 p.m., with CNA 2, CNA 2 stated that on 5/22/2026, while CNA 2 was charting (the systematic process of documenting a resident's medical data, treatments and responses to care) in the dining room, she (CNA 2) heard noise from the hallway (near the kitchen area) and responded immediately. CNA 2 stated that upon arrival, she (CNA 2) observed Resident 2 standing in front of Resident 1, who was seated in a wheelchair. CNA 2 stated that Resident 2 grabbed Resident 1's wheelchair, and both residents ended on the floor. CNA 2 further stated that Resident 2 punched Resident 1 in the face and body multiple times with closed fists using both hands, while Resident 1 attempted to defend himself. CNA 2 stated that the incident was resident-to-resident physical abuse and that based on her (CNA 2) observations, Resident 2 was the primary aggressor (a person that attacks first or starts a conflict). During a concurrent interview and record review on 6/5/2026 at 3:22 p.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 reviewed the CIC Evaluation dated 5/22/2026 for both residents (Resident 1 and Resident 2) documented by LVN 3. LVN 3 stated that on 5/22/2026, after hearing screaming from the hallway near the kitchen area, LVN 3 immediately responded. LVN 3 stated that upon arrival, staff (did not specify) had already separated the residents (Resident 1 and Resident 2). LVN 3 stated that Resident 1 reported he (Resident 1) had been sitting in his wheelchair when Resident 2 suddenly came out of his room and struck Resident 1. LVN 3 further stated that another licensed nurse (referring to Licensed Vocational Nurse 4 [LVN 4]) assessed Resident 1 and identified a skin tear on Resident 1's right forearm and redness to the left temple. LVN 3 stated that based on information obtained from staff and the involved residents, LVN 3 concluded that physical abuse had occurred between the residents (Resident 1 and Resident 2). During a concurrent interview on 6/5/2026 at 4:03 p.m., with the Administrator (ADM) and the Director of Nursing (DON), the ADM stated that what occurred between Resident 1 and Resident 2 was resident-to-resident physical abuse. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect (failure to provide necessary care, supervision, or basic needs to a resident) and Exploitation (illegal, improper, or unauthorized use of a resident's funds, property or assets for someone else's personal profit or advantage), last reviewed (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	on 1/14/2026, the P&P indicated, It is the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedure that prohibit and prevent abuse. Abuse means the willful infliction of injury. with resulting physical harm, pain or mental anguish, which can include. certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes . physical abuse. Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate measurement and documentation of a skin tear (a wound that happens when the layers of skin separate or peel back) in accordance with professional standards of practice and the facility's policy and procedure (P&P) for one of four sampled residents (Resident 1). This deficient practice had the potential to adversely affect wound assessment, monitoring, treatment planning, and the delivery of care and services necessary for wound healing. During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted the resident (Resident 1) on 10/22/2025 with diagnoses that included intestinal hernia (a condition in which part of the intestine [long, tube-shaped organ in the abdomen {known as belly or stomach}] pushes through a weak area in the abdominal wall, creating a bulge), and osteoarthritis (a degenerative joint [physical point where two or more bones connect] disease where the protective cartilage [strong tissue that protects the joints and bones] that cushions the ends of the bones wears down over time) of right knee. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/27/2026, the MDS indicated Resident 1 had intact cognition (ability to think and make decisions). The MDS further indicated Resident 1 was independent with activities of daily living (ADLs- activities related to personal care such as bathing, dressing and toileting). During a review of Resident 1's Change in Condition (CIC- any noticeable or significant alteration in a person's physical health, mental status, or functional ability) Evaluation dated 5/22/2026, the CIC Evaluation indicated that on 5/22/2026, Resident 1 received physical aggression (any behavior that intentionally inflicts, or threatens to inflict, physical harm or bodily injury on another person) by Resident 2. The CIC Evaluation form indicated that according to Resident 1, Resident 1 was sitting in a wheelchair near the dining room when Resident 2 suddenly came out of Resident 2's room and struck Resident 1, causing both residents (Resident 1 and Resident 2) to fall to the floor. The CIC Evaluation further indicated that Resident 1 sustained an unsized skin tear to the right forearm and unsized redness to the left temple. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted the resident (Resident 2) on 5/11/2026, with diagnoses that included multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder, (a mood disorder that causes a persistent feeling of sadness and loss of interest in daily activities), and epilepsy (brain disorder in which nerve cells in the brain sometimes send the wrong signals and cause seizures [a sudden burst of electrical activity in the brain that can cause changes in behavior, movements, feelings and levels of consciousness {term used to describe a person's awareness and understanding of what is happening in his or her surroundings})). During a review of Resident 2's MDS dated [DATE], the MDS indicated that Resident 2 had intact cognition. The MDS further indicated Resident 2 required moderate assistance from staff with bed mobility (movement), transfers, and walking. During a review of Resident 2's CIC Evaluation dated 5/22/2026, timed at 8:22 p.m., the CIC Evaluation indicated that on 5/22/2026, Resident 2 initiated physical aggression towards another resident (Resident 1), which was witnessed by Certified Nursing Assistant 2 (CNA 2). When Resident 2 was asked what happened, Resident 2 stated that Resident 1 poked him (Resident 2) in the eye while he (Resident 2) was walking on the patio. The CIC Evaluation indicated that according to Resident 1, he (Resident 1) was sitting in a wheelchair in the hallway near the dining room when Resident 2 suddenly came out of a room and struck him (Resident 1), resulting in both residents (Resident 1 and Resident 2) falling to the floor. During an interview on 6/5/2026 at 8:28 a.m., with Resident 1, Resident 1 stated he remembered the incident involving Resident 2. Resident 1 stated that Resident 2 approached and punched him (Resident 1) without warning while he (Resident 1) was sitting in a wheelchair and returning a meal tray to the kitchen after dinner. Resident 1 stated that Resident 2 punched him (Resident 1) multiple (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times in the face and body with closed fists, causing injuries to the right forearm and face. During a concurrent interview and record review on 6/5/2026 at 12:54 p.m., with Treatment Nurse 1 (TN 1), TN 1 reviewed Resident 1's CIC Evaluation dated 5/22/2026 and skin checks dated 5/22/2026. TN 1 stated that the documentation identified a right forearm skin tear and left temple redness but did not include wound measurements. TN 1 further stated wound measurements should have been obtained and documented to establish a baseline and monitor wound healing progress. During a concurrent interview and record review on 6/5/2026 at 3:05 p.m., with the Director of Nursing (DON), the DON reviewed Resident 1's CIC Evaluation dated 5/22/2026 and skin checks dated 5/22/2026, and stated that licensed nursing staff should measure and document wound dimensions/wound sizes when skin tears are initially identified to facilitate monitoring of the healing process. The DON further stated that at a minimum, wound measurements should have been obtained during subsequent treatment assessments. The DON stated that wound measurements for Resident 1's injuries were not obtained until 6/5/2026. During a concurrent interview and record review on 6/5/2026 at 3:42 p.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4, who completed the skin check on 5/22/2026, reviewed Resident 1's skin check dated 5/22/2026. LVN 4 stated he assessed Resident 1's skin injuries on 5/22/2026 but did not measure the right forearm skin tear or left temple (the sunken area on the sides of the head, located just behind the eyes, between the forehead and the ears) redness. LVN 4 stated that wound measurements were required only for pressure ulcers (PU - localized damage to the skin and/or underlying tissue usually over a bony prominence) and not for skin tears, or other skin conditions. During a review of the facility's P&P titled, Skin Integrity- Skin Tears last reviewed on 1/14/2026, the P&P indicated, it is the policy of the facility to provide proper treatment and care to maintain skin integrity. This policy pertains to the prevention and management of skin tears. According to the policy and procedure, Interventions will be modified in a resident's plan of care as needed. Considerations for needed modifications include. Changes in medical condition or factors affecting the risk for skin tears. New onset or recurrent skin tear. Lack of progression towards healing, During a review of the facility's P&P titled, Skin Assessment last reviewed on 1/14/2026, the P&P indicated, this policy includes the following procedural guidelines in performing the full body skin assessment. The assessment may also be performed after a change of condition or after any newly identified pressure injury. Documentation of skin assessment. Include date and time of the assessment, name, and position title. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). Document type of wound. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). Document if residents refused assessment and why. Document other information as indicated or appropriate.		