

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055287	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
NAME OF PROVIDER OR SUPPLIER Valley Palms Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13400 Sherman Way N Hollywood, CA 91605	

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. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 1) when on 8/22/2025, at approximately 9:30 p.m., Resident 1 reported to facility staff that Resident 2 had hit her (Resident 1) legs. This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect Resident 1 from further abuse. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 2/14/2025 and readmitted on [DATE] with diagnoses including anxiety disorder (feeling of anxiousness that affects daily life), multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), and chronic pain syndrome (an ongoing pain that lasts longer than three months, persisting even after the initial injury or illness has healed or is no longer present). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 3/17/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/5/2025, the MDS indicated Resident 1 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 was dependent (helper does all the effort) on facility staff with toileting hygiene, showers, upper and lower dressing. During a review of Resident 1's Care Plan, initiated on 8/25/2025, the Care Plan indicated that on 8/25/2025, Resident 1 was the recipient of physical abuse from another resident (Resident 2). The Care Plan indicated Resident 1 was at risk for emotional distress related to allegations of physical abuse from another resident. During a review of Resident 1's Situational Background Assessment and Recommendation (SBAR - a communication tool used to provide concise, clear, and effective information regarding a resident's condition) Communication Form, dated 8/25/2025, the SBAR form indicated that on 8/25/2025 (time not indicated), Resident 1 verbalized an incident of physical abuse by Resident 2 (Resident 1's roommate). During a review of facility-provided record titled, 5 Day Investigative Summary, dated 8/30/2025, the record indicated that on 8/25/25, at approximately 3:30 pm, Resident 1 had informed the Administrator that Resident 2 hit her legs. The record indicated Resident 1 could not indicate the exact date of the incident and had stated the incident took place on 8/21/2025 or 8/22/2025. The form indicated that Resident 1 verbalized an allegation of abuse by Resident 2. The form indicated facility staff had failed to report Resident 1's allegation of abuse because they had concluded that Resident 2 was not capable of hitting Resident 1. The form indicated that on 8/25/2025 the facility had initiated the investigation of Resident 1's allegation of physical abuse. During an interview on 9/4/2025 at 8:50 a.m. with Resident 1, Resident 1 stated approximately two weeks prior to 8/4/2025 (Resident 1 could not indicate the exact date of the incident), Resident 1 and Resident 2 (Resident 1's roommate) were in Room A (Resident 1 and 2's room) when Resident 2 approached Resident 1's bed and started hitting Resident 1's both legs with hands. Resident 1 stated she (Resident 1) screamed and called facility staff for help. Resident 1 stated a few minutes later (Resident 1 could not indicate the exact time) Certified Nurse Assistant (CNA) 1 walked into Room A while Resident 2 was walking back to her (Resident 2's) bed. Resident 1 stated she (Resident 1) informed CNA 1 that Resident 2 hit her (Resident 1's) legs. During an interview on 9/5/2025 at 9:38 a.m. with Registered Nurse (RN) 1, RN 1 stated that on 8/22/2025, at approximately 10 p.m., she (RN 1) entered Room A and found Resident 1 screaming at Licensed Vocational Nurse (LVN) 1 and asking for pain medication. RN 1 stated Resident 1 informed her (RN 1) that she (Resident 1) was in pain because Resident 2 hit her (Resident 1's) legs. RN 1 stated Resident 1's statement that Resident 2 had hit her legs on 8/22/2025 was an alleged incident of physical abuse. RN 1 stated she (RN 1) should have immediately contacted the Administrator who was the Abuse Coordinator (a staff member responsible for managing and addressing issues related to abuse or neglect within the facility) of the facility to report the allegation of physical abuse and to prevent further abuse of Resident 1. During an interview on 9/5/2025 at 9:59 a.m. with LVN 1, LVN 1 stated that on 8/22/2025, at approximately 9:40 p.m., CNA 1 informed him (LVN) 1 that Resident 1 had verbalized that Resident 2 hit Resident 1's legs. LVN 1 stated that on 8/22/2025 at approximately 9:40 p.m. to 10 p.m., he (LVN) 1 entered Room A and found Resident 1 in bed complaining of pain in her (Resident 1) legs. LVN 1 stated Resident 1 informed him (LVN) 1 that while attempting to go to the bathroom, Resident 2 had stopped near Resident 1's bed and started</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received treatment and care in accordance with professional standards of practice to meet the resident's physical, mental, and psychosocial (relating to the interrelation of social factors and individual thoughts and behavior) by failing to: 1. Complete a body assessment when on 8/22/2025 Resident 1 reported an allegation of physical abuse by Resident 2. On 8/22/2025, at approximately 9:30 p.m., Resident 1 informed Certified Nurse Assistant (CNA) 1 that Resident 2 hit Resident 1's legs with Resident 2's hands.2. Notify the physician of Resident 1's allegation of physical abuse by Resident 2, when on 8/22/2025, at approximately 9:30 p.m., Resident 1 informed CNA 1 that Resident 2 hit Resident 1's legs with Resident 2's hands. These deficient practices had the potential to delay Resident 1's care and negatively affect Resident 1's well-being. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 2/14/2025 and readmitted on [DATE] with diagnoses including anxiety disorder (feeling of anxiousness that affects daily life), multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), and chronic pain syndrome (an ongoing pain that lasts longer than three months, persisting even after the initial injury or illness has healed or is no longer present). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 3/17/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/5/2025, the MDS indicated Resident 1 had intact cognition (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 was dependent (helper does all the effort) on facility staff with toileting hygiene, showers, upper and lower dressing. During a review of Resident 1's Care Plan, initiated on 8/25/2025, the Care Plan indicated that on 8/25/2025, Resident 1 was the recipient of physical abuse from another resident. The CP indicated Resident 1 was at risk for emotional distress related to allegations of physical abuse from another resident (Resident 2). During a review of Resident 1's Situational Background Assessment and Recommendation (SBAR - a communication tool used to provide concise, clear, and effective information regarding a resident's condition) Communication Form, dated 8/25/2025, the SBAR form indicated that on 8/25/2025 (time not indicated), Resident 1 verbalized an incident of physical abuse by Resident 2. During a review of facility-provided record titled, 5 Day Investigative Summary, dated 8/30/2025, the record indicated that on 8/25/25, at approximately 3:30 pm, Resident 1 informed the Administrator that Resident 2 hit her (Resident 1) legs. The record indicated Resident 1 could not indicate the exact date of the incident and stated the incident took place on 8/21/2025 or 8/22/2025. The form indicated that Resident 1 verbalized an allegation of abuse by Resident 2. The form indicated the facility staff failed to report Resident 1's allegation of abuse because they had concluded that Resident 2 was not capable of hitting Resident 1. The form indicated that on 8/25/2025 the facility had initiated the investigation of Resident 1's allegation of physical abuse. During an interview on 9/4/2025 at 8:50 a.m. with Resident 1, Resident 1 stated approximately two weeks prior to 8/4/2025 (Resident 1 could not indicate the exact date of the incident), Resident 1 and Resident 2 (Resident 1's roommate) were in Room A (Resident 1 and 2's room) when Resident 2 approached Resident 1's bed and started hitting Resident 1's both legs with Resident 2's hands. Resident 1 stated she (Resident 1) screamed and called facility staff for help. Resident 1 stated a few minutes later (Resident 1 could not indicate the exact time) CNA 1 walked into Room A while Resident 2 was walking back to her (Resident 2's) bed. Resident 1 stated she (Resident 1) informed CNA 1 that Resident 2 hit her (Resident 1's) legs. During an interview on 9/5/2025 at 9:59 a.m. with LVN 1, LVN 1 stated that on 8/22/2025, at approximately 9:40 p.m., CNA 1 informed him (LVN) 1 that Resident 1 verbalized that Resident 2 hit Resident 1's legs. LVN 1 stated that on 8/22/2025 at approximately 9:40 p.m. - 10 p.m., he (LVN) 1 entered Room A and found Resident 1 in bed complaining of pain in her (Resident 1) legs. LVN 1 stated Resident 1 informed him (LVN) 1 that while attempting to go to the bathroom, Resident 2 stopped near Resident 1's bed and started hitting Resident 1's legs. LVN 1 stated he (LVN) 1 informed RN 1 about the alleged incident between Resident 1 and Resident 2. During a concurrent interview and record review on 9/5/2025 at 11:10 a.m., with Registered Nurse (RN) 2, Resident 1's SBAR Forms, dated 8/22/2025 to 9/5/2025 were reviewed. The SBAR forms indicated there was no documentation of Resident 1's assessment and physician notification on 8/22/2025 when Resident 1</p>		