STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055287	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Palms Care Center	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its abuse policy and procedure by failing to thoroughly investigate allegation of resident-to-resident physical abuse for two of three sampled residents (Residents 1 and 2) by failing to interview and obtain a written statement from Certified Nursing Assistant 1 (CNA 1).This deficient practice had the potential to result in unidentified abuse in the facility and had the potential for further resident abuse.Findings:a. During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 4/21/2022, with diagnoses that included multiple right rib fracture (break in a bone), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and essential hypertension (HTN-high blood pressure).During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 12/24/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 1/16/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired.During a review of Resident 1's Progress Notes, dated 2/6/2026, the Progress Notes, indicated the Nurse Practitioner (NP) saw Resident 1 and documented that Resident 1 reported that Resident 2 entered his (Resident 1) room multiple times telling him (Resident 1) to get out. Resident 1 reported becoming upset and attempted to block Resident 2 with his (Resident 1) walker. (Resident 1) reported that Resident 2 pushed him (Resident 1) causing him (Resident 1) to lose balance and hit the wall.During a review of Resident 1's Situation Background Assessment Recommendation (SBAR, technique that provides a framework for communication between members of the health care team about a resident ' s condition) Communication Form, dated 2/6/2026, the SBAR indicated on 2/5/2026, Resident 1 reported , Resident 2 came into his (Resident 1) room and when asked what he (Resident 2) was doing, got into an altercation (argument or disagreement), Resident 2 raised both his (Resident 2) hands and he (Resident 1) thought Resident 2 was going to hit him (Resident 1) so he (Resident 1) raised his (Resident 1) walker up in defense. The SBAR indicated Resident 1 stated he (Resident 1) lost his (Resident 1) balance and hit the wall and sustained right forearm skin tear (acute, often painful, traumatic wounds common in older adults, caused by friction or shear that separates skin layers).b. During a review of Resident 2‘s admission Record, the admission Record indicated the facility admitted Resident 2 on 10/9/2025, with diagnoses that included other sequelae of cerebral infarction (the long-term, lasting complications or physical/mental disabilities that remain after a stroke [brain tissue death] has occurred), generalized muscle weakness and difficulty in walking.During a review of Resident 2's H&P, dated 10/12/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions.During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decisions were severely (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impaired.During a review of Resident 2's SBAR, dated 2/5/2026, the SBAR indicated Resident 2 went into Resident 1's room, which he (Resident 2) thought was his (Resident 2) room, and while in the room had a verbal altercation with Resident 1 which led to a physical altercation. The SBAR indicated he (Resident 2) claimed Resident 1 raised his (Resident 1) front wheel walker towards him (Resident 2) so he (Resident 2) got tangled with the walker and got hit on the chest and he (Resident 2) accidentally hit him (Resident 1) on the face. During an interview on 2/12/2026, at 10:11 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated on 2/5/2026, saw Housekeeper 1 (HSK 1), and CNA 1 inside the room and Administrator (ADM) passing by the hallway.During an interview on 2/12/2026, at 10:21 a.m., with HSK 1 and translated by Maintenance Supervisor (MS), HSK 1 stated on 2/5/2026, as she (HSK 1) was walking by the hallway in front of Resident 1's room, observed Resident 1's holding his (Resident 1) walker up in the air while in front of Resident 2. HSK 1 stated she (HSK 1) separated Resident 1 and Resident 2 then saw the ADM walking inside Resident 1's room.During an interview on 2/12/2026, at 10:43 a.m., with CNA 1, CNA 1 stated she (CNA 1) was walking in the hallway going to the laundry room when she (CNA 1) saw and heard HSK 1 scream for help to separate the two residents. CNA 1 stated both residents tried to fight with each other. CNA 1 stated Resident 1 had his walker up and tried to hit Resident 2 while Resident 2's right fist was up in the air. CNA 1 stated Resident 2 tried to punch Resident 1 but did not make contact. CNA 1 stated she (CNA 1) stayed in the room with the ADM and helped Resident 1 to sit on the bed and calmed him (Resident 1) down.During an interview on 2/13/2026, at 8:47 a.m., with RN 1, RN 1 stated when she (RN 1) responded and went to Resident 1's room, CNA 1 was inside the room standing beside Resident 1 who was seated on the bed. RN 1 stated when she (RN 1) went to Resident 1's room she (RN 1) saw Treatment Nurse (TN), LVN 1 and LVN 2. RN 1 stated she (RN 1) spoke to Resident 1 with CNA 1 as translator.During an interview on 2/13/2026, at 9:12 a.m., with the Director of Nursing (DON), the DON stated she (DON) was not aware that CNA 1 responded and went to Resident 1's room. The DON stated she (DON) did not interview CNA 1 and did not ask CNA 1 to write a written statement. The DON stated she (DON) had interviewed and made a written statement from HSK 1, RN 1, LVN 1, CNA 2 (who was Resident 1's CNA on 2/5/2026), CNA 3 who was Resident 2's CNA, and LVN 2.During a concurrent interview, and record review on 2/13/2026, at 9:34 a.m., with the DON, facility's policy and procedure (P&P), titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 9/2022, and last reviewed on 1/28/2025, the P&P indicated, 7. The individual conducting the investigation as a minimum: .e. interviews with any witnesses to the incident,h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; The DON stated the allegation between Resident 1 and Resident 2 happened on 2/5/2026, and she (DON) just interviewed CNA 1 yesterday 2/12/2026. The DON stated she (DON) did not interview CNA 1 timely. The DON stated the policy for abuse was not followed. The DON stated it is important to interview all staff who were in the incident to verify if they all saw the same thing. The DON stated she (DON) should have interviewed CNA 1 for accurate investigation.

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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. Based on interview and record review, the facility failed to ensure the residents received care consistent with professional standards of practice for one of three sampled residents (Resident 1) by failing to ensure changes in Resident 1's skin was measured as indicated in the facility's policy and procedure.This failure resulted in Resident 1's incomplete medical record.Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 4/21/2022, with diagnoses that included multiple right rib fracture (break in a bone), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and essential hypertension (HTN-high blood pressure).During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 12/24/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 1/16/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired.During a review of Resident 1's Skin Assessment, dated 2/5/2026, the Skin Assessment indicated the Treatment Nurse (TN) documented that Resident 1 had right outer forearm skin tear (acute, often painful, traumatic wounds common in older adults, caused by friction or shear that separates skin layers) and left cheek abrasion (scrape, is a superficial wound where the top layer of skin is rubbed or scraped off).During a review of Resident 1's Situation Background Assessment Recommendation (SBAR, technique that provides a framework for communication between members of the health care team about a resident's condition) Communication Form, dated 2/6/2026, the SBAR indicated on 2/5/2026, Resident 1 reported that Resident 2 came into his (Resident 1) room and when asked what he (Resident 2) was doing, got into an altercation (argument or disagreement), Resident 2 raised both his (Resident 2) hands and he (Resident 1) thought Resident 2 was going to hit him (Resident 1) so he (Resident 1) raised his (Resident 1) walker up in defense. The SBAR indicated Resident 1 reported he (Resident 1) lost his (Resident 1) balance and hit the wall and sustained right forearm skin tears. The SBAR indicated Resident 1 had right outer forearm skin tear and left cheek abrasion.During an interview on 2/12/2026, at 10:28 a.m., with the TN, the TN stated he (TN) did Resident 1's skin check on 2/5/2026 and noted right forearm skin tear and left cheek abrasion with minimal bleeding. The TN stated he (TN) did not measure the skin tear. The TN stated he (TN) does not measure skin issues all the time. The TN stated measurement of skin issues should be done with any new skin changes to keep track of whether they are improving or not.During an interview on 2/12/2026, at 11:04 a.m., with the Director of Nursing (DON), the DON stated the TN should have measured Resident 1's skin tear. The DON stated the facility would not know if Resident 1's skin tear was getting better or worse, if treatment was effective and if there were signs of improvement. The DON stated Resident 1's medical record was incomplete, and the facility's policy was not followed.During a review of facility's policy and procedure (P&P), titled, Wound Care, dated 10/2010, and last reviewed on 1/28/2026, the P&P indicated, The following information should be recorded in the resident's medical record.6. All assessment data (wound bed color, size, drainage) obtained when inspecting the wound.During a review of facility's P&P, titled, Investigating Resident Injuries, dated 4/2021, and last reviewed on 1/28/2025, the P&P indicated All resident injuries are investigated.2. Documentation includes information relevant to risk factors and conditions that could cause or predispose (having an increased likelihood or higher risk of developing a specific disease) someone to similar signs and symptoms (example given like receiving anticoagulants [medication used to treat blood clot], having osteoporosis [weak and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	brittle bones due to lack of calcium and Vitamin D]). a. Descriptions in the medical record must be objective and sufficiently detailed (example given, dimensions [a measurable extent of some kind, such as length, breadth, depth, or height] and location of bruises) and should not speculate about causes.