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	04/21/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its written abuse policy and procedure (P&P) titled, Abuse and Neglect Exploitation or Misappropriation-Reporting and Investigating Policy designed to prevent, respond to and report abuse-related incidents after a physical abuse (includes, but is not limited to, hitting, slapping, punching, biting, and kicking) for one of three sampled residents (Resident 1) when staff did not immediately separate roommates Residents 1 and Resident 2 who had a physical altercation on 4/10/2026.This failure had the potential for Resident 1 to be subjected to further abuse from Resident 2 while under the care of the facility. Findings: During a record review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/20/2025 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury).During a record review of Resident 1's Minimum Data set [MDS-a resident assessment tool), dated 1/28/2026, the MDS indicated that Resident 1's cognition (the mental process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated that Resident 1 was dependent (helper does all of the effort) with activities of daily living (ADLs-toileting, shower, upper body dressing, lower body dressing and personal hygiene). During a review of Resident 1's History and Physical (H&P), dated 11/21/2025, the H&P indicated that Resident 1 had the capacity to make decisions. During a record review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 facility on 9/16/2025 with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), and schizophrenia (a mental illness that is characterized by disturbances in thought).During record review of Resident 2's MDS, dated [DATE] indicated that Resident 2's cognition was severely impaired (never/rarely made decisions). The MDS indicated that Resident 2 requires maximal assistance (helper does more than half the effort) with ADLs. During a review of Resident 2's H&P dated 9/19/2025, the H&P indicated that Resident 2 can understand and make decisions.During an interview on 4/20/2026 at 1:48 p.m. with Resident 1, Resident 1 stated that on 4/10/26 between 3 a.m. and 4 a.m., their roommate (Resident 2) went through Resident 1's nightstand. Resident 1 reported that Resident 2 grabbed a bottle of moisturizer from the nightstand and threw it, striking Resident 1's left shin. Resident 1 stated that Resident 2 then grabbed additional objects from the nightstand and threw them towards Resident 1's direction. Resident 1 reported the incident to CNA 4, who instructed Resident 2 to stop opening and closing the privacy curtain. Prior to the physical altercation, Resident 2 repeatedly opened and closed the privacy curtain to look towards Resident 1's side of the bed. Resident 1 stated that he felt uncomfortable being in the same room as Resident 2 because he could not do anything to defend himself. Resident 1 stated that the staff kept him and the roommate in the same room and were not separated until after lunch when the roommate was no longer in the room. During an interview on 4/20/2026 at 3:44 p.m., with Certified Nurse Assistant (CNA) 2, CNA 2 stated that on 4/10/2026 during breakfast, Resident 1 informed her that his (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
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	roommate (Resident 2) had taken items from his nightstand and thrown something at him. While CNA 2 assisted Resident 1's with breakfast in his room, Resident 2 slept in the same room. CNA 2 stated that she reported the incident to the Social Services Assistant (SSA) at approximately 2 p.m. due to a busy morning with her assignment. CNA 2 stated that she continued to monitor Resident 1 and the roommate that morning to determine whether Resident 2 would continue playing with the curtain or taking items from Resident 1's nightstand. CNA 2 reported that Resident 1 expressed that he did not feel safe sharing a room with his roommate because he feared Resident 2 might harm him. CNA 2 further stated that she felt scared to report the incident directly, so she chose to inform the SSA instead. During an interview on 4/21/2026 at 9:05 a.m. with CNA 4, CNA 4 stated that on 4/10/2026 after she came back from break, heard voices from Resident 1 and Resident 2 room. CNA 4 stated that she entered the room, where Resident 1 told her that Resident 2 had thrown a bottle of lotion, which struck Resident 1's right shin. CNA 4 stated that Resident 2 had the nightstand drawer open and the privacy curtain was open so Resident 2 could see Resident 1. CNA 4 stated that Resident 2 repeatedly opened and closed the curtain. CNA 4 stated that she removed the bottle of lotion from Resident 1's bed and put it back in the nightstand. CNA 4 stated that she reported the incident to Registered nurse (RN) 1 and that they both entered the room and separated the residents by pushing Resident 2's bed towards the wall and away from the nightstand. During an interview on 4/21/2026 at 11:46 a.m. with Registered Nurse (RN) 1, RN 1 stated that Resident 1 expressed concern about Resident 2 taking things from his nightstand. RN 1 stated that she asked CNA 4 to assist her in moving the nightstand closer to Resident 1 to keep it away from Resident 2's reach. RN 1 stated that she did not separate Resident 1 from his roommate and both roommates continued in the same room. During an interview on 4/21/2026 at 12:38 p.m. with Director of Nursing (DON), the DON stated that she was aware of the physical altercation between Resident 1 and Resident 2. DON stated that staff needed to immediately separate Resident 1 from Resident 2 (roommate) to make sure Resident 1 feels safe. The DON stated that if staff do not separate residents immediately further physical or emotional harm can occur. The DON stated that the abuse policy was not followed by staff members because staff should immediately separate the residents and reported it to the abuse coordinator right away. During a record review of Residents Care plan initiated 4/14/2026 titled, Resident 1 at risk for emotional distress related to physical allegation, the care plan goal indicated that Resident would demonstrate reduced emotional distress and verbalized a since of safety within the facility. The care plan intervention indicated to Ensure immediate safety of resident, separate from alleged source if indicated.During a review of the facility's P&P titled, Abuse and Neglect Exploitation or Misappropriation-Reporting and Investigating Policy, revised on 9/2022, the P&P indicated that upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions are needed for the protection of the resident.

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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. **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 within two hours for one of three sampled residents (Resident 1) when on 4/10/2026 there was an allegation that Resident 2 threw a bottle of lotion and landed on Resident 1's right shin. This deficient practice had the potential to place Resident 1 at an increased risk for further abuse which could have led to additional unreported incidents. Findings: During a record review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/20/2025 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs) , and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury).During a record review of Resident 1's Minimum Data set [MDS-a resident assessment tool), dated 1/28/2026, the MDS indicated that Resident 1's cognition (the mental process of acquiring knowledge and understanding through thought, experience, and senses) was intact. The MDS indicated that Resident 1 was dependent (helper does all of the effort) of activities of daily living (ADLs-toileting, shower, upper body dressing, lower body dressing and personal hygiene). During a review of Resident 1's History and Physical (H&P), dated 11/21/2025, the H&P indicated that Resident 1 had the capacity to make decisions. During a record review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 9/16/2025 with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), schizophrenia (a mental illness that is characterized by disturbances in thought).During record review of Resident 2's MDS, dated [DATE], the MDS indicated that Resident 2's cognition was severely impaired (never/rarely made decisions). The MDS indicated that Resident 2 required maximal assistance (helper does more than half the effort) with ADLs. During a review of Resident 2's H&P, dated 9/19/2025, the H&P indicated that Resident 2 can understand and make decisions.During an interview on 4/21/2026 at 8:31 a.m. with Social Services Assistant (SSA), the SSA stated that on 4/10/2026 around 11 a.m. Certified Nurse Assistant (CNA) 2 reported to her that Resident 1 had a concern about something that happened in the middle of the night. SSA stated that before lunch she went to speak with Resident 1. The SSA stated that Resident 1 narrated that he (Resident 1) was sleeping and woke up hearing his roommate (Resident 2) going through his stuff. The SSA stated Resident 1 said Resident 2 grabbed a bottle of lotion and threw it striking his (Resident 1) left shin. The SSA stated that CNA 2 reported the incident to her and that she then reported it to the Director of Social Services (DSS) around 11:30 a.m. The SSA stated that the report was made until 2 p.m. because it was a busy day.During an interview on 4/20/2026 at 3:44 p.m., with CNA 2, CNA 2 stated that on 4/10/2026 during breakfast, Resident 1 told her that his roommate (Resident 2) had taken items from his nightstand and thrown something at him. While CNA 2 assisted Resident 1 with breakfast in his room. CNA 2 stated that she reported the incident to the Social Services Assistant (SSA) at approximately 10 a.m. due to a busy morning. CNA 2 stated that she continued to monitor Resident 1 and the roommate that morning to determine whether Resident 2 would continue playing with the curtain or taking items from Resident 1's nightstand. CNA 2 reported that Resident 1 said he did not feel safe sharing a room with his roommate because he feared Resident 2 might harm him. CNA 2 further stated that she felt scared to report the incident and chose to wait and report it to the SSA instead before lunch. During an interview on 4/21/2026 at 9:05 a.m. with CNA 4, CNA 4 stated that on 4/10/2026 after she came back from break, she heard voices from Resident 1 and Resident 2 room. CNA 4 stated that she went into the residents' room and Resident 1 stated that Resident 2 threw a bottle of lotion and landed on Resident 1's right shin. CNA 4 stated that (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2 had the nightstand drawer open and the privacy curtain was open to be able to see Resident 1. CNA 4 stated that Resident 2 kept opening and closing the curtain multiple times. CNA 4 stated that she removed the bottle of lotion from Resident 1's bed and put it back in the nightstand. CNA 4 stated that she reported the incident to Registered Nurse (RN) 1 and that they both went in the room and separated residents by pushing Resident 2's bed towards the wall and away from the nightstand.During an interview on 4/21/2026 at 11:46 a.m. with Registered Nurse (RN) 1, RN 1 stated that Resident 1 expressed concern about Resident 2 taking things from his nightstand. RN 1 stated that she asked CNA 4 to assist her in moving the nightstand closer to Resident 1 to keep it away from Resident 2. RN 2 stated that she did not separate Resident 1 from his roommate. RN 1 stated that she did not report it to anyone or documented in progress note.During an interview on 4/21/2026 at 12:38 p.m. with Director of Nursing (DON), the DON stated that she was aware of the physical altercation between Resident 1 and Resident 2. The DON stated that allegations of physical abuse should be reported immediately, but no later than 2 hours after the allegation is made. DON stated that the night staff should have reported the allegation right away and not waited until the morning to report. The DON stated that everyone in the facility is a mandated reporter and should follow the policy for abuse reporting. During a review of the facility's policy and procedure (P&P) titled, Abuse and Neglect Exploitation or Misappropriation-Reporting and Investigating Policy, revised on 9/2022, the P&P indicated that the individual making the allegation immediately reports his or her suspicious to the following agencies: the state licensing, ombudsman.immediately within two hours of an allegation involving abuse.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to revise a resident's care plans for one of four sampled residents (Resident 2). This failure had the potential to result in Resident 2 receiving inappropriate care because the care plan was not updated to address and meet the resident's needs.Findings: During a record review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 9/16/2025 with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), schizophrenia (a mental illness that is characterized by disturbances in thought)During record review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 4/12/2026 indicated that Resident 2's cognition (the mental process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired (never/rarely made decisions). The MDS indicated that Resident 2 required maximal assistance (helper does more than half the effort) with ADLs. During a review of Resident 2's History and Physical (H&P), dated 9/19/2025, the H&P indicated that Resident 2 can understand and make decisions.During an interview and record review on 4/21/2026 at 10:03 a.m. with Minimum Data Set (MDS) Nurse, Resident 2 care plan and nursing notes were reviewed. The MDS Nurse stated that nursing staff failed to initiate a care plan for Resident 2's behavior of opening and closing the privacy curtain in the room. The MDS nurse stated that it is important to initiate Resident 2's care plan for his behavior so that staff can monitor it and provide appropriate care for the resident. MDS nurse stated that nursing staff are responsible for initiating and revising care plans, and they should update care plans whenever a new condition arises or an issue is resolved. During an interview on 4/21/2026 at 11:46 a.m. with Registered Nurse (RN) 1, RN 1 stated that Resident 2 likes to play with the curtain by opening it and closing it to see Resident 1. RN 1 stated that she did not document Resident 2's behavior on progress notes or updated Resident 2's care plan. RN 1 stated that it was important to update the care plan because staff can monitor Resident 2 and place interventions in place that meet resident needs. During an interview and record review on 4/21/2026 at 12:38 p.m. with the Director of Nursing (DON), Resident 2 care plan and nursing notes were reviewed. The DON stated that she expects all licensed nurses to document any changes in condition and create a nursing progress note every shift to monitor the resident. The DON stated that Resident 2's behavior of closing and opening the curtain was not documented in nursing progress notes and nursing staff did not monitor the behavior every shift. The DON stated that it was important to document in nursing progress notes because all staff can anticipate and monitor the behavior. The DON stated that nursing staff should initiate or update the care plans every time a resident's condition change. DON further stated Resident 2's care plan was not updated to reflect the resident's current needs. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised on 3/2022, indicated assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's conditions.