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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056389	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36087 Based on observation, interview, and record review, the facility failed to ensure residents received care and services in accordance with professional standards of practice when: 1. For one of four sampled residents (Resident 3), the Interdisciplinary Team ' s (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their residents) recommendation for Psychology (Psych) Consult related to an abuse allegation was not referred by Social Services (SS) Department. This failure had the potential to put Resident 3 ' s safety at risk and could lead to abuse re-occurrence and resident feeling depressed, angry, and vulnerable. 2. For one of four sampled residents (Resident 1), an appropriate physical abuse care plan (CP, a document that outlines the resident ' s assessment health and social care needs and how it will be supported) was not created. This failure had the potential to put Resident 1 ' s safety at risk and for resident to not receive the care that he needed. 3. For four of four sampled residents (Resident 1, Resident 2, Resident 3, and Resident 4), IDT Meeting Notes showed but one member signature and did not reflect other IDT members ' attendance in developing new goals to meet the needs of the residents. This failure had the potential for the residents ' care plans to not be reviewed and revised by each team member ' s expertise as changes in the residents ' care and treatment occurred. Findings: 1. A review of Resident 3 ' s Face Sheet, printed on 10/30/24, indicated resident was admitted on [DATE] with multiple diagnoses that included diabetes mellitus (high blood sugar) and obesity (overweight). (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 3 ' s Minimum Data Set (MDS, a resident assessment tool used to provide care), dated 8/12/24, indicated Resident 3 had clear speech, was understood, and was able to understand others. The MDS also indicated Resident 3 was able to ambulate with a cane, and only required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to setup or clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) during his activities of daily living (ADLs, the basic self-care tasks an individual does on a day-to-day basis). A review of Resident 4 ' s Face Sheet, printed on 10/30/24, indicated Resident 4 was admitted on [DATE] with multiple diagnoses that included diabetes mellitus and hemiplegia (complete paralysis on one side of the body), and hemiparesis (partial weakness on one side of the body. A review of Resident 3 ' s SBAR-General (Situation Background Assessment Recommendation/Interventions, a structured communication tool to enhance communication between members of the healthcare team about a resident issue that needs to be addressed) dated 10/22/24, indicated Resident 3 had an altercation with Resident 4. A review of Resident 3 ' s Physician Order (PO), dated 10/23/24, indicated, MAY REFER TO PSYCHOLOGIST FOR AGGRESSIVE BEHAVIOR. A review of Resident 3 ' s Progress Notes, dated 10/23/24, at 9:52 a.m., indicated, MAY REFER TO PSYCHOLOGIST FOR AGGRESSIVE BEHAVIOR, SOCIAL SERVICE AWARE. During an interview on 11/7/24, at 12:05 p.m., with Social Services Assistant (SSA), SSA stated when Psych Consult was ordered and received for a resident, SS Department ' s responsibility was to contact and schedule an appointment with the Psych Clinic, usually via fax and/or a phone call. During an interview on 11/15/24, at 9:55 a.m., with Social Services Director (SSD), SSD stated Physician and/or Nursing Department would communicate with SS Department regarding ordered Psych Referrals. SSD stated SS Department was made aware regarding Resident 3 ' s PO for Psych Referral on 10/23/24, due to Resident 3 ' s aggressive behavior. However, SSD further stated SS Department was unable to find documentation that a fax was sent to Psych Clinic on that day. A review of the facility ' s record titled, Facsimile Transmittal, dated 11/5/24, indicated SSD submitted a request for Psych Consult for Resident 3 on this date. 2. A review of Resident 1 ' s Face Sheet, printed on 10/20/24, indicated resident was admitted on [DATE] with multiple diagnoses that included cirrhosis of the liver (chronic liver damage) and history of alcohol and nicotine dependence. A review of Resident 1 ' s MDS dated [DATE], indicated Resident 1 had clear speech, was usually understood, and was usually able to understand others. The MDS also indicated Resident 1 was independently able to ambulate with walker, and only required setup or clean-up assistance during his ADLs. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 2 ' s Face Sheet, printed on 10/30/24, indicated Resident 2 was admitted on [DATE] with multiple diagnoses that included paraplegia (paralysis of the legs and lower body caused by spinal injury or a disease), depression, and psychoactive substance abuse (a strong desire to take drugs). A Review of Resident 1 ' s SBAR, dated 10/12/24, indicated Resident 1 had a physical altercation with Resident 2. A review of Resident 1 ' s Care Plan, dated 10/14/24, indicated, Behavioral Symptoms AGGRESSIVE BEHAVIOR TOWARDS ROOMMATE . During a concurrent interview and record review on 10/30/24, at 1 p.m., with the Minimum Data Set Coordinator (MDSC), MDSC stated she was unable to find the care plan for Resident 1 and Resident 2 ' s physical altercation that took place on 10/12/24. MDSC stated the only documented care plan closest to the date of altercation was the care plan, dated 10/14/24, regarding behavioral symptoms aggressive behavior towards roommate. During a telephone interview on 11/7/24, at 11:25 a.m., with the Director of Nursing (DON), DON confirmed Resident 1 ' s care plan, dated 10/14/24, for resident-to-resident altercation, was incorrect. DON stated care plan verbiage should have been adjusted and updated in a timely manner. A review of the facility ' s undated policy and procedure (P&P) titled, Comprehensive Plan of Care, indicated, Each resident will have a comprehensive care plan developed that includes goals, measurable objectives, and timetables to meet their medical, nursing, mental, and psychosocial needs identified during the comprehensive assessment .The comprehensive plan of care must: Address the resident ' s individual needs, strengths, and preferences .Include treatment goals and measurable objectives .Include interventions to attempt to manage risk factors .Be developed by an interdisciplinary team that includes the attending physician, a registered nurse, and other appropriate staff as determined by the resident ' s needs .Be periodically reviewed and revised by the interdisciplinary team as changes in the resident ' s care and treatment occur . 3. A review of Resident 1 ' s Risk Meeting Notes Weekly, dated 10/12/24, created by Registered Nurse 1 (RN 1), indicated notes were completed and recorded on 10/19/24. The IDT signature list revealed but one IDT member signature and did not reflect other IDT members ' attendance. A review of Resident 2 ' s Risk Meeting Notes Initial Week One, dated 10/14/24, indicated notes were completed and recorded on 10/14/24, created by RN 2. The IDT signature list revealed but one RN signature and did not reflect other IDT members ' attendance. A review of Resident 3 ' s Risk Meeting Notes Initial Week One, dated 10/22/24, indicated notes were completed and recorded on 10/22/24, created by RN 2. The IDT signature list revealed but one RN signature and did not reflect other IDT members ' attendance. A review of Resident 4 ' s Risk Meeting Notes Initial Week One, dated 10/22/24, indicated notes were completed and recorded on 10/22/24, created by RN 2. The IDT signature list revealed but one RN signature and did not reflect other IDT members ' attendance. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview with the Director of Nursing (DON), on 11/7/24, at 11:25 a.m., the DON confirmed that Risk Meeting Notes were the facility ' s IDT Notes and IDT members were required to go back to the document to complete their part and sign their names as soon as possible. DON further stated it is a work in progress that needed to be corrected. During a concurrent interview and record review on 11/15/24, at 9:40 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 1, Resident 2, Resident 3, and Resident 4 ' s Risk Meeting Notes were checked. MDCS stated the Meeting Notes only showed the creator ' s signature and no other IDT members had signed the completed notes. During an interview on 11/15/24, at 10:10 a.m., with the Assistant Director of Nursing (ADON), the ADON stated IDT members should sign their part on the Risk Meeting Notes as proof of IDT members ' attendance during the meeting, of which the resident ' s current issues had been reviewed, care plans updated, and interventions/goals have been discussed to prevent further negative incidents from happening. A review of the facility ' s undated policy and procedure (P&P) titled, Risk Meeting, indicated, The Risk Meeting is designed to bring current resident/patient issues to the interdisciplinary team for discussion, potential alterations to the care plan, notification to all disciplines regarding current status of residents/patients, and to develop proactive approaches designed to prevent acute episodes from ocurring . The following attendance is required for the meeting: Administrator .Director of Nursing (DON), Assistant Director of Nursing (ADON), Director of Staff Development (DSD), Unit Manager, Social Services, Activities, Minimum Data Set Coordinator (MDSC), Dietary, Therapy .Infection Preventionist .Wound Care Nurse . Restorative Nursing Assistant (RNA) .The process of the meeting is as follows: The DON runs the meeting, All team members will sign in on the Risk Meeting sign-in sheet .The DON will take notes using the Risk Meeting Minutes. Each discipline will receive a copy of the minutes immediately following completion of the meeting. Each discipline is to complete their departments ' section for recommendations and report back to the DON within 48 hours of meeting completion .