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 01/20/2026

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 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, observation, and record review, the facility failed to report Resident 2's verbal abuse and threat of harm against Resident 1 (one of three sampled residents) to the State Agency, local law enforcement, and/or the Long-Term Care Ombudsman (Resident advocate for rights and care in long-term facilities). This failure had the potential to place residents at risk for further abuse and psychosocial harm.During a record review of Resident 1's Face Sheet (resident demographic and clinical summary), Face Sheet indicated Resident 1 was admitted to the facility on [DATE].During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 11/17/25, MDS indicated Resident 1 had a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information). This score indicated Resident 1 had a score of 15/15 indicating cognitively intact and the mental capacity to make medical decisions.During an interview with Resident 1 in his room on 1/2/26 at 10:55 a.m., Resident 1 was found lying on his left side in bed. Resident 1 stated his former roommate (Resident 2) threatened to kill him. Resident 1 stated Resident 2 threw many things across the room and broke dishes. Resident 1 stated the facility initially moved Resident 2 to another room, however, an hour later they brought Resident 2 back and moved Resident 1 to another room. Resident 1 stated when he expressed his concern for his safety staff asked him, What else do you want me to do?During a record review of Resident 1's Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on [DATE].During a record review of Resident 2's MDS, MDS indicated Resident 2 had a BIMS score of 15 out of 15. This score indicated that Resident 2 had the mental capacity to make medical decisions.During an interview with Resident 2 in his room on 1/20/25 at 1:30 p.m., Resident 2 stated he didn't remember much about the incident. Resident 2 stated he was moved to another room because Resident 1 was talking too loudly on the phone in the mornings.During a record review of Resident 1's Progress Notes, dated 11/3/25 at 11:24am, Social Services Assistant (SSA) documented, spoke with resident [Resident 1] regarding altercation with roommate [Resident 2]. Per resident [Resident 1], he was on the phone this morning and roommate got upset.he [Resident 2] called me faggot and threatens to 'kill me'. Progress notes stated, reassured resident his roommate already moved to another room and staff is aware of the altercation.During a record review of Resident 2's Progress Notes, dated 11/3/25 at 8:11 a.m., Licensed Vocational Nurse 1 (LVN 1) documented, .resident [Resident 2] got upset that every morning he [Resident 1] is on the phone . [Resident 2] throw his breakfast tray on the floor. [Resident 2] said he wants to change his room.During an interview with LVN 1 on 1/20/25 at 1:10 p.m., LVN 1 stated she was the assigned nurse for Resident 1 and Resident 2 on 11/3/25. LVN 1 stated she was made aware of the incident between Resident 1 and Resident 2 while doing her rounds the morning of 11/3/25. LVN 1 stated Resident 2 had pushed his breakfast tray on the floor. LVN 1 (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 2 told her that Resident 1 was always on the phone in the morning and that he was sick of this Bull shit. LVN 1 stated she was not aware of any verbal altercation or exchange between Resident 1 and Resident 2.During an interview with SSA on 1/20/25 at 2:00 p.m., SSA stated the assigned nurse for Resident 1 and Resident 2 made her aware of the incident between the two of them, . when she arrived the morning of 11/3/25. SSA stated threats between residents are considered abuse and must be reported to the State agency, local law enforcement and the Ombudsman. SSA stated facility's Administrator was the Abuse Coordinator and she did not recall whether she spoke with Administrator regarding the incident. SSA also stated if she talked to the Administrator, she would have documented it, but she did not.During an interview with Director of Nursing (DON) on 1/2/25 at 2:00 p.m., DON stated the incident between Resident 1 and Resident 2 was not reported to the State Agency, local law enforcement, or the Ombudsman. The DON stated the incident was not reported because an internal investigation was conducted and found unsubstantiated (not supported or proven by evidence).During a record review of Policy and Procedure (P&P) titled Abuse Investigation and Reporting, dated 11/17/25, P&P indicated All allegations of resident abuse.shall be promptly reported to the appropriate local, state, and/or federal agencies.and thoroughly investigated by Company Management.