STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	03/17/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to implement adequate supervision and interventions to prevent a resident-to-resident physical altercation for two of two sampled residents (Resident 1 and Resident 2), when Resident 2 entered Resident 1's room and punched Resident 1 in the face.This failure resulted in redness to Resident 1's face and caused feeling upset, and had the potential to result in serious physical injury and psychosocial harm including fear and emotional distress.During a record review of Resident 1's Face Sheet dated on 3/17/26, the Face Sheet indicated Resident 1 was admitted to the facility in September 2024 with diagnoses of malignant neoplasm (cancer) of rectum and depression (serious mental health condition characterized by persistent sadness and a loss of interest).During a record review of Resident 1's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) Resident 1's BIMS score was 15.During a record review of Resident 2's Face Sheet dated on 3/17/26, the Face Sheet indicated Resident 2 was admitted to the facility in March 2024 with diagnosis of alcoholic cirrhosis of liver with ascites (advanced liver scarring from chronic alcohol misuse).During a record review of Resident 2's Progress Notes dated 1/27/26 at 2:15 p.m., the Progress Notes indicated, Around this time, the staff noted Resident 2 with different speech.Resident 2 was noted with a slurred speech (when someone talks in a way that's hard to understand). When Resident 2 was intervened about drinking alcohol.During a record review of Resident 2's SBAR (Situation, Background, Assessment, Recommendation) Note dated 1/27/26, the SBAR indicated the physical altercation between Resident 1 and Resident 2 occurred at 4:30 p.m. SBAR also indicated Resident 1 reported Resident 2 looking drunk, entered Resident 1's room, talking in a loud manner and hit Resident 1 on the right side of the face. SBAR further indicated Resident 2 was suspected of consuming alcohol earlier in the afternoon.During an interview on 3/17/26 at 10:53 a.m. with Resident 1, Resident 1 stated a physical altercation occurred a couple of months ago during the afternoon. Resident 1 described being in a wheelchair in their room, when Resident 2, who was also in a wheelchair and appeared to be under the influence of alcohol, entered the room. Resident 1 stated they repeatedly requested Resident 2 to leave their room, but Resident 2 did not comply. Resident 1 stated Resident 2 stood up from the wheelchair, approached Resident 1, and punched Resident 1 on the right side of the face. Resident 1 stated being upset that the facility failed to protect them from Resident 2. Resident 1 further stated the facility was aware of Resident 2's alcohol use and associated behaviors yet failed to adequately monitor and implement interventions to prevent Resident 2's physical aggression.During an interview on 3/17/26 at 2:09 p.m. with the Social Worker (SW), SW stated they were aware of Resident 2's alcohol use and aggression. The SW stated staff should have monitored Resident 2 if alcohol use was suspected, due to unpredictable behavior toward others.During an interview on 3/17/26 at 2:38 p.m. with the Administrator (ADM), ADM stated during the incident, she was passing by the hallway when she observed Resident 2 standing partially inside Resident 1's doorway. ADM stated suddenly, she heard yelling and she immediately proceeded to Resident 1's room. ADM stated Resident 1 informed her that (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2 struck Resident 1 in the face. ADM stated she observed redness on the right side of Resident 1's face. ADM further stated, it looked like Resident 1 was hit in the face. ADM stated Resident 2 could have possibly consumed alcohol prior to the incident. ADM stated they checked Resident 2's room and found a full bottle of alcohol. ADM also confirmed that they were aware of Resident 2's use of alcohol and Resident 2 should have been monitored for safety and to prevent escalation of negative behaviors.During a record review of the facility's undated policy and procedure (P&P), titled, Abuse Prevention Program, the P&P indicated, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.Protect our residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual.