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	04/09/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to protect residents in the facility from potential physical abuse when Certified Nursing Assistant 1 (CNA1) was accused of deliberately slapping one resident (Resident 1) on the left arm and the facility failed to maintain documentation of a thorough abuse investigation and failed to notify the responsible party (RP) for Resident 1 of the allegation as required by facility policy.This failure resulted in placing all residents in the facility at risk of physical abuse and resulted in the RP for Resident 1 feeling alarmed.During a record review of facility's document titled, Resident Face Sheet, dated 4/7/26, for Resident 1, the document indicated Resident 1 was originally admitted to the facility in April 2023 with multiple diagnoses including nontraumatic intracranial hemorrhage (bleeding within the skull) and chronic kidney disease, stage 4 (the final stage of long-term kidney disease when the kidneys are no longer sufficiently able to remove waste products and excess water to support the body's needs), dependence on renal dialysis (a treatment for kidney failure to remove waste products and excess fluids by external filtration of blood).During a record review of Resident 1's Minimum Data Set (MDS, a tool used to guide care) Assessment, Section GG, dated 1/15/26, the MDS, Section GG indicated Resident 1 was totally dependent (helper does all of the effort) on staff for care.During a record review of facility's document titled, Care Plan, dated 2/15/24, for Resident 1, the document indicated Resident 1 was totally dependent (resident relies entirely on other people for care) due to impaired cognition (ability to think, learn, make decisions). During a record review of facility's document titled, General Order, dated 9/16/25, for Resident 1, the General Order indicated Resident 1 was to have a sitter (a caregiver who provides constant supervision) during renal dialysis to monitor and ensure that any care concerns are addressed.During an interview on 4/7/26 at 1:50 p.m. with the Director of Nursing (DON), DON stated they conducted the investigation into an allegation that CNA1 slapped Resident 1's arm on 3/6/26. DON stated they interviewed CNA1 and the Registered Nurse (RN1) who reported the incident. DON stated they did not keep notes about these interviews and were not sure of the dates and times the interviews occurred. During a concurrent interview and record review on 4/7/26 at 2:10 p.m. with DON, facility's document titled, Investigation Summary, dated 3/11/26 was reviewed. DON stated the document represented the entire record of their investigation into the allegation of abuse involving CNA1 and Resident 1. DON stated there were no notes in the document about the interviews with CNA1 and RN1.During a concurrent interview and record review on 4/9/26 at 2:35 p.m. with the facility's administrator (ADM), the facility's document titled, Investigation Summary, dated 3/11/26 was reviewed. ADM stated the document contains all records related to the allegation of abuse involving CNA1 and Resident 1. ADM stated there should have been a written and dated statement from CNA1 and RN1.During a concurrent interview and record review on 4/9/26 at 2:40 p.m. with ADM, facility's policy titled, Abuse Investigation & Reporting, undated, was reviewed. ADM stated the policy was not dated and the policy indicated that witnesses should sign and date statements involving allegations of abuse. ADM stated the reason to take notes on interviews with witnesses is to help remember and to write the report.During an interview on 4/9/26 at 4:33 p.m., ADM stated the RP should be notified of allegations of abuse. ADM stated they were out of the office when the allegation of abuse between CNA1 and Resident 1 occurred on 3/6/26 and, in their absence, the DON should (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	have notified the RP for Resident 1. ADM stated the reason to notify the RP is so they are informed and the RP should know what's going on.During a phone interview on 4/9/26 at 4:41 with DON, DON stated they did not notify the RP for Resident 1 about the incident. During a phone interview on 4/9/26 at 12:23 p.m. with the RP for Resident 1 (RP1), RP1 stated they were not aware of the abuse allegation involving CNA1 and Resident 1 on 3/6/26. RP1 stated they use a cell phone and there would be a record of a missed call or a voicemail. RP1 stated that they checked their call and voicemail history and there was no record of a missed call or a voicemail from the facility about this incident. RP1 stated they would want to be informed and it makes them feel alarmed that they were not notified. RP1 stated that, if they had known, they would have followed up and asked questions when they visited the facility.During a review of the facility's policy and procedure, titled, Abuse Investigation & Reporting, undated, the policy indicated, .Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and ate it. The policy also indicated, All alleged violations involving abuse. will be reported by the Company Administrator, or his/her designee, to the following persons. The Resident's Representative.