

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

Printed: 10/09/2026
Form Approved OMB
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 07/28/2026
NAME OF PROVIDER OR SUPPLIER Vale Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident 1 was free from physical abuse when Resident 2 hit Resident 1 with a cane during an encounter in the resident hallway. This failure resulted in Resident 1 sustaining a skin abrasion on the left arm. Findings: On 5/5/26, the facility reported an allegation of abuse incident to the California Department of Health (CDPH) involving Resident 1 (the victim) and Resident 2, the suspected abuser. During a record review of the facility's Investigation Summary (IS), dated 5/11/26, the IS indicated, On 5/5/2026 at approximately 9:40 AM, [Resident 1] was headed to the smoking area when he encountered [Resident 2]. [Resident 2] allegedly confronted him [Resident 1] and struck him with his cane. CNA [Certified Nursing Assistant] who was in the hall nearby witnessed [Resident 2] make contact with [Resident 1] approximately 3-4 times. [Resident 1] was hit by [Resident 2] with a cane. Staff nearby responded and separated the residents. During a record review of Resident 1's Observation Detail List Report, with completion date 5/5/26, the report indicated, Observation Date: 05/05/2026 12:57 PM. Situation - Physical Altercation Between Residents. Description of Change of Condition - .the resident [Resident 1] sustained an [sic] abrasion on his left posterior arm. During a record review of Resident 1's Face Sheet (FS), the FS indicated, Resident 1 was admitted to facility on 4/9/2024 with diagnoses that included, Chronic obstructive pulmonary disease (long term lung disease causing breathlessness), Displaced simple supracondylar fracture without Intercondylar fracture of left humerus (a break in the upper part of the lower arm bone just above the elbow joint), and fracture of humerus following insertion of orthopedic implant, joint prosthesis or bone plate right arm (a break in the upper arm bone around or near previously placed surgical hardware). 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 7/13/2026, the MDS indicated Resident 1 had a Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status about attention, orientation, and ability to register and recall information) score of 12 out of 15. A BIMS score of thirteen to fifteen is an indication of intact cognitive status. During a record review of Resident 2's Face Sheet (FS), the FS indicated, Resident 2 was admitted to facility on 5/7/2024 with diagnoses that included, Hypertension (high blood pressure) and Type II Diabetes Mellitus (high blood sugar level). During a record review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had a BIMS score of 15. A BIMS score of thirteen to fifteen is an indication of intact cognitive status. During an interview on 7/28/26 at 10:21 a.m. with Licensed Vocational Nurse (LVN) 1, LVN1 stated she had heard of the alleged incident involving Resident 1 and Resident 2. LVN 1 stated she viewed the video footage of the incident. LVN 1 stated in the video, Resident 2 was seen hitting Resident 1 on the left elbow with his cane. During a concurrent (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	observation and interview on 7/28/26 at 11:11 a.m., with Resident 1, in his room, Resident 1 was lying on the bed. Resident 1 was alert and oriented. When asked about the incident, Resident 1 stated he had used the bathroom shared with Resident 2 and the room next door. Resident 1 stated several days later when he was passing by Resident 2's room on his way to the smoking area, Resident 2 was standing in the doorway of the room and Resident 2 began hitting him with a cane. Resident 1 stated he put his left arm up to block blows from Resident 2. Resident 1 stated his left arm was the one previously broken in a fall. Resident 1 stated staff were present and witnessed the incident. During a review of the facility's policy and procedure (P&P), titled, Abuse, Neglect and Exploitation Prohibition, undated, the P&P indicated, Purpose - Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. During a review of the facility's policy and procedure (P&P), titled, Abuse and Neglect Prohibition California Addendum, undated, the P&P indicated, The purpose of this policy is to establish procedures for the prevention, identification, reporting, investigation, response, and documentation of abuse. and other alleged violations involving residents in accordance with Federal regulations. This facility is committed to maintaining an environment free from abuse. The facility shall protect residents from further potential harm during all investigations and shall ensure residents maintain the right to dignity, privacy, self-determination, and freedom from abuse.		