

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555184	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Heartwood Avenue Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1044 Heartwood Ave. Vallejo, CA 94591	

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. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview, and record review, the facility failed to ensure an allegation of abuse was reported within the required timeframe for one of four sampled residents (Resident 1) when an allegation of abuse was not reported to the State Agency. This failure resulted in delays in the abuse investigation process and decreased the facility's potential to protect patients from physical and psychosocial harm. Findings: During a review of Resident 1's admission records, the records indicated Resident 1 was admitted in September 2024 with diagnoses that included anxiety disorder (repeated episodes of sudden feelings of anxiety and fear or terror), dementia (a progressive state of decline in mental abilities), and depression (persistent feeling of sadness and loss of interest). Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 1 had moderate cognitive impairment. During a review of Resident 2's admission records, the records indicated Resident 2 was admitted in March 2025 with diagnoses that included metabolic encephalopathy (occurs when problems with metabolism cause brain dysfunction), vascular dementia (decline in thinking skills caused by conditions that block or reduce blood flow to the brain), schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), depression, and delusional disorders (an illness where a person cannot tell what is real from what is imaginary). Resident 2's MDS indicated Resident 2 had severe cognitive impairment. During a review of the SOC 341 (Report of Suspected Dependent Adult/Elder Abuse), dated 8/4/25, the report indicated, "[Resident 2] was walking down the hallway toward nurses station passed [Resident 1's room] where [Resident 1] was sitting in her wheelchair. [Resident 1] was reaching for gloves and [Resident 2] went to reach for the same glove box. [Resident 2] then made contact with [Resident 1's] left arm with her right hand - with an open palm. [Resident 2] and [Resident 1] were immediately separated by staff and both assessed with no injuries noted. The report further indicated that the report was faxed to the ombudsman on 8/4/25 but not to the Department. During a review of Resident 1's Interdisciplinary (IDT) Notes, dated 8/7/25, the notes indicated, IDT met to discuss a report of an incident between 2 residents. On 8/4/25 approximately 0120 PM [1:20 p.m.] CNA [Certified Nursing Assistant] staff was walking down the hallway and observed [Resident 1] sitting in her wheelchair near her room and attempted to reach for a box of gloves. [Resident 2] was also observed to be reaching for the same box of gloves. [Resident 2] with an open palm made contact with [Resident 1's] left arm. Police and Ombudsman were notified. SOC 341 was faxed to the Ombudsman. During an interview on 8/8/25 at 10:33 a.m. with the Administrator (ADM), the ADM stated, "On 8/4/25, we filed a SOC to the ombudsman. We did not report to CDPH because both residents had dementia and there were no injuries. [the incident was] Witnessed by CNA staff, [Resident 1] stopped [Resident 2] from getting the box, [Resident 2] held the arm that [Resident 1] used to grab the box. The ADM further stated the incident was reported to ombudsman but not to CDPH per the All-Facilities Letter (AFL - informs health facilities about changes in requirements, new technologies, scope of practice, or general information affecting them) 24-09. During an interview on 8/8/25 at 3:02 p.m. with the Director of Nursing (DON), the DON stated he was aware of the incident that happened on 8/4/25 between Resident 1 and Resident 2. The DON stated, "[Resident 2] was in the wheelchair and there was a glove box nearby. [Resident 2] was reaching for the glove box, [Resident 2] touched [Resident 1's] left arm. It was witnessed. Happened in 8/4/25. It was submitted to ombudsman, not to CDPH. The DON further stated the expectation is to report immediately any allegation of abuse and stated, "If aggressor has diagnosis of dementia, it is something that you have to report to ombudsman only and the police, no need to report it to CDPH. they need to know what's going on. and to conduct investigations and follow up. The DON added, "we're here to take care of them [residents] and we try to provide a safe place for the residents. During a telephone interview on 8/8/25 at 3:22 p.m. with CNA 1, CNA 1 stated, "I was pushing another resident in the wheelchair, I was in the hallway, I saw [Resident 2] reaching the box of gloves by [Resident 1's room]. [Resident 1] tried to stop [Resident 2] and [Resident 2] didn't liked that so she tapped [Resident 1] on the left arm. During a review of the facility's policy and procedure (P&P) titled Abuse Investigation and Reporting, revised 7/2025, the P&P indicated, All reports of resident abuse shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. 1. All alleged violations involving abuse will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a The State licensing/certification agency responsible for surveying/licensing the facility</p>		