

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/18/2026
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 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 interviews and record review, the facility failed to ensure required 1:1 supervision was provided for one of three sampled residents (Resident 2) when the assigned staff member was not closely supervising Resident 2 and did not intervene when a verbal altercation between Resident 1 and Resident 2 escalated into a physical altercation. This failure resulted in Resident 1 and Resident 2 physically kicking each other placed both residents at risk for physical harm. Findings:Resident 1 was admitted to the facility on September of 2024 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD) (a long-term, progressive lung disease that makes it difficult to breathe) and muscle weakness.A review of Resident 1's Minimum Data Set (MDS, a standardized assessment tool used in nursing homes), dated 3/30/26, indicated Resident 1 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment.A review of Resident 1's Change in Condition (CIC) Evaluation, dated, 6/2/26, indicated, At 1250 today [Resident 2] was peacefully wheeling [a resident's room number] in the hallway when [Resident 1] told her [Resident 2] to stop then [Resident 2] turned around (sic) both [Resident 2] and [Resident 1] exchanged kicks simultaneously .A review of Resident 1's Interdisciplinary Team (IDT) Notes dated, 6/4/26 indicated Behavior Committee Review: Resident with recent event of inappropriate physical contact with another resident this week. Resident with history of spontaneous inappropriate verbalizations and impulsive actions toward others.A review of Resident 1's Order Summary Report (ORS) indicated, .Monitor episodes of Anxiety.agitation.aggressive behavior towards staff every shift .Start date 6/8/26A review of Resident 1's Care Plan (CP), revised date 6/18/26, indicated multiple incidents of physical aggression towards other Residents, .they each made contact to lower legs of each other. 6/3/26 resident with no recall of incident [6/2/26].no psychosocial disharmony.immediately separated from each other.On 2/7/25, resident was upset at male peer after hearing rude remarks and inappropriately made physical contact to the back of peers head.2/22/25: unpredictably, made inappropriate physical contact to female peers shoulder.Body check and pain assessment to hand. staff to immediately intervene when triggers of angry outburst in behavior are observed.Resident 2 was admitted to the facility on March of 2025 with diagnoses which included Diabetes Mellitus Type 2 (a chronic medical condition in which the body cannot use insulin properly, causing blood sugar (glucose) levels to rise above normal and Schizophrenia (a chronic, severe mental health disorder that affects how a person thinks, feels, and behaves)A review of Resident 2's ORS indicated, Monitor target behavior: physical aggression towards staff. Notify MD if observed. every shift .start date 8/7/25.A review of Resident 2's CP, dated 11/17/25 indicated Miss [Resident 2] is currently on 1:1 [a safety intervention where a dedicated staff member is assigned exclusively to observe and protect a single individual at all times] with a staff member every 30 minutes to minimize behavior .1:1 monitoring, assign staff every 30 minutes rotation .attempt to redirect resident.A review of Resident 2's MDS, dated [DATE], indicated that Resident 2 had BIMS score of 0 out of 15, indicating severe cognitive impairment.During an interview with Certified Nursing Assistant (CNA) 3 on 6/18/26 at 12:01 p.m., CNA 3 confirmed that he was assigned to be Resident 2's 1:1 when the altercation (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555184	Facility ID: 555184 If continuation sheet Page 1 of 2

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	between Resident 1 and Resident 2 occurred in front Resident 2 room in the hallways. CNA 3 stated that Resident 2 was already agitated before the incident. While CNA 3 assisting another resident with meals, he observed Resident 1 verbally provoking Resident 2 by calling her crazy, you are in love, and you are acting crazy again which escalated the situation. CNA 3 stated he told Resident 1 to stop but did not intervene further. CNA 3 reported he did not know that 1:1 supervision required remaining within arm's reach to the resident and confirmed that he was assisting Resident 2's roommate in the room with meals when the altercation occurred. CNA 3 stated both residents kicked each other and acknowledged that he did not separate or redirect the residents until after the physical altercation had happened. CNA 3 stated he had never received formal 1:1 training. CNA 3 stated that when the commotion occurred and he turned around, the MRD (Medical Records Director) was already there and informed him that Resident 2 had kicked Resident 1 because Resident 1 may have thrown something at Resident 2. CNA 3 further stated that the altercation was witnessed by both the MRD and the Staffing Director (SD). During an interview on 6/18/26 at 1:04 p.m., the MRD stated, I was inside the medical records when it happened. The MRD reported hearing a commotion outside and seeing Resident 1 calling Resident 2 crazy. The MRD stated she exited the office and told CNA 3 to separate the residents, but Resident 1 continued to antagonize Resident 2, wheeled closer to Resident 2, and kicked Resident 2's leg. The MRD stated that Resident 2 became upset and told Resident 1, You kicked me, and then turned around and kicked Resident 1's right leg. During an interview on 6/18/26 at 1:18 p.m., the Director of Staff Development (DSD) stated that when a resident was on 1:1 supervision, staff must not leave the resident unless the next assigned person was present to relieve them. The DSD reported that staff were expected to follow the policy and remain focused because 1:1 supervision was intended for resident safety, including preventing elopement, falls, and potential verbal or physical altercations. The DSD also stated that staff assigned to 1:1 should not be assisting other residents with meals and must remain within arm's reach to the resident so they could react quickly. The DSD stated that Resident 2 was on 1:1 supervision by CNA 3 at that time of the incident. The DSD confirmed that CNA 3 was also assigned to assist another resident with meals. The DSD stated, [CNA 3's name] was scheduled to be 1:1, but it was also lunchtime. He asked [MRD's name] to watch Resident 2 while he fed the roommate. In addition, contrary to the DSD's statement, during the interview on 6/18/26 at 1:04 p.m., with the MRD, the MRD did not report being asked by CNA 3 to supervise Resident 2 while CNA 3 assisted another resident with meals. During an interview with the Director of Nursing (DON) on 6/18/26 at 2:10 p.m., the DON confirmed the findings regarding the incident between Resident 1 and Resident 2. The DON stated that 1:1 supervision was an important assignment from the time it began until the time it ended. The DON reported that 1:1 supervision required the staff member to remain within arm's reach to the resident and to provide constant observation. The DON stated there must always be a staff member next to a resident who required 1:1 supervision. The DON stated, That's the only thing they have to do; you are not supposed to be doing other things such as feeding. The DON acknowledged that resident safety was compromised when the assigned staff member was positioned far from the resident on 1:1 supervision and was unable to respond quickly to prevent the incident. A review of the facility Policy and Procedures (P&P) titled, 1:1 Continuous Supervision Policy and Procedures the P&P indicated, This facility provides a safe environment for all residents. High-risk behaviors includes and aggressive incidents. Staff must remain within arm's reach of the resident at all times to maintain maximum vigilance. Purpose. To prevent resident behavioral incidents though uninterrupted, close-proximity tracking. Arm's Reach Standard: Staff must remain within 3 feet (arms reach). No Distractions: Staff cannot or assist other residents while on 1:1 duty. A review of the facility P&P titled, Resident Rights, revised 12/2024, indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents rights to be treated with respect, kindness, and dignity. be free from abuse.		