STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555184	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Avenue Healthcare	1044 Heartwood Ave. Vallejo, CA 94591

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to meet professional standards of quality for three of 19 sampled residents (Resident 7, Resident 22 and Resident 60) when:1. Resident 7's blood pressure was not accurately assessed;2. Resident 22 was administered a blood pressure medication outside of the ordered parameters;3. Resident 60 was administered a lower than prescribed dose of medication; and4. Resident 60's oxygen was not accurately documented and monitored. These failures increased the risk for an inaccurate blood pressure for Resident 7, low blood pressure for Resident 20, subtherapeutic dose of medication, breathing problems, and hallucinations for Resident 60.1.Resident 7 was admitted to the facility in early 2026 with diagnoses that included high blood pressure and heart failure. During an observation and interview on 5/4/26 at 1:30 p.m. of Licensed Nurse (LN3), LN 3 was in the hallway taking Resident 7's blood pressure. Resident 7 was wearing a long sleeve down jacket. LN 3 placed the cuff end (the part of the blood pressure cuff that wraps around the bare upper arm) on Resident 7's forearm (from wrist to elbow) over the top of the jacket. LN 3 confirmed the observation and stated that it was not an accurate way to monitor a resident's blood pressure. During an interview on 5/4/26 at 1:39 p.m. with the Director of Staff Development (DSD, implements staff training), the DSD stated blood pressure should be checked on the upper arm and not over a jacket; the cuff should be on bare skin. The DSD stated it was important to obtain accurate blood pressure readings so the staff could give the appropriate medications. During an interview on 5/7/26 at 10:12 a.m. with the Director of Nursing (DON), the DON stated a blood pressure reading should not be taken on the forearm over a down jacket, as it would give an inaccurate reading. The DON stated they expected the staff to take an accurate blood pressure. During a review of the facility policy and procedures (P&P) titled, Blood Pressure, Measuring, dated 9/25, the P&P indicated, The purpose of this procedure is to measure the pressure exerted by the circulating volume of blood on the walls of the arteries, veins and chambers of the heart.Steps in the Procedure.Expose the resident's arm by rolling the sleeve up about 5 inches above the elbow.Wrap the blood pressure cuff evenly around the upper arm, approximately one (1) inch from the elbow. 2. Resident 22 was admitted to the facility in early 2026 with diagnoses that included high blood pressure, heart failure, and a heart attack. During a review of Resident 22's Order Summary Report [OSR], order date 1/26/26, the OSR indicated, amLODIpine Besylate [medication used to lower blood pressure and treat chest pain] 10 MG [milligram, unit of measurement] Give 1 tablet by mouth one time a day for HTN [hypertension, high blood pressure] HOLD SBP [systolic blood pressure, top number of blood pressure reading] <110 HR [heart rate] <65. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 22's Medication Administration Record [MAR], dated 4/1-4/30/26, the MAR indicated Resident 22's SBP was 98 on 4/20/26 and 107 on 4/24/26. The MAR indicated Resident 22 was administered the amlodipine on both dates and the medication was not held as directed in the physician orders (hold for SBP less than 110). During a concurrent interview and record review on 5/6/26 at 9:58 a.m. with LN 1 regarding Resident 22's MAR, LN 1confirmed she had administered Resident 22 the amlodipine on 4/20/26 and did not follow the hold parameters when the SBP was less than 110. LN 1 stated she should not have administered the medication. During a concurrent interview and record review on 5/6/26 at 11:01 a.m. with the DON regarding Resident 22's MAR, the DON confirmed the amlodipine was given outside of the physician-ordered hold parameters. The DON stated the staff was not following physician orders, and it was important to follow physician orders, as the orders were in place to prevent complications. 3. A review of Resident 60's admission record indicated that Resident 60 was admitted to the facility in February 2026 with diagnoses that included congestive heart failure (a weak heart causing fluid buildup and difficulty breathing), obstructive sleep apnea (breathing that stopped and started during sleep), adjustment disorder with anxiety (stress causing excessive worry or nervousness), and autistic disorder (a condition affecting communication, behavior, and social interaction). A review of Resident 60's Brief Interview for Mental Status (BIMS), dated 2/28/26, indicated that Resident 60 had a BIMS score of 15 out of 15, indicating intact cognition. A review of Resident 60's OSR, dated 4/27/26, indicated an order for Mounjaro (tirzepatide, once-weekly injectable medication designed to improve blood sugar control in adults and children 10 and older with Type 2 diabetes) Subcutaneous Solution Autoˆinjector 15 mg/0.5 mL (milliliter, unit of meausrement) to be injected subcutaneously once every Monday for obesity. A review of Resident 60's MAR for the month of May indicated that the resident received one dose of Mounjaro 15 mg/0.5 mL on 5/4/26. During an interview on 5/6/26 at 3pm with Resident 60, Resident 60 stated that the staff had been giving him Mounjaro 2.5 mg instead of 15 mg, Resident 60 further stated that he knows that he received Mounjaro 2.5 mg because it was a singleˆdose injection labeled 2.5 mg/0.5 mL. During a concurrent observation, interview, and record review on 5/7/26 at 6:30 a.m. with LN 5 in the medication room, LN 5 stated that the Mounjaro available in the medication refrigerator was a box of prefilled pens of 2.5 mg/0.5 mL. The box was labeled Use one pen every week. 4 singleˆdose prefilled pens. Upon opening the box, there was one of the four singleˆdose prefilled pens remaining, labeled Mounjaro 2.5 mg/0.5 mL. During a phone interview on 5/7/26 at 7:11 a.m. with the Pharmacy Technician (PhTc), the PhTc stated that the Mounjaro 15 mg dose was not delivered. During an interview on 5/7/26 at 8:52 a.m. with the DON, the DON confirmed that the 15 mg dose of Mounjaro was not delivered due to insurance issues. Since Resident 60 received a dose and stated that he received Mounjaro on Monday (5/4/26) in a 2.5 mg dose, the DON stated that the nurse administered a lower dose than ordered. The DON stated that the expectation was for the nurse to (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administer medication in accordance with the physician's order, and that if the medication was not available, it should be placed on hold until available and the physician should be notified. 4. A review of Resident 60's OSR, dated 3/27/26, the OSR indicated an order for Oxygen: At 2 Liters/Min [Liters per minute, flow rate of the oxygen) via Nasal Cannula [thin tube connecting the oxygen source to the resident's nose for administration] PRN [pro re nata, meaning as needed] as for o2 sat [oxygen saturation] less than 92% as needed. During an observation and interview on 5/4/26 at 9:04 a.m. with Resident 60, Resident 60 lay upright in bed on oxygen via nasal cannula. Resident 60 stated he needed continuous oxygen to prevent hallucinations, shortness of breath, and chest pain. The resident continued to be observed on oxygen via nasal cannula on the following dates and times: 5/4/2026 at 12:47 p.m., 2:15 p.m., and 3:20 p.m. 5/5/2026 at 11:20 a.m. 5/6/2026 at 10:15 a.m. During a concurrent interview and record review with the DON on 5/6/26 at 10:22 a.m., the DON confirmed that no nurse had documented in the May MAR or progress notes who administered the oxygen or the reason for administration. The DON stated that the oxygen order was for 2 liters per minute when oxygen saturation was less than 92%. The DON further stated that nurses should have documented when the resident was on oxygen, why it was administered, and whether the resident required continuous oxygen. The DON stated that if the resident required continuous oxygen, the physician should have been notified so the order could be changed from PRN to continuous or routine. A review of the facility's P&P titled Administering Medications, dated 4/25, indicated, Medications are administered in a safe and timely manner and as prescribed. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication .If a resident uses PRN medications frequently, the Attending Physician and Interdisciplinary Care Team, with support from the Consultant Pharmacist as needed, shall reevaluate the situation, examine the individual as needed, determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medication is clinically indicated. A review of the facility's P&P titled Oxygen Administration, dated 10/25, indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration.After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1.The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3.The rate of oxygen flow, route, and rationale. 4.The frequency and duration of the treatment. 5.The reason for p.r.n. administration. 6 All assessment data obtained before, during, and after the procedure. 7.How the resident tolerated the procedure.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure accurate reconciliation and accountability of controlled medications for three of 19 sampled residents (Resident 22, Resident 56 and Resident 57) when discrepancies were found during the random controlled medication audits.These failures resulted in the facility lacking accurate accountability of controlled substances and increased the potential for diversion in a 60-certified-bed facility. Findings:The controlled medication record for three randomly selected residents (Resident 22, Resident 56 and Resident 57) who received as-needed controlled medications were requested for review during the survey.During a review of Resident 22's Medication Administration Record (MAR) dated 4/20-4/25/26, the MAR indicated an order for Morphine Sulfate [medication to treat pain] Solution 20 mg/ml (mg, milligrams: unit of measurement. ml, milliliter: measurement for a volume of liquid) Give 0.25 ml by mouth every 4 hours as needed.for pain.During a review of Resident 22's CONTROLLED DRUG RECORD [CDR], [a form that keeps count of the number of narcotics dispensed to a resident], entries from 4/20-4/25/26, the CDR indicated 0.25 ml of Morphine Sulfate was removed from the medication bottle on 4/22/26 at (time not documented) and on 4/23/26 at 6 p.m. These doses were not documented in the MAR as given to Resident 22.During a review of Resident 22's MAR dated 4/25-5/5/26, the MAR indicated an order for, Morphine Sulfate Solution 20 mg/ml Give 0.5 ml by mouth every 2 hours as needed.for pain.During a review of Resident 22's CDR, entries from 4/25-5/5/26, the CDR indicated 0.5 ml of Morphine Sulfate was removed from the medication bottle on 4/25/26 at 11:22 p.m., 4/27/26 at 5 a.m., 4/28/26 at 2:30 a.m., and 5/3/26 at 4 a.m. These medications were not documented in the MAR as given to Resident 22.During a review of Resident 56's MAR dated 4/26-5/5/26, the MAR indicated an order for, Percocet [medication to treat pain] 10-325 MG.Give 1 tablet by mouth every 4 hours as needed for.pain.During a review of Resident 56's CDR, entries from 4/26-5/5/26, the CDR indicated Percocet 10-325 was removed from the narcotic medication card (pre-packaged medications dispensed from a pharmacy) on 4/28/26 at 4 a.m. and 5/2/26 at 12:48 a.m. These doses were not documented in the MAR as given to Resident 56.During a review of Resident 57's MAR dated 4/19-4/27/26, the MAR indicated an order for, Hydrocodone-Acetaminophen [medication to treat pain] 10-325 MG.Give 1 tablet by mouth every 6 hours as needed for.pain.During a review of Resident 57's CDR, entries from 4/19-4/27/26, the CDR indicated Hydrocodone-Acetaminophen 10-325 MG was removed from the narcotic medication card on 4/23/26 at 6:05 p.m. This dose was not documented in the MAR as given to Resident 57.During an interview on 5/5/26 at 2:30 p.m. with Licensed Nurse (LN 1), LN 1 stated when narcotics were administered, the nurse was required to sign both the CDR and the MAR. LN 1 stated this was important because the CDR ensured accurate counts of controlled medication and the MAR reflected what the resident received, helping staff determine when the last dose was given.During a concurrent interview and record review on 5/6/26 at 11:01 a.m. with the Director of Nursing (DON), the DON reviewed the MAR and CDR for Resident 22, Resident 56, and Resident 57. The DON confirmed the MAR had missed entries for narcotic administration. The DON stated that she expected nurses to sign narcotics in both the MAR and CDR to ensure accurate documentation of doses and administration times.During a review of the facility policy and procedures (P&P) titled, Administering Medications, dated 4/25, the P&P indicated, .As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered.Any results achieved and when those results observed.The signature and title of the person administering the drug.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure that two of 19 sampled residents (Resident 4 and Resident 9) were free from significant medication errors when nursing staff did not administer prescribed asˆneeded antihypertensive medications during repeated, documented episodes of elevated systolic blood pressure.This failure compromised the residents' safety and placed both Resident 4 and Resident 9 at increased risk for serious and potentially lifeˆthreatening outcomes, including hypertensive crisis, stroke, and cardiac arrest.1.Resident 9 was admitted to the facility in late 2022 with diagnoses that included a stroke, an irregular heartbeat, and heart disease. During a review of Resident 9's Order Summary Report [OSR], order dated 4/2/26, the OSR indicated, cloNIDine HCl Oral Tablet 0.1 MG [milligram, unit of measurement].Give 0.1 mg by mouth every 12 hours as needed for SBP [systolic blood pressure, top number of blood pressure reading] >150. A review of Resident 9's documented blood pressure readings from 4/2/26-4/30/26, showed 15 systolic blood pressure (SBP) readings greater than 150. On 4/2/26 at 9 a.m., SBP was 167, and at 6 p.m., SBP was 163. On 4/3/26 at 9 a.m., SBP was 164. On 4/4/26 at 9 a.m., SBP was 170, and at 6 p.m., SBP was 156. On 4/5/26 at 9 a.m., SBP was 158. On 4/7/26 at 6 p.m., SBP was 172. On 4/9/26 at 6 p.m., SBP was 164. On 4/10/26 at 9 a.m., SBP was 167, and at 6 p.m., SBP was 154. On 4/11/26 at 9 a.m., SBP was 152. On 4/12/26 at 6 p.m., SBP was 154. On 4/28/26 at 6 p.m., SBP was 157. On 4/29/26 at 6 p.m., SBP was 155. On 4/30/26 at 6 p.m., SBP was 151. During a review of Resident 9's Medication Administration Record [MAR], dated 4/2/26-4/30/26, the MAR indicated clonidine was not administered for any SBP reading greater than 150. A review of Resident 9's documented blood pressure readings from 5/1/26-5/6/26 showed five SBP readings greater than 150. On 5/1/26 at 9 a.m., SBP was 154, and at 6 p.m., SBP was 166. On 5/2/26 at 6 p.m., SBP was 154. On 5/4/26 at 9 a.m., SBP was 189, and at 6 p.m., SBP was 157. During a review of Resident 9's Medication Administration Record [MAR], dated 5/1/26-5/6/26, the MAR indicated clonidine was not administered for any SBP reading greater than 150. During a concurrent interview and record review on 5/6/26 at 9:39 a.m. with Licensed Nurse (LN 1), LN 1 reviewed Resident 9's OSR and stated that if Resident 9 had an SBP greater than 150, clonidine should have been administered per the physician's orders. LN 1 reviewed the MAR and confirmed there were multiple SBP readings greater than 150 and clonidine had not been administered. LN 1 stated the staff should have followed the physician's orders. During a concurrent interview and record review on 5/6/26 at 11:01 a.m. with the Director of Nursing (DON), after reviewing Resident 9's MAR for clonidine, the DON confirmed that clonidine was not administered in April and May for SBP readings greater than 150. The DON stated Resident 9 had high blood pressure and the clonidine was needed. During an interview on 5/6/26 at 11:40 a.m. with the Medical Doctor (MD), the MD stated that if a resident had an order to give clonidine for an SBP greater than 150, they would expect the nurse to administer the medication as ordered. 2. A review of Resident 4's admission record indicated that Resident 60 was initially admitted to the facility in February 2026 with diagnoses that included congestive heart failure (a weak heart causing (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fluid buildup and difficulty breathing), hypertension (HTN, high blood pressure) and hypertensive urgency (blood pressure extremely high that needs medical attention). A review of Resident 4's OSR, dated 4/4/26, indicated an order for clonidine hydrochloride oral tablet 0.1 mg, Give 1 tablet by mouth every 8 hours as needed for HTN systolic blood pressure above 160, diastolic blood pressure above 90. A review of Resident 4's Weights and Vital Summary (WVS) from 4/20/26-5/6/26, the WVS indicated: 4/28/26 1:03 a.m., BP (blood pressure) = 175/87 mmHg (milliliters of mercury, unit used to measure blood pressure) 4/23/26 8:49 p.m., BP = 240/112 mmHg During a concurrent interview and record review on 5/7/26 at 8:52 a.m. with the DON, the DON stated that no PRN (pro re nata, meaning as needed) clonidine had been administered on 4/23/26 at 8:49 p.m. or on 4/28/26 at 1:03 a.m. The DON stated that the expectation was for the nurse to administer the PRN blood pressure medication as ordered and notify the physician. The DON further stated that high blood pressure could cause stroke and cardiac arrest. A review of the facility's policy and procedure (P&P) titled Administering Medications, dated 4/25, indicated, Medications are administered in a safe and timely manner and as prescribed.As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered; b. The dosage; c.The route of administration; d. The injection site (if applicable); e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g.The signature and title of the person administering the drug.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and documentation review, the facility failed to implement their medication storage policy when: Multiple medications were unlabeled, and Expired medications were stored and available for use.These failures had the potential for residents to receive unsafe, ineffective, or inappropriate medications for a census of 56.Findings:1. A review of the tuberculin (bacteria extract used to diagnose tuberculosis infections) manufacturer's box indicated that the tuberculin vial should be discarded 30 days after opening. During a concurrent observation and interview on 5/5/26 at 9:20 a.m., with the Director of Nurses (DON), a vial of tuberculin was observed to be open without an opened date in the medication storage fridge. The DON confirmed the finding and stated, it is not labeled.During a concurrent observation and interview on 5/5/26 at 9:47 a.m. with Licensed Nurse 1 (LN 1), two 15mg mirtazapine tablets (a prescription antidepressant drug) , one tablet of 8mg ondansetron (a medication used to treat nausea), and three 4mg tablets of ondansetron were found unlabeled without a resident name and available for use in medication cart 2. LN 2 confirmed the medications were not labeled.2. During a concurrent observation and interview on 5/5/26 at 9:20 a.m., with the DON, an emergency kit containing emergency intravenous (medications given through the veins) medications was observed to have an expiration date of April 2026. The DON verbally confirmed the observation.A review of the fluticasone propionate and salmeterol (inhaled medications to improve breathing) 500mcg/50mcg (micrograms, a unit of measurement) inhaler manufacturer's box indicated that the inhaler should be discarded one month after opening.A review of degludec (long lasting insulin variant) insulin pen (multi use insulin syringe) manufacturer's instructions indicated that the pen should be tossed eight weeks after opening.During a concurrent observation and interview on 5/5/26 at 9:47 a.m. with LN 1, the following medications were found to be expired and stored in medication cart two: one packet containing 30 10mg tablets of olanzapine (a medication used to treat mental disorders such as schizophrenia) with an expiration date of 12/2/25, one fluticasone propionate 500mcg/50mcg inhaler with an open date of 3/10/26 (four weeks past manufacturer's recommended discard date), and one degludec insulin pen with an open date of 2/11/26 (three weeks and six days past manufacturer's recommended discard date). LN 1 confirmed the observations and indicated that expired medications should have been disposed of.During an interview on 5/6/26 at 9:39 a.m. with the DON, the DON indicated that expired medications should not have been available for use and expected staff to have thrown them away. The DON further indicated that medications needed to be labeled with an opened date if required.During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, revised 11/20, the P&P indicated, Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was prepared and stored in a safe and sanitary manner for a census of 54 residents who received food prepared from the kitchen, when: 1. Food debris and dried watermarks was observed on several kitchen utensils stored inside the plastic container. The bottom of the container, which was designated for storing clean utensils, contained visible dirt and food debris; 2. Several kitchen utensils, stock pot, plastic trays, metal pans were found stacked wet and stored at the clean and ready-to-use storage areas; 3. A plastic coffee carafe on the countertop contained a white substance adhered to the interior walls and debris collected at the bottom; 4. A staff used wiping cloth from the red bucket to wipe the countertop during cooking and food preparation without wearing gloves. The staff returned the used cloth to the red bucket and continued cooking and preparing food without washing their hands; and 5. The inside of the van which used to transport food to the facility from an off˜site kitchen contained food debris and both new and dried liquid marks. Three plastic food warmers inside the van also contained food debris, dried liquid, and dried food drippings on their interior surfaces. The exterior surfaces of the food warmers appeared dirty. 6. A white plate stored in the clean and dry storage container was found with dried food debris; These failures increased the risk of cross-contamination affecting a census of 54 residents. Findings:1.During a concurrent observation and interview with the Dietary Manager (DM) on 5/4/26 at 8:31 a.m. during the initial kitchen tour, several kitchen utensils stored inside a plastic tray contained visible food debris and watermarks. Some utensils were stored wet inside the plastic container, and the bottom of the container contained visible dirt and food debris. The DM confirmed the findings and stated that clean utensils must be stored completely dry and free of food particles. During an interview with the Registered Dietitian (RD) on 5/6/26 at 11:33 a.m., the RD stated that staff must make sure dishes come out of the dishwasher fully clean and completely dry before being stored. The RD also stated that the containers used for storing dishes must be cleaned and sanitized. The RD further stated that when it's stored wet, It creates an environment for bacterial growth. 2.During the initial kitchen tour and a concurrent interview with the DM on 5/4/26 at 8:46 a.m., 35 metal pans and several plastic trays and stock pots, were stacked while still wet on the clean rack. The DM confirmed the findings and stated that these items must be completely dry before being stored on the dry rack. During an interview with the RD on 5/6/26 at 11:33 a.m., the RD stated that dishes must come out of the dishwasher fully clean and completely dry before being stored. The RD also stated that when it's stored wet, It creates an environment for bacterial growth. 3.During a concurrent observation and interview with the DM and Dietary Aide (DA) 1 on 5/4/26 at 8:46 a.m., during the initial kitchen tour, a plastic coffee carafe was observed on the countertop. Upon inspection, the carafe contained a white substance adhered to the interior walls and debris collected at the bottom. The DM confirmed the findings and DA 1 verified that the coffee carafe came from the other facility. During an interview with DA 2 on 5/5/26 at 9:58 a.m., DA 2 stated that coffee carafes brought in from the other facility must be cleaned every day because, if they are not cleaned right away, they become unsafe for residents. During an interview with the RD on 5/6/26 at 11:33 a.m., the RD stated that coffee carafes should be cleaned after every meal and that staff should take them to the other facility for cleaning. 4.During a concurrent observation and interview with FC on 5/5/26 at 10:47 a.m., the FC was cooking and preparing food when the FC took a wet wiping cloth from the red bucket with bare hands and used it to wipe the countertop used for food preparation. The FC then placed the used wiping cloth back into the red bucket and continued cooking without washing hands. The FC repeated this action a second time without washing hands. When asked about the importance of handwashing after touching the red bucket, the FC stated that she needed to wash her hands after using the wiping cloth before cooking and stated, We do not want contamination during cooking. 5.During an observation on 5/4/26 at 8:49 a.m., the facility's food (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555184	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Avenue Healthcare	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transport van was inspected and it was verified by the DM that the facility used the van to deliver residents' meals that were cooked and prepared at a different facility. The interior of the van contained food debris and both new and dried liquid stains. In addition, three plastic food warmers inside the van were inspected and were found to contain food debris, dried liquid marks and dried food drippings on the interior surfaces. The exterior surfaces of the food warmers also appeared dirty. During an interview with the DA 1 on 5/4/26 at 10:07 a.m., the DA 1 confirmed the findings mentioned above. When asked when the last time the van was cleaned, DA 1 stated that the food transportation van was last cleaned on Friday [5/1/26]. During an interview with the RD on 5/6/26 at 11:33 a.m., the RD stated that the food transportation van and the plastic food warmers needed to be clean and sanitized after each meal and that staff in charge should check with the DM with regards to deep cleaning. 6.During an observation of the food transportation van on 5/4/26 at 10:09 a.m., while serving wares on the cart were being unloaded from the van and brought into the facility for later use during lunch, a plate was observed with visible dried food debris on its surface. DA 1 confirmed the finding and stated that the plate was in the clean tray and should not have had any food debris on it. During an interview with the Registered Dietitian (RD) on 5/6/26 at 11:33 a.m., the RD stated that staff must make sure dishes come out of the dishwasher fully clean and completely dry before being stored. A review of the facility Policy and Procedures (P&P) titled Sanitization revised 2024, the P&P indicated, The food services area shall be maintained in clean and sanitary manner.areas shall be kept clean, free from litter and rubbish.All utensils.equipment shall be kept clean.food contact surfaces and utensils shall be washed to remove or completely loosen soils.scrape food particles.food preparation equipment and utensils that are manually washed will be allowed to air dry.Food service staff will be trained to maintain cleanliness throughout their work areas during all task, and to clean after each task. A review of the facility P&P tilled Dishwashing Machine Use Revised 03/24 indicated After running items through entire cycle, allow to air-dry A review of facility documents titled, Food & Nutrition: Competency Checklist - Cook the document indicated, Knowledge of Infection Control Practices.Correct handwashing procedure.Proper use of gloves/change between tasks.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure the medication rate did not exceed 5% for one of three sampled residents (Resident 9) when:Resident 9 did not receive diclofenac sodium gel 1% (a gel used treat joint pain and inflammation from osteoarthritis) to his leg or as needed clonidine (fast acting medication to lower blood pressure).These failures resulted in two medication errors out of 35 opportunities, yielding a medication error rate of 5.71%.Findings:During a review of Resident 9's Order Summary Report [OSR], order dated 4/30/25, the OSR indicated, Diclofenac Sodium External gel 1% .Apply to left leg topically [to the skin] four times a day for pain.During a medication pass observation on 5/4/26 at 8:42 a.m. with Licensed Nurse (LN 4), LN 4 did not apply the diclofenac gel 1% to Resident 9's left leg. LN 4 looked through the cart and stated there was no diclofenac gel 1% available. LN 4 checked Resident 9's blood pressure and recorded a reading of 189/73.During a review of Resident 9's OSR, order date 4/2/26, the OSR indicated, cloNIDine HCl Oral Tablet 0.1 MG [milligram, unit of measurement].Give 0.1 mg by mouth every 12 hours as needed for SBP >150 [Systolic Blood Pressure, top number of blood pressure reading].During a review of Resident 9's Medication Administration Record [MAR], dated 5/4/26, the MAR indicated diclofenac sodium was marked as refused, and clonidine 0.1 mg was not documented as administered when SBP was 189.During a concurrent interview and record review on 5/4/26 at 3:12 p.m. with LN 4, LN 4 confirmed she did not apply the diclofenac sodium gel because it was not available in the medication cart. LN 4 confirmed Resident 9's SBP was 189 during the morning medication pass and stated it was greater than 150. LN 4 confirmed she did not administer clonidine as ordered and stated it should have been given because it was important for preventing cardiac complications. LN 4 stated she forgot to check the as-needed medications.During an interview on 5/7/26 at 10:12 a.m. with the Director of Nursing (DON), the DON stated she expected medications to be administered correctly according to physician orders.During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/25, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber order, including any required time frame .