STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. BUILDING _____ B. WING _____	03/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. provide adequate monitoring and supervision systems during an extended fire watch, 2. while the fire alarm system was malfunctioning; 3. submit a request for an emergency fire alarm panel for ten days after the fire panel malfunction; and, 4. establish effective monitoring and supervision procedures for prevention/identification of intentional fire setting. These failures had the potential to result in injury, or loss of life, for all residents in the facility in the event of an uncontrollable fire in the facility. On [DATE] at 4:06 p.m., the facility Administrator and Director of Nursing was informed of an Immediate Jeopardy situation (IJ - a situation in which the provider's noncompliance with requirements has caused or is likely to cause serious injury, harm, impairment, or death to a resident), for failure to implement adequate protective measures in a timely manner against the threat of fire from both accidental and deliberate causes. Through observation, interview, and record review, the facility demonstrated they had initiated the plan of action for providing monitoring and supervision against the threat of fire. The Immediate Jeopardy was lifted on 3/13/2020 at 2:03 p.m. Findings: During a review of the facility license, expiration date of [DATE]5/2020, the license indicated the facility was licensed for 202 beds. During a review of a fax signed by the Administrator (ADM), with a transmission date of [DATE], at 6:18 p.m., the fax indicated the fire alarm system had an uncorrectable issue identified, and was currently nonfunctional. The fax indicated the facility had implemented a fire watch until the system was completely restored. During review of two voice messages on 2/20/2020 at 12:09 p.m., and 1:58 p.m., from the ADM, the ADM stated there was a small fire in a resident room, which was extinguished before the Fire Department arrived. The Fire Department told the ADM the fire appeared to be accidental. During a review of a fax signed by the ADM, with a transmission date of [DATE]20 at 6:40 p.m., the fax indicated facility staff discovered a fire on [DATE]20, at 11:44 a.m., by Bed C, in room [ROOM NUMBER], a three-bed room. At that time, two residents occupied the room: Resident 1, who was sleeping in Bed A, and Resident 2, who was in Bed C, and was not alert. The fax indicated both residents were evacuated, and staff had extinguished the fire before arrival of the Fire Department. At 11:56 a.m., with the Fire Department on site, facility staff discovered a fire in room [ROOM NUMBER], a two-bed room. room [ROOM NUMBER] had no occupants in the room at the time of the fire; the fire was contained and extinguished. The fax indicated the Fire Department Fire Investigator deemed the causes of the two fires as suspicious, and would investigate further. The fax indicated the Plan of Action was: notifications to (local) Fire Department, CDPH ([ST] Department of Public Health), ombudsman, Medical Director, and physicians; fire watch in place; Fire Investigator in facility to investigate fire as they were treating the fires as suspicious and continuing their investigation; monitor residents for respiratory or emotional distress; social services to meet with residents to provide emotional support, with referral to psychological services for affected residents; and isolation and cleaning of the affected rooms by a Restoration Management Company. During an observation in room [ROOM NUMBER] on [DATE]20, at 2:10 p.m., room [ROOM NUMBER] smelled of smoke, and had a blackened foam-like material on the floor by Bed C. The bedside table at 19C had a blackened area approximately four inches wide running the entire length of the bedside table back; the baseboard and wall adjacent to the bedside table was blackened. The electrical cord for the bed of 19C was partially melted. During an observation in room [ROOM NUMBER] on [DATE]20, at 3:10 p.m., room [ROOM NUMBER] smelled of smoke; the mattress of bed 40B had a blackened area on the right hand side in the middle of the mattress. During an interview on [DATE]20, at 4:10 p.m., with the Vice President of Operations (VPO), the VPO stated the fire alarm system was still not in service for one side of the building, but was expected to be repaired by 2/25/2020. The VPO stated until the fire alarm system was completely functional, the facility would be completing fire watch rounds on a continual basis, utilizing two staff members. The VPO stated the facility would be applying to the Office of Statewide Health Planning and Development (OSHPD) for an emergency fire panel permit. During a telephone interview on [DATE] at 10:35 a.m., with the ADM, the ADM stated the facility was still on fire watch because the fire system had not been completely repaired yet on both floors of the two floors of the facility, with further repair work not scheduled until [DATE]20. The ADM stated the facility was still on fire watch, which meant each room and area was checked on an ongoing basis. The ADM stated the facility tried to schedule two dedicated personnel for the fire watch each shift, but sometimes were only able to schedule one fire watch person per shift. During a review of the facility Fire Watch Patrol Log Sheets dated [DATE], 2/29/2020, [DATE], and [DATE], the Log Sheets indicated only one person was on fire watch: [DATE], from 3 p.m., until 2/29/2020, at 7 a.m.; 2/29/2020, from 11 a.m., to 12 p.m.; 2/29/2020, from 3 p.m., until [DATE], at 7 a.m.; and [DATE], at 11 p.m., until [DATE], at 7 a.m. During a telephone conference on [DATE] at 1:05 p.m., with OSHPD District Structural Engineer (DSE) and the facility-contracted architect (ARC), ARC stated the request for the emergency fire panel was sent to OSHPD on 2/29/2020. DSE stated OSHPD had received the facility request for a special urgent fire panel permit on [DATE]. During a conference on [DATE] at 1 p.m. attended by the ADM, the VPO, and the facility Attorney (AAL), the ADM, the VPO and the AAL, all stated they had timed how long it took to do a fire watch covering all areas of the facility, and it had taken staff a total of 60 to 64 minutes for completion of the circuit of all patrolled areas. During a review of the facility policy and procedure (PNP), Fire Watch Procedures, dated 11/5/13, the PNP indicated the Uniform Fire Code required the facility to establish and maintain a fire watch when fire protection equipment/system/sprinklers were rendered inoperable. The PNP indicated the fire watch included assignment of a qualified person or persons whose sole responsibility was a continuous patrol of the building/premises. The fire watch patrol rounds included, check the entire building-all rooms, offices, storage areas, and areas outside the building. The PNP indicated the patrol rounds should be completed every thirty minutes, with documentation of the history of the rounds maintained in a log book. During an interview on [DATE], at 11:41 a.m., Fire Department Inspector 1 (FD 1), FD 1 stated the fires on [DATE]20 were a result of arson. During a review of a fax with a transmission date of [DATE]20, at 2:53 a.m., signed by the ADM, the fax indicated on [DATE]20, at 11:30 p.m., the facility remained on fire watch. The fire watch personnel had just completed a patrol in room [ROOM NUMBER] a few minutes earlier, when Certified Nursing Assistant 1 (CNA 1) passed the doorway of room [ROOM NUMBER], and saw a fire in the two-bed room. The fax indicated a bed-bound resident occupied Bed A, and Bed B was unoccupied at the time of the fire. Facility staff evacuated the resident in Bed A, and extinguished the fire before the arrival of the Fire Department. A review of the Fire Watch Log Sheet dated [DATE]20, for the area of Station 1A and Station 1B, the log indicated Security Guard 1 (SG 1), patrolled the area for the time period of [DATE]20, at 10 p.m., to [DATE]20 at 2 a.m., with an average time per round of 19 minutes. For the same time period, the log indicated in the column labeled, Finding, of smoke in room [ROOM NUMBER]. During an interview on 3/13/2020 at 8:20 a.m., with Security Guard 1 (SG 1), SG 1 stated he had been doing continuous fire watch rounds, on a fifteen minutes per round schedule. SG 1 stated he had patrolled room [ROOM NUMBER], and had only seen one resident in Bed A. SG 1 stated he had been out of room [ROOM NUMBER] for three to five minutes, when he

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) heard there was a fire in room [ROOM NUMBER], and went to assist. During an interview on 3/13/2020, at 8:32 a.m., with CNA 1, CNA 1 stated he had passed by room [ROOM NUMBER], and noticed a fire behind the nightstand between Bed A and B. CNA 1 stated he called out to alert staff of the fire, and went into the room to extinguish the fire, while other staff evacuated the resident in Bed A. During an interview on 3/11/2020, at 8:30 a.m., with the ADM, the ADM stated six cars were set on fire this morning at 5:35 a.m., on a street adjacent to the facility. The ADM stated the facility had not been physically damaged, but the smoke from the fires necessitated evacuation of 38 residents to dining areas of the facility for three hours. During an interview on 3/13/2020, at 2:03 p.m., with the ADM, and Director of Nursing (DON), the ADM stated on the morning of 3/11/2020, at 5:35 a.m., facility staff had responded to a loud noise, which sounded like an explosion at the north side of the building. The ADM stated the responding staff were at the intersection of two streets, by the northwest corner of the building. The staff saw that cars parked along the curb of the sidewalk adjacent to the building were on fire, and gasoline was running downhill in the gutter, toward the northwest corner. The responding staff extinguished the gasoline fire at the corner, but the smoke from the burning cars continued to enter the facility. The ADM stated at the time of the car fires, the facility had patrol areas along the building perimeter, including the smoking area, but no designated patrols or fire watch of the sidewalks surrounding the building. During a concurrent observation and interview on 3/13/2020, at 3:03 p.m., with the ADM, and Maintenance Supervisor ([CONDITION]), the north side of the facility had a resident and staff smoking area along the length of the building, bordered on the north by a concrete wall, and on the south, by the building. Unlocked metal gates closed the eastern and western ends, and separated the resident and staff smoking areas. Two streets intersected at the northwest corner of the facility; the northern street came to a dead end at its eastern end, and sloped downhill toward the western street. The western street sloped downhill toward the south and the southern side of the building. The smoking area was below the street level on both the north and west street sides, with variable depth due to the sloping of the streets. The north concrete wall varied in height on the sidewalk side between three and five feet, with the shortest height at the uphill, eastern end. The sidewalk curb along the north side of the facility had a black discoloration roughly the length of the building. [CONDITION] measured the following distances, which were confirmed by the ADM: from the northwest edge of the facility roof, to the street side of the top of the concrete wall was 8 feet and 4 inches; from the exterior north wall of the facility to the exterior edge of the concrete wall was 11 feet and 10.5 inches; from the curb of the north street sidewalk to the concrete wall was 5 feet and 5.5 inches.