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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055239	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Bay Post-Acute	20259 Lake Chabot Road Castro Valley, CA 94546

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 44823 Based on observation, interview and record review, the facility failed to follow physician ' s order of supervised feeding for one (Resident 1) of two residents. This failure resulted in Resident 1 potentially choking and aspirating (accidental inhalation of food or liquid into the lungs) when eating. Findings: During a record review of Resident 1 ' s face sheet, undated, Resident 1 was admitted in July 2023 with dysphagia (difficulty swallowing). During an observation on 9/6/24, at 8:32 a.m., Resident 1 had his breakfast tray in front of him. Resident 1 had breakfast on his own with no staff assisting him with feeding. Resident 1 was observed with food particles on his beard. During a record review of Order Summary Report, a physician order with a start date of 8/5/23 indicated, 1:1 feeding assist; aspiration precautions. LUA (left upper arm) flaccid (a type of paralysis in which muscle becomes soft) due to stroke, with meals. During a record review of Resident 1 ' s care plan (how facility will help manage care), the care plan for activities of daily living (ADL-skills required to care for oneself such as eating) for eating indicated need for one-on-one assist. During an interview on 10/24/24, at 10:17 a.m., with Dietary Manager (DM), DM stated Resident 1 required one-on-one feeding assistance with aspiration precautions. During an interview on 10/24/24, at 10:43 a.m., with Registered Dietician (RD), RD stated Resident 1 had a physician order for one-on-one feeding assistance. RD added Resident 1 had dysphagia and was at risk for choking. During an interview on 10/24/24, at 12:20 p.m., with the Director of Nursing (DON), the DON stated Resident one is on one-to-one feeding.

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