

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER East Bay Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview and record review, the facility failed to ensure doors to enter the building were locked for all 84 of 84 sampled residents when the facility failed to ensure two doors (main entrance and rear exit) had functioning locks and failed to ensure staff kept the rear exit closed and supervised according to facility expectations while the doors locks were broken. The failure had the potential for unauthorized people to enter the facility building which had to potential to affect all residents' safety. During an observation on 11/8/25, at 5:02 a.m., in the parking lot at the back of the facility, the rear exit door of the facility was inspected. From 5:02 a.m. to 5:40 a.m., the rear exit door was propped open by a wet floor sign. Facility staff were exiting and reentering the building without closing the door. A sign affixed to a nearby window indicated the facility Visiting Hours 8:00 a.m. to 8:00 p.m. During an observation on 11/8/25, at 5:41 a.m., the surveyor entered the building and entered a resident hallway with resident rooms 16, 17, 18 and 19 without encountering any staff members. Residents were observed sleeping in bed. Surveyor walked down to the dining room near the nurses' station before encountering a certified nursing assistant exiting a resident's room outside of the dining room. During an interview on 11/8/25, at 5:43 a.m., with Registered Nurse 1 (RN 1), RN 1 stated the front door of the facility was expected to be closed and locked to prevent outside access when outside of visiting hours. RN 1 stated the visiting hours were 8:00 a.m. to 8:00 p.m. During an observation on 11/8/25, at 6:10 a.m., the front entrance door was inspected. The front entrance door was not locked and could be opened from the outside. During an observation on 11/8/25, at 6:19 a.m., the rear exit door was open and propped open by the same wet floor sign. During an observation 11/8/25, at 6:40 a.m., the Maintenance Director (MDir) removed the wet floor sign from the rear exit and closed the door. During an observation on 11/8/25, at 6:51 a.m., a staff member assisted Resident 1 through the rear exit door. The staff member left the door propped open. During a concurrent record review and interview on 11/8/25, at 7:25 a.m., with MDir, the facility maintenance logs titled, Maintenance Work Order, dated from 10/1/25 to 11/8/25, were reviewed. MDir stated the maintenance records did not include any reports about the broken rear exit door lock. During a concurrent observation and interview on 11/8/25, at 8:00 a.m., with MDir, the rear exit door was inspected. MDir stated the rear exit door's locking mechanism was broken and the rear exit door could not be locked. During a concurrent interview and record review on 11/8/25, at 8:10 a.m., with MDir, an online order for a door lock titled, Details for Order #114-1624816-4441814, dated 11/8/25, was reviewed. MDir stated they were informed of the broken lock a week ago and requested a locksmith to service the door. MDir stated the locksmith could not repair the door and had to order a new lock. The online order indicated MDir had E-procurement order placed: 11/8/25. MDir stated the lock would be installed on Monday. During an interview on 11/8/25, at 8:21 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the rear exit doors should remain closed but unlocked during visiting hours. LVN 1 stated all doors needed to be closed and locked from the outside after visiting hours. LVN 1 stated they were not aware of the rear exit door lock being broken. During a concurrent observation and interview on 11/8/25, at 8:37 a.m., with Operations Assistant (Operations Assistant), MDir and the Administrator present, the front door's locking mechanism was inspected. MDir stated they were not aware of any issues with the front door lock. Upon inspection, MDir could not engage the locking mechanism to lock the front doors. MDir stated the door was misaligned and prevented the front entrance door from being locked. OA stated the front entrance and rear exit doors were expected to be closed and locked to prevent unauthorized outside access outside of the visiting hours of 8:00 a.m. to 8:00 p.m. OA stated all doors should remain closed but unlocked during visiting hours. OA stated the facility was aware of the inoperable lock and expected staff to supervise the hallway to prevent unauthorized entry and exit. During a concurrent interview and review on 11/8/25, at 9:05 a.m., with OA, the facility policy and procedure (P&P) titled, Exits or Means of Egress, dated 07/2024, was reviewed. The P&P indicated exit doors remain unlocked at all times. OA clarified the expectation was the exit and entrance doors would be locked from the outside but were unlocked from the inside. During an observation on 11/25/25, at 8:10 a.m., the rear exit door was inspected. The rear exit door was propped open by an orange traffic pylon.</p>		