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	04/07/2026

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 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 observation, interview and record review, the facility failed to protect one of three sampled residents (Resident 1) from physical abuse when Resident 2 pushed Resident 1 on the ground, while Resident 1 was sitting in a wheelchair in facility's smoking area. Resident 1 fell on his back on the ground.This failure resulted in Resident 1 sustaining a skin tear on his right hand, and a transfer to Acute Care Hospital (ACH 1) requiring hospitalization for three consecutive days. It resulted in Resident 1 feeling scared of Resident 2.During a record review of Resident 1's admission Record dated 01/03/23, the record indicated Resident 1 had a diagnosis of major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (nervousness). During a record review of Resident 1's Annual Minimum Data Set (MDS, an assessment tool used to evaluate a resident's functional capabilities, health needs, and clinical status) assessment dated [DATE], the assessment showed Resident 1 was able to understand others and make self-understood. Resident 1 was assessed with Annual Brief Interview for Mental Status (BIMS, an assessment for mental status) score of 15 out of 15, indicating no impaired cognition (mental status). During a record review of Resident 2's admission Record dated 8/6/25, the record indicated Resident 2 had diagnosis of dementia (memory loss), and cognitive communication deficit (a condition where someone has trouble organizing thoughts). During a record review of Resident 2's MDS assessment dated [DATE], the assessment indicated Resident 2 had a BIMS score of six (6) out of 15, indicating severely impaired cognition. During observation and interview on 4/7/26 at 11:00 a.m. with Resident 2, Resident 2 was sitting down on the chair in the smoking patio. Resident 2 stated he did not recall any altercations with other residents in the facility. During an observation and interview on 4/7/26 at 11:02 a.m., Resident 1 was lying in bed. Resident 1 stated there had been an altercation between him and Resident 2 around Christmas time in 2025. He was in the facility's smoking area and Resident 2 was also sitting there at the table. Resident 1 stated he put his canned drink on top of the table and Resident 2 placed his drink next to his. He told Resident 2 not to do it almost four times, then Resident 2 got upset and pushed him to the ground. Resident 1 stated he fell backwards on his back, hit his head onto the ground, and after Resident 2 pushed him on the ground, Resident 2 jumped on top of him and kneeled him on the chest. Resident 1 stated he had to shout as he could not breathe and he had to grab Resident 2 to get him off of him. Resident 1 stated that incident made him feel scared of Resident 2. Resident 1 stated he was hospitalized for a few days after that incident. During a phone interview on 4/7/26 at 12:11 p.m. Licensed Vocational Nurse (LVN 1) stated she was the desk nurse on 12/27/25, on the day of altercation between Resident 1 and Resident 2. LVN 1 stated Resident 3 was coming back from the smoking area and alerted her that a fight had happened in the smoking area. LVN 1 stated then she saw Resident 2 walking in the hallway through the door that goes into facility's smoking area. LVN 1 stated she immediately went outside the smoking area to assess the situation. LVN 1 stated Resident 1 was on his back on the ground and Resident 1 told her he's gotten into a verbal argument with Resident 2 physically pushed him down, causing him to fall on his back. LVN1 stated, her and another nurse (LVN 2) assisted Resident 1 back to his wheelchair. LVN 1 stated (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 had a laceration (open skin) on his right hand and he was transferred to Acute Care Hospital (ACH 1) for further evaluation. During an interview on 4/7/26 at 3:25 p.m., LVN 2 stated she recalled requesting assistance from LVN 1 to assist Resident 1 back in his wheelchair on 12/27/25, after Resident 2 had pushed him down on the floor in the smoking area. LVN 2 stated Resident 1 told her Resident 2 continued to move his cup next to Resident 1's drink cup which caused the altercation. LVN 2 stated Resident 1 was alert and oriented with time, place, person and situation; and she had no reason to not believe Resident 1. LVN 2 also stated Resident 2 was strong and had the strength to push someone down as Resident 1 had described and Resident 3 had witnessed on 12/27/25. During a record review of Resident 3's BIMS score assessment dated [DATE], the assessment indicated Resident 3's BIMS score was 15/15, indicating no impaired cognition. Resident 3 remained unavailable for an interview during the investigation. During a record review of Resident 1's progress notes dated 12/27/25, indicated, LVN 1 documented [Resident 3] entered the facility and notified staff that [Resident 1] was intentionally provoking [Resident 2] . a physical altercation started in the designated smoking area.[LVN 1] and another nurse approached [Resident 1], who was observed lying flat on his back on the ground yelling .requesting assistance to get up .assessments revealed a superficial open area on the right hand. During a record review of Resident 2's progress notes dated 12/27/25, the progress note indicated Resident 2 stated he went outside to smoke as usual and Resident 1 got mad at him, because he didn't want Resident 2 by him. Resident 2 kicked Resident 1, his chair fell and he went down with it. During a record review of Resident 1's Emergency Department Provider notes from ACH 1 dated 12/30/25, indicated Resident 1 was seen at the hospital for assault altercation with another SNF (Skilled nursing facility) patient while smoking cigarettes outside. Resident 1 was struck to the chest, and wrestling on the floor, sustained abrasion to right hand. During a review of facility's Policy and Procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2021, the P&P indicated, Resident has the right to be free from abuse. This includes but is not limited to freedom from verbal, mental, sexual or physical abuse .resident abuse prevention program consists of a facility-wide commitment and resources allocation to support the following objectives of protecting residents from abuse from other residents .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not report an alleged abuse incident involving Resident 1 and Resident 2, nor the investigation results, to the State Survey Agency for over three months. Furthermore, notification to the Long Term Care Ombudsman was also delayed nearly three weeks. Resident 2 pushed Resident 1 from a wheelchair, causing a fall, a skin tear on the right hand, and hospitalization at Acute Care Hospital (ACH 1).This failure resulted in facility not adhering to the abuse reporting timelines.During a record review of Resident 1's admission Record dated 01/03/23, the record indicated Resident 1 had a diagnosis of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (nervousness). During a record review of Resident 1's Annual Minimum Data Set (MDS, an assessment tool used to evaluate a resident's functional capabilities, health needs, and clinical status) assessment dated [DATE], the assessment showed Resident 1 was able to understand others and make self-understood. Resident 1 was assessed with Annual Brief Interview for Mental Status (BIMS, an assessment for mental status) score of 15 out of 15, indicating no impaired cognition (mental status). During a record review of Resident 2's admission Record dated 8/6/25, the record indicated Resident 2 had diagnosis of dementia (memory loss), and cognitive communication deficit (a condition where someone has trouble organizing thoughts). During a record review of Resident 2's MDS assessment dated [DATE], the assessment indicated Resident 2 had a BIMS score of six (6) out of 15, indicating severely impaired cognition. During an observation and interview on 4/7/26 at 11:02 a.m., Resident 1 was lying in bed. Resident 1 stated there had been an altercation between him and Resident 2 around Christmas time in 2025. He was in the facility's smoking area and Resident 2 was also sitting there at the table. Resident 2 got upset and pushed him to the ground. Resident 1 stated he fell backwards on his back, hit his head onto the ground, and after Resident 2 pushed him on the ground, Resident 2 jumped on top of him and kneeled him on the chest. Resident 1 stated he was hospitalized for a few days after that incident. Resident 1 stated he had to tell the nurse to call the police as he wanted the incident to be documented. During an interview on 4/7/26 at 11:02a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated on 12/27/25, she saw Resident 1 lying on his back on the floor in the smoking area. LVN 1 stated Resident 1 told her he's gotten into a verbal argument with Resident 2 and Resident 2 physically pushed him down, causing him to fall on his back. LVN 1 stated Resident 1 wanted her to call the police for reporting. During a phone interview on 4/7/26 at 2:21 p.m. with the Ombudsman, Ombudsman stated he did not receive the report on physical altercation between Resident 1 and Resident 2 until 1/12/26 for the incident tht had occurred on 12/27/25. During an interview and record review on 4/7/26 at 3:40 p.m. with facility's Administrator (Admin) in presence of Director of Nursing (DON), an undated investigation report for abuse incident between Resident 1 and Resident 2 was reviewed. The Admin stated he was unable to find any documentation indicating that the facility notified the State Survey Agency or Ombudsman about the abuse incident or its investigation involving Resident 1 and Resident 2. The DON stated facility Administrator was responsible for notifying the Ombudsman and State Survey Agency. The Admin stated he had also checked his emails from the Administrator at the time of the incident; however, he was unable to locate any records of timely notification to above agencies. During a review of facility's Policy and Procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2021, the P&P indicated the facility would investigate and report of all allegations within federally required timeframes. This includes immediately reporting all allegations within two hours of the incident, results of investigation must be reported within five working days, maintain documentation proof of time of allegation, time reported, who was notified, and investigation steps and findings. However, based on record review and interview, the facility failed to provide evidence (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	demonstrating compliance with these requirements. Record review of facility's internal investigation report summary lacked documented date and time when it was submitted to CDPH or ombudsman.