

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/02/2026
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, for Residents 1-10, the scheduled (controlled medication, narcotic) medication record system was complete (all documents available) and accurate (numbers match). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance (drug) Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration), and destruction logs. The facility did not have complete records. The facility did not have accurate records. These failures resulted in the potential for undetected loss and diversion of scheduled medications. In addition, these failures resulted in the potential for avoidable medication errors. Findings: During an interview, on 9/8/25 at 10:15 a.m., the Medical Record Director (MRD) was asked to describe the medical records system. MRD's description included that scheduled medicine delivery receipts were kept for seven years. In addition, MRD stated that controlled drug administration sheets (MAR) were kept for seven years. During a concurrent observation and interview, on 9/8/25 at 11:05 a.m., Licensed Vocational Nurse (LVN 1), identified a medication cart. LVN 1 was asked to describe the scheduled medication accountability process. Her description included that scheduled medications were delivered with a CDR (documents the amount of scheduled medication remaining). She further stated that the nurse placed the scheduled medication in the cart and filed the CDR at the cart. During an interview, on 9/8/25 at 11:30 a.m., Director of Nursing (DON) was asked to describe the scheduled medication accountability process with the automated dispensing unit (ADU, machine that dispenses medication). Her description included that the ADU printed a daily ADU Controlled Dispenses log (scheduled medications delivered to the facility). She was requested to provide the daily ADU Controlled Dispenses log for 3/4/24, 3/14/24, 3/22/24, 3/27/24, 4/6/24, 4/9/24, 4/18/24, 4/21/24, 5/2/24, 5/7/24, 5/16/24, 5/20/24, and 5/30/24. During a concurrent interview and record review, on 9/8/25 at 2:35 p.m., DON identified and provided the requested daily ADU Controlled Dispenses logs. During a concurrent interview and record review, on 9/10/25 at 11:15 a.m., DON identified the ADU Controlled Dispenses log documentation for: 3/14/24 12:31 am Resident 1 Hydroco (narcotic pain reliever) /APAP (acetaminophen, pain reliever) TAB (tablet) 5-325MG (milligram) 3/14/24 2:23 am Resident 2 Hydroco/APAP TAB 5-325MG 3/14/24 2:24 am Resident 3 Oxycodone (narcotic pain reliever) TAB 5 mg 3/14/24 2:38 am Resident 4 Oxycodone TAB 5 mg 3/14/24 7:43 am Resident 5 Hydroco/APAP TAB 5-325MG 3/14/24 7:44 am Resident 6 Hydroco/APAP TAB 5-325MG 3/22/24 8:20 am Resident 7 Hydroco/APAP 5/3253/22/24 8:20 am Resident 8 Oxycodone TAB 5 mg 3/27/24 12:45 am Resident 9 Oxycod/APAP TAB 5-325MG 3/27/24 12:19 am Resident 10 Hydroco/APAP TAB 5-325MG DON was requested to provide the corresponding CDR records for the above Residents. During a concurrent interview and record review, on 9/10/25 at 12:50 p.m., DON identified the list of requested CDRs from the ADU Controlled Dispenses log. The DON stated the facility was unable to (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	find the corresponding CDRs. During a concurrent interview and record review, on 9/11/25 at 2:45 p.m., DON identified the ADU Controlled Dispenses logs and Medication Administration Records for:3/14/24 12:31 am Resident 1 Hydroco/APAP TAB 5-325MG3/14/24 2:23 am Resident 2 Hydroco/APAP TAB 5-325MG3/14/24 2:24 am Resident 3 Oxycodone TAB 5 mg3/14/24 2:38 am Resident 4 Oxycodone TAB 5 mg3/14/24 7:43 am Resident 5 Hydroco/APAP TAB 5-325MG3/14/24 7:44 am Resident 6 Hydroco/APAP TAB 5-325MG3/22/24 8:20 am Resident 7 Hydroco/APAP 5/3253/22/24 8:20 am Resident 8 Oxycodone TAB 5 mg3/27/24 12:45 am Resident 9 Oxycod/APAP TAB 5-325MG3/27/24 12:19 am Resident 10 Hydroco/APAP TAB 5-325MG The DON acknowledged, for the Residents listed, that the ADU Controlled Dispenses logs showed the scheduled medications listed were dispensed by the ADU. The DON further acknowledged, for the scheduled medication dispensed, the facility was unable to locate the corresponding CDRs. The DON acknowledged the Resident's corresponding MAR showed the doses were administered.The DON acknowledged the facility's Policy required Controlled Drug Accountability Sheets to have been completed for the above Residents and scheduled medications. During an administrative record review, of the Quality Assurance & Performance Improvement, Medication Management/Pharmacy Services reports, dated March 2024-August 2024, did not document issues with scheduled medication accountably. During an administrative record review, of the Facilities Policy for Controlled Substances (Revision Date: November 2024) showed, Policy Interpretation and Implementation, Handling Controlled Substances, 4. If the count is correct, an individual resident controlled substance record is made for each resident who will be receiving a controlled substance. Continued review showed, Dispensing and Reconciling Controlled Substances, 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following.a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records. CDR is a declining inventory record.		

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the facility administrator was managed by a state licensed nursing home administrator (NHA) when the facility assigned the Operations Assistant (OA), who was not a state licensed nursing home administrator, as the administrator and posted Administrator 1's (ADM 1) license on the wall without assigning ADM 1 actual administrative duties. This failure resulting in the facility operations being managed by an unlicensed administrative staff for four months. A review of Resident 11's admission record indicated Resident 11 was originally admitted to the facility on [DATE] and discharged on 1/9/26. A review of Resident 12's medical record indicated Resident 12 was admitted for pressure ulcer care, diabetes and weakness. During a record review of Resident 12's minimum data set (MDS, an assessment tool to guide resident care), dated 10/13/25, the MDS indicated Resident 12 had Brief Interview for Mental Status score of 15 (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) A review of Resident 12's weekly nursing assessment titled, Nursing Weekly Summary, dated 11/3/25, indicated Resident 12 was alert and oriented with no impairments to vision or hearing. During an interview on 11/8/25 at 5:43 a.m., with Registered Nurse 1 (RN 1), RN 1 stated OA was the administrator for the facility. RN 1 did not know who ADM 1 was. During an observation on 11/8/25 at 5:45 a.m., ADM 1's NHA license was posted on the facility bulletin board. During an interview on 11/8/25 at 7:32 a.m., with Resident 12, Resident 12 stated OA was the administrator who replaced ADM 2. Resident 12 stated they didn't know who ADM 1 was. During a review of state licensing database titled, Licensing and Certification Verification Detail Page, dated 7/6/26, the database indicated OA was licensed as a Nursing Home Administrator on 1/16/26. During a record review of State Agency records, titled ELMS Facility Entity Tab - [Facility], dated 7/6/26, the record indicated: Administrator 2 (ADM 2) was the facility administrator from 1/29/25 to 1/15/26. OA was listed as the administrator from 1/16/26 to 3/6/26. Administrator 1 (ADM 1) was not listed. During a concurrent interview and record review on 7/1/26, at 11:24 a.m., with Administrative Staff 1 (AS 1), Resident 10's progress notes titled [Facility] Progress Notes *NEW* dated 7/2/26, was reviewed. AS 1 stated their note indicated, on 1/5/26, Resident 11 had a negative interaction with a CNA, and AS 1 had informed Resident 11 that administrator and ombudsman had a plan to address Resident 10's concerns against CNAs. AS 1 stated OA was the administrator at the time of the note. AS 1 stated ADM 2 was no longer working at the facility on 9/2025. AS 1 could not recall the exact date of OA's arrival. AS 1 stated Resident 11 would get upset about certified nursing assistant (CNA) care and would go directly to the administrator to complain. AS 1's desk was in front of the administrator's office so AS 1 would know how often Resident 11 would complain to the administrator. During a concurrent interview and record review on 7/2/26 at 12:00 p.m., with Human Resources (HR) the facility list of the past 12 months of employee terminations titled, Termination Details: Termination Details, undated, HR stated the list included all employee hire dates and termination dates. The list indicated ADM 2's termination date was 9/18/25 and OA's hire date was 9/30/24 and termination date was 3/6/26. During a phone interview on 7/2/26 at 1:13 p.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 10's progress notes by LVN 1 titled [Facility] Progress Notes *NEW*, dated 7/1/25, was reviewed. LVN 1 stated Resident 11 had a behavioral plan which was monitored by the administrator and the ombudsman because Resident 11 often made complaints against the CNA staff. A Behavioral Plan progress note, dated 9/8/26, indicated (continued on next page)		

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administrator and LN discussed with the resident the terms of agreement with the facility and the ombudsmen, refusing one cna is refusing both cna's. LVN 1 stated the past three administrators were ADM 2, OA and ADM 1. LVN 1 stated ADM 2 was the administrator in the note, and OA was the subsequent administrator continuing the plan. LVN stated Resident 11 had been discharged from the facility before ADM 1 had assumed responsibilities of the administrator. During a concurrent interview and record review on 7/1/26 at 4:00 p.m., with ADM 1, Resident 11's grievance report titled, Grievance/Complaint Report, dated 12/31/25, was reviewed. ADM 1 stated they were not familiar with Resident 11's grievance report because OA had completed this report. ADM 1 stated they had never spoken to Resident 11. ADM 1 stated OA was assigned as the operations assistant of the facility, but OA operated essentially as the administrator without a license. ADM 1 stated their license was posted on the wall so the facility would technically have a licensed nursing administrator. ADM 1 stated OA received their nursing home administrator license on 1/16/26 and was not licensed in the state prior. ADM 1 stated they did not hire OA to the position and OA's function as the facility administrator was outside of ADM 1's control. ADM 1 stated OA was at the facility daily, and ADM 1 received telephone updates from OA about the facility. During an interview on 7/2/26 at 11:14 a.m., with ADM 1, ADM 1 stated OA was assigned to the facility on 9/15/25 until 3/7/26. During a record review of OA's employment record, untitled and undated, the record indicated OA had started as Operations Assistant at the facility from 9/15/25 to 1/15/26. A review of facility job descriptions titled, Administrator, dated 2/18, and Operations Manager, dated 2/24, indicated both job descriptions had identical General Purpose, Essential Duties, Supervisory Requirements and Qualifications. Both job descriptions indicated the individual must maintain licensing credentials for an Administrator and Reports to: Regional Director of Operations. A review of facility policy and procedure (P&P) titled, Complaints and Greivances, dated 4/2017, the P&P indicated the Administrator is responsible to thoroughly investigate, assure resolution of the grievance/complaint and complete documentation of the facility's action. During a review of state health and safety code titled, California Code, Health and Safety Code 1416.6, the code indicated it shall be a misdemeanor for any person to act or serve in the capacity of a nursing home administrator, unless he or she is the holder of an active nursing home administrator's license. A person who is acting as an administrator shall notify the program in writing within five days of acting in this capacity and provide factual information and specific circumstances necessitating the use of an acting administrator. No person shall act as an administrator for more than 10 days unless arrangements have been made for part-time supervision of his or her activities by a nursing home administrator who holds a license or provisional license under this chapter. Supervision shall include at least 8 hours per week of direct onsite supervision by the licensed administrator. The program shall be notified in writing of the nature of this arrangement. No person shall act as an administrator for more than two months without the written approval of the program. During a review of state regulation titled, Title 22, Chapter 3. Skilled Nursing Facilities, 72007 Administrator, the regulation defined an administrator as a person licensed as a nursing home administrator by the California Board of Examiners of Nursing Home Administrators.		