

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

Printed: 07/18/2026
Form Approved OMB
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 11/17/2025
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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and record review, the facility failed to post the most recent Statement of Deficiencies (form CMS- 2567) results in a location where residents (14, 21, 36, 75, and 79), visitors, or other individuals had readily accessible access and did not have to ask to see the survey results. The resident council members felt their inability to access the survey results without asking fostered dependence on the staff and decreased their ability to act according to their own wishes. During an interview on 9/9/25 at 10:30 a.m. with the Resident Council members (14, 21, 36, 75, and 79) all members stated they did not know where the binder with the most recent survey results were located or if the results were available for their review without request. During a concurrent observation and interview on 09/09/2025 at 1:24 p.m. with the Activities Director (AD), the AD stated the East Bay Post Acute Survey binder was located at the receptionist desk. The AD was unable to locate the survey binder at the receptionist desk. During an observation and interview on 9/09/25 at 1:26 p.m. with the Administrator (Admin), Admin stated the survey binder was in his office and not accessible to the residents. During a concurrent observation and interview on 09/09/25 at 2:30 p.m. with the Admin and Maintenance Director (Maint. D), Admin stated there was a holder on the wall outside the copy room that housed the East Bay Post Acute survey binder. The Maint. D stated the holder was removed during facility renovations and painting. During an interview on 9/11/25 at 8:30 a.m. with the Maint. D, Maint. D. stated the facility renovations started in 2022 and finished in 2024. During a review of the facility's policy and procedure titled, Resident Rights dated 2001, the Resident Rights policy indicated federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' rights to . examine survey results.		

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
--	-------	-----------

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

Printed: 07/18/2026
Form Approved OMB
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 11/17/2025
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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to ensure qualified, full-time oversight of Dietary Services when the Registered Dietitian (RD) did not work full time and the dietary manager (DM) was not qualified to supervise the kitchen for 19 weeks. These failures had the potential to compromise the safety and nutritional status of residents through potential transmission of foodborne illness and decreased quality of food for 81 residents who received food from the kitchen out of 85 residents in the facility. During a concurrent interview and record review on 9/9/25, at 4:13 p.m., with Dietary Manager (DM), DM's Safe-serv Food Manager certificate was reviewed. DM stated the Safe-serv Food Manager certificate was the only certificate they had. DM stated they were not a certified dietary manager (CDM) and had not completed education requirements to qualify as a qualified dietetic service manager. DM stated they were hired in April 2025 as the dietary manager. During an interview on 9/10/25, at 11:30 a.m., with Registered Dietitian (RD), RD stated they were contracted to work 24-32 hours per week based on the facility needs. RD stated DM had oversight of the day-to-day kitchen supervision. RD stated CDM education included training in regulations, therapeutic diets, food texture and serving residents according to strict regulations to avoid harm. During a review of RD's facility visit invoices titled, [RD contractor] dated from May 2025 to August 2025, the invoices indicated on: May 2025, RD worked 42 hours in the first week of May, then worked 29-38 hours the rest of the month, June 2025, RD worked 32-33 hours per week, July 2025, RD worked 24-37 hours per week, and August 2025, RD worked 24-27 hours week. During an interview on 9/11/25, at 3:05 p.m, with Administrator (ADM), ADM stated the facility had not hired a qualified CDM to replace the previous CDM. ADM stated DM was responsible for kitchen supervision, and RD was responsible for clinical management of residents. During a record review of DM's job description titled, Job Description: Dietary Manager, dated 2/2024, the job description indicated Qualification Education and/or Experience must be a graduate of an approved dietary manager's course that meet the state and federal care regulations. The job description indicated DM signed the document on 4/10/25. During a record review of DM's competency checklist titled, Dietary Manager Competency Checklist, dated 4/10/25, the checklist indicated RD had reviewed the checklist and RD indicated DM did not maintain CDM/[Certified Food Protection Professional] credential and [continuing education unit] requirements. During a record review of facility's contract with RD titled, [Contractor] Agreement to Provide Consultant Services, dated 5/31/24, the contract indicated RD had contracted hours .16-24 hours a week.		

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 11/17/2025
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents' medical records were updated to indicate information pertaining if an advanced directive (written statement of a person's wishes regarding the medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor), was offered and if the resident or responsible representative (RR) accepted or declined to create an advance directive, whether or not the resident had executed an advance directive, or the resident wishes for six / six sample residents (Residents 1, 2, 4, 7, 8, and 10). This had the potential for the facility to provide treatment and services against the residents' wishes. During a review of Resident 1's admission Record (AR), printed 9/10/25, indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia (a condition where the body's lungs are unable to adequately provide oxygen to the tissues, leading to low oxygen levels in the blood). During a review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 8/19/25 indicated Resident 1's BIMS (an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was 15/15. A BIMS score 15 indicated short and long-term memory was intact and the resident had decision-making capacity. During a review of Resident 1's baseline care plan person-centered care plan dated 8/13/2025, the baseline care plan indicated the advanced directive was discussed with the resident. The baseline care plan did not detail the advance directive discussion with the resident or the RP. The baseline care plan did not indicate if the advance directive was offered, if the resident accepted or declined to create an advance directive, whether or not the resident had executed an advance directive, or the resident wishes. During a review of Resident 2's AR, printed on 9/10/25, AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following nontraumatic intracerebral hemorrhage affecting right non-dominant side. During a review of Resident 2's MDS dated [DATE] under Section C, a brief interview for mental status (BIMS) was performed and resulted in a summary score of 8/15. A BIMS score of 8 indicated moderate problems with thinking and memory (moderate cognitive impairment). During an interview and record review with the Social Services Assistant (SSA) on 9/10/25 at 10:00 a.m., the SSA stated Resident 2's baseline care plan was not available due to the resident's length of time in the facility. SSA would attempt to have the documents located. During a review of Resident 4's admission Record (AR), printed 9/10/25, indicated, Resident 4 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (where the kidneys have permanently lost most of their ability to function). During a review of Resident 4's MDS dated [DATE] under Section C, a brief interview for mental status (BIMS) as performed and resulted as a summary score of 15/15. A BIMS score of 15 indicated short and long-term memory was intact and the resident had decision-making capacity. During a review of Resident 4's baseline care plan person-centered care plan dated 7/30/2025 indicated the advanced directive was discussed with the resident. The baseline care plan did not detail the advance directive discussion with the resident. The baseline care plan did not indicate if the advance directive was offered, if the resident accepted or declined to create an advance directive, whether or not the resident had executed an advance directive, or the resident wishes. During a review of Resident 7's admission Record (AR), printed 9/10/25, indicated, Resident 7 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebrovascular disease affecting left non-dominant side. During a review of Resident 7's MDS dated [DATE] under Section C, a brief interview for mental status (BIMS) as performed and resulted as a summary score of 7/15. A BIMS (continued on next page)		

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 11/17/2025
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	score of 7 indicated severe problems with thinking and memory (severe cognitive impairment).During a review of Resident '7s baseline care plan person -centered care plan dated 7/20/2025 indicated the advanced directive was discussed with the RR. The baseline care plan did not detail the advance directive discussion with the resident or the RP. The baseline care plan did not indicate if the advance directive was offered, if the resident or RP accepted or declined to create an advance directive, whether or not the resident had executed an advance directive, or the resident wishes. During a review of Resident 8's admission Record (AR), printed 9/10/25 , indicated, Resident 8 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction CI (CI occurs when blood flow to the brain is interrupted, causing damage to brain tissue) due to embolism of left middle cerebral artery. During a review of Resident 8's MDS dated [DATE] under Section C, a brief interview for mental status (BIMS) as performed and resulted as a summary score of 6/15 A BIMS score of 6 indicated severe problems with thinking and memory (severe cognitive impairment).During a review of Resident 8's baseline care plan person -centered care planning dated 7/06/2025 indicated the advanced directive was discussed. The baseline care plan did not detail the advance directive discussion with the resident or the RP. The baseline care plan did not indicate if the advance directive was offered, if the resident or RP accepted or declined to create an advance directive, whether or not the resident had executed an advance directive, or the resident wishes.During a review of Residen10's admission Record (AR), printed 9/10/25 , indicated, Resident 10 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 10's MDS dated [DATE] under Section C, a brief interview for mental status (BIMS) as performed and resulted as a summary score of 10/15 A BIMS score of 10 indicated moderate problems with thinking and memory (moderate cognitive impairment).During an interview and record review with the Social Services Assistant (SSA) on 9/10/25 at 10:00 a.m., the SSA stated Resident 2's baseline care plan was not available due to the resident's length of time in the facility. SSA would attempt to have the documents located.During a concurrent interview and record review on 9 /10/2025 at 9: 37 a.m. with the admission Coordinator (AC) The AC stated the admission packet the resident or resident representative receives contain resident rights, grievance, consent to treat, financial arrangements, transfers and discharges, bed holds and readmission, personal property, photos, confidentiality documents, facility rules and grievance procedures and agreement and signature page. AC stated the documents listed on the admission Agreement for Skilled Nursing Facilities .are discussed and reviewed at admission. Review of the records for residents 1, 2, 4, 7, 8 and 10, the AC stated there was no documentation relating to the advance directive discussion details, if an option to create an advance directive was offered, whether or not the resident had executed an advance directive, nor the resident wishes. During an interview on 09/10/2025 at 10:18 a.m. with Director of Nursing (DON), DON stated the admitting nurse will query the resident or RR if they have an Advance Directive. If the residents have an advanced directive they are requested to provide the document to social service. Social Services is to follow up to ensure advance directive was offered or requested again. DON stated social services document the discussion about the advance directive in the medical record. DON stated if the resident becomes incapacitated the facility refers to the Physician Orders for Life Sustaining Treatment (POLST) for the resident. During a concurrent interview and record review on 9/10/25 at 3:15 p.m., with Social Services Assistant (SSA), the SSA stated each resident is assessed upon admission for an advance directive. She stated the resident, or resident representative (RR) is verbally informed an advance directive, do not resuscitate (DNR) and POLST is a document that will make their wishes know when they become incapacitated. SSA stated a baseline care plan is initiated within 48 hours after admission and discussed at the baseline care conference. Reviews of residents' 1, 4, 7, and 8 baseline care plans were reviewed. SSA stated baseline care plans did not indicate specific advance directive information discussed, or information given to the resident or RR. SSA stated resident 2 and 10's advanced (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
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 11/17/2025
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	directive documents from 2022 were not available but will attempt to get. SSA stated she tries to document the advance directive discussion in the progress notes but does not always. She stated she needs to improve her documentation. During an interview on 9/10/25 at 3:40 p.m. with residents 1, 4, and 10, all Resident's stated they were not asked if they had an advanced directive, informed what an advance directive was or given the option to create one. During a review of Social Services policy dated 2001, the policy and procedure indicated the facility must provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident.enhance resident dignity. The policy and procedure indicated assisting residents with advance care planning, including but not limited to completion of advance directives'During a review of Advance Directives policy dated 2001, the policy and procedure indicated advance directive -a written instructions , such as a living will or durable power of attorney for health care. relating to the provisions of health care when the individual is incapacitated. Physician Orders for Life Sustaining Treatment (POLST) paradigm form is designed to improve patient care by creating a portable medical order so that emergency personnel know what treatment the patient wants in the event of a medical emergency. A POLST paradigm form is not an advance directive.If the resident does not have an advanced directive nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. If the resident had an advanced directive, copies of the document are obtained and maintained in the medical record		

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 11/17/2025
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of 25 sampled residents (Resident 29 and 87)'s Minimum Data Set (MDS, an assessment used to plan care) assessment reflected accurate information when the following was noted: 1. Resident 29's MDS assessment inaccurately indicated use of antianxiety medications (chemical agents used to treat anxiety disorder), when Resident 29 was not taking any. 2. Resident 87's discharge MDS assessment inaccurately indicated Resident 87 was discharged to an acute care hospital, when Resident 87 went home. This failure resulted in inaccurate reflection of Resident 29's clinical status and discharge disposition for Resident 87. 1. During an observation on 9/8/25 at 10:15 a.m., Resident 29 was sitting up in her bed. Resident 29 stated she was paralyzed from her waist down and had adapted to do her self care with both arms. Resident 29 stated she enjoyed spending time with her plants, iPad and art activities such working with crystal beads. During a record review of Resident 29's MDS assessment dated [DATE] indicated, Resident 29 was able to understand others and make herself understood. Resident 29's Brief Interview for Mental Status (BIMS, an assessment for mental status) was 15 out of 15, indicating intact mental status. During an interview and record review on 9/9/25 at 2:58 p.m., with MDS Coordinator (MDSC 1), Resident 29's clinical record including MDS assessment dated [DATE], and Medication Administration Record dated 7/2025 were reviewed. MDSC 1 stated around 7/23/25, Resident 29 reported having anxiety, restlessness, lack of sleep to facility staff and stated that she was experiencing these symptoms for a month but did not tell anyone. MDSC 1 stated facility reported above to Resident 29's physician, who prescribed Hydroxyzine (antihistamine, a medication that is usually used to treat allergy symptoms). MDSC 1 stated Resident 29 was prescribed to take one tablet of Hydroxyzine 25 milligrams (mg) by mouth as needed for anxiety, restlessness for five days at bedtime and she received it from 7/23/25 through 7/27/25. MDSC 1 stated Resident 29's MDS assessment dated [DATE], hence indicated that she was taking Antianxiety medications within the seven (7) days look back period. MDSC 1 stated she checked drug classification for Hydroxyzine under Order Entry where it indicated Hydroxyzine HCl was an antianxiety agent. When asked if facility used an approved Drug book as a reference, MDSC 1 stated she would get back shortly. Resident 29's MDS assessment section N-Medications, under section N0415 indicated, check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. During an interview and record review on 9/9/25 at 3:30 p.m. with MDSC 1, facility's drug book titled Nursing Drug Handbook updated as of 2024 was reviewed. MDSC 1 stated on page 1238, the drug book indicated Hydroxyzine was used to relieve symptoms of anxiety, pruritis and urticaria. MDSC 1 stated however, pharmacologic category for Hydroxyzine did not indicate if the medication belonged to Antianxiety classification. 2. During a record review, of Resident 87's admission Record printed on 9/9/25, the admission Record indicated Resident 87 was admitted to the facility on [DATE]. During a concurrent record review and interview on 09/10/25 at 1015am with Licensed Vocational Nurse (LVN2) , Resident 87's nursing progress notes from 7/18/25 through 7/30/25 were reviewed. The notes indicated Resident 87 left the facility on 7/30/25, with a Antianxiety medications they wanted to go home but never came back. (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
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 11/17/2025
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 09/11/25, at 1037 am, MDSC (Minimum Data Set Coordinator) Resident 87's discharge MDS assessment dated [DATE] was reviewed. MDSC stated the MDS assessment inaccurately indicated that Resident 87 was discharged to hospital when they actually went home and never returned back to the facility.		

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 11/17/2025
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of 20 sampled residents (Resident 75, 76, and 77) had physician orders followed promptly. This failure resulted in Resident 77 not being treated for promptly for pitting edema (swollen part of the body due to excess watery fluid that dimple or pit up to four millimeters when it's pressed for a few seconds) on both lower extremities. This failure resulted in Resident 77 feeling tightness and pain in both legs and frustration. It had the potential for Resident 77's both legs' edema to get worsened and to suffer from edema related complications such as fluid overload (a medical condition with excessive accumulation of fluids in the body's tissue and organs). This failure to follow physician orders resulted in Resident 75 and 76 not having their weight and/or nutritional intake monitored, which had the potential to result in inaccurate treatment and/or monitoring. During a review of Resident 77's record, admission Record printed on 9/9/25, the record showed Resident 77 was admitted to the facility on [DATE]. During a record review of Resident 77's Minimum Data Set (MDS, an assessment tool used to direct care) dated 7/5/25, indicated Resident 77 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating intact mental status. During a concurrent observation and interview on 09/08/25 at 9:00 a.m., Resident 77 was sitting on the edge of his bed. Resident 77 stated he had swelling in both legs, no one had been treating it, it's painful and made him feel frustrated and uncomfortable. Resident 77 had grey colored loose fitted nonskid socks on both feet. During an observation on 09/09/25 at 12:35 p.m., Resident 77 was sitting in a wheelchair in his room, with non-skid socks on. During a concurrent observation and interview on 9/9/25 at 10:51a.m., with MDSC Coordinator (MDSC, a licensed nurse who completes residents' assessment), Resident 77's was lying in his bed with nonskid socks on. MDSC removed Resident 77's socks and stated Resident 77 had 3+ pitting edema (when pressed the dimple was about three millimeters deep) on right lower leg and 2+ pitting edema with a dimple of two millimeters) on left lower leg. MDSC stated she assisted Resident 77 to put the nonskid socks back on. During a concurrent interview and record review on 9/9/25 at 11:45 a.m., with MDSC, Resident 77's electronic health record including physician orders dated 9/2025 were reviewed. MDSC stated the orders indicated to monitor Resident 77's edema in both lower extremities and to apply compression stockings (are medical devices that apply graduated pressure to the legs to improve circulation and reduce swelling) on both lower extremities during the day, removed at bedtime. During an interview, 09/10/25 at 1:33 p.m. Director of Nursing(DON) stated having edema for long time puts the resident at risk for fluid overload and related complications such as heart failure. The DON stated nurses were responsible to put compression stockings on Resident 77's lower extremities. During the review of the facility Policy and Procedures (P&P) title, Edema Management dated July 2025, the P&P showed, it is our facility policy to ensure that residents with edema are assessed , monitored, and treated with California Code of Regulations, (Title 22) and Centers for Medicare & Medicaid Services (CMS) Federal Requirements for Long Term Care Facilities. Care will be delivered (continued on next page)		

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 11/17/2025
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to maintain resident comfort, prevent complications, and promote optimal health. During a record review of facility's document titled, admission Record, dated 9/11/25, the admission Record indicates Resident 76 is a [AGE] year old man initially admitted to the facility on [DATE] with multiple diagnoses including unspecified protein calorie malnutrition and chronic kidney disease, stage 5 (also called end-stage renal disease, when kidneys have lost almost all ability to filter waste and fluids from the blood). During a concurrent interview and record review on 9/11/25 at 1:40 p.m. with the Director of Nursing (DON), physician orders for Resident 76, dated 6/5/25 and 2/27/25, and facility's document titled Weights and Vitals Summary, dated 6/1/25 & 6/30/25, were reviewed. DON stated the documents indicate on 2/27/25, Medical Doctor (MD1) ordered to weigh Resident 76 every week. DON stated on 6/5/25, MD1 ordered to re-weigh Resident 76 to confirm weight gain. (See F842). DON stated the Weights and Vitals Summary shows that Resident 76 was weighed on 6/3/25 and not weighed again until 6/17/25. DON stated the order to reweigh the patient on 6/5/25 was not followed until 6/17/25 and this is not a reasonable time frame for the order to be followed. DON stated the risk of not repeating a weight for 12 days after it was ordered is that there is a potential risk for inaccurate nutrition evaluation. During a concurrent record review and interview on 9/11/25 at 1:19 pm with DON, physician order for Nepro (a nutritional supplement) 8 oz one time a day, monitor % intake dated 1/23/25 and Medication Administration Record (MAR, a document where medication and supplement administration are recorded), dated January 2025, February 2025, and March 2025, for Resident 76 were reviewed. DON stated the order to monitor Resident 76's intake of Nepro was not followed between 1/23/25 to 3/6/25. DON stated the risk of not recording intake is that the facility would not know how much Nepro resident is consuming, and the lack of knowledge means they would not know how to address. During a review of facility's document titled, admission Record, dated 9/11/25 for Resident 75, the admission Record indicated Resident 75 is a [AGE] year old woman initially admitted to the facility on [DATE] with multiple diagnoses including acute respiratory failure (when lungs cannot provide enough oxygen to the blood), unspecified protein calorie malnutrition, and muscle weakness. During a concurrent interview and record review on 9/12/25 at 9:51 a.m. with DON, physician orders dated 1/29/25 and facility's document titled Weights and Vitals Summary dated 9/11/25 for Resident 75 were reviewed. DON stated the documents indicated that on 1/29/25, MD1 ordered that Resident 75 should be weighed weekly. DON stated weights were checked on 9/9/25, 9/3/25, and 8/18/25 and there was a 16-day gap in between the weights performed on 9/3/25 and 8/18/25. DON stated that the risk of not checking the residents weight weekly is not providing information to monitor the resident and to not be able to monitor for weight loss and status. (See F692)		

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 11/17/2025
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to prepare, distribute and serve food in a sanitary manner when:1. [NAME] 1 picked up Resident 11's meal ticket (printed tray ticket containing a resident's specific dietary needs, allergies, preferences, and even adaptive equipment requirements) from the floor and placed it on Resident 11's meal tray during meal tray food assembly.2. Two black oven mitts were dirty and in poor condition.These failures had the potential for cross contamination of food items and food borne illness for 81 residents who receive food in the kitchen.1. During an observation on 9/9/25 at 12:23 p.m., in the kitchen, [NAME] 1 took Resident 11's meal ticket from the second tray of station 2's meal cart to read the information. The meal ticket dropped on the floor, [NAME] 1 picked up the meal ticket with blue gloved left hand and placed it back on the second tray. [NAME] 1 did not remove the gloves nor performed hand hygiene and continued to scoop the food items from the steam table with the same gloved hand.During an interview on 9/10/25 at 8:35 a.m., the [NAME] recalled picking up meal ticket and placing it back on to the tray. The [NAME] stated the meal ticket was contaminated. The [NAME] stated a new meal ticket should have been printed.During an interview on 9/10/26 at 8:40 a.m., in the kitchen, the Dietary Director (DD) stated the meal ticket should have been discarded and replaced.2. During an observation on 9/9/25 at 11:43 a.m., in the kitchen, [NAME] 1 removed the pureed creamy polenta from the oven using two black mitts with dry brownish matter and two torn area.During an interview on 9/9/25 at 2:53 p.m. with [NAME] 2 and the DA, [NAME] 2 stated the black oven mitts were dirty. The DA stated the oven mitts should either be thrown away or washed.During an interview on 9/10/26 at 8:40 a.m., the Dietary Director (DD) stated the two dirty oven mitts were replaced with a new one.During a review of the undated facility's policy and procedure titled, Delivery of Food Carts and Tray Service, indicated, Meals will be delivered to residents/patients. free from the risk of cross contamination by those who are serving them.During a review of the facility's policy and procedure titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, dated 2001, indicated, 6. Employees must wash their hands:. h. after engaging in other activities that contaminate the hands.		

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 11/17/2025
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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on observation, interview and record review, the facility failed to follow state regulations when:1. the facility did not have a qualified social worker to supervise, train and ensure the facility provided medically-related social services for nine months,2. the facility did not post the Centers for Medicare and Medic-aid Services (CMS) star rating in the facility.These failures resulted in1. Six residents did not have updated advanced directives (See Ftag 578), one resident did not have glasses because the facility failed to have trained staff conduct a vision test (See Ftag 685) and had the potential for all 85 residents to receive inadequate social services,2. and had the potential for residents and visitors to be uninformed about the overall quality of the facility.1. During an interview on 9/8/25, at 3:13 p.m., with social services assistant (SSA), SSA stated they were the only social service staff in the social services department and there was no social worker overseeing the department. SSA stated they were not a qualified social worker. SSA stated they had some training for a few months while assisting a former social services director in 2024.During a concurrent interview and record review on 9/9/25, at 9:40 a.m., with Director of Staff Development (DSD), SSA's employee file was inspected. DSD stated there was no training record for SSA's position.During a record review of SSA's employment history document titled, View Employee History [SSA], undated, the document indicated on 8/18/24, SSA had a Promotion.Social Services Assistant.During a record review of SSA's job description titled, Job Description: Social Services Assistant, dated 2/2024, the job description indicated the SSA reports to Social Service Director.assist in planning, developing, organizing and implementing.facility's social service programs in accordance with.state and local standards.During an interview on 9/8/25, at 3:26 p.m., with Activities Director (AD), AD stated they were the social services director from 10/2024 to 1/2024 when the social services director left. AD stated they were not a social worker and did not have previous training in social work. AD stated they had training for three days in social services at another facility before being designated the social services director. AD stated they were the social services director until a Social Services Director (QSSD) was hired in the beginning of 2025. AD stated SSA was the sole social services staff after QSSD left after a few weeks.A review of AD's employment history document titled, View Employee History [AD], undated, the document indicated AD was hired on 5/9/25 as the Activities Director, on 9/1/2024, AD had a Promotion.Social Services and on 2/19/25 AD had a Lateral Move.Activities Director.A review of FSSD's employment history document titled, Worker History, undated, the document indicated FSSD was hired on 1/6/25 and was terminated on 2/5/25.During an interview on 9/11/25, at 3:05 p.m., with Administrator (ADM), ADM stated there was no plan to have a social worker be a part of the social services department. ADM stated SSA was the only staff member working in the social services department. ADM stated they were unaware of any regulations which required the social services departmentDuring a review of facility's facility assessment titled, [Facility] Facility Assessment, dated 7/24/25, the facility assessment indicated a staffing plan which included Total Number Needed or Average or Range.Social Worker.FULL-TIME on AM and PM shift.During a review of facility's policy and procedure (P&P) titled, Social Services, dated September 2024, the P&P indicated the facility provided medically-related social services During a review of California state regulation titled, Title 22 S72437, the state regulation indicated Social Work Service Unit-Staff.the social work service unit shall be organized, directed and supervised by a social worker, who is responsible for supervision of other social work staff, including social work assistants.2. During an observation on 9/9/25, at 11:00 a.m., an inspection of the facility main posting board, two dining areas and facility entrance indicated there was no posting of the facility star rating.During a concurrent observation and interview, on 9/12/25, at 3:15 p.m. with ADM, the facility entrance, main posting board near the entrance and the reception desk area was inspected. ADM stated there was no (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
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 11/17/2025
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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	posting of the facility's CMS star rating in the observed areas. ADM stated they did not know the CMS star rating posting was required. During a review of California state regulation titled, Health and Safety Code section 1418.21, dated 1/1/11, the state regulation indicated A skilled nursing facility that has been certified for purposes of Medicare or Medicaid shall post the overall facility rating information determined by the federal CMS in accordance with the following requirement: the information shall be posted in at least the following locations. an area accessible and visible to members of the public. an area used by residents for communal functions such as dining, resident council meetings, or activities.		

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 11/17/2025
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility failed to maintain accurate and complete medical records for four (Residents 6, 7, 75, and 76) out of twenty sampled residents. This deficient practice had the potential to cause inaccurate assessments of nutritional status, inappropriate care planning and unnecessary dietary restrictions, which could place residents at risk for unmet needs or avoidable decline. During a review of facility's document titled, admission Record, dated 9/12/25 for Resident 6, the admission Record indicated Resident 6 is a [AGE] year old woman initially admitted to the facility on [DATE] with multiple diagnoses, including unspecified protein-calorie malnutrition (a condition that occurs when an individual does not consume enough protein and calories to meet their nutritional needs), hypertension (high blood pressure), multiple sclerosis (a chronic disease of the brain and spinal cord characterized by changes in sensation, visual problems, weakness, depression, difficulties with coordination and speech, and impaired mobility and disability). During an interview and concurrent observation on 9/10/25 at 12:35 pm with Dietary Manager (DM), DM observed two Chobani Greek yogurts with peaches and a vanilla magic cup (sugar-free) on Resident 6's tray. DM observed a diet order slip on Resident 6's tray that indicated Resident 6 was allergic to milk and under notes stated do not give milk or dairy products. DM stated the yogurt and ice cream are dairy products, and they are given because of resident preference. During a concurrent interview and record review on 9/10/25 at 12:48 p.m. with the Registered Dietician (RD), the diet order for Resident 6 was reviewed. RD stated the document indicated that Resident 6 is allergic to milk and the document stated do not give milk or dairy products. RD stated that Resident 6 is not allergic to milk. RD stated this could create confusion and it should be removed. During a review of facility's document titled, admission Record, dated 9/11/25 for Resident 75, the admission Record indicated Resident 75 is a [AGE] year old woman initially admitted to the facility on [DATE] with multiple diagnoses including acute respiratory failure (when lungs cannot provide enough oxygen to the blood), unspecified protein calorie malnutrition, and muscle weakness. During a concurrent interview and record review on 9/11/25 at 12:55 p.m. with DON, facility's documents titled Nursing Weekly Summary dated 9/8/25, 9/1/25, and 8/26/25 for Resident 75 were reviewed. DON stated the weekly summaries state that Resident 75 ate 100% of her meals. During a concurrent interview and record review on 9/11/25 at 1:01 pm with DON, facility worksheets titled amount eaten dated September 2025 and August 2025 were reviewed. DON stated the worksheets show that the resident intake was not 100%. DON stated September 2025 amount eaten worksheet shows Resident 75 refused 10 meals in the past two weeks. DON stated in August 2025 the amount eaten worksheet indicated Resident 75 did not eat 100% of meals. (See F692) During a record review of facility's document titled, admission Record, dated 9/11/25, the admission Record indicated Resident 76 is a [AGE] year old man initially admitted to the facility on [DATE] with multiple diagnoses including unspecified protein calorie malnutrition and chronic kidney disease, stage 5 (also called end-stage renal disease, when kidneys have lost almost all ability to filter waste and fluids from the blood). (continued on next page)		

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 11/17/2025
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 9/10/25 at 3:09 p.m. with RD, facility's documents titled Weights and Vitals Summary, dated 6/1/25 & 6/30/25, for Resident 76 was reviewed. RD stated the document indicated on 6/3/25 Resident 76 weighed 149 pounds and on 6/17/25, Resident 76 weighed 139 pounds. RD stated that she believed the 6/3/25 weight was incorrect and asked for it to be rechecked. RD stated she was not sure why the weight on 6/3/25 was not struck out and marked as incorrect. During an interview on 9/10/25 at 4:10 p.m. with Registered Nurse (RN 3), RN 3 stated that she entered a weight on 9/2/25 for Resident 76. RN 3 stated the weight from the dialysis center is in kilograms (a unit of measurement in the metric system, a decimal-based logical system) and they convert the weight to lbs (also called pounds, a unit of measurement in the US customary system, a historical system dating back from when the US was a British colony.) During a concurrent interview and record review on 9/11/25 at 1:19 p.m., with DON, facility's documents titled, Weights and Vitals Summary, dated 6/1/25 & 6/30/25 and document titled Dialysis Center Hemodialysis Communication Observation/Assessment dated 6/3/25 were reviewed. DON stated the Dialysis Center document indicated on 6/3/25, the resident weight was 57.5 kg, which is 126.7 lbs. DON stated the weight entered by the RN on 6/3/25 was 149 lbs and this weight was incorrect. DON stated inaccurate weights should be reevaluated and struck out because if the weight is inaccurate, we should re-weight to make sure the weight is accurate. DON stated the risk of the weight not being accurate could affect the plan of care. During a concurrent interview and record review on 9/11/25 at 1:19 p.m., with DON, facility's documents titled Nursing Weekly Summary dated 9/10/25 were reviewed. DON stated the weekly summary indicated that Resident 76 ate 100% of his meals in the time period of 9/3/25 & 9/10/25. During a concurrent interview and record review on 9/11/25 at 1:19 p.m., with DON, facility's documents titled amount eaten, dated September 2025 was reviewed. DON stated the documents indicate Resident 76 did not eat 100% of his meals. DON stated the amount eaten document between 9/3/25 & 9/10/25 shows that Resident 76 refused meals eight times. The document indicated between 9/3/25 & 9/10/25, Resident 76 ate 75-100% of his meals four times. DON stated the risk to not accurately recording resident intake is that if the facility does not know what the resident is eating, they will not know how to address the issue. During a review of the facility's policy and procedure titled, Charting Errors and/or Omissions, dated December 2023, indicated, .if an error is made while recording the data in the medical record, line through the error with a single line and correct the error. For electronic documentations, strike out the entry and state the reason for striking out. During a review of Resident 7's admission Record (AR), printed on 9/12/25, The AR indicated, Resident 7 was originally admitted on [DATE]. Resident readmitted on [DATE] with diagnoses that included hemiplegia (the total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a weakness on one side of the body) following cerebrovascular disease affecting left non-dominant side. During a review of Resident 7's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 6/28 /25, indicated Resident 7's BIMS (an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 7/15. BIMS score (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
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 11/17/2025
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of 7 indicated the resident had severe cognitive impairment. During a review of Resident 7's care plan Bowel & Bladder (B&B) care plan initiated on 10/18/23, the care plan indicated Resident 82 or Resident 83 requires check and change due to bowel and bladder incontinence. The care plan was revised on 01/10/2025. During a review of the facilities MDS Resident Matrix dated 9/8/2025, the MDS Resident Matrix indicated Resident 82 and Resident 83 had the same last name. During an interview on 9/11/25 at 2:41 a.m. with Medical Records Director (MRD), the MRD stated resident record reviews are performed in Point Click Care (PCC - electric health record). MRD stated the record reviews completed by the MDR assess for completion of the evaluation forms and updates to the care plan. The MRD stated she does not review the document themselves. She reviews the care plan and evaluation banner section in PCC. MRD stated when the evaluations have been completed, and the care plans are updated by the staff the banner section turns green. During a concurrent interview and record review on 9/11/25 at 3:00 p.m. with MRD, Resident 7's care plan B & B initiated on 10/18/23 was reviewed. The care plan for Resident 7 indicated Resident 82 /83 requires check and changes due to bowel and bladder incontinence. MRD stated she does not review nursing documentation for accuracy. MRD stated nursing services review their own documents. During a concurrent interview and record review on 9/12/25 at 8:19 a.m. with MRD, the facility's policy and procedure Charting and Documentation dated 2001 was reviewed. The Charting and Documentation section 5 indicated, Information documented in the resident's clinical record is confidential and may only be released in accordance with state law, the Health Insurance Portability and Accountability Act (HIPPA) and facility policy. MRD stated the Medical Records Administrative Services Manual does not have a section that requires the facility to maintain medical records for each resident, . that are complete, and accurate.		

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 11/17/2025
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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of two sampled residents (Resident 35) was provided reading glasses as prescribed by the doctor. This failure resulted in Resident 35 to be unable to see things clearly, participate in activities fully and feeling frustrated. During a review of Resident 35's admission Record printed on 09/10/25, the record indicated Resident 35 was admitted to the facility on [DATE]. During a review of Resident 35's Minimum Data Set (MDS, an assessment used to guide care) assessment dated [DATE], the assessment indicated Resident 35 did not wear glasses at the time of assessment. The assessment indicated the Resident 35 was able to understand others and make her self understood. During a review of Resident 35's care plan for vision dated 6/20/25, indicated Resident 35 had altered visual ability related to visual loss, and may impact ability to participate in ADL (activities of daily living). The care plan indicated to perform eye exam as ordered/if indicated. During an observation on 09/08/25 at 10:10 a.m., Resident 35 was sitting up in her bed. Resident 35 stated she was not able to read the time on the wall clock in her room. Resident 35 stated she needed eye glasses to see better, however she did not have any. Resident 35 stated her eyes usually burn and she felt frustrated as that was ongoing issue for a while. During an interview on 09/09/25 at 9:53 a.m., in Activity Room , Resident 35 was sitting in a chair, coloring a coloring book. Resident 35 stated she could not play bingo game very well because she could not see well. During an interview on 09/09/25 at 9:57 a.m., with Activity Assistant (AA), AA stated she had been working at the facility for last two years. AA stated playing bingo was Resident 35's favorite activity. AA stated however, she had to assist Resident 35 in activities many times because Resident 35's vision was blurry and she could not see very well. AA stated she had informed Resident 35's direct care nurses about this issue in the past. During an interview on 09/10/25 at 12:40 p.m. with Certified Nursing Assistant Certified Nursing Assistant (CNA) 5, CNA 5 stated he was direct care staff for Resident 35. CNA 5 stated he did not see Resident 35 wearing eyeglasses or having eye glasses in her possession since he had been taking care of her. During an interview on 09/10/25 at 12:50 p.m. Licensed Vocational Nurse (LVN) 2, stated she was not aware if Resident 35 had any issues with her vision. During a concurrent interview and record review with Social Services Assistant (SSA) on 09/09/25 at 3:13 p.m., Resident 35's Vision Examination Report dated 7/22/24 was reviewed. The report indicated a prescription for reading glasses for Resident 35. SSA stated she was unaware if facility ever followed up on the reading glasses prescription. SSA also stated she was responsible for scheduling eye exam appointments and following through on the recommendations. SSA stated 7/22/24 was the most recent eye exam conducted for Resident 35 and she was not seen by an eye doctor since then. During a review of facility's Policy and Procedure (P&P) titled_Ancillary Services, dated_January 2025, the P&P indicated, it is the policy of this Skilled Nursing Facility (SNF), to provide or arrange for medically necessary ancillary services to meet the individualized needs of residents in accordance with California Code of Regulations (Title22) and federal CMS requirements. Ancillary services include, but are not limited to, pharmacy, laboratory, radiology, rehab therapies, social services, and dietary services.		

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 11/17/2025
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents maintained adequate nutrition status in accordance with professional standards of practice and resident preferences for 2 out of 20 sampled residents (Resident 75 and 6). This deficient practice had the potential to result in unrecognized weight loss, inaccurate assessment of nutritional status, and failure to meet resident's dietary needs and preferences, placing residents at risk for avoidable weight loss and decline. During a review of facility's document titled, admission Record, dated 9/11/25 for Resident 75, the admission Record indicated Resident 75 is a [AGE] year old woman initially admitted to the facility on [DATE] with multiple diagnoses including acute respiratory failure (when lungs cannot provide enough oxygen to the blood), unspecified protein calorie malnutrition, and muscle weakness. During a review of Resident 75's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 7/12/25, the document indicated Resident 75's BIMS (an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was 15/15. A BIMS score of 15 indicated short and long-term memory was intact and the resident had decision-making capacity. During an interview on 9/10/25 at 12:40 p.m. with Resident 75, Resident 75 stated she is given a supplement called Nepro (a nutritional shake), but she doesn't like it. Resident 75 stated it is hard to drink things she doesn't enjoy. Resident 75 stated she requested Glucerna (a different type of nutritional shake) instead. Resident 75 also stated she has been asking for chocolate pudding instead of yogurt. Resident 75 stated she is frustrated by her weight loss and states she is trying to gain weight so that she can have surgery to reverse her colostomy. During a concurrent interview and record review on 9/10/25 at 12:48 with Dietary Manager (DM), facility's documents titled progress notes dated 9/3/25 and 9/9/25 were reviewed. DM stated the documents indicate that on 9/3/25 and 9/9/25, Resident 75 requested chocolate pudding instead of yogurt. DM stated on 9/3/25 when Resident 75 requested chocolate pudding, the nurse should have sent a diet order communication slip to the kitchen. DM stated that the request for chocolate pudding was not received by the kitchen until 9/9/25. During an interview on 9/10/25 at 13:00 with Registered Dietician (RD), RD stated that dietary preferences should be honored, as they are trying to encourage Resident 75 to eat. During an interview and concurrent record review on 9/10/25 at 12:48 p.m. with RD, facility's document's titled progress notes dated 8/6/25 for Resident 75 was reviewed. RD stated she wrote the progress note on 8/6/25 and she recommended switching Resident 75 from Glucerna to Nepro. RD stated there is no note after 8/6/25 on if Resident 75 liked Nepro and she will see Resident 75 today. During a record review of facility's documents titled progress notes, dated 9/10/25, for Resident 75, RD wrote a progress note on 9/10/25 at 2:45 p.m. The progress note indicated Resident 75 lost 8.4 pounds in 7 weeks due to not eating and drinking enough. The note indicated that Resident 75 prefers Glucerna instead of Nepro. In the progress note, RD recommended changing Resident 75's supplement to Glucerna. During a concurrent interview and record review on 9/12/25 at 9:51 a.m. with DON, physician orders dated 1/29/25 and facility's document titled Weights and Vitals Summary dated 9/11/25 for Resident 75 were reviewed. DON stated the documents indicated that on 1/29/25, MD1 ordered that Resident 75 should be weighed weekly. DON stated there was a 16-day gap in between Resident 75's weights being checked between 8/18/25 and 9/3/25. During a review of facility's document titled Weights and Vitals Summary dated 9/11/25 for Resident 75, the document indicated that after MD1 entered the order for Resident 75 to be weighed weekly, Resident 75 was weighted 9/9/25, 9/3/25, 8/18/25, 8/11/25, 8/4/25, 7/30/25, 7/21/25, 7/15/25, 7/2/25, 6/18/25, 6/9/25, 6/3/25, 5/27/25, 5/20/25, 5/13/25, 5/9/25, 4/29/25, 4/22/25, 4/16/25, 4/11/25, 4/1/25, 3/6/25, 2/25/25, 2/18/25, 2/10/25, 2/4/25, 1/30/25. The document indicated 16 days in between the weights recorded on 8/18/25 to 9/3/25 and 26 days in between the weights recorded on 3/6/25 and 4/1/25. During an interview on 9/12/25 at 9:51 a.m., DON stated that the risk (continued on next page)		

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 11/17/2025
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of not checking the residents' weight weekly is not having information to monitor the resident for weight loss and health status. (See F684)During a review of facility's document titled, admission Record, dated 9/12/25 for Resident 6, the admission Record indicated Resident 6 is a [AGE] year old woman initially admitted to the facility on [DATE] with multiple diagnoses, including unspecified protein-calorie malnutrition (a condition that occurs when an individual does not consume enough protein and calories to meet their nutritional needs), hypertension (high blood pressure), multiple sclerosis (a chronic disease of the brain and spinal cord characterized by changes in sensation, visual problems, weakness, depression, difficulties with coordination and speech, and impaired mobility and disability).During an interview and concurrent observation on 9/10/25 at 12:35 pm with Dietary Manager (DM) of Resident 6's lunch tray and diet order slip (a piece of paper indicating resident allergies, preferences, and items of food they receive), DM observed two Chobani Greek yogurts with peaches and a vanilla magic cup ice cream on Resident 6's lunch tray. DM stated the diet order slip indicated Resident 6 was allergic to milk and stated .Notes: do not give milk or dairy products. DM stated the yogurt and ice cream given to Resident 6 are dairy products and they were given because of resident preference. During a concurrent interview and record review on 9/10/25 at 12:48 p.m. with RD, the diet order for Resident 6 was reviewed. RD stated the diet order indicated that Resident 6 is allergic to milk and the document stated do not give milk or dairy products. RD stated that Resident 6 is not allergic to milk. RD stated this could create confusion and the diet order should be corrected. (See F842)		

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 11/17/2025
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure least restrictive alternatives were attempted for a reasonable amount of time, prior to installing bedrails (adjustable metal or rigid plastic bars attached to the bed) for one of one samples residents (Resident 70) upon admission to the facility. This failure placed the Resident 70 at risk for injury, entrapment, psychosocial harm, up to and including death. During a review of Resident 70's admission Record printed on 9/10/25, the record indicated Resident 70 was admitted to the facility on [DATE]. During a review of Resident 70's Minimum Data Set (MDS, an assessment used to plan care) assessment dated [DATE], the assessment indicated Resident 70's Brief Interview for Mental Status (BIMS) score was six out of 15, indicating severe cognitive impairment. The assessment indicated Resident 70 had impairment in range of motion on both sides of her extremities and was dependent upon staff for activities of daily living, indicating Resident 70 had minimal strength to use her arms. During an observation on 9/8/25 at 11:25 a.m., Resident 70 was lying in her bed, with bedrails up on both sides of her bed. Both bedrails were padded with blue colored fabric cushion. During an observation on 9/8/25 at 12:13 a.m., Resident 70 was sitting up in the bed with the back of the bed raised, eating her lunch. Both bedrails were raised at the time. During an interview with Certified Nursing Assistant (CNA) 3 on 9/11/25 at 1:17 p.m., CNA 3 stated that she has been working in the facility for one year. CNA 3 stated Resident 70's bedrails were used because she was at risk for falls. CNA 3 stated Resident 70 did not use bedrails to prop herself up in bed. During an interview with CNA 4 on 9/11/25 at 1:28 p.m., CAN 4 stated she had known Resident 70 since her admission to the facility, and bedrails on Resident 70's bed were being used to avoid her from falling out of bed. During an interview on 9/11/25 at 3:45 p.m. with CNA 2, CNA 2 stated she has been working with Resident 70 since she was admitted to the facility. CNA 2 stated that she did not know why Resident 70's bedrails are raised at all times. CNA 2 stated Resident 70 could pull on the rail for positioning during incontinence care, but it required staff's assistance to place her hands on the rail. During a phone interview with Registered Nurse (RN) 1 on 9/11/25 at 2:44 p.m., RN 1 stated Resident 70 was usually restless and was often found leaning on the bedrails. RN 1 stated bedrails were always kept in the upright position. During an interview on 9/11/25 at 3:50 p.m. with RN 2, RN 2 stated the bedrails were kept up on Resident 70's bed as a safety precaution. RN 2 stated that she had not seen Resident 70 use the bedrails for support. During a concurrent interview and record review on 9/11/25 at 2:48 p.m. with the Assistant Director of Nursing (ADON), Resident 70's Physician Orders, dated 8/20/24, were reviewed. The physician orders indicated Resident 70 may have both 1/4 side rails (bedrails) while in bed as an enabler for bed mobility and not a restraint. The order was updated on 8/20/25, indicating May have bilateral 1/4 side rails as enabler for bed motility and position. May have side rail pads to prevent injury. ADON stated that Resident 70's bedrails were being used to prevent falls. ADON stated that she had not observed Resident 70 using them for support. ADON stated the risks of installing bedrails placed Resident 70 at risk for entrapment, injury, or even death. During a Record Review of Resident 70's care plan for siderail/bedrail use, dated 8/25/25, indicated Resident 70 is at risk for injury related to use of siderail/bedrail. Resident noted with possible injury to right side of face [manifested by] discoloration [related to] bedrail use. During an interview with the Director of Nursing (DON) on 9/11/25 at 11:47 a.m., DON stated Resident 70 had anxiety, restlessness, and frequently laid her head near the rails. DON stated since Resident 70 recently sustained a bluish discoloration from an unknown origin, the care team decided to pad the bedrails. During an interview on 9/11/25 at 4:06 p.m. with DON, DON stated that Resident 70 needed bedrails up at all times for mobility purposes. DON stated she thought removing the bedrails would hinder Resident 70's chances of improved mobility. (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
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 11/17/2025
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON then also stated with the padding on the bedrails, Resident 70 was no longer able to hold onto the bedrails (at least since 8/20/25). During a concurrent interview and Record Review on 9/12/25 at 11:06 a.m. with the DON, Resident 70's Electronic Health Record (HER), including Bed Rail and Entrapment Risk Observation/assessment dated [DATE], and 8/25/25 were reviewed. The assessment dated [DATE], indicated facility used adjustable bed as an alternative for bedrail on that same day. The assessment dated [DATE], indicated facility used anticipation of needs, bedside floor mat, and items within reach as alternatives to bedrails. The DON stated however, she was unable to find any documentation on when and for how long the alternatives were used and if the alternatives were successful for Resident 70. The HER did not have any information indicating if facility attempted to remove bedrails for re-evaluation. During a Record Review of facility's Policy and Procedure (P&P) titled Bed Safety and Bed Rails, dated 8/2022, the P&P indicated staff are required to attempt and document alternative interventions before using bedrails. Additional safety measures are implemented for residents who have been identified as having higher than usual risk for injury including bed entrapment (e.g. altered mental status, restlessness, etc.)		

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

Printed: 07/18/2026
Form Approved OMB
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 11/17/2025
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 maintain procedures to ensure accurate accountability and replacement of drugs in the emergency intravenous (IV) kit for 1 of 1 kits reviewed. This deficient practice resulted in the lack of documentation, missing medications, and failure to follow required procedures for notifying the pharmacy, which placed residents at risk of not having necessary emergency medications available when needed. During an observation on 09/08/2025 at 11:15 AM of the emergency IV kit, it was noted that the kit was missing normal saline. When asked when the kit was last opened, LVN 4 stated that typically a form is left inside the kit and faxed to the pharmacy; however, no such documentation was present. LVN 4 stated she could not determine when the kit had last been opened. During an interview 09/08/2025 at 12:00 PM Minimum Data Set Coordinator stated that she found the Emergency Drug Kit usage slip. She acknowledged that the policy was to change the kits within 72 hours once they are opened. A review of the Emergency Drug Kit usage slip dated 08/27/25 at 10:00 AM showed that 0.9% normal saline was removed for a resident. As of the survey observation on 09/08/25, this indicated the kit had been opened 12 days earlier. Despite being opened on 08/27/25, the facility failed to replace or properly document the emergency kit contents in accordance with policy, leaving the kit incomplete and unavailable for emergency use. According to facility policy titled 3.4 Emergency Pharmacy Service and Emergency Kits (E-Kits), emergency pharmaceutical services must be available 24 hours a day through either the facility's approved emergency kit or by special order from the provider pharmacy. The policy requires that medications in the E-Kit are kept secure, checked regularly for integrity and expiration dating, and only removed with a valid prescriber order. Upon removal, staff must document the medication on the emergency kit log, fax or notify the pharmacy immediately, and reseal the kit until exchange. The policy further directs that opened or used kits be replaced promptly, with a new seal affixed as required, and that accountability for all items is maintained through pharmacy notification and proper recordkeeping		

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 11/17/2025
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with manufacturer instructions and accepted standards of clinical practice observed during medication pass. These failures included the administration of an expired inhaler and improper inhaler technique and potentially contaminating a syringe of Lispro prior to administration. As a result, 2 medication errors were identified out of 25 opportunities, resulting in a medication error rate of 8%. This placed residents at risk of reduced potency, diminished therapeutic benefit, and compromised clinical outcomes.1. During an observation on 09/08/2025 at 10:07 AM of medication administration by LVN 4 to Resident 79, LVN 4 administered Breo Ellipta inhaler, but failed to instruct the resident to fully exhale prior to inhaling the dose. During an interview after the medication pass on 09/08/225 at 10:20 AM, LVN 4 acknowledged that she had not instructed the resident to exhale before using the inhaler. She further stated she was unaware that Breo Ellipta inhalers expire six weeks after opening and admitted she had administered the expired inhaler without realizing it. The nurse reported she would check the other inhalers and be more careful in the future. According to the Breo Ellipta manufacturer's instructions, patients must exhale completely before inhalation to ensure medication reaches the lungs effectively. Resident 79 was not provided this instruction, resulting in a medication error. 2. Review of the Breo Ellipta inhaler label revealed it was opened on 07/26/2025 and expired six weeks later on 09/06/2025 per manufacturer guidance. On 09/08/2025, LVN 4 administered the inhaler beyond its expiration date. Administration of expired medication constituted an additional medication error and placed Resident 79 at risk of reduced potency and therapeutic effect. 3. During a medication pass observation on 09/09/25 at 8:15 AM, RN 2 was observed drawing up Lispro insulin into a syringe at the medication cart. Prior to administering the injection to Resident 93, RN 2 placed the uncapped insulin syringe directly onto the resident's overbed table. This same surface was observed to hold personal food items and beverages during the survey. The syringe remained in direct contact with the table for approximately 20 seconds before the nurse picked it up and administered the dose. During an interview on 09/09/25 at 8:20 AM, RN 2 stated, she did leave the syringe on the table. She also stated that she had forgotten and should not have left it for a short period of time on the table. She acknowledged that it was inappropriate because of potential contamination of the syringe. According to the safe injection practices of the CDC guidelines, (https://www.cdc.gov/injection-safety/hcp/clinical-safety/index.html). This guidance establishes that medications must be prepared and handled in environments that protect them from contamination. Once a syringe is prepared, it should remain in a clean, controlled space and be administered promptly. Placing a prefilled syringe on a side table introduces a direct risk of contamination because such surfaces are frequently touched, not disinfected between uses, and cannot be considered sterile. Doing so compromises the sterility of the medication and places the resident at risk for infection, violating accepted standards of practice for safe injection and medication administration.		

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 11/17/2025
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were labeled and stored in accordance with accepted professional principles and manufacturer instructions for 3 of 4 medication carts observed. This deficient practice resulted in the presence of unidentifiable medications, expired drugs, and opened medications without required dating, which placed residents at risk of receiving unsafe or ineffective therapy. During a medication storage observation on 09/08/2025 at 11:00 AM, cart number 4, was reviewed. Multiple unidentifiable loose pills were observed in the cart. When asked if she was aware of what these pills were, LVN 4 stated she did not know and confirmed they should not have been present in the cart. During an interview on 09/08/2025 at 11:00 AM LVN 4 stated that she did not know what the loose pills were and she acknowledged that they should be removed because they were unidentifiable. A review on 09/09/2025 of the facility's Medication Labeling and Storage Policy revision date 02/2023 requires that medications be stored in the packaging or containers in which they are received and prohibits transferring medications between containers, yet this standard was not maintained. 2. During a medication storage observation on 09/08/2025 at 11:00 AM, cart number 4, was reviewed, a Breo Ellipta inhaler was observed in the cart that had expired on 09/06/2025, two days prior to the observation. During an interview on 09/08/2025 at 11:00 AM LVN 4 stated that she did not know the Breo Ellipta was expired. She said she did not know to check the open date and to calculate the expiration date. She also stated that it was a confusing process. A review on 09/09/2025 of the facility's Medication Labeling and Storage Policy revision date 02/2023 requires that medications be stored in the packaging or containers in which they are received and prohibits transferring medications between containers, yet this standard was not maintained. 3. During a medication storage observation on 09/08/2025 at 12:00 PM, multiple opened medications were observed in medication cart 1 and cart 2. The following items were noted: Advair HFA (fluticasone propionate/salmeterol 115 mcg/21 mcg) inhaler Advair Diskus (fluticasone propionate/salmeterol 500 mcg/50 mcg) inhalation powder Azelastine HCl 0.1% nasal spray Each of these products was observed to be opened; however, none were labeled with the date opened. During interview on 09/08/2025 at 12:00 PM at the time of the observation, RN 2 and LVN 3 confirmed the medications had been opened but were not dated. Both staff stated they were not aware of when the medications had been opened and acknowledged there was no documentation available to establish open dates. (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
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 11/17/2025
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Advair and Azelastine manufacturer instructions require that these products be dated upon first use, as they must be discarded after a defined period of time to ensure safety and effectiveness (e.g., Advair Diskus must be discarded one month after opening, and Azelastine nasal spray has a defined in-use period once opened). Without an open date, staff could not determine whether the medications remained safe and effective for resident use. A review on 09/09/2025 of the facility's Medication Labeling and Storage Policy revision date 02/2023 requires that medications be stored in the packaging or containers in which they are received and prohibits transferring medications between containers, yet this standard was not maintained.		

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 11/17/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain infection prevention and control practices during a medication administration for 1 of 1 residents (Resident 93) when RN 2 prepared Lispro Subcutaneous injection and left it on an uncleaned overbed table. This failure had the potential to expose residents to contamination and increased risk of infection. During a medication pass observation on 09/09/25 at 8:15 AM, RN 2 was observed drawing up Lispro insulin into a syringe at the medication cart. Prior to administering the injection, RN 2 placed the uncapped insulin syringe directly onto Resident 93's overbed table. This surface was observed at other times during the survey to hold personal food items and beverages. The syringe remained in contact with the table for approximately 20 seconds before the nurse picked it up and administered the dose. When interviewed on 09/09/25 at 8:20 AM, RN 2 stated, Yes, I did leave the syringe on the table. I forgot, and I should not have left it there, even for a short period of time. She further acknowledged the action was inappropriate because of the potential contamination of the syringe. According to the safe injection practices of the CDC guidelines, (https://www.cdc.gov/injection-safety/hcp/clinical-safety/index.html). This guidance establishes that medications must be prepared and handled in environments that protect them from contamination. Once a syringe is prepared, it should remain in a clean, controlled space and be administered promptly. Placing a prefilled syringe on a side table introduces a direct risk of contamination because such surfaces are frequently touched, not disinfected between uses, and cannot be considered sterile. Doing so compromises the sterility of the medication and places the resident at risk for infection, violating accepted standards of practice for safe injection and medication administration.		