

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2025
NAME OF PROVIDER OR SUPPLIER  Valley Pointe Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  20090 Stanton Avenue 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, facility failed to provide meal assistance in a dignified manner to Resident 254.</p> <p>This failure resulted in an undignified and disrespectful treatment of Resident 254 which could potentially result in more serious negative outcomes.</p> <p>Findings:</p> <p>During a meal observation on 6/16/25 at 12:29 p.m., in the dining room, Resident 254 was sitting in a wheelchair and Occupational Therapist (OT) 1 was standing beside the resident. OT 1 began to assist and spoon feed Resident 254 her lunch meal. On interview, OT 1 stated, when she fed the residents, she would stand sometimes and would sometimes be seated which depended on the cues that she had to give to the residents while assisting the residents with their meals.</p> <p>A review of Resident 254's admission record, dated 6/18/25, indicated that the resident was admitted on [DATE] with diagnoses which included dysphagia (difficulty swallowing), hemiplegia (paralysis that affects only one side of the body), and dementia (loss of memory, language, problem-solving and other thinking abilities).</p> <p>During a review of Physician's orders dated 6/18/25, it indicated an order of 1:1 feeding (means a dedicated staff member provides personalized support to a resident during meals, ensuring they can eat and drink sufficiently).</p> <p>During an interview on 6/18/25 at 3:21 p.m. with the Director of Nursing (DON), the DON stated, staff should be seated at an eye level (positioned at roughly the same height as a person's eyes) with the residents when assisting with meals to preserve the residents' dignity. Further stated, the staff should not be standing while they assisted the residents in eating their meals because the residents could choke while eating.</p> <p>During an interview on 6/19/25 at 1:26 p.m. with the Director of Rehabilitation (DOR), DOR stated, when assisting the residents to eat, the staff should always be sitting beside the resident and should be at an eye level to preserve the resident's dignity.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure, titled Assistance with Meals, Revised March 2022 indicated, . 3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: not standing over residents while assisting them with meals .</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to maintain a safe, comfortable and homelike environment when one of four sampled resident room (Resident 102) had dust covering the ceiling air vent, scattered areas of peeling paint on the wall, and task lighting cord was not long enough for resident to reach.</p> <p>This failure had the potential to compromise Resident 102's health by exacerbating (making something that is already bad even worse) the respiratory symptoms and decreasing the resident's autonomy (the capacity to decide for oneself and pursue that course of action) .</p> <p>Findings:</p> <p>A review of Resident 102's face sheet dated 6/17/25, indicated Resident 102 was admitted to the facility on [DATE] with diagnoses of acute respiratory failure (a severe condition where the respiratory system cannot adequately oxygenate the blood, leading to low blood oxygen levels and potentially affecting tissue oxygenation), chronic obstructive pulmonary disease with acute exacerbation (COPD, a type of progressive lung disease characterized by chronic respiratory symptoms and airflow limitations with a sudden and significant worsening of respiratory symptoms), and asthma ( a chronic lung condition that causes inflammation and narrowing of the airways, making it difficult to breath).</p> <p>During a review of Resident 102's Minimum Data Sheet (MDS, an assessment tool used to guide care), dated 5/31/25, the MDS indicated that Resident 102's Brief Interview for Mental Status (BIMS, a standardized assessment tool used to screen for cognitive impairment) score was 12 out of 15, indicating moderate cognitive impairment.</p> <p>During a concurrent observation and interview on 6/17/25 at 12:30 p.m. with Maintenance Director (MD), in Resident 102's room, ceiling air vent was covered with dust and there was no string for Resident 102 to turn task light on /off. The paint of the wall between the nightstand and headboard were peeling off. Resident 102 stated she had COPD and asthma which had the potential to flare up when she inhaled the dust and paint particles. She stated she preferred to activate the task light by herself but was unable to reach the cord.</p> <p>During a concurrent interview and record review on 6/17/25 at 12:12 p.m. with MD, the facility's preventive maintenance log binder was reviewed. The MD stated there were no maintenance activities performed for wall patching, and repainting from 2/6/25 until 6/16/25. MD stated he was responsible for finding areas in the physical plant requiring repair, and complete them as soon as possible.</p> <p>During a review of the facility's undated policy and procedure (P&amp;P) titled Homelike Environment, P&amp;P indicated Residents are provided with a safe, clean, comfortable and homelike environment . -The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflects a personalized, homelike setting. These characteristics include comfortable (minimum glare) yet adequate (suitable to the task) lighting. -Comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable and homelike environment. The lighting design emphasizes sufficient general lighting in resident -use areas task lighting as needed .</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&amp;P titled Maintenance Service revision date 2009, P&amp;P indicated The maintenance department is responsible for maintaining the buildings Function of the maintenance personnel include, .maintaining the building in compliance with current federal, state, and local laws, regulations and guidelines, maintain the building in good repair ., maintain lighting levels that are comfortable .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide a safe environment for one of 13 sampled residents (Resident 3) who was not assessed for smoking.</p> <p>This deficient practice created a potential risk for burn injury to Resident 3 while smoking and placed other residents' lives in danger.</p> <p>Findings:</p> <p>During a review of Resident 3's admission record, it indicated that resident was admitted on [DATE] with diagnoses that included weakness and need for assistance with personal care.</p> <p>During an interview on 6/17/25 at 3:40 p.m., Resident 3 stated he stepped out of the facility to smoke a cigarette accompanied by staff two times a day every day.</p> <p>During a joint interview on 6/17/25 at 3:28 p.m. with Registered Nurse (RN) 1 and RN 2, RN 1 and RN 2 both stated that Resident 3 was a cigarette smoker, and the facility did not have a smoking schedule for Resident 3. RN 1 stated during day shift (7:00 a.m. to 3:30 p.m.) which she worked, Resident 3 went out to smoke in the mornings once a day and RN 2 stated, on the evening shifts (3:00 p.m. to 11:30 p.m.) Resident 3 went outside of the facility to smoke once during the shift. RN 1 and RN 2 both stated Resident 3 did not wear a smoking apron when he smoked (a smoking apron is a durable, fire-resistant cover-up that helps protect wheelchair users from falling ashes and smoking debris).</p> <p>Review of Resident 3's Minimum Data Set (an assessment tool) dated 6/13/25, indicated he had a brief interview for mental status or BIMS of 8 (BIMS score of 8-12 points indicates moderate cognitive impairment). The MDS indicated Resident 3 needed supervision from a helper once sitting in the wheelchair to wheel himself at least 150 feet in a corridor or similar space.</p> <p>During an interview on 6/17/25 at 4:35 p.m., with Certified Nursing Assistant (CNA)1, CNA 1 stated he accompanied Resident 3 during smoke breaks outside of the facility. Resident did not have a smoking apron. The cigarette butts were discarded on the ground because there was no ash tray.</p> <p>During a concurrent interview and record review of Resident 3's departmental notes on 6/17/25 at 3:25 p.m. with Minimum Data Set Coordinator (MDSC), MDSC was unable to find a safe smoking evaluation form and a care plan on smoking (A smoking care plan is a structured approach to help residents who smoke to quit or reduce their smoking, and to ensure their safety while smoking. It involves assessment, education, support, and individualized plans to address both the physical and psychosocial aspects of smoking. A safe smoking evaluation is a comprehensive assessment to determine a resident's ability to smoke safely, either unsupervised or with assistance. It involves evaluating a resident's physical and cognitive abilities, as well as their understanding of smoking policies and safety procedures. The goal is to minimize fire hazards and ensure resident safety while respecting their independence).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/18/25 at 3:21 p.m., with the Director of Nursing (DON), DON stated that because Resident 3 did not have a smoking evaluation and care plan on smoking, the facility had just added Resident 3's smoking evaluation and smoking care plan to prevent the hazards of smoking.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Smoking Policy - Residents , dated 2001, the P&amp;P indicated, .2. Smoking is only permitted in designated resident smoking areas which are located outside of the building . 7. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: a. current level of tobacco consumption; b. method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.); c. desire to quit smoking; and d. ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). 8. The staff consults with the attending physician and the director of nursing services (DNS) to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. 9. A resident's ability to smoke safely is reevaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. 10. Any smoking related privileges, restrictions and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure safe medication storage and labeling when:</p> <ol style="list-style-type: none"> <li>1. Resident 5's Latanoprost was stored beyond the use by date in the medication cart (Latanoprost is an eyedrop used to treat a condition in which increased pressure in the eye can lead to gradual loss of vision).</li> <li>2. Six Retacrit medication vials which belonged to discharged resident 261 were found in medication room refrigerator (Retacrit is a medication used to treat a blood disorder caused by a kidney disease).</li> <li>3. One opened unlabeled Lispro insulin vial was found in medication room refrigerator (Lispro insulin is a fast-acting injection medication that helps treat high blood sugar in the body).</li> <li>4. Resident 11 did not have an accurate medication card label for Metoclopramide that matched the physician's order. (Metoclopramide is a medication that helps in nausea and vomiting).</li> <li>5. Eighteen whole loose pills were found scattered underneath the medication cards in the medication cart.</li> <li>6. Six Acetaminophen suppositories which belonged to discharged Resident 259 were found in the medication cart (Acetaminophen suppository is a medication given thru the rectum to relieve pain and to reduce a fever).</li> <li>7. Six Acetaminophen suppositories which belonged to discharged Resident 260 were found in the medication cart.</li> </ol> <p>This failure could potentially result in medication error and expose residents to expired medications with questionable potency and efficacy.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a concurrent observation and interview on 6/17/25 at 10:54 a.m. with the Minimum Data Set Coordinator (MDSC), while inspecting medication cart two, Resident 5 had one opened bottle of Latanoprost eyedrops. The eyedrop bottle had an open date of 4/8/25. The medication box of the eyedrop bottle indicated: to dispose the eyedrops after 42 days from the date opened. MDSC stated, the eyedrop should have been discarded on 5/20/25 as the 42nd day after 4/8/25 would have been 5/20/25. (This observation was conducted on 6/17/25).</li> </ol> <p>A review of Resident 5's admission record dated 6/18/25 indicated Resident 5 was admitted on [DATE], with the diagnosis of glaucoma (glaucoma is an eye disorder).</p> <p>A review of Resident 5's Physician Order dated 6/18/25 indicated an order for Latanoprost Ophthalmic Solution 0.005 %, instill 1 drop in both eyes at bedtime for glaucoma.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/17/25 at 11:24 a.m. with Registered Nurse (RN) 3, she stated the Latanoprost eyedrops should have been discarded 42 days after the open date.</p> <p>During an interview on 6/18/25 at 3:21 p.m. with the Director of Nursing (DON), DON stated Latanoprost eyedrops with past use by dates should have been disposed because the risk of giving the eyedrops past their use by date might not be effective in treating the illness due to diminished potency.</p> <p>2. During a concurrent observation and interview on 6/16/25 at 11:28 a.m. with Licensed Vocational Nurse (LVN) 1 , while inspecting the medication storage room, six Retacrit medication vials which belonged to discharged Resident 261 were found in the medication room refrigerator. LVN stated Resident 261 has been discharged from the facility.</p> <p>Review of Resident 261's admission record dated 6/18/25 indicated Resident 261 was admitted to the facility on [DATE] and was discharged on 6/12/25. The admission record also indicated that the resident was admitted to the facility with diagnoses which included dependence on renal dialysis (a treatment that helps clean the blood when the kidneys aren't working properly).</p> <p>During a review of Resident 261's Physician Order dated 6/12/25, it indicated an order for Retacrit 10,000 unit/ml vial, inject 1.5 ml. subcutaneously every Tuesday, Thursday and Saturday for anemia (ml. is milliliters, unit and ml. are form of measurements; subcutaneously means under the skin; anemia is a blood disorder).</p> <p>During an interview on 6/18/25 at 3:21 p.m. the DON stated medications which belonged to discharged residents should have been disposed on the same day of resident discharge due to the risk of medication error.</p> <p>3. During a concurrent observation and interview on 6/16/25 at 11:28 a.m. with LVN 1 while inspecting the medication storage room, one opened and unlabeled Lispro insulin vial was found inside the medication room refrigerator. LVN 1 stated the insulin vial should have been labeled with an open date.</p> <p>During an interview on 6/19/25 at 2:08 p.m., with Director of Nursing (DON), DON stated unlabeled vial of lispro insulin in the medication refrigerator should have been labeled with the resident's name and date the vial was opened.</p> <p>4. During a medication administration observation on 6/16/25 at 1:08 p.m. with Registered Nurse (RN)1, RN 1 gave Resident 11 one tablet of Metoclopramide 10 milligrams (mg., a form of measurement) from Resident 11's medication card with a direction label that indicated to give Metoclopramide 10 mg. one tablet as needed every six hours for nausea and vomiting.</p> <p>A review of Resident 11's physician's orders dated 6/18/25 indicated an order of Metoclopramide 10 milligrams one tablet two times a day. A review of admission record dated 6/18/25 indicated Resident 11 was admitted on [DATE], with the diagnoses which included nausea and vomiting.</p> <p>During an interview on 6/16/25 at 1:08 p.m., RN 1 stated she followed the physician's order for the Metoclopramide and not the directions from the medication card.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/19/25 at 2:08 p.m. with the DON, she stated the medication nurse should have put the change in direction sticker on the Metoclopramide medication card to prevent a medication error.</p> <p>5. During a concurrent observation and interview on 6/17/25 at 10:54 a.m. with the MDSC while inspecting medication cart two, 18 whole loose tablets were found underneath the medication cards.</p> <p>During a concurrent observation and interview on 6/17/25 11:24 a.m. with RN 3, RN 3 was unable to identify the loose tablets and stated the loose tablets should be disposed according to policy and procedure.</p> <p>During an interview on 6/19/25 at 2:08 p.m. with Director of Nursing (DON), she stated there should be no loose pills in the medication cart due to the risk of medication error.</p> <p>6. During a concurrent observation and interview on 6/17/25 at 10:54 a.m. with the MDSC, while inspecting medication cart two, six Acetaminophen suppositories which belonged to discharged Resident 259 were found.</p> <p>During an interview on 6/17/25 11:24 a.m. RN 3 stated expired medications and medications which belonged to discharged residents should be disposed right away to prevent medication error and/or diversion.</p> <p>Review of Resident 259's admission record dated 6/18/25 indicated Resident 259 was admitted to the facility on [DATE] and was discharged on 5/12/25. The admission record also indicated the resident had diagnoses which included Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills).</p> <p>A review of Resident 259's physician's orders dated 5/12/25 indicated an order of Acetaminophen suppository 650 mg., insert one suppository rectally as needed for mild pain and fever.</p> <p>During an interview on 6/18/25 at 3:21 p.m. with the DON, she stated medications which belonged to discharged residents should be disposed on the same day of discharge due to the risk of medication error.</p> <p>7. During a concurrent observation and interview on 6/17/25 at 10:54 a.m. with the MDSC, while inspecting the medication cart two, six Acetaminophen suppositories belonging to discharged Resident 260 were found.</p> <p>During an interview on 6/17/25 11:24 a.m. RN 3 stated expired medications and medications which belonged to discharged residents should be disposed right away to prevent medication error.</p> <p>Review of Resident 260's admission record dated 6/18/25 indicated Resident 260 was admitted to the facility on [DATE] and was discharged on 5/10/25. The admission record also indicated the resident had diagnoses which included chronic pain.</p> <p>A review of Resident 260's physician's orders dated 5/10/25 indicated an order of Acetaminophen suppository 650 mg. insert one suppository rectally as needed every six hours for mild pain and fever.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/18/25 at 3:21 p.m. with the DON, DON stated medications which belonged to discharged residents should have been disposed on the same day of resident discharge due to the risk of medication error.</p> <p>A review of the facility's policy and procedure, titled medication labeling and storage, dated 2001, indicated: . Medication Labeling 1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. 2. The medication label includes at a minimum: a. medication name .b. prescribed dose; c. strength; d. expiration date, when applicable; e. resident's name; f. route of administration; and g. appropriate instructions and precautions . 12. the nursing staff must inform the pharmacy of any changes in physicians orders for a medication.</p> <p>A review of the facility's policy and procedure, titled Discarding and Destroying Medications dated 2001, indicated: Medications that cannot be returned to the dispensing pharmacy ( . medications refused by the resident and/or medications left by residents upon discharge are disposed of in accordance with federal, state and local regulations .2. Non controlled and scheduled V ( non-hazardous) controlled substances are disposed of in accordance with state regulations and federal guidelines regarding disposition of nonhazardous medications .</p> <p>(Controlled medications are substances that have been classified by the government as having the potential for abuse and addiction. Non controlled medications are substances that are not considered to have a significant potential for abuse or dependence, as compared to controlled substances).</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that food was stored, prepared, and served in a safe and sanitary manner, when food preparation utensils and equipment were not cleaned and/or maintained in good condition.</p> <p>These failures placed 44 residents who received food from the kitchen at risk for food borne illnesses or illnesses related to use of contaminated utensils.</p> <p>Findings:</p> <p>During an observation and concurrent interview with the Registered Dietitian (RD) on 6/17/25 at 3:21 p.m., the following were observed:</p> <ol style="list-style-type: none"> <li>1. A two-slot toaster situated on an open shelf across the stove, had hardened, black, burned particles which resembled bread crumbs on its surface, and had a significant amount of the same substance between its slots and its bottom.</li> <li>2. A knife stored in a knife rack attached to the wall adjacent to the stove had a silicone coating on its handle which was warped, jagged and dented.</li> <li>3. An industrial can opener mounted on a kitchen preparation table had black/dark brown sticky substance on its blade and on the crevices of the feed wheel.</li> <li>4. A plastic container stored under a preparation table contained numerous utensils such as spatulas, scoops, measuring spoons, whisks, ladles and tongs which were supposed to be air drying, but the container was too crowded to allow air to circulate.</li> <li>5. Newly washed muffin pans, baking trays and baking sheets were stacked while still wet. The baking pans and muffin pans had burnt surfaces, stains, dents and deep scratches.</li> <li>6. The interior of the industrial oven in the kitchen was soiled and had a build up of burnt grease and burnt food particles.</li> </ol> <p>RD stated damaged and old equipment needed to be discarded and replaced. The oven and can opener needed to be cleaned thoroughly, and the staff need to know how to air dry utensils.</p> <p>According to the 2022 Federal Food Code, food-contact surfaces of equipment and utensils are to be clean to sight and touch. Non food-contact surfaces are to be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled: Sanitization dated 2001, P&amp;P indicated: 2. All utensils, counters, shelves and equipment are kept clean,maintained in good repair</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2025
NAME OF PROVIDER OR SUPPLIER  Valley Pointe Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  20090 Stanton Avenue 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to follow infection control procedures when the specimen refrigerator (a specimen refrigerator is a specialized cooling unit used to store various biological samples collected from patients, such as urine, stool, blood, or tissue) was observed to be stored in the medication storage room.</p> <p>These failures had the potential to contaminate the residents' medications and for the spread of infectious disease.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 6/16/25, at 11:28 a.m., with Licensed Vocational Nurse (LVN) 1, in the facility medication storage room, the specimen refrigerator was observed to be stored below the medication refrigerator (a medication refrigerator is a specialized appliance specifically designed and used for storing temperature-sensitive medications).</p> <p>Observed inside the specimen refrigerator were a stool specimen in a container and urine specimen samples. LVN 1 stated the specimen refrigerator have been in the medication storage room for a long time, but she could not remember the exact time when the specimen refrigerator was initially stored in the medication storage room.</p> <p>During a concurrent observation and interview on 6/17/25 at 1150 a.m., with the Director of Nursing (DON), in the medication storage room, the specimen refrigerator in the medication room was observed to contain stool specimen in a container and urine specimen samples stored inside. DON acknowledged the risk of storing the specimen refrigerator inside the medication storage room was spread of infection because of the risk of contaminating the medications with the specimen samples of the residents.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Infection Prevention and Control Program, dated 2001, the P&amp;P indicated, . An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .4. The IPCP provides a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2025
NAME OF PROVIDER OR SUPPLIER  Valley Pointe Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 20090 Stanton Avenue Castro Valley, CA 94546	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation and interview, the facility failed to provide 10 of 45 residents in resident rooms [ROOM NUMBER] with at least 80 square feet per resident.</p> <p>This failure had the potential to result in lack of sufficient space for the provision of care by facility staff, and for the lack of sufficient space for residents to have personal belongings at the bedside. After observation and interview, there was adequate space for residents and staff to move about safely and without obstruction. The State Agency recommends renewal of waiver.</p> <p>Findings:</p> <p>During an interview with the Maintenance Director (MD) on 6/17/25 at 11:43 a.m., MD confirmed that resident rooms 19, 20 and 21 had four beds each. MD measured all three rooms:</p> <p>room [ROOM NUMBER] measured a total of 16'6 X 19'6 = 432 sq ft with 73.56 sq ft per bed.</p> <p>room [ROOM NUMBER] measured a total of 16'6 X 19'6 = 432 sq ft with 73.56 sq ft per bed.</p> <p>room [ROOM NUMBER] measured a total of 16'6 X 19'6 = 432 sq ft with 73.56 sq ft per bed.</p> <p>Random observations of resident rooms 19, 20 and 21 were done from 6/16/25 to 6/20/25 at various times throughout the day. There were no negative observations related to resident care/provision attributed to the decreased space in rooms [ROOM NUMBER]. There were no safety concerns noted.</p>