

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

Printed: 08/27/2026  
Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555673                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                          | (X3) DATE SURVEY<br>COMPLETED<br><br>06/17/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Asbury Park Nursing and Rehabilitation Center                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2257 Fair Oaks Boulevard<br>Sacramento, CA 95825 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                               |                                                 |
| F 0658<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on interview and record review, the facility failed to ensure professional standards of practice were followed for one of three sampled residents (Resident 1) when: Resident 1's PET/CT (Positron Imaging Tomography/Computed Tomography - an imaging test that combines metabolic data with detailed structural images) scan preparation was not followed as ordered by the physician; and, Resident 1 was transferred to a different hospital contrary to the physician-ordered hospital. These failures had the potential to result in complications during Resident 1's procedure, and had the potential to result in confusion regarding Resident 1's location for continuity of care. Findings: 1. During a review of Resident 1's admission records, the records indicated Resident 1 was admitted to the facility in April 2026 with diagnoses that included ST elevation myocardial infarction (STEMI - heart attack caused by a total blockage of a heart artery) and diplopia (the perception of two images of a single object). Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 4/28/26, indicated Resident 1 had intact cognition. During a review of Resident 1's Appointment Details, dated 5/27/26, the details indicated, .Pet/Ct Skull to Mid Thigh. 5/29/26. Arrive by 9:40 AM. Starts at 10:00 AM. Visit Instructions. 1. Nothing to eat 6 hours before appointment, this includes gum, candy mints etc. During a review of Resident 1's physician order, dated 5/28/29, the order indicated, 5/29/2026 Check in @ [at] 9:45am PET Scan 10am [Name of Hospital]. During a review of Resident 1's NUTRITION - Amount Eaten task, dated 5/19/26 to 6/1/26, the task indicated 26-50% of Resident's meal was eaten on 5/29/26 at 9 a.m. The task further indicated alternative meal was offered to Resident 1 and Resident 1 ate 26-50% of the alternative meal on 5/29/26 at 9 a.m. During a review of Resident 1's NURSE PROGRESS NOTE, dated 5/29/26, the note indicated, .[Resident 1] returned from appt [appointment] today. Appt. was not able to be complete [sic] d/t [due to] [Resident 1] having multiple BM [bowel movement] at appt. will need to reschedule. there are specific instructions attached to binder. [Resident 1] is to be NPO [nothing by mouth] 6 hours ahead. During an interview on 6/17/26 at 12:23 p.m. with Licensed Nurse 1 (LN 1), LN 1 stated the facility has a binder for appointments and all instructions are there. LN 1 further stated that if instructions or preparations for an appointment were followed, the procedure would be smooth and will be followed on time, but if these instructions were not followed, there could be complications during the appointment. During a concurrent interview and record review on 6/17/26 at 1:25 p.m. with the Director of Nursing (DON), the DON confirmed Resident 1 had an appointment for PET/CT of Skull to Mid Thigh on 5/29/26 at 10 a.m. The DON also confirmed that preparations before the procedure included Resident 1 not eating six hours prior to the procedure. The DON further confirmed Resident 1's Nutrition - Amount Eaten task indicated Resident 1 ate 26-50% of meals on 5/29/26 at 9 a.m. The DON stated Resident 1 did not complete appointment and the procedure was cancelled because Resident 1 had bowel movement during the procedure. The DON also stated that the expectation was for Resident 1 not to receive food prior to the procedure to see what the doctor wanted to rule out, and that the instructions from the doctor were followed. The DON added that if Resident 1 received meals at 9 a.m. on 5/29/26, then the order was not followed. During a review of the facility's policy and procedure (P&amp;P) titled Medication and Treatment Orders, revised 7/2016, the P&amp;P indicated, .13. Orders for withholding food prior to a test or treatment ( NPO) shall be made by the attending (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.

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|--------------------------------------------------------------------------|-----------|--------------------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE     | (X6) DATE                            |
| FORM CMS-2567 (02/99)<br>Previous Versions Obsolete                      | Event ID: | Facility ID:<br>555673               |
|                                                                          |           | If continuation sheet<br>Page 1 of 2 |

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| F 0658<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>physician as necessary. During a review of the facility's P&amp;P titled PHYSICIANS ORDERS, undated, the P&amp;P indicated, .It is the policy of this facility to ensure that: - Medications and treatments are administered according to standards of clinical practice upon the written order of a person duly licensed and authorized to prescribe such medications and treatments in this state. 2. During a review of Resident 1's physician order, dated 5/30/26, the order indicated, .Per [name of physician] from [Hospital A] send [Resident 1] to [Hospital A]. During a review of Resident 1's Hospital Transfer Form, dated 5/30/26, the form indicated, .Reason(s) for transfer.new onset vision change.Is the primary reason for transfer for diagnostic testing, not admission? .Yes.Tests: per [name of physician] send pt [patient] out to [Hospital A]. The form further indicated, .Sent To.[Hospital B]. During a telephone interview on 6/17/26 at 8:54 a.m. with the Inpatient Social Worker (ISW), the ISW stated that the outpatient physician ordered to send Resident 1 to Hospital A Emergency Department (ED), however, the family member called and asked Hospital A's ED and Resident 1 was not there, and the facility sent Resident 1 to Hospital B instead of Hospital A, and none of the staff were able to tell where Resident 1 was transported. During a concurrent interview and record review with Licensed Nurse 2 (LN 2), LN 2 stated nurses fill out the transfer form and if the physician had a specific hospital ordered, the order should be followed. LN 2 confirmed Resident 1 had an order to be transferred to Hospital A on 5/30/26. LN 2 also confirmed that Resident 1's hospital transfer form indicated Resident 1 was sent to Hospital B contrary to the physician order to send Resident 1 to Hospital A. LN 2 stated there was no progress notes regarding the transfer and stated, .I'm not sure where she was taken. During a concurrent interview and record review on 6/17/26 at 1:25 p.m. with the DON, the DON confirmed Resident 1 was transferred out of the facility on 5/30/26 and stated it was a planned transfer to the hospital. The DON also confirmed that the order was for Resident 1 to be sent to Hospital A but the hospital transfer form indicated Resident 1 was sent to Hospital B. The DON further confirmed that there were no progress notes indicating Resident 1 went to Hospital A instead of Hospital B and stated that the best practice was for staff to document the transfer and stated, .but I don't see it. The DON stated the expectation was for staff to document what was being done and to document accurately. During a review of the facility's P&amp;P titled Transfer or Discharge, Facility-initiated, revised 10/2022, the P&amp;P indicated, .Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy.Notice of Transfer or Discharge (Planned).2. The resident and representative are notified in writing of the following information:.c. The specific location (such as the name of the new provider.to which the resident is being transferred or discharged .Documentation of Facility-Initiated Transfer or Discharge.1. When a resident is transferred or discharged from the facility, the following information is documented in the medical record:.d. The new location of the resident.</p> |                                                                                               |                                                 |