STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Park Nursing and Rehabilitation Center	2257 Fair Oaks Boulevard Sacramento, CA 95825

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs for two of 30 sampled residents (Resident 18 and Resident 62) when:1. Resident 18's call light was not within reach and was not appropriate; and,2. Resident 62's call light system was not appropriate.This failure placed Resident 18 and Resident 62's safety at risk and had the potential for the residents' needs to be not met.Findings:1. A review of Resident 18's clinical record indicated Resident 18 was admitted June of 2013 and had diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions causing memory loss and confusion), dementia (memory loss that interferes with daily functions), and muscle weakness.A review of Resident 18's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 3/12/26, indicated Resident 18 was rarely/never understood. A review of Resident 18's MDS Functional Abilities, dated 3/12/26, indicated Resident 18 was dependent with oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene, and needed substantial/maximal assistance with eating and showering/bathing herself. A further review of Resident 18's MDS Functional Abilities indicated Resident 18 was dependent with rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfer, and toilet/shower transfers.A review of Resident 18's care plan, dated 3/26/24, indicated, The resident [Resident 18] has a communication problem r/t [related to] Dementia, non-verbal .Ensure/provide a safe environment: Call light in reach .During an observation on 3/23/26 at 9:43 a.m. in Resident 18's room, Resident 18 was observed sitting on her bed, awake. There was no observed call system provided to Resident 18. During a concurrent observation and interview on 3/23/26 at 10:45 a.m. with Certified Nurse Assistant (CNA) 4, in Resident 18's room, Resident 18 was observed lying on bed, awake, and there was no call system provided to resident 18. CNA 4 searched Resident 18's room and found Resident 18's call light button on the bottom of her bedside drawer which was 4-5 feet away from Resident 18. CNA 4 confirmed that Resident 18's call system was not within her reach. CNA 4 stated Resident 18 was not able to use and press the call light button and she needed total care. CNA 4 also stated Resident 18 needed the soft touch call system instead of the call light button. CNA 4 further stated that all call systems should be within the residents' reach so they could call for help whenever they need it.During a concurrent observation and interview on 3/24/26 at 2:50 p.m. with Licensed Nurse (LN) 3, in Resident 18's room, Resident 18 was observed lying on bed, awake, and was provided with a call light button. LN 3 confirmed the observation. LN 3 stated Resident 18 was non-verbal and was not able to hold and use her hands to press on the call light button. LN 3 further stated the call light button was not appropriate for Resident 18 and that Resident 18 needed a soft touch call system so she could call for assistance whenever she needed help.2. A review of Resident 62's clinical record indicated Resident 62 was admitted December of 2025 and had diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), parkinsonism (a clinical syndrome characterized by tremor, slowed movement, rigidity, and postural instability), and muscle weakness.A review of Resident 62's Minimum Data Set Cognitive Patterns, dated 3/13/26, indicated Resident 62 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 14 out (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of 15 which indicated Resident 62 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 18's MDS Functional Abilities, dated 3/13/26, indicated Resident 62 was dependent with toileting hygiene, showering/bathing herself, lower body dressing, and putting on/taking off footwear, and needed partial/moderate assistance with personal hygiene. A further review of Resident 62's MDS Functional Abilities indicated Resident 62 was dependent with rolling left and right, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfer, and toilet/shower transfers.During a concurrent observation and interview on 3/23/26 at 10:23 a.m. with resident 62, in Resident 62's room, Resident 62 was observed lying on her bed, awake, and was provided with a call light button. Resident 62's hands were observed to be shaking repeatedly. Resident 62 stated she could not hold and press her light button because her hands were very shaky.During a concurrent observation and interview on 3/23/26 at 1:43 a.m. with CNA 3, in Resident 62's room, Resident 62 was observed lying on her bed, awake, and her hands were shaking. CNA 3 confirmed Resident 62 was provided with call light button. CNA 3 stated the call light button was not appropriate for Resident 62 because her hands were shaky and she would not be able to hold and press the call light button. During a concurrent observation and interview on 3/24/26 at 2:52 p.m. with LN 3, in Resident 62's room, Resident 62 was observed lying on bed, awake, and was provided with a call light button. LN 3 confirmed the observation. LN 3 stated Resident 62 has tremors and would not be able to hold and use the call light button. LN 3 further stated a soft touch call system would be better so Resident 62 could call for help when she needed assistance. During an interview on 3/25/26 at 4:17 p.m. with the Director of Staff Development (DSD), the DSD stated she would expect staff to place residents' call system within their reach so they could use it whenever they need it. The DSD also stated that for residents who could not use the call light button, a soft touch call system should have been provided. The DSD further stated that the resident would be at risk for accident or her needs would not be met if the call button was not within her reach or if she would not be able to use the call system provided.During an interview on 3/26/26 at 12:12 p.m. with the Director of Nursing (DON), the DON stated that she would expect that resident's call system to be appropriate for them and are placed within the residents reach so they could call for help whenever they need something.A review of the facility's policy and procedures titled, Call System, Resident, revised 9/2022, indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station .1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor .4. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on interview, and record review, the facility failed to provide appropriate treatment and services to maintain or improve mobility and prevent decline in range of motion (ROM) for one out of 30 sampled residents (Resident 13) when Resident 13's restorative nursing program (RNA program-interventions that actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning) frequency was not followed.This failure had the potential for Resident 13 to experience a decline in range of motion or impairment in mobility.Findings:A review of Resident 13's clinical record indicated Resident 13 was admitted March of 2021 and had diagnoses that included diabetes mellitus (a chronic condition causing too much sugar in the blood), polyneuropathy (a condition characterized by damage to multiple peripheral nerves causing numbness, burning pain, and muscle weakness), and muscle weakness.A review of Resident 13's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 3/19/26, indicated Resident 13 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 13 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 13's MDS Functional Abilities, dated 3/19/26, indicated Resident 13 was dependent with toileting hygiene and putting on/taking off footwear, substantial/maximal assistance with shower/bathing self, lower body dressing, and personal hygiene, and partial /moderate assistance with upper body dressing. A further review of Resident 13's MDS Functional Abilities indicated Resident 13 was dependent on sitting to standing, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer, and needed partial/moderate assistance with rolling left and right, sitting to lying, and lying to sitting on side of the bed. During an interview on 3/23/26 at 10:44 a.m. with Resident 13, Resident 13 stated she was receiving exercises, but she does not think it was enough. Resident 13 stated she needed to get more exercise.A review of Resident 13's care plan, dated 10/24/24, indicated, Resident is at risk for physical decline and requires restorative nursing assistance (RNA) program for therapeutic exercises/range of motion.A review of Resident 13's care plan, dated 10/24/24, indicated, Resident is at risk for physical decline and requires restorative nursing assistance (RNA) program for Bed Mobility.A review of Resident 13's active physician's order, dated 1/8/26, indicated, [RNA PROGRAM]: Patient will complete bed mobilitymovements rolling L<>R [left and right] supine [lying flat on the back] in bed and complete supine<>sit [supine to sit or vice versa] .transitions using side bed rails for assist as necessary for 3x/wk [3x a week] or as tolerated. for 90 Days.A review of Resident 13's active physician's order, dated 1/8/26, indicated, [RNA PROGRAM]: Patient will complete RLE [Right lower extremity/ Right leg] PROM [passive range of motion] exercises targeting all planes of motion for 3x/wk or as tolerated. for 90 Days.During a concurrent interview and record review on 3/25/26 at 9:52 a.m. with Restorative Nurse Assistant (RNA) 1, Resident 13's RNA records for March 2026 were reviewed. RNA 1 confirmed that Resident 13 only received bed mobility exercises on 3/7, 3/13, 3/14, and 3/15. RNA 1 also confirmed that Resident 13 only received PROM exercises on 3/7, 3/13, 3/14, 3/15, and 3/24. RNA 1 further confirmed that Resident 13 did not get her exercises in accordance with the ordered RNA program frequencies which were three times a week. RNA 1 stated the RNA frequency order should have been followed. RNA 1 also stated there were only two RNAs in the facility and they also have to do checking of weekly weights and Monthly weights for residents so sometimes they could not complete the 3 times a week RNA program frequency. RNA 1 further stated there would be a risk of decrease in range of motion and decline in function if Resident 13's RNA program frequencies were not consistently followed.During an interview on 3/25/26 at 4:17 p.m. with the Director of Staff Development (DSD), the DSD stated RNA program frequency should have been followed and there should have been documentation about why the exercises were not done and be reported to therapy. The DSD further stated Resident 13 would be at risk for decreased range of motion, could cause (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	muscle weakness and possible contracture if the RNA program frequency was not followed.During an interview on 3/26/26 at 12:12 p.m. with the Director of Nursing (DON), the DON stated that she would expect that RNA program frequency to be followed. The DON further stated that the resident would be at risk for decrease in range of motion if the RNA program frequency was not followed.A review of the facility's policy and procedures titled, Restorative Nursing Services, revised 7/2017, indicated, Residents will receive restorative nursing care as needed to help promote optimal safety and independence .Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure one out of 30 sampled residents (Resident 147) received appropriate pain management services consistent with professional standards of practice, facility's policy and procedure (P&P), and physician's orders when Resident 147's pain medication orders were not consistently followed. This failure had the potential for Resident 147 to experience unrelieved pain and/or over-medication and not attain her highest practicable well-being.Findings:A review of Resident 147's clinical record indicated Resident 147 was admitted March of 2026 and had diagnoses that included fracture (a break in the continuity of a bone) of the right femur (thigh bone), Pain due to internal orthopedic prosthetic devices, implants and grafts, muscle weakness, and rheumatoid arthritis (a chronic autoimmune disorder causing systemic inflammation, pain, and stiffness, primarily targeting joint linings).A review of Resident 147's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 3/21/26, indicated Resident 147 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 147 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 147's MDS Health Conditions, dated 3/21/26, indicated Resident 147 received scheduled and as needed pain medications and non-medication intervention for pain.A review of Resident 147's Care Plan Report, initiated 3/18/26, indicated, [Resident 147] is at risk for pain R/T [related to]: SURGICAL INC [incision]/CHRONIC PAIN SYNDROME [condition that involves persistent pain that lasts for weeks to years] .Administer medication as ordered .During an interview on 3/23/26 at 8:31 a.m. with Resident 147, Resident 147 stated she has been in pain because of her surgery. Resident 147 further stated that her pain has not been controlled because sometimes the medication does not relieve her pain and other times, the medication was too much which made her feel like things are floating. A review of Resident 147's physician's order, dated 3/17/26, indicated, Acetaminophen [a potent pain reliever] Oral Tablet 500 MG [milligrams- unit of measurement] .Give 2 tablet by mouth every 8 hours as needed for MILD PAIN (1-3) [numeric pain scale from 1 to 10; 1-3 is mild pain, 4-7 is moderate pain, 8-10 is severe pain] .A review of Resident 147's physician's order, dated 3/17/26, indicated, oxyCODONE HCl [a controlled pain medication] Oral Tablet 5 MG .Give 1 tablet by mouth every 4 hours as needed for MODERATE PAIN (4-7).A review of Resident 147's physician's order, dated 3/17/26, indicated, oxyCODONE HCl Oral Tablet 5 MG .Give 2 tablet by mouth every 4 hours as needed for SEVERE PAIN (8-10) 2 TABS [tablets] = 10 MG.A review of Resident 147's medication administration record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of March 2026 indicated Resident 147 received 2 tablets of Acetaminophen which was indicated for Mild pain on the following occasion:3/21/26 at 8:36 p.m.- pain level was 6 (moderate pain)A review of Resident 147's MAR for the month of March 2025 indicated Resident 147 received 10 mg of oxycodone which was indicated for severe pain on the following occasions:3/18/26 at 12 a.m.- pain level was 7 (moderate pain)3/24/26 at 4:33 a.m.- pain level was 7 (moderate pain)During a concurrent interview and record review on 3/24/26 at 12:40 p.m. with Licensed Nurse (LN) 2, Resident 147's clinical records were reviewed. LN 2 confirmed that Resident 147's pain medication orders were not consistently followed. LN 2 stated that nurses should always follow the physician's order when administering pain medications. LN 2 also stated that if the resident requested for a different pain medication, then there should have been a documentation for it. LN 2 further stated that the resident would be at risk for unrelieved pain or over-medication if the physician's orders for pain medications are not followed.During an interview on 3/25/26 at 4:17 p.m. with the Director of Staff Development (DSD), the DSD stated nurses should follow the physicians order and medicate the resident following the ordered parameters. The DSD further stated the resident would be at risk for unrelieved pain or over-medication which could cause undesired effects if the physician's order was not followed.During an interview on 3/26/26 at 12:12 p.m. with the Director of Nursing (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(DON), the DON stated she would expect nurses to follow the doctor's order and set parameters in administering pain medications. The DON further stated the resident's pain would not be controlled if the physicians order is not consistently followed.A review of the facility's P&P titled, Pain Assessment and Management, revised 3/2020, indicated, 2. Pain management interventions shall reflect the sources, type and severity of pain .1. Document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program.A review of the facility's P&P titled, Administering Medications, revised 4/2019, indicated, Medications are administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with prescriber orders .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure strict controls were maintained for the accounting, storage, and documenting of controlled substances (medications with high potential for abuse and addiction under strict government control) as evidenced by:Medication physical inventory counts did not reconcile with the controlled substance record (CSR, for an inventory count sheet to record usage of controlled medications) for six medications for Residents 149, 155, 125, 166, and 133 during an inspection of two out of three medication carts sampled.Discontinued controlled substances remained stored in one of two medication refrigerators and one of three medication carts sampled for Residents 163,165,50, 69, 15 and 7.Medication Administration Records (MARs) did not reconcile with the Controlled Substance Records (CSRs) for two of four residents sampled (Residents 20 and 67). The medications were signed out on the CSRs, indicating removal from inventory, but there was no corresponding documentation on the MARs showing the residents received the controlled medications. These failures resulted in inaccurate documentation and inventory control and created the potential for medication errors, improper dosing, and placed the facility at risk for unaccounted for medication or risk of diversion (unlawful distribution or use) of controlled medications. Findings:1a. During an inspection of the 1C medication cart on 3/23/26 at 10:39 a.m. with Licensed Nurse (LN 6), a physical inventory was conducted, and the following discrepancies were noted between the physical inventory and the Controlled Substance Record (CSR): Buprenorphine (controlled substance medication used to treat opioid addiction or pain management) 5 microgram/hour patch (patch applied to the skin to deliver medication) for Resident 149: Inventory = 1; CSR = 2 (1 patch not accounted for) Oxycodone (controlled substance, strong pain medication) 5 milligram, mg (strength) for Resident 155: Inventory = 39; CSR = 41 (2 pills-unaccounted for) Pregabalin (controlled substance, medication for nerve pain or treatment of seizures) 200 mg for Resident 125: Inventory = 16; CSR = 17 (1 pill unaccounted for) Pregabalin 25 mg for Resident 125: Inventory = 44; CSR = 45 (1 pill unaccounted for)During an interview on 3/23/26 at 10:53 a.m. at the 1C medication cart, LN 6 stated the process is to sign medication out of the CSR and pop (remove the medication from bubble pack) as the medication is administered. LN 6 confirmed the 4 discrepancies and stated the morning nurse is on break and will sign out the medication when he returns. During an interview on 3/23/26 at 11:08 a.m. at the 1C medication cart LN 5 confirmed he did not sign out the 4 medications for Residents 149, 155, 125, during morning medication pass on 3/23/26 and stated he will sign them out now. He acknowledged the controlled substance medications should be signed out during medication administration.1b. During a concurrent inspection and interview of the 2B medication cart on 3/24/26 at 8:27 a.m. with Licensed Nurse (LN 10), the following discrepancies were identified: Lacosamide (controlled substance used to control seizures) 100 mg for Resident 166: physical count = 15; CSR = 14. LN 10 stated she did not sign out the medication during the a.m. medication pass. Lacosamide 100 mg for Resident 133: physical count = 25; CSR (Controlled Substance Record) count = 24. Licensed Nurse (LN 10) confirmed the discrepancy and stated she did not administer the medication that morning and did not know what happened to the missing dose.During an interview with the Director of Nursing (DON) on 3/25/26 at 8:30 a.m. stated her expectation is for the nurses to check the order, pull the medication from the cart then log it out of the CSR. She acknowledged nurses did not sign out medications at the time of removal or after administration.During a phone interview with the Consultant Pharmacist (CP) on 3/25/26 at 11:09 a.m., the CP stated nursing should follow the 5 R's [Rights] when administering medications. He acknowledged nurses should sign out the controlled medication at the time of administration this minimizes the risk of documentation errors and the risk of diversion.During a review of the facility's policy and procedure titled, Controlled Substances, revised date November 2022, indicated, 1. Controlled substance inventory is monitored to identify loss or potential diversion in a manner that (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing and dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records.2a. During an inspection of the medication refrigerator located in the 1A medication room on 3/23/26 at 4:06 p.m. with the Assistant Director of Nursing (ADON 2), a metal lockbox with the key inside was observed in the refrigerator. ADON 2 opened the lockbox, and a bottle of liquid lorazepam 2 milligrams per milliliter (mg/mL) (a controlled substance, concentrated liquid sedative medication) for Resident 163 was found inside. ADON 2 acknowledged the lorazepam stored in the lockboxA review of the clinical record for Resident 163 indicated admitting diagnoses which included, malignant neoplasm (cancerous tumor) and palliative care (care to provide relief of pain, stress of serious illness) further review indicated the resident was discharged on 2/23/26.During an interview and record review with the DON on 3/25/26 at 8:49 a.m. the DON confirmed she received Resident 163's lorazepam bottle (2 mg/mL concentration, approximately 30 mL) after it was identified during the survey. The DON confirmed the resident was discharged on 2/23/26 and acknowledged she received the medication 28 days after discharge.2 b. During an inspection and concurrent interview on 3/23/26 at 4:44 p.m. with LN 8 the following medications were observed wrapped with their corresponding CSR and stored in the 1B medication cart:Oxycodone (controlled medication, strong pain medication with potential for abuse) 5 mg (0.5 tab; 2.5 mg) quantity 59 half-tabs, for Resident 165.Oxycodone 5 mg tablets, quantity 14 tablets, for Resident 69.Oxycodone 5 mg tablets (0.5 tabs; 2.5 mg) quantity 60 half-tabs, for Resident 50.Tramadol (controlled medication, pain medication for moderate to severe pain) 50 mg tablets quantity 34 tablets for Resident 15Oxycodone 5 mg tablets, quantity 26 tablets for Resident 7.Oxycontin (controlled medication, long-acting pain medication) 10 mg tablets, quantify 14 tablets for Resident 7.LN 8 stated that she and the off^going morning nurse did not count the discontinued controlled medications that were wrapped in the cart. She confirmed these discontinued medications were not included in the shift^to^shift controlled substance count and that only the active controlled substances were counted with the off^going nurse. During an interview on 3/24/26 at 8:10 a.m. with LN 9 at the 1 C medication cart, LN 9 stated discontinued controlled medications are given to the DON right away.During an interview and record review on 3/24/26 at 8:52 a.m. with the DON, the DON acknowledged receiving the controlled substances and corresponding CSR's on 3/23/26 for Resident's 165, 69, 15, 50 and 7. The DON stated she encourages nurses to give discontinued medications to her and acknowledged the potential risk for diversion when discontinued controlled substances remain in the medication cart.During a follow-up interview and clinical record reviews on 3/25/26 at 8:53 a.m. the DON confirmed the following: Resident 163: discharged on 2/23/26; lorazepam liquid remained in the medication refrigerator 28 days past discharge. Resident 165: discharged on 2/26/26; oxycodone half^tablets remained in the medication cart 25 days past discharge. Resident 69: discharged on 3/10/26; oxycodone tablets remained in the medication cart 13 days past discharge. Resident 50: discharged on 3/10/26; oxycodone half^tablets remained in the medication cart 13 days past discharge.During a phone interview with the CP on 3/25/26 at 11:09 a.m., when asked if it was acceptable to keep discontinued controlled medications in the medication cart for a month, the CP stated No, that would not be acceptable. He acknowledged the risk of accidental administration and the potential for diversion, stating there is always that problem.During a review of the facility's policy and procedure titled, Controlled Substances, revised date November 2022, indicated, 1. Controlled substance inventory is monitored to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. 4. The nurse coming on duty and nurse going off duty make the count together.3 a. A review of Resident 67's clinical record indicated the following physician order, dated 1/23/26:Oxycodone 5 mg, give 0.5 tablet (2.5 mg) by mouth every 4 hours as needed for moderate pain (pain scale 4-6).Oxycodone 5 mg, give 1 tablet by mouth every 4 hours as needed for severe pain (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Park Nursing and Rehabilitation Center	2257 Fair Oaks Boulevard Sacramento, CA 95825

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(pain scale 7-10).During a concurrent interview and clinical record review on 3/25/26 at 8:39 a.m. with the DON the DON reviewed Resident 67's Controlled Substance Record (CSR) for oxycodone 2.5 mg (5 mg; 0.5 tablet) and the March 2026 Medication Administration Record (MAR). The CSR indicated that one halfˆtablet (2.5 mg) of oxycodone was removed on 3/21/26 at 9:39 p.m. There was no corresponding administration documented on March 2026 MAR. The DON acknowledged the medication was signed out on the CSR and that there was no corresponding administration documented. 3b. A review of Resident 20's clinical record indicated the following physician order,Tramadol 50 mg tablet, give 0.5 tablet (25 mg) by mouth every 6 hours as needed for moderate pain.Tramadol 50 mg tablet, give 1 tablet by mouth every 6 hours as needed for severe pain.During a concurrent interview and clinical record review on 3/25/26 at 8:46 a.m. with DON, the DON reviewed Resident 20's CSR for Tramadol 50 mg tablets, CSR for Tramadol 25 mg (50 mg, 0.5 tabs) and March 2026 MAR. The CSR for Tramadol 50 mg indicated 1 tablet signed out on 3/14/26 at 5 p.m. and 1 tablet signed out on 3/14/26 at 10 p.m. There were no corresponding administrations on March 2026 MAR. The DON confirmed there were no tramadol administrations documented for 3/14/26 on the MAR and no nursing notes corresponding to the CSR removals on that date.During a review of the facility's policy and procedure titled, Controlled Substances, revised November 2022, indicated, The facility complies with all laws, regulations and other requirements related to handling, storage, disposal and documentation of controlled medications. further review indicated, The system of reconciling the receipt, dispensing and .of controlled substances includes the following: a. records of personnel access and usage; b. medication administration records; c. declining inventory records .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review the facility had a medication error rate of 6.45% when four medication errors occurred out of 62 opportunities during the medication administration for three out of nine residents observed (Residents 9, 157 and 112).Resident 9 received a dose of cholecalciferol (Vitamin D3 supplement, used to prevent or treat Vitamin D deficiency) 25 times greater than prescribed. Resident 157 received the wrong dose of Humulin R (Regular Insulin, a shortˆacting insulin used to lower blood sugar), and the ordered dose of Humulin N (NPH Insulin, an intermediateˆacting insulin providing basal coverage) was not administered.Resident 112 received acetaminophen (an overˆtheˆcounter medication to reduce fever and mild pain) not in accordance with the prescribed pain level.These failures resulted in incorrect medication doses, omitted medication and medications administered not per the physician orders and had the potential to adverse drug effect, low or high blood sugar levels and inadequate pain management.Findings:1. During a medication observation on 3/23/26 at 9:42 a.m. at the 1 A medication cart, LN 4 prepared 10 medications for Resident 9, including 1 capsule of cholecalciferol from a bottle labeled, BioTech D3-50 and proceeded to the resident's room for administration. Resident 9 was observed taking the prepared medications with soda.A review of Resident 9's clinical record indicated a physician order, dated 2/27/26, for cholecalciferol oral tablet 50 micrograms (mcg, strength), Give 1 tablet by mouth one time a day for supplement. It was scheduled for 8 a.m.During an interview and clinical record review on 3/24/26 at 1:05 p.m. at the 1 A medication cart with LN 4, when asked to identify the cholecalciferol bottle used for Resident 9's medication pass on 3/23/26, LN 4 removed a bottle labeled BioTech D3ˆ50 Cholecalciferol. Upon further inspection, the label indicated: Vitamin D3 (cholecalciferol), serving size: 1 capsule, amount per serving: 1,250 mcg, % Daily Value: 6,250 %. LN 4 reviewed Resident 9's physician orders and acknowledged the order was for 1 tablet of cholecalciferol 50 mcg, and that 1 capsule of 1,250 mcg was administered.During an interview on 3/25/26 at 8:21 a.m. with the Director of Nursing (DON), the DON stated she expected nursing staff to follow physician orders when administering medications. She acknowledged Resident 9 received a 1,250-mcg dose of vitamin D (cholecalciferol)During a review of the facility's policy and procedure titled, Administering Medications, revised date April 2019, indicated, .4. Medications are administered in accordance with prescriber orders, including any required time frame. and further indicated, .10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time .before giving the medication.2. During a medication observation on 3/23/26 at 10:06 a.m. at the 1A medication cart, Licensed Nurse (LN 4) prepared 10 medications for Resident 157, including Humulin R. LN 4 stated she would administer a total of 8 units of insulin: 2 units for a blood sugar reading of 239 and 6 units as the fixed dose. LN 4 was observed removing Resident 157's Humulin R vial, swabbing the vial, and drawing up 8 units of Humulin R into an insulin syringe. The Humulin R was then observed being injected into Resident 157's left abdomen.A review of Resident 157's clinical record indicated 11 medications were due during the morning medication pass. Physician orders, dated 3/21/26 included:Humulin R 100 unit/milliliter (unit/mL, concentration) to be given per sliding scale, (a set of instructions for administering insulin dosages based on specific blood glucose readings), to give 2 units for a blood sugar between 201-250. Blood glucose checks were scheduled for 8 a.m., 1 p.m. and 5 p.m.Humulin N 100 unit/mL, inject 6 unit [s] two times a day for DM-2 (type 2, diabetes mellitus, condition causing high blood sugar), Hold for Finger Stick Glucose (FSG, method of pricking finger to obtain blood for testing sugar) < (less than) 100; Give Insulin after meal is consumed, dated 3/21/26. It was scheduled for 8 a.m. and 5 p.m. During an interview and record review on 3/23/26 at 2:28 p.m. at the 1A medication cart with LN 4, when asked to identify the insulin administered to Resident 157 during the morning medication pass, LN 4 removed the resident's Humulin R vial from the cart and confirmed the resident received 8 units that morning. Upon further review of Resident 157's clinical records, LN 4 acknowledged the resident (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should have received 2 units of Humulin R instead of 8 units per the sliding scale order. LN 4 also acknowledged she did not administer the resident's Humulin N as ordered by the physician.During an interview and clinical record review on 3/25/26 at 8:21 a.m., the DON acknowledged that on 3/23/26 the wrong dose of Humulin R was administered, and the Humulin N dose was omitted for Resident 157. The DON also stated she provided education to LN 4 regarding NPH and Regular Insulin.A review of the drug manufacturer's prescribing information (PI, a regulatory-approved document providing detailed drug information) for Humulin R, revised 6/2023, indicated, . Always check the insulin label before administration to confirm the correct insulin product is being used.Humulin R .injection should generally be used in regimens with intermediate-or long-acting insulin. Hypoglycemia (low blood sugar): May be life-threatening. Increase monitoring with changes to insulin dosage.A review of the drug manufacturer's PI, for Humulin N, revised 12, 2025, indicated, .Humulin N is an intermediate-acting insulin with a slower onset of action and a longer duration of activity than that of a regular human insulin.During a review of the facility's policy and procedure titled, Administering Medications, revised date April 2019, indicated, .4. Medications are administered in accordance with prescriber orders, including any required time frame. and further indicated, .10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time .before giving the medication.3. During a medication observation on 3/23/26 at 4:25 p.m. at the 1B medication cart with LN 8, LN 8 stated Resident 112 was requesting pain medication and that she would assess the resident's pain before administering it. LN 8 returned to the cart and stated the resident's back pain was rated as a 5 [pain scale from 0 to 10]. She then prepared one tablet of acetaminophen 325 mg (an over-the-counter medication to reduce fever and mild pain) and two tablets of ibuprofen 200 mg, [400 mg] (medication to lower fever and reduce pain.) Resident 112 was observed swallowing the three tablets with water.A review of Resident 112's clinical record indicated the following physician orders, dated 3/9/26:Acetaminophen oral tablet 325 mg, give one tablet by mouth every 4 hours as needed (prn) for MILD pain (1-3 pain scale)/ Headache.Ibuprofen oral tablet 400 mg, give one tablet by mouth every 4 hours as needed for MILD (1-3 pain scale) or Moderate (4 -6 pain scale) give with food.A review of the nursing administration notes written by LN 8 on 3/23/25 at 4:39 p.m. indicated that acetaminophen 325 mg 1 tablet was administered for complaint of (c/o) back pain rated 5 out of 10. During an interview and clinical record review on 3/25/26 at 8:11 a.m. with the DON, the DON stated pain medication is to be administered based on the physicianˆordered pain scale for mild, moderate, or severe pain. The DON reviewed Resident 112's clinical records, including the medication administration record (MAR) and nursing notes, and acknowledged the acetaminophen administration did not follow the pain scale as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications and diagnostic agents were properly labeled according to manufacturer guidelines when:Several opened and undated medications, and one opened and undated container of glucose test strips, were observed stored in 2 of 3 medication carts sampled.One opened and undated Forteo pen (preˆfilled injection device used to deliver specialty medication to treat osteoporosis, a condition of weakened bones), was observed stored in 1 medication room refrigerator of two medication rooms sampled.This failure had the potential for residents to receive ineffective, expired, or unstable medications, and for staff to use expired or inaccurate glucose test strips when monitoring residents' blood glucose levels.Findings: 1a. During an inspection of the 1 C medication cart and concurrent interview on [DATE] at 11:14 a.m. with Licensed Nurse (LN 5) the following medications were observed:One opened, undated vial of Insulin Glargine (long-acting insulin to control blood sugars) for Resident 110. LN 5 read the manufacture label that indicated, Use within 28 days after initial use. LN 5 confirmed the opened vial was not dated.One opened Breo Ellipta inhaler (medication inhaled into the lungs used for breathing problems) for Resident 161 without an open date. A review of the manufacturer's labeling with LN 5 indicated, Discard the inhaler 6 weeks after opening the .foil tray or when the counter reads 0 .whichever comes first. LN 5 confirmed no open date on the inhaler.One opened Trelegy Ellpta Inhaler (medication inhaled into the lungs used for breathing problems) for Resident 148. A review of the manufacturer's labeling with LN 5 indicated, Discard 6 weeks [after tray opened]. LN 5 confirmed the inhaler had no open date.1b. During an interview and record review on [DATE] at 10:34 a.m. at the 1 A medication cart with LN 4, Resident 156's Epidiolex (oral solution to treat rare seizure disorders) bottle was observed open without an open date. The manufacturer labeling indicated, Discard unused portion 12 weeks after first opening. LN 4 confirmed the opened bottle was not dated.1c. During an inspection of the 1 B medication cart on [DATE] at 4:44 p.m. with LN 8, one multi-dose container of EvenCare, G3 Blood Glucose Test Strips (diagnostic strips used to test blood sugar) was observed open and without open date. A review of the manufacturer's label with LN 8 indicated, Use within 6 months after first opening. LN 8 confirmed there was no open date on the container.2. During an inspection of the medication room [ROOM NUMBER] refrigerator on [DATE] at 3:42 p.m. with the Assistant Director of Nursing (ADON 2), one opened and undated Forteo pen for Resident 162 was observed. The manufacturer labeling indicated, Throw away 28 days after first use. ADON 2 acknowledged the medication was opened and undated.During an interview and record review on [DATE] at 9:11 a.m. with the Director of Nursing (DON), the DON stated medications are to be dated when opened in accordance with manufacturer guidelines. After reviewing photographs of the undated medications observed, the DON acknowledged the findings and stated that undated, opened medications could expose residents to medications that may be expired or unstable.During a review of the facility's policy and procedure titled, Administering Medications, revised date [DATE], indicated, The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.

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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 ensure food was prepared, stored, served, or distributed in accordance with professional standards of food service safety when:Three dietary staff did not wear hair and beard restraints; andOne dietary staff did not practice hand hygiene between soiled and clean dishes during the dishwashing process.These failures had the potential to result in food contamination which could cause illness for 132 residents who received food prepared from the facility kitchen. During an observation on 3/24/26 at 8:30 and 11:00 a.m., Dietary Aide (DA) 2 wore a beanie in the kitchen without a hair restraint and hair was exposed in the back and sides of the head. DA 1 and [NAME] (CK) 1 had beards without beard restraints during food preparation.During an interview on 3/24/26 at 8:45 and 11 a.m. with the Dietary Supervisor (DS), the DS confirmed DA 2 was wearing a beanie with exposed hair and was not wearing a hair net and DA 1 and CK 1 had exposed beard hair and were not wearing beard restraints. The DS stated they should be wearing a hair net and beard restraints to prevent hair from contaminating food or getting on food prep surfaces.A review of the facility policy and procedure (P&P) titled, Dress Code, dated 2023, indicated, .PROPER DRESS: .6. Hat for hair, if hair is short which completely covers the hair, 7. Hair net for hair, if hair is long (over the ears or longer), 8. beards and mustaches (any facial hair) must wear beard restraint.According to the FDA Food Code 2022, Section 2-402.11, Hair Restraints, A. FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.During an concurrent observation and interview on 3/25/26 at 10:30 a.m., DA 3 touched the dirty dishes on the dirty side of the dishwashing machine and then touched the clean dishes without washing hands. The DS confirmed it was not the correct process and stated there should be two dishwashers and the person on the dirty side should not touch the dishes on the clean side without washing their hands to prevent cross contamination and spreading bacteria. During a review of the facility P&P titled, Sanitation, dated 2023, indicated, . 18. A minimum of two employees will be used when dishes are machine washed. One will handle soiled area, and one will handle the clean side. If an employee does need to go from soiled to dirty end, a strict hand-washing routine must be followed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program when;1. A facility staff did not wear required personal protective equipment (PPE) when providing high contact care and handling the indwelling catheter (a thin, hollow tube that is inserted into the bladder to drain urine and is left in place for a period of time) for one out of 30 sampled residents (Resident 130) who was on enhanced barrier precaution (EBP- also known as enhanced standard precaution/ESP, infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs- bacteria that resist treatment with more than one antibiotic] that employs targeted gown and glove use);2. Money was stored in a medication cart, creating a risk for crossˆcontamination of medications, and3. The facility failed to perform PICC line (PICC, peripherally inserted central catheter. Long, thin tube inserted through a vein in the arm, and is passed through to the larger veins near the heart) dressing changes, as ordered for one of 30 sampled residents (Resident 132).These failures resulted in an increased risk for cross contamination, and potential exposure of residents to germs and infection.Findings: 1. A review of Resident 130's clinical record indicated Resident 130 was admitted December of 2024 and had diagnoses that included Urinary tract infection (UTI- an infection in the bladder/urinary tract), hydronephrosis (swelling of one or both kidneys caused by a buildup of urine, usually due to an obstruction or blockage), kidney stones, and neuromuscular dysfunction of bladder (the nerves and muscles in the urinary bladder don't work together properly). A review of Resident 130's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 3/3/26, indicated Resident 130 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 130 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 130's MDS Bladder and Bowel Status, dated 3/3/26, indicated Resident 130 uses an indwelling catheter. A review of Resident 130's care plan, undated, indicated, [Resident 130] requires Enhanced Barrier Precautions r/t [related to] indwelling catheter .Implement enhanced standard precautions (gown, gloves) when providing direct patient care and when cleaning the room. A review of Resident 130's active physician's order, dated 1/13/25, indicated, Indwelling .catheter .due to Dx [diagnosis] ofNeurogenic bladder [also known as neuromuscular dysfunction of bladder] /urinary retention [caused by a blockage or a failure of the bladder to squeeze hard enough to expel all of the urine]. A review of Resident 130's active physician's order, dated 1/19/25, indicated, Enhanced Barrier Precautions r/t Indwelling Catheter. A review of the list of residents on EBP, provided by the Infection Preventionist (IP), on 3/23/26 at 10:28 a.m. indicated Resident 130 was on EBP due to his indwelling catheter. During an observation on 3/23/26 at 3:12 p.m. in Resident 130's room, a facility staff was observed changing Resident 130's hospital gown, providing hygiene care, changing his briefs, and handling Resident 130's indwelling catheter while only wearing gloves and not wearing a gown. There was an EBP signage posted on the board on top of Resident 130's bed which indicated, STOP .ENHANCE BARRIER PRECAUTIONS .PROVIDERS AND STAFF MUST .Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing .Providing Hygiene .Changing briefs .Device care or (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	use: .urinary catheter . During a subsequent interview on 3/23/26 at 3:18 p.m. with Certified Nurse Assistant (CNA) 5, CNA 5 confirmed that she was only wearing gloves when she changed Resident 130's hospital gown, provided hygiene care, changed his briefs, and handled Resident 130's indwelling catheter. CNA 3 stated she does not know if she should have worn a gown when doing high contact care to Resident 130. CNA 3 further stated she does not know if Resident 130 was on EBP and that there was an EBP signage posted on Resident 130's board. During a phone interview on 3/25/26 at 10:25 a.m. with the IP, the IP stated that staff should be aware and should be wearing both gloves and gown when providing high-contact care to a resident who was on EBP to prevent spreading germs and prevent the risk of the resident getting infection. During an interview on 3/26/26 at 12:12 p.m. with the Director of Nursing (DON), the DON stated that staff should follow EBP and wear both gloves and gown when providing high contact care to a resident who was on EBP to prevent the risk of possible infection of the resident. A review of the facility's policies and procedures (P&P) titled, Enhanced Barrier Precautions, revised 6/2024, indicated, 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) .3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing .d. providing hygiene .f. changing briefs .g. device care or use (.urinary catheter .). 9. Staff are trained prior to caring for residents on EBPs. 2.During an inspection and concurrent interview on 3/23/26 at 4:44 p.m. at the 1B medication cart with Licensed Nurse (LN 8), money was observed stored inside the secondary locked section of the medication cart. The bills were wrapped in a small blue piece of paper and stored within the compartment containing controlled substance medications (medications that the use and possession of are controlledby the federal government) and antibiotics. LN 8 confirmed the finding and stated her understanding was that money should not be stored in the medication cart. During an interview on 3/25/26 at 9:06 a.m. with the Director of Nursing (DON), the DON acknowledged that money should not be stored in the medication cart. During a review of the facility's policy and procedure, titled, Medication Labeling and Storage, revised date, indicated, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. 3.During a review of Resident 132's admission Record, (AR), the AR indicated that Resident 132 was admitted to the facility in February 2026 with diagnoses that included Bacteremia (bacteria in the blood), and infection following a procedure. During a review of Resident 132's Minimum Data Set (MDS a federally mandated resident assessment tool) dated 3/2/26, Section C, Cognitive Patterns (mental process of acquiring knowledge and understanding) showed a score of 15 which indicated intact cognition. During a review of Resident 132's Order Summary Report (OSR), dated 3/7/26, the OSR indicated, CHANGE PICC LINE/MIDLINE(Specify) DRESSING QWEEK [every week] AND PRN [as needed] FOR (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	SOILED OR DISPLACED. During an observation of Resident 132's PICC Line dressing on 3/23/26 at 8:48 a.m., the PICC Line dressing was dated 3/7/26 and the white tape used to secure the dressing had started to peel off. During a concurrent observation and interview with LN 11 inside the room of Resident 132 on 3/23/26 at 9 a.m., LN 11 confirmed that Resident 132's PICC Line dressing to his right upper arm was dated 3/7/26, the dressing edge appeared brownish in color and started to peel off. LN 11 stated the dressing should have been changed every week as ordered by the physician to prevent potential infection. LN 11 stated further that Resident 132 was receiving antibiotics daily to treat infection. During an interview with the DON, on 3/23/26 at 11:02 a.m. the DON stated her expectations from the nurses were to change the PICC Line dressing of Resident 132 every week, and as needed if the dressing got soiled or displaced. The DON further stated, it should be labeled and dated to verify who changed the dressing and to ensure it was replaced per physician's order to prevent infections. During a review of Resident 132's Order Summary Report (OSR), dated 2/26/26, the OSR indicated, cefTRIAXone Sodium [antibiotics] Intravenous Solution . Use 2 gram [unit measurement] intravenously [through the veins] at bedtime for Streptococcus Bacteremia [a serious condition often leading to high morbidity, sepsis, or mortality. Commonly originated from infections such as skin infections]. During a review of Resident 132's Order Summary Report (OSR), dated 2/26/26, the OSR indicated, DAPTOmycin Intravenous Solution. Use 500 mg intravenously at bedtime for Streptococcus Bacteremia. During a review of Resident 132's Care Plan (CP), undated, the CP indicated, Resident has PICC line to RUE [right upper extremity] .Change PICC line dressing every week and as needed for soiling or displacement. During a review of the facility's policy and procedure, titled INTRAVENOUS THERAPY (IT), undated, the IT indicated, .To provide standards for the safe maintenance of the P.I.C.C. catheter in order to reduce the risk of infection or dislodging.TSM [transparent semi permeable membrane, adhesive dressing that covers the catheter insertion site] dressing will then be changed at least weekly .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to administer insulin (a medication used to lower blood sugar) according to the sliding scale in a timely manner (a set of instructions for administering insulin dosages based on specific blood glucose readings) when the insulin was administered more than 2 hours after the blood glucose reading for one of nine residents observed during the medication pass (Resident 157). This failure created the potential for inaccurate dosing and adverse effects from uncontrolled blood sugar.Findings: During a medication observation on 3/23/26 at 10:06 a.m. at the 1 A medication cart, Licensed Nurse (LN 4) was observed preparing 10 medications, for Resident 157, which included Regular Insulin (short acting insulin). At 10:15 a.m., LN 4 was observed administering the Regular Insulin to Resident 157's left lower abdomen. A review of Resident 157's physician order indicated the following order for Regular Insulin 100 unit/milliliter (concentration) to be given as per sliding scale, dated 3/21/26: Finger Stick Glucose (FSG, a method of pricking a finger to test blood sugar)less than 70 (milligrams/deciliter, mg/dL, concentration measurement) initiate facility hypoglycemia (low blood sugar) protocol and notify MD.71 to 150= 0 units 151- 200 = 1 unit201- 250= 2 units251-300= 4 units301-350= 6 units351-400= 8 units401-450=10 units recheck FSG in 1 hour and notify MD During a review of Resident 157's Medication Administration Record (MAR), the Insulin Regular 100 units/milliliter per sliding scale dose was scheduled for 8 a.m., 1 p.m. and 5 p.m., further review indicated on 3/23/26 the 8 a.m. dose of Insulin Regular was given at 10:11 a.m. During an interview and a review of Resident 157's clinical medication records on 3/23/26 at 2:28 p.m. at the 1A medication cart, LN 4 stated the resident's blood sugar was taken around 7:00 a.m., with a result of 239. She confirmed the Regular Insulin, scheduled for 8:00 a.m., and was administered after 10:00 a.m. LN 4 acknowledged the Regular Insulin dose was sliding scale based on the blood sugar level and should have been given sooner. During an interview and record review on 3/25/26 at 8:21 a.m., the Director of Nursing (DON) stated the facility's standard practice is to administer insulin within 30 minutes of obtaining the blood glucose reading. The DON reviewed Resident 157's March MAR, specifically the entry for 3/23/26, and confirmed the Regular Insulin was administered outside of this standard. She acknowledged the Regular Insulin was given over 2 hours after the blood glucose was obtained, creating the potential for inaccurate slidingˆscale dosing based on a nonˆcurrent blood sugar result. During a review of the facility's policy and procedure titled, Administering Medications, revised date April 2019, indicated, .4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication. b. preventing potential medication or food interaction;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Park Nursing and Rehabilitation Center	2257 Fair Oaks Boulevard 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure one out of 30 sampled residents (Resident 160) received care in accordance with professional standards of practice, and facility's policy and procedure (P&P) when Resident 160's suprapubic catheter (a tube that drains urine from the bladder through a small incision in the lower abdomen) bag was left on the floor.This failure had the potential for Resident 160 to develop infection and possible urinary catheter complications.Findings:A review of Resident 160's clinical record indicated Resident 160 was admitted March of 2026 and had diagnoses that included malnutrition (state of poor nutrition that occurs when the body does not receive enough or the right nutrients to function properly), benign prostatic hyperplasia (BPH- the prostate gland grows larger than normal potentially causing urinary problems), and obstructive and reflux uropathy (occurs when the urine cannot drain through the urinary tract).A review of Resident 160's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 2/13/26, indicated Resident 160 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 12 out of 15 which indicated Resident 160 had moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 160's MDS Bladder and Bowel Status, dated 2/13/26, indicated Resident 160 uses indwelling catheter (a thin, hollow tube that is inserted into the bladder to drain urine and is left in place for a period of time).A review of Resident 160's care plan, dated 3/11/26, indicated, The resident [Resident 160] has Indwelling Catheter r/t [related to] URINARY RETENTION .The resident will show no s/sx [signs and symptoms] of Urinary infection through review date .The resident will be/remain free from catheter-related trauma through review date .A review of Resident 160's active physician's order, dated 3/12/26, indicated, SUPRAPUBIC catheter .Gravity drainage bag due to Dx [diagnosis] of OBSTRUCTIVE AND REFLUX UROPATHY.During an observation on 3/24/26 at 10:20 a.m. of Resident 160, in Resident 160's room, Resident 160 was observed lying on bed, awake and was connected to a urinary catheter tubing attached to a urinary catheter bag which was on the floor.During a concurrent observation and interview on 3/24/26 at 12:40 p.m. with Licensed Nurse (LN) 2, in Resident 160's room, Resident 160's urinary catheter bag was still on the floor. LN 2 confirmed the observation. LN 2 stated the urinary catheter bag should not be left on the floor because the catheter bag could get contaminated which may cause infection and urinary complications.During an interview on 3/25/26 at 4:17 p.m. with the Director of Staff Development (DSD), the DSD stated urinary catheter bags should be hanging on the bedside and not touching the floor. The DSD stated there would be a risk of infection if the urinary catheter bag was left on the floor and the urine could also flow back which could cause potential urinary catheter complications.During an interview on 3/26/26 at 12:12 p.m. with the Director of Nursing (DON), the DON stated that urinary catheter bags should be hanging on the bedside and should not be touching the floor. The DON further stated that if the urinary catheter bag was on the floor, it could cause urinary complications like infection or possible back flow of the urine.A review of the facility's policy and procedures titled, Catheter Care, Urinary, revised 8/2022, indicated, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections .2. Be sure the catheter tubing and drainage bag are kept off the floor .