

9-27-11  
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 FORM APPROVED

## California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  CA030000001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 08/18/2011
NAME OF PROVIDER OR SUPPLIER  ASBURY PARK NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	Initial Comments  The following reflects the findings of the California Department of Public Health during the investigation of complaint #CA00223300.  Representing the Department of Public Health: HFEN 1408/14362  The inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility.  The Department was unable to substantiate a violation of regulations.	A 000		9/27/11	

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X8) DATE

5899

OE4Y11

If continuation sheet 1 of 1