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 _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	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) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00910416. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 32096 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000	Preparation and/or execution of this response and Plan of Correction (POC) do not constitute an admission or agreement by the provider of truth or accuracy of the alleged facts or conclusions set forth in the Statement of Deficiencies. This POC is prepared and/or executed solely for the provisions of Federal and State required regulations. This POC is not an admission of non compliance with cited regulation(s)	
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to ensure a safe environment for the residents, staff, and the public when the evacuation routes were cluttered with carts, bedside commode, linen bins, and garbage bins in a 139-bed facility. This failure caused Resident 4 to feel unsafe in the facility and increased the potential for a delay in an evacuation should an emergent situation arise that would have the facility use this evacuation route. Findings: Review of Resident 4's clinical record, "Admission	F 921	Facility removed bins from the egress and pathway of the emergency exits Although in the case of an emergency evacuation residents need an egress from the facility without obstruction, there were no residents harmed in any way from the alleged deficient practice. Facility will move bins from the emergency exit egress and pathway and place them in a way that does not hinder a safe egress in case of an emergency. Maintenance (MaintD) and Housekeeping Directors (HK/L) will monitor bins to ensure they are not obstructing the emergency exit. If bins are an obstruction, they will move them to their designated areas to ensure emergency exits are clear. MaintD and/or HK/L will report any findings during morning IDT and share progress at the facility quarterly QA meeting.	5.24.24 5.24.24 on-going on-going

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6.17.24

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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F 921	Continued From page 1 Record " , indicated the resident was admitted to the facility for aftercare of back surgery. In an observation and concurrent interview on 5/23/24 starting at 3:23 p.m. in Resident 4's room, the resident stated that he had concerns regarding the resident safety in the building. Resident 4 stated, "I want to show you something" and got out of his bed and took the lead in his wheelchair to one of the emergency exit doors. It was a double exit door with a sign on the window of the door, "EMERGENCY EXIT ONLY. NO RESIDENT IS ALLOWED THIS WAY." Below it, another sign marked on the door, "EMERGENCY EXIT ONLY ALARM WILL SOUND." When Resident 4 pushed the door open, no alarm went off. Outside the double exit door, there was an approximate 32-gallon size yellow linen bin full of soiled linen placed blocking the left exit door. The exit double door was faced to the wooden fence and on the fence, a sign wrote, "Emergency Evacuation Route" with an arrow pointing to the right. The evacuation route was about 8 feet wide from the building wall to the wooden fence and about half of the width from the building was paved with concrete otherwise covered with soil and gravel towards the fence. A metal cart was observed below the evacuation route sign on the fence. On the paved route, there were three grey garbage bins, about the same size as the yellow linen bin, and a wheelchair occupied most of the paved route surface. Resident 4 demonstrated evacuating himself in his wheelchair on the paved route but was unsuccessful because one of the wheels of his wheelchair fell onto the gravel as the evacuation route surface was too narrow with the garbage bins for his wheelchair to pass through. Resident 4 stated, "This will increase the injury for	F 921		

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F 921	Continued From page 2 the residents" in case of an emergency. Resident 4 pointed to the 2nd exit door closer to the lobby for the Department to check on his way back to his room. It was also a double exit door with a sign, "EMERGENCY EXIT ONLY. NO RESIDENT IS ALLOWED THIS WAY." Below it, another sign wrote, "EMERGENCY EXIT ONLY ALARM WILL SOUND." No alarm went off, either when the 2nd exit door opened. The configuration of the evacuation route outside the 2nd exit door was similar to that of the first evacuation route observed. On the wooden fence wall, a sign indicated, "Emergency Evacuation Route" with an arrow pointing to the left. Under the sign there were a cart and a bedside commode observed. There were two 32-gallon yellow soiled linen bins uncovered blocking the left exit door and four grey garbage bins, about the same size of the linen bins, placed on the paved route without lids. Review of the facility's January 2019 policy and procedure, "Exits or Means of Egress," stipulated, "Our facility has designated exits for each area of the building to allow for rapid evacuation...Primary and secondary exit routes have been assigned for rapid and orderly evacuation...All personnel shall do all they can to keep exits clear at all times." In a concurrent observation and interview on 5/23/24 at 3:34 p.m., the Director of Nursing (DON) verified the alarms did not go off for both exit doors when they opened. The DON verified there were carts, bedside commode, linen bins, garbage bins, wheelchair and bedside table in the evacuation routes and acknowledged those should have been removed to ensure the evacuation routes maintained free from clutter should the resident be evacuated quickly in an	F 921		

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F 921	Continued From page 3 emergent situation. The DON verified the garbage bins and linen bins outside the exit doors were uncovered and should have been covered for infection control. In a concurrent observation and interview on 5/23/24 at 3:51 p.m., Certified Nurse Assistant (CNA 1) was observed to dump the dirty garbage bag into the garbage bin outside the first exit door. CNA 1 stated the dirty linen bins, and the garbage bins were "always" outside the exit doors for staff to dump garbage or soiled linens. CNA 1 stated she was aware the exit doors and the evacuation route were for an emergency use. In an interview on 5/23/24 at 4:23 p.m. at the administrator's office, the Administrator agreed that the evacuation routes should have been kept clutter-free at all times and acknowledged a resident's concern for the cluttered evacuation route was valid	F 921		