

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER Burbank Healthcare & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1041 S. Main St. Burbank, CA 91506	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37861</p> <p>Based on observation, interview, and record review, the facility failed to have a system-wide (something that extends or exists throughout a system) method of accountability for controlled medications (drugs that are regulated by the government because it may be abused or cause addiction) and ensure safeguarding of controlled medications for two of nine sampled residents (Resident 1 and Resident 2) by:</p> <ol style="list-style-type: none"> 1. Failing to ensure licensed nurses document the administration of controlled substances in Resident 1's electronic Medication Administration Record (eMAR- an electronic report detailing the drugs administered to a resident) 2. Failing to maintain records on the transfer of controlled medications from licensed nurses to the Director of Nursing (DON) after Resident 1 was discharged , and after the controlled medications were no longer in use and were cleared for disposition (process of returning and/or destroying unused medications). 3. Failing to ensure the DON investigate all discrepancies related to Resident 1's and Resident 2's controlled medication reconciliation (process of comparing a resident's medication orders to all of the medications that the resident has been taking) to determine the cause of the missing controlled medications. 4. Failing to ensure the DON reported Resident 1 and Resident 2's missing controlled medications to the Administrator (ADM). <p>These deficient practices resulted to the facility not able to account for 43 doses of Norco (a controlled medication used to treat moderate to severe pain) 5-325 milligrams (mg - unit of measure) belonging to Resident 1 and was not able to account for the exact amount of Oxycodone-Acetaminophen (generic name for Percocet, a controlled medication used to treat moderate to severe pain) 5-325 mg belonging to Resident 2.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The failure to maintain a system to ensure accountability of controlled medications increased the risks of diversion (when a medication is taken for use by someone other than whom it is prescribed or for an indication other than what is prescribed) of medications, staff working in an impaired state (weakened or imperfect condition that results in a loss of function or ability), or accidental exposure of controlled medications to 163 of 188 total residents (facility census [a complete count of residents in the facility] on 1/29/2025) possibly resulting in respiratory depression (inability to breathe) leading to hospitalization and death.</p> <p>On 1/29/2025 at 5:01 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, and/or death to a resident)) under 42 CFR S483.45 Pharmacy Services in the presence of the Regional Administrator (RAdm), Infection Prevention Nurse (IP), and the Director of Staff Development (DSD), due to the facility's failure to have a system in place to ensure safeguarding of controlled medications for Resident 1 and Resident 2.</p> <p>On 1/31/2025 at 5:29 p.m., the RAdm provided the SSA with an acceptable IJ Removal Plan (a detailed plan that identifies all actions the facility will take to immediately address the non-compliance that has resulted to IJ situation) which included the following summarized actions:</p> <ol style="list-style-type: none"> 1. Resident 1 was discharged from the facility on 1/21/2025. Resident 1 left against medical advice (AMA - a situation where a resident leaves a healthcare facility or discontinues treatment against the advice of their physician). 2. On 1/30/2025, a complete search of all six medication carts (Medication Cart 1, Medication Cart 2, Medication Cart 3, Medication Cart 4, Medication Cart 5, Medication Cart 6), all two medication rooms (Medication room [ROOM NUMBER], Medication room [ROOM NUMBER]), and the controlled medications for disposal (discarding or destroying unused medications that remain after the end of medical treatment) inside the controlled medications drawer located in the DON's office for Resident 1's hydrocodone-acetaminophen 5-325 mg was conducted and confirmed a total of ten remaining hydrocodone-acetaminophen 5-325 mg tablets with the corresponding Controlled Medication Count Sheet (a form used to account for all controlled medications, and to transfer accountability from the out-going nurse to the on-coming nurse). A total of 43 tablets of Hydrocodone Acetaminophen 5-325 mg were confirmed missing and unaccounted for. 3. The DON was suspended pending completion of investigation, effective 1/27/2025. 4. The Assistant Director of Nursing (ADON), who also had access to the DON's office where the controlled medications for disposal were stored, will be placed on suspension upon her return from her medical leave (projected on 2/4/2025). 5. On 1/29/2025, 1/30/2025, and 1/31/2025, in-services (staff trainings) were provided to licensed nurses regarding the controlled medication policy, covering the following: All licensed nurses are responsible for maintaining accurate records of controlled medication receipts, medication administrations, disposal, loss of medications or possible drug (medication) diversion. 6. Documentation of controlled medication disposal will be maintained accurately in a log, including the following endorsement information: <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a. Date of endorsement</p> <p>b. Medication information, including name, strength and quantity</p> <p>c. Releasing nurse signature</p> <p>d. Receiving party (Acting DON) signature</p> <p>e. Disposal information including the medication information, medication name, strength and quantity.</p> <p>7. Proper procedures for controlled medications when discharging a resident to a lower level of care (a healthcare setting or situation where a resident requires minimal assistance and has less complex medical needs), including residents who discharged AMA will be implemented.</p> <p>a. The discharging licensed nurse will be responsible for controlled medication(s) when discharging a resident to a lower level of care, including AMA.</p> <p>b. Obtain a physician's order specifying the controlled medications, including the name and quantity of medications to be provided to the resident or responsible party (the person who is responsible in the resident's health and well-being and may also be financially responsible for paying a resident's medical bill), if indicated.</p> <p>c. The discharging licensed nurse must document the released quantity of the controlled medication in the Controlled Medication Count Sheet with signatures from the licensed nurse and receiving party.</p> <p>d. For resident(s) who are discharging on weekends, the licensed nurse will continue to keep and account for the discharged controlled medications stored in the controlled medication drawer inside the medication cart until the Acting DON is back on duty to receive the controlled medications.</p> <p>8. On 1/29/2025, 1/30/2025, 1/31/2025, during the in-services, the licensed nurses were observed for possible signs of being under the influence of using controlled medications. No staff were identified to be under the influence of using controlled medications.</p> <p>9. On 1/30/2025, the local Police Narcotic Unit (consists of officers responsible in investigating and apprehending individuals suspected of illegal sale or use of narcotics [a medication or substance that in moderate doses dulls the senses, affects mood or behavior, relieves pain and induces sleep]) was notified and went onsite to obtain information regarding the missing controlled substances.</p> <p>10. On 1/31/2025, the Maintenance Supervisor (MS) replaced the locks to the DON's office, the storage room inside the DON's office, and the controlled medications drawer inside the storage room of the DON's office.</p> <p>11. On 1/31/2025, the universal key (a key that works with many locks that is less secure than other options) that accesses all medication carts, including controlled medications drawer, was discontinued and removed from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 1/31/2025 at 6:10 p.m., while onsite at the facility and after verifying the facility's full implementation of the IJ removal plan, the SSA accepted the IJ Removal Plan and removed the IJ situation in the presence of the RAdm, Quality Assurance Nurse 1 (QA 1), and Quality Assurance Nurse 2 (QA 2).</p> <p>Findings:</p> <p>a. During a review of Resident 1's Admission Record, the Admission Record indicated the facility originally admitted Resident 1 to the facility on [DATE] and readmitted on [DATE] with diagnoses including malignant neoplasm (a cancerous tumor [mass of abnormal cells that form in the body]) of unspecified part of the left lung, asthma (a chronic lung disease that causes inflammation and narrowing of the airways, making breathing difficult), and anxiety disorder (a mental health condition that involves excessive fear and worry that interferes with daily life).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/2/2024, indicated Resident 1 had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 1 required maximum assistance from staff with lower body dressing and moderate assistance with toileting hygiene, shower or bathing, upper body dressing and personal hygiene.</p> <p>During a review of Resident 1's Physician's Orders, dated 9/20/2024, timed at 7:22 a.m., the Physician Orders indicated an order for Norco 5-325, give one tablet by mouth every six hours as needed for severe pain (pain rated seven to ten, using the pain scale as a tool to measure and describe the intensity of pain, using numbers from zero [no pain] to ten [worst possible pain]).</p> <p>During a review of the document titled, Leaving Facility Against Medical Advice, the document indicated Resident 1 left the facility AMA on 1/21/2025 at 9:30 a.m.</p> <p>During an interview on 1/27/2025 at 12:34 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated a physician's order is required in order for the resident to be discharged with the controlled medication. LVN 1 stated that the Controlled Medication Count Sheet will be signed by two licensed nurses and would then release the remaining controlled medication doses to the resident or resident's responsible party. LVN 1 further stated that if a resident is to be discharged and the controlled medications are not to be released with the resident, the Controlled Medication Count Sheet will be signed by two licensed nurses and will then be handed off to the DON, who would also sign the Controlled Medication Count Sheet and will conduct a count of the remaining controlled medication confirming the medication, the dose, and the total amount removed from the medication cart given to the DON for disposal or destruction. LVN 1 stated that the DON had informed her that in this facility, we do not have to do that. LVN 1 stated that the DON just asks for it (referring to discontinued controlled medications or controlled medications for discharged residents). LVN 1 was asked how licensed nurses can prove the controlled medications are no longer in the medication carts if there is no signature proof it was provided to the DON, LVN 1 replied, There would be no evidence we turned in the controlled medications to the DON.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/28/2025 at 1:17 p.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated, The DON would come around asking if there are controlled medications to be removed from our medication carts. I have only worked here in this facility, but the previous DON never went around asking for our discontinued or discharged controlled medications. LVN 2 stated, If a resident is discharged , we normally give the discharged controlled medications to the DON. We (licensed nurses) don't sign anything. The DON has never asked us to sign a form that indicated we are handing off the discharged controlled medications to her. LVN 2 further stated that Controlled medications can impair the person, like being under the influence, be drowsy (sleepy) or lethargic (having little energy), affecting judgment and decision making. Controlled medications can slow or stop breathing and ultimately cause someone to pass away. It is very dangerous if handled incorrectly. That is why we have the two locked system. The DON has access to a master key. For us (licensed medication nurses), we have two separate keys to access the medication cart. One key is to open the main medication cart, the second key is to open the controlled medication drawer (part of the medication cart located on the side). The DON has access to a key that can open both medication cart and controlled medication drawer with just one key. I don't feel safe that someone has that key in the facility.</p> <p>During a phone interview on 1/28/2025 at 2:20 p.m. with Pharmacist 1 (PD 1), from the facility's contracted pharmacy, PD 1 stated that there were 30 tablets of Norco 5-325 mg delivered to the facility for Resident 1 on 9/20/2024, 26 tablets of Norco 5-325 mg delivered to the facility for Resident 1 on 10/6/2024, 30 tablets of Norco 5-325 mg delivered to the facility for Resident 1 on 10/16/2024, and, lastly, 26 tablets of Norco 5-325 mg were delivered to the facility for Resident 1 on 11/18/2024, for a total of 112 tablets of Norco 5-325 mg delivered to the facility for Resident 1's pain management needs as ordered.</p> <p>During a concurrent observation and record review on 1/28/2025 at 2:47 p.m., observed Resident 1's bubble pack (a form of tamper-evident packaging where an individual pushes individually sealed tablets through the foil in order to take the medication) for Norco 5-325 mg, located in Medication Cart 1, where Resident 1's medications were stored, and the Controlled Medication Count Sheet for Resident 1 was reviewed. The observed bubble pack for Resident 1's Norco 5-325 mg and Controlled Medication Count Sheets indicated there were only ten tablets of Norco 5-325 mg under the name of Resident 1 that were found in the medication cart.</p> <p>During an observation on 1/29/2025 at 11:10 a.m., a facility-wide search for Resident 1's missing Norco 5-325 mg tablets was initiated on all nursing medication carts (total of 6 medication carts) and nursing medication rooms (total of 2 medication rooms) at both facility's nursing stations. Resident 1's Norco 5-325 mg were not found. There were 43 doses of Norco 5-325 mg belonging to Resident 1 that are missing and unaccounted for.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 1/29/2025 at 12:09 p.m., with the DON, Resident 1's eMARs, from 9/20/2024 to 1/21/2025 were reviewed. The DON stated Resident 1 had an order on 9/20/2024 for Norco 5-325 to be given every six hours as needed for management of severe pain. The DON stated Resident 1 received a total of five doses of Norco 5-325 mg for 9/2024. The DON stated Resident 1 received a total of 54 tablets of Norco 5-325 mg during 10/2024, with the last dose administered to Resident 1 on 10/22/2024 at 12:17 p.m. The DON stated a total of 112 tablets were delivered by the pharmacy to the facility, with a total of 59 tablets recorded as administered to Resident 1 and ten tablets remaining in the medication cart. The DON stated a total of 43 tablets of Norco 5-325 remained missing. The DON stated the last disposal or destruction of controlled medications with Consulting Pharmacist 1 (CP 1) was on 1/8/2025. The DON stated Resident 1 was discharged from facility on 1/21/2025, and confirmed Resident 1's controlled medications were not inside the DON's office even with Resident 1's discharge date happening after the controlled medication destruction date of 1/8/2025. When the DON was asked if the ADM was informed of the missing controlled medications, the DON stated the ADM was not made aware and that there was no investigation started regarding the missing controlled medications.</p> <p>During a concurrent interview and record review on 1/30/2025 at 7:44 a.m., with Licensed Vocational Nurse 3 (LVN 3), Resident 1's eMARs, from 9/20/2024 to 1/21/2025 and Controlled Drug Records (Controlled Medication Count Sheet) were reviewed. LVN 3 stated, Most residents know what medications they have, such as Norco. So, I check when the controlled medication was last administered, then I prepare the controlled medication, sign the controlled medication count sheet, then administer the medication to the resident. I then document on the eMAR that it was administered. A review of Resident 1's eMARs and Controlled Drug Records indicated a total of 10 doses of Norco 5-325 mg that was dispensed by LVN 3, but not recorded as administered to Resident 1 on the eMAR. LVN 3 stated, I was failing to document the administration of the controlled medication.</p> <p>During an interview on 1/30/2025 at 7:52 a.m., with RN 1, RN 1 stated, I think there is a lack of training in the facility. The LVNs (licensed vocational nurses in general) think that by signing the Controlled Medication Count Sheet, it is equal to administering the controlled medication itself. They (LVNs) don't realize that the count sheet only counts the remaining controlled medications, but they (LVNs) would still need to sign the eMAR to prove the controlled substance was administered to the resident.</p> <p>b. During a review of Resident 2's Admission Record, the Admission Record indicated the facility originally admitted Resident 2 to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertensive urgency (a medical condition in which a person's blood pressure is very high), osteoarthritis of hip (a degenerative disease that causes cartilage in the hip joint to wear away, causing pain and stiffness), and depression (a mental health condition that involves persistent feelings of sadness, hopelessness, and loss of interest in activities).</p> <p>During a review of Resident 2's Physician's Order, dated 2/8/2022, timed at 9:12 p.m., the Physician's Order indicated an order for Oxycodone-Acetaminophen 5-325 mg, give one tablet by mouth twice a day as needed for moderate to severe pain.</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had moderate cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/29/2025 at 3:20 p.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated that on 1/2/2025, while counting the controlled medications with Licensed Vocational Nurse 5 (LVN 5), the controlled medications (Oxycodone-Acetaminophen 5-325 mg) of Resident 2 were missing. LVN 4 stated she (LVN 4) was informed by LVN 5 that in the morning (7 a.m. to 3 p.m.) shift, the DON had asked for the keys to the medication cart from LVN 5. LVN 4 stated in the afternoon of that same day (1/2/2025) that she (LVN 4) was in a meeting when the DON had called her (LVN 4) to step out and was handed Resident 2's missing Oxycodone-Acetaminophen 5-325 mg. LVN 4 stated that Resident 2's bubble packet for Oxycodone-Acetaminophen 5-325 mg only contained 16 tablets when LVN 4 recalled there were over 20 tablets of Resident 2's Oxycodone-Acetaminophen 5-325 mg just the day before (1/1/2025). LVN 4 stated she (LVN 4) witnessed the DON returned the Controlled Medication Count Sheet and noticed it was in handwritten form with the DON's handwriting. LVN 4 stated she took pictures of the incident. LVN 4 stated, No, there is no form that she (DON) has us sign when we give her the discharged residents' controlled medications, so there is no proof that the staff (LVNs) even gave the controlled medications to the DON. LVN 4 stated she (LVN 4) called the facility's pharmacy on 1/2/2025 at around 3:30 p.m. and confirmed the DON ordered more Oxycodone-Acetaminophen 5-325 mg for Resident 2. LVN 4 stated having days off in between, then she (LVN 4) returned to work on 1/5/2025, only to notice Resident 2's delivered Oxycodone-Acetaminophen 5-325 mg controlled medications were now missing (total amount of missing tablets unknown).</p> <p>During an interview on 1/30/2025 at 11:24 a.m., with LVN 5, LVN 5 stated on 1/2/2025 in the morning shift (7 a.m. to 3 p.m.), the DON had borrowed the keys to the Medication Cart 5 (containing Resident 2's medications). LVN 5 stated during the change of shift with the 3 p.m. to 11 p.m. shift nurse (LVN 4), LVN 5 was asked by LVN 4 on where Resident 2's Oxycodone-Acetaminophen 5-325 mg medications were. LVN 5 stated feeling panicked, but that was when another LVN (Licensed Vocational Nurse 6 [LVN 6]) working in the same unit stated witnessing the DON borrow the keys from LVN 5 in the morning shift on 1/2/2025 and removing a Controlled Medication Count Sheet and controlled medication bubble packet from LVN 5's assigned medication cart. LVN 5 stated the DON had taken controlled medications in the past from LVN 5's assigned medication cart. LVN 5 stated the facility has a universal key that can open the main medication cart and controlled medications drawer with just one key. LVN 5 stated that was why LVN 4 was skeptical, because the DON was ordering Oxycodone-Acetaminophen 5-325 mg when Resident 2 does not always need to take the controlled medication (Oxycodone-Acetaminophen 5-325 mg). LVN 5 stated LVN 4 found out when she (LVN 4) called the pharmacy, and confirmed that the DON ordered Resident 2's Oxycodone-Acetaminophen 5-325 mg to be refilled on 1/2/2025 at 3:30 p.m.</p> <p>During an interview on 1/30/2025 at 12:04 p.m., with LVN 6, LVN 6 stated seeing the DON grabbed medications from LVN 5's medication cart during the morning shift on 1/2/2025. LVN 6 stated hearing LVN 4 and LVN 5 discussing missing controlled medications during their controlled medication counts, that was when LVN 6 told LVN 4 and LVN 5 that she (LVN 6) saw the DON took the medications (narcotic controlled medications) and Controlled Medication Count Sheet from Medication Cart 5. LVN 6 stated LVN 4 was able to get the controlled medications from the DON during her (LVN 4) shift (3 p.m. to 11 p.m.).</p> <p>During an interview on 1/30/2025 at 12:35 p.m. with the RAdm, the RAdm stated being aware of the missing controlled medications a week prior to the SSA's investigation. RAdm stated, We were missing the controlled medications. It was identified that we had issues. The system we have works, but we were not following the procedures such as tracking the controlled medications once received or safeguarding the controlled medications when the residents are discharged . This was a system-wide failure.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation on 1/30/2025 at 1:45 p.m. to 1:49 p.m., with Registered Nurse 2 (RN 2), RN 2 was able to access all facility medication carts (Medication Cart 1, Medication Cart 2, Medication Cart 3, Medication Cart 4, Medication Cart 5, Medication Cart 6), and the controlled medication drawers using just one universal key. The universal key was used on the following times:</p> <ul style="list-style-type: none"> - 1/30/2025 at 1:45 p.m., opened nursing station 1 medication cart 1 and narcotic drawer. - 1/30/2025 at 1:46 p.m., opened nursing station 1 medication cart 2 and narcotic drawer. - 1/30/2025 at 1:47 p.m., opened nursing station 1 medication cart 3 and narcotic drawer. - 1/30/2025 at 1:48 p.m., opened nursing station 2 medication cart 4 and narcotic drawer. - 1/30/2025 at 1:48 p.m., opened nursing station 2 medication cart 5 and narcotic drawer. - 1/30/2025 at 1:49 p.m., opened nursing station 2 medication cart 6 and narcotic drawer. <p>During an interview on 1/30/2025 at 3:03 p.m. with the facility's CP 1, CP 1 stated the difference from controlled medications depends on the category, how potent the medication is, how it affects a person, and dependence to the medication. Class II controlled substances (are drugs or medications with high potential for abuse, with use potentially leading to severe psychological [a mental reliance on a substance to feel good, cope with problems, or avoid feeling bad] or physical dependence [when the body adjusts to a substance and needs it to prevent withdrawal symptoms]) are highly abused and we need to have it controlled. The lower the class number, such as Class II, would be stricter than a Class V (drugs with lower potential for abuse and consist of preparations containing limited quantities of certain narcotics). CP 1 stated that drug diversion would consist of doing something with the controlled substance medication outside of what the medication was ordered for, such as not administering to the correct resident, not being stored properly, or not being destroyed properly. CP 1 confirmed Norco would be a Class II controlled medication. CP 1 stated the medication carts should have two keys, one to open the main medication cart, and the second (separate) key is for the double lock for the controlled medication drawer. CP 1 stated not knowing the facility has a universal key that can open all medication carts and all controlled medication drawers with just one key. CP 1 stated, This key means it is not double locked. This goes against management of controlled medications. CP 1 stated the use of the controlled medication Norco can lead to decreased breathing rate, lead to high risk for overdose or the dose of the medication is too high for a resident, it could lead to fainting (to pass out due to low blood flow to the brain), have difficulty breathing, possible need for hospitalization, and the possibility of death.</p> <p>During a review of the current facility-provided policy and procedure (P&P) titled, Controlled Substances, with last revised date of 3/2023, the P&P indicated, The facility complies with all laws, regulations, and other requirements related to administration, handling, storage, disposal, and documentation of controlled substances. The policy indicated controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. The policy indicated, Upon Admission:</p> <p>a. The nurse administering the medication is responsible for recording:</p> <p>(1) Name of the resident receiving the medication,</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER Burbank Healthcare & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1041 S. Main St. Burbank, CA 91506	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>(9) name, strength and dose of the medication,</p> <p>(10) time of administration,</p> <p>(11) method of administration,</p> <p>(12) quantity of medication remaining; and</p> <p>(13) signature of nurse administering medication.</p> <p>During a review of the current facility-provided P&P titled, Controlled Medication Storage, dated 8/2014, the P&P indicated, Medications included in the Drug Enforcement Administration (DEA - is a United States federal law enforcement agency under the U.S. Department of Justice tasked with combating illicit drug trafficking and distribution within the U.S.) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state, and other applicable laws and regulations. The policy stated, Schedule II-V (Class 2 to 5) medications and other medications subject to abuse are stored in separate area under double lock. The policy indicated:</p> <p>1) If a major discrepancy or pattern of discrepancies occurs or if there is apparent criminal activity, the director of nursing notifies the administrator and consultant pharmacist immediately.</p> <p>2) The administrator, the consultant pharmacist, and/or the director of nursing determine whether other action(s) are needed, e.g. (abbreviation for the Latin phrase <i>exempli gratia</i> which means for example), notification of police or other enforcement personnel.</p> <p>During a review of the current facility-provided P&P titled, Controlled Medication Disposal, with last revised date of 1/2025, the P&P indicated, The facility will document the disposal of controlled substances in a log that includes the following details:</p> <p>- Endorsement information:</p> <p>Date of endorsement</p> <p>Medication information, including name, strength and quantity</p> <p>Releasing nurse signature</p> <p>Receiving party (DON or designated RN) signature</p> <p>During a review of the current facility-provided P&P titled, Drug Diversion, with last revision date of 1/2025, the P&P indicated, Drug diversion refers to illegal or unauthorized use, distribution, or theft of prescription medications intended for patients under the care of the facility. This policy is designed to prevent and address possible drug diversion and ensure patient safety and regulatory compliance. All Facility staff who have access to controlled substances are required to comply with the state and federal laws regarding handling, and security, as well as the facility policies. The policy indicated the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>B. Recordkeeping</p> <p>1) All records of controlled substances, including receipts, administration, waste, disposal, loss, or possible diversion must be accurate and maintained.</p> <p>D. Investigation and Reporting</p> <p>1) Any suspected drug diversion must be reported to the facilities designated authority immediately. The incident must be investigated immediately and thoroughly.</p>