STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056129	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burbank Healthcare & Rehab	1041 S. Main St. Burbank, CA 91506

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46445 Based on interview and record review, the facility failed to ensure a comprehensive, person-centered care plan with measurable objectives and interventions for one of seven sampled residents (Resident 3) was created and implemented that addressed Resident 3's indwelling urinary catheter (a flexible plastic tube inserted into the bladder that helps provide continuous urinary drainage). This deficient practice had placed Resident 3 at risk for not receiving the necessary services and assistance that can result in resident injury or serious condition. Findings: During a record review of Resident 3's Admission Record, the Admission Record indicated the facility admitted the resident on 7/14/2020 with diagnoses including acute kidney failure (condition in which the kidneys suddenly cannot filter waste from the blood), benign prostatic hyperplasia (BPH - a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream), and obstructive and reflux uropathy (a condition in which the flow of urine was blocked and the urine flow backward to the kidney). During a record review of Resident 3's Care Plan on obstructive uropathy, last revised on 1/2/2025, the Care Plan indicated the resident had alteration in urinary elimination and was at risk for urinary tract infection (UTI - an infection in any part of the urinary system [kidneys, bladder, or urethra])secondary to use of indwelling urinary catheter. The Care Plan Interventions indicated to monitor the indwelling urinary catheter, monitor urine for sediment, cloudiness, odor, blood, and amount of output, and to report urine output findings promptly to the Attending Physician (MD). During a record review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 3/18/2025, the MDS indicated Resident 3's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were moderately impaired. The MDS indicated Resident 3 required moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) on toileting hygiene. The MDS indicated Resident 3 had an indwelling urinary catheter. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/10/2025 at 11:11 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she observed Resident 3's urinary catheter tubing and drainage bag had dark yellow, blood tinged, and cloudy urine. LVN 2 stated she observed Resident 3's urinary catheter tubing was not anchored to the resident's leg strap located on the resident's right leg. During an interview on 4/10/2025 at 11:25 a.m. with LVN 3, LVN 3 stated on 4/10/2025 at 9:40 a.m., LVN 3 provided Resident 3 with urinary catheter care (keeping the area around the catheter clean and ensure proper drainage to prevent infection and complications) and changed the soiled urinary catheter bag. LVN 3 stated the output on Resident 3's urinary catheter was dark yellow with hematuria. LVN 3 stated she did not report Resident 3's output appearance to the MD. LVN 3 stated Resident 3 was at risk for UTI. During an interview on 4/10/2025 at 2:58 p.m. and concurrent record review of Resident 3's medical records, reviewed with the Director of Nursing (DON), the DON stated sediments and hematuria in the urinary catheter output indicated potential infection. The DON stated resident Care Plans should indicate the care provided for the resident. The DON stated Care Plans should be accurate and resident centered. Resident 3's Treatment Administration Records (TAR), dated 3/1/2025 to 3/31/2025 and 4/1/2025 to 4/30/2025 were reviewed. The DON stated Resident 3's urinary catheter care orders were not reordered after the resident came back from General Acute Care Hospital (GACH) on 3/10/2025. Resident 3's medical records did not indicate documented evidence of urinary catheter care were provided. The DON stated Resident 3's urinary catheter was not monitored for visible hematuria and was not reported to the MD. The DON stated Care Plans that were not followed may result to the Resident 3's undetected change of condition and the resident had the potential to not receive the care based on the identified resident needs. The DON stated the facility failed to implement Resident 3's Care Plan that addressed the resident's urinary catheter. During a record review of the facility's policy and procedure (PnP) titled, Comprehensive Person-Centered Care Plans, last reviewed on 3/21/2025, the PnP indicated a comprehensive, person-centered care plan that includes measurable objectives to meet the resident's physical, psychological, and functional needs were developed and implemented for each resident. The PnP indicated the care plan interventions were chosen after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. The PnP indicated assessment of residents were ongoing and care plans were revised as information about the residents and the residents' condition change. During a record review of the facility's PnP titled, Charting and Documentation, last reviewed on 3/21/2025, the PnP indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The PnP indicated the medical record should facilitate communication between the interdisciplinary team (IDT, a team of healthcare professionals from different professional disciplines who work together to manage the physical, psychological and spiritual needs of the patient) regarding the resident's condition and response to care. The PnP indicated documentation in the medical record will be objective, complete, and accurate.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 46445 Based on observation, interview, and record review, the facility failed to follow professional standards of practice for one of three sampled residents (Resident 3) by failing to: 1. Ensure Resident 3 had physician orders for the resident's indwelling urinary catheter (a flexible plastic tube inserted into the bladder that helps provide continuous urinary drainage) care and monitoring. 2. Ensure Resident 3's indwelling urinary catheter was monitored for signs and symptoms of urinary tract infection (UTI - an infection in any part of the urinary system [kidneys, bladder, or urethra]). 3. Ensure Licensed Vocational Nurse (LVN) 2 and LVN 3 did not perform indwelling urinary catheter treatments on Resident 3 without a physician orders. 4. Ensure Resident 3's Care Plan on obstructive uropathy (a condition in which the flow of urine was blocked and the urine flow backward to the kidney) was implemented. 5. Ensure Resident 3's change of condition (COC) was reported timely to the resident's Attending Physician (MD). These deficient practices had the potential to place Resident 3 at risk for undetected UTI which could negatively impact the resident's health and safety. Findings: During a record review of Resident 3's Admission Record, the Admission Record indicated the facility admitted the resident on 7/14/2020 with diagnoses including acute kidney failure (condition in which the kidneys suddenly cannot filter waste from the blood), benign prostatic hyperplasia (BPH - a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream), and obstructive and reflux uropathy (a condition in which the flow of urine was blocked and the urine flow backward to the kidney). During a record review of Resident 3's Care Plan on obstructive uropathy, last revised on 1/2/2025, the Care Plan indicated the resident had alteration in urinary elimination and was at risk for urinary tract infection (UTI - an infection in any part of the urinary system [kidneys, bladder, or urethra])secondary to use of indwelling urinary catheter. The Care Plan Interventions indicated to monitor the indwelling urinary catheter, monitor urine for sediment, cloudiness, odor, blood, and amount of output, to provide urinary catheter care every shift as ordered, and to report urine output findings promptly to the Attending Physician (MD). (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 3/18/2025, the MDS indicated Resident 3's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were moderately impaired. The MDS indicated Resident 3 required moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) on toileting hygiene. The MDS indicated Resident 3 had an indwelling urinary catheter. During a record review of Resident 3's Progress Notes, dated 3/27/2025, the Progress Notes indicated Physician Assistant (PA) 1 documented to monitor for hematuria for Resident 3's obstructive uropathy. During a record review of Resident 3's Licensed Nurses Note, dated 4/8/2025, the Licensed Nurses Note indicated the resident was incontinent on bladder elimination (the process of emptying the bladder of urine). The Licensed Nurses Note indicate there were no signs and symptoms of UTI. During a concurrent observation and interview on 4/10/2025 at 10:40 a.m. with Physical Therapy Assistant (PTA) 1, PTA 1 stated the output on the urinary catheter tubing was dark yellow to dark red in color. During a concurrent observation and interview on 4/10/2025 at 11:11 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she observed Resident 3's urinary catheter tubing and drainage bag had dark yellow, blood tinged, and cloudy urine. LVN 2 stated she did not report Resident 3's urinary catheter output findings to MD 1 because the observed urinary catheter output appearance was the resident's baseline. LVN 2 stated on 4/10/2025 at 9 a.m., LVN 2 performed a urinary catheter irrigation (a procedure to flush and clean a urinary catheter Resident 3's urinary catheter tubing (undetermined amount). During an interview on 4/10/2025 at 11:25 a.m. with LVN 3, LVN 3 stated on 4/10/2025 at 9:40 a.m., LVN 3 provided Resident 3 with urinary catheter care (keeping the area around the catheter clean and ensure proper drainage to prevent infection and complications) and changed the soiled urinary catheter bag. LVN 3 stated the output on Resident 3's urinary catheter was dark yellow with hematuria. LVN 3 stated she did not report Resident 3's output appearance to MD 1 because she was informed at shift report (a summary of completed tasks, activities, and what was needed to be done for the next work shift) that this was Resident 3's usual urine output appearance. LVN 3 stated Resident 3 was at risk for UTI. During a record review of Resident 3's COC Interact Assessment Form, dated 4/10/2025, the COC Interact Assessment Form indicated that on 4/10/2025 at 12 p.m., Resident 3 was observed with hematuria. The COC Interact Assessment Form indicated MD 1 was notified on 4/10/2025 at 9 a.m., three hours before Resident 3's observed COC. The Nursing Notes section indicated there were no physician orders for Resident 3's reported COC. The Nursing Notes section indicated Resident 3's urine was collected and dated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 3's Progress Notes, dated 4/10/2025, the Progress Notes indicated that on 4/10/2025 at 1:05 p.m., LVN 3 documented PA 1 responded to the telephone message left at 12 p.m. regarding Resident 3's urinary catheter output appearance. The Progress Notes indicated Resident 3's urine was dark yellow and had hematuria. The Progress Notes indicated PA 1 gave urinary catheter orders that included placement of a urinary catheter anchor, scheduled urinary drainage bag change, and to monitor Resident 3 for signs and symptoms of UTI. During an interview on 4/10/2025 at 2:58 p.m. and concurrent record review of Resident 3's medical records, reviewed with the Director of Nursing (DON), the DON stated sediments and hematuria in the urinary catheter output indicated potential infection. Resident 3's Physician Orders, dated 4/2025, were reviewed and the DON stated there were no urinary catheter care orders for Resident 3 before 4/10/2025 at 12:59 p. m. Resident 3's Treatment Administration Records (TAR), dated 3/1/2025 to 3/31/2025 and 4/1/2025 to 4/30/2025 were reviewed. The DON stated Resident 3's urinary catheter care orders were not reordered after the resident came back from General Acute Care Hospital (GACH) on 3/10/2025. Resident 3's medical records did not indicate documented evidence of urinary catheter care were provided. The DON stated Resident 3's urinary catheter was not monitored. The DON stated Resident 3's visible hematuria on the urinary catheter was not reported to the MD and may result to the resident's undetected change of condition. The DON stated the facility failed to assess and monitor Resident 3's urinary catheter. During a record review of Resident 3's Laboratory Results Report, dated 4/11/2025, the urinalysis (urine test), indicated the resident's urine specimen was collected on 4/10/2025 at 4:50 p.m. Resident 3's urinalysis result indicated a white blood count (measures the number of white blood cells [WBCs - a part of the immune system that protects the body from infection] in the blood) of greater than 182 high power field (HPF - unit of measurement with reference range or normal range of a medical test result was less than or equal to three). Resident 3's urinalysis indicated three plus (3+) HPF bacteria (reference range or normal range of a medical test result was none). During a record review of the facility's policy and procedure (PnP) titled, Urinary Catheter Care, last reviewed on 3/21/2025, the PnP indicated the purpose was to prevent urinary catheter- associated complications, including UTI. The PnP indicated to observe the resident for complications associated with urinary catheters and to report unusual findings to the physician . if urine had an unusual appearance such as color or blood. The PnP indicated urinary catheter irrigation may be ordered to prevent obstruction. The Documentation section of the PnP indicated the date and time the catheter care was given and the character of urine such as color, clarity, and odor should be recorded in the resident's medical records. During a record review of the facility's PnP titled, Change in a Resident's Condition or Status, last reviewed on 3/21/2025, the PnP indicated the facility promptly notifies the resident, his attending physician, and the resident representative of changes in the resident's medical and mental condition and status. The PnP indicated prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider. During a record review of the facility's PnP titled, Medication Orders, last reviewed on 3/21/2025, the PnP indicated the purpose to establish uniform guidelines in the receiving and recording of medication orders. The PnP indicated recording treatment orders required the specific treatment, frequency and duration of the treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's PnP titled, Charting and Documentation, last reviewed on 3/21/2025, the PnP indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The PnP indicated the medical record should facilitate communication between the interdisciplinary team (IDT, a team of healthcare professionals from different professional disciplines who work together to manage the physical, psychological and spiritual needs of the patient) regarding the resident's condition and response to care. The PnP indicated documentation in the medical record will be objective, complete, and accurate.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46445 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 3) received care consistent with professional standards of practice to prevent pressure ulcers (PU, a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) by failing to ensure Resident 3's low air-loss mattress (LALM - a mattress composed of inflatable air cushions that is used to relieve pressure on body parts) was set to appropriate setting per manufacturer's guidelines. This deficient practice had placed Resident 3 at risk for the development of pressure ulcers. Findings: During a record review of Resident 3's Admission Record, the Admission Record indicated the facility admitted the resident on 7/14/2020 with diagnoses including acute kidney failure (condition in which the kidneys suddenly cannot filter waste from the blood), benign prostatic hyperplasia (BPH - a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream), and anemia (condition in which the body does not get enough oxygen-rich blood). During a record review of Resident 3's Care Plan on low air loss mattress (LALM - an air mattress used for wound care), last revised on 1/27/2025, the Care Plan interventions indicated to ensure LALM were inflated as recommended. During a record review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 3/18/2025, the MDS indicated Resident 3's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were moderately impaired. The MDS indicated Resident 3 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) on rolling to the left or the right side. During a record review of Resident 3's Braden Scale for Predicting Pressure Sore Risk, dated 3/18/2025, the Braden Scale for Predicting Pressure Sore Risk indicated the resident had a score of 11. A score of 10 to 12 indicated high risk for the development or worsening of pressure ulcers. During a record review of Resident 3's Physician Order, dated 3/21/2025, the Physician Order indicated LALM for wound care and management. During a record review of Resident 3's Weight Summary, dated 4/7/2025, the Weight Summary indicated the resident's documented weight was 116 pounds (lbs, unit of measurement). During on observation on 4/10/2025 at 10:40 a.m., observed Resident 3's LALM was set at 200 lbs. The white tape attached to the LALM machine indicated a setting at 120 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/10/2025 at 11:11 a.m. with Licensed Vocational Nurse (LVN) 2, observed Resident 3's LALM was set at 200 lbs. LVN 2 stated the white tape attached to the LALM machine indicated a setting at 120 lbs. LVN 2 stated Resident 3's LALM was on a wrong setting. LVN 2 stated Resident 3 had the potential to develop PU. LVN 2 changed Resident 3's LALM setting to 120 lbs. During an interview on 4/10/2025 at 11:25 a.m. and a concurrent record review of Resident 3's weight, reviewed with LVN 3, LVN 3 stated the resident's weight was 116 lbs. LVN 3 stated Resident 3's LALM setting should be based on the resident's weight. During an interview on 4/10/2025 at 2:58 p.m. with the Director of Nursing (DON), the DON stated LALM were used for skin management on residents that were high risk for PU development. The DON stated Resident 3's LALM setting should be based on the resident's weight. The DON stated Resident 3's LALM was not on the correct setting. The DON stated inaccurate LALM setting placed Resident 3 at risk on developing PU and had the potential for the resident's condition to decline. The DON stated the facility failed to ensure Resident 3's LALM was on the correct setting based on the resident's most recent documented weight. During a record review of the facility's policy and procedure (PnP) titled, Pressure-Reducing Mattresses, last reviewed on 3/21/2025, the PnP indicated an objective to provide mattresses that will prevent and / or minimize pressure on the skin. During a record review of the undated facility-provided LALM Operation Manual, the Operation Manual indicated to adjust air mattress to a desired firmness according to patient's weight or the suggestion from a health care professional.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46445 Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 3 and Resident 5) with indwelling urinary catheter (a flexible plastic tube inserted into the bladder that helps provide continuous urinary drainage) received proper care and services by failing to: 1. Ensure Resident 3's urine output was monitored for presence of hematuria (blood in the urine). 2. Ensure Resident 3's indwelling urinary catheter tubing was anchored (secured) to the resident's thigh. These deficient practices resulted to Resident 3's urinary catheter tubing and drainage bag with dark yellow to dark red, cloudy urine with visible sediments and hematuria during an observation on 4/10/2025 at 10:40 a.m. On 4/11/2025 at 1:17 a.m., Resident 3's Laboratory Results Report, dated 4/11/2025, the resident's urinalysis (urine test) indicated a white blood count (measures the number of white blood cells [WBCs - a part of the immune system that protects the body from infection] in the blood) of greater than 182 high power field (HPF - unit of measurement with reference range or normal range of a medical test result was less than or equal to three). Resident 3's urinalysis indicated three plus (3+) HPF bacteria (reference range or normal range of a medical test result was none). 1. Ensure Resident 5's urine output was monitored for presence of sediments. 2. Ensure Resident 5's urinary catheter stoma (a surgically created opening on the abdomen that allows waste to be diverted from the body to the outside) had a wound dressing (a material placed directly on a wound to protect it and help it heal). These deficient practices resulted to Resident 5's urinary catheter tubing and drainage bag with yellow, cloudy urine with visible sediments during an observation on 4/10/2025 at 11:44 a.m. On 4/11/2025 at 4:15 a.m., Resident 5's Laboratory Results Report, dated 4/11/2025, of the resident's urinalysis indicated a white blood count of 59 HPF, budding yeast (the presence of fungal cells in the urine and may be a sign of fungal infection) of two plus (2+) HPF (reference range or normal range of a medical test result was negative). Findings: a. During a record review of Resident 3's Admission Record, the Admission Record indicated the facility admitted the resident on 7/14/2020 with diagnoses including acute kidney failure (condition in which the kidneys suddenly cannot filter waste from the blood), benign prostatic hyperplasia (BPH - a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream), and obstructive and reflux uropathy (a condition in which the flow of urine was blocked and the urine flow backward to the kidney). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 3's Care Plan on obstructive uropathy, last revised on 1/2/2025, the Care Plan indicated the resident had alteration in urinary elimination and was at risk for urinary tract infection (UTI - an infection in any part of the urinary system [kidneys, bladder, or urethra])secondary to use of indwelling urinary catheter. The Care Plan Interventions indicated to monitor the indwelling urinary catheter, monitor urine for sediment, cloudiness, odor, blood, and amount of output, and to report urine output findings promptly to the Attending Physician (MD). During a record review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 3/18/2025, the MDS indicated Resident 3's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were moderately impaired. The MDS indicated Resident 3 required moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) on toileting hygiene. The MDS indicated Resident 3 had an indwelling urinary catheter. During a record review of Resident 3's Progress Notes, dated 3/27/2025, the Progress Notes indicated Physician Assistant (PA) 1 documented to monitor for hematuria for Resident 3's obstructive uropathy. During a record review of Resident 3's Licensed Nurses Note, dated 4/8/2025, the Licensed Nurses Note indicated the resident was incontinent on bladder elimination (the process of emptying the bladder of urine). The Licensed Nurses Note indicate there were no signs and symptoms of UTI. During a concurrent observation and interview on 4/10/2025 at 10:40 a.m. with Physical Therapy Assistant (PTA) 1, PTA 1 stated he observed Resident 3's indwelling urinary catheter tubing was not attached to the resident's right leg strap. PTA 1 stated the output on the urinary catheter tubing was dark yellow to dark red in color. During a concurrent observation and interview on 4/10/2025 at 11:11 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she observed Resident 3's urinary catheter tubing and drainage bag had dark yellow, blood tinged, and cloudy urine. LVN 2 stated she observed Resident 3's urinary catheter tubing was not anchored to the resident's leg strap located on the resident's right leg. LVN 2 stated on 4/10/2025 at 9 a.m., LVN 2 irrigated Resident 3's urinary catheter tubing (undetermined amount). LVN 2 stated Resident 3's urinary catheter tubing should be anchored to the leg strap to prevent the urinary catheter from being pulled. LVN 2 stated Resident 3's unanchored urinary catheter had the potential to cause urinary tract trauma, hematuria, irritation, and infection. During an interview on 4/10/2025 at 11:25 a.m. with LVN 3, LVN 3 stated on 4/10/2025 at 9:40 a.m., LVN 3 provided Resident 3 with urinary catheter care (keeping the area around the catheter clean and ensure proper drainage to prevent infection and complications) and changed the soiled urinary catheter bag. LVN 3 stated the output on Resident 3's urinary catheter was dark yellow with hematuria. LVN 3 stated she did not report Resident 3's output appearance to the MD. LVN 3 stated Resident 3 was at risk for UTI. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056129	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burbank Healthcare & Rehab	1041 S. Main St. Burbank, CA 91506

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/10/2025 at 2:58 p.m. and concurrent record review of Resident 3's medical records, reviewed with the Director of Nursing (DON), the DON stated Resident 3's urinary catheter should be anchored with the leg strap to prevent dislodgement. The DON stated sediments and hematuria in the urinary catheter output indicated potential infection. Resident 3's Physician Orders, dated 4/2025, were reviewed and the DON stated there were no urinary catheter care orders for Resident 3 before 4/10/2025 at 12:59 p.m. Resident 3's Treatment Administration Records (TAR), dated 3/1/2025 to 3/31/2025 and 4/1/2025 to 4/30/2025 were reviewed. The DON stated Resident 3's urinary catheter care orders were not reordered after the resident came back from General Acute Care Hospital (GACH) on 3/10/2025. Resident 3's medical records did not indicate documented evidence of urinary catheter care were provided. The DON stated Resident 3's urinary catheter was not monitored. The DON stated Resident 3's visible hematuria on the urinary catheter was not reported to the MD and may result to the resident's undetected change of condition. The DON stated the facility failed to ensure Resident 3's urinary catheter was anchored to the leg strap. The DON stated the facility failed to assess and monitor Resident 3's urinary catheter. During a record review of the facility's policy and procedure (PnP) titled, Urinary Catheter Care, last reviewed on 3/21/2025, the PnP indicated the purpose was to prevent urinary catheter- associated complications, including UTI. The PnP indicated to ensure that the catheter remains secured with a securement device to reduce friction and movement at the insertion site. The PnP indicated to observe the resident for complications associated with urinary catheters and to report unusual findings to the physician . if urine had an unusual appearance such as color or blood. The PnP indicated urinary catheter irrigation may be ordered to prevent obstruction. The Documentation section of the PnP indicated the date and time the catheter care was given and the character of urine such as color, clarity, and odor should be recorded in the resident's medical records. b. During a record review of Resident 5's Admission Record, the Admission Record indicated the facility admitted the resident on 5/17/2024 and readmitted on [DATE] with diagnoses including acute kidney failure, obstructive and reflux uropathy, and benign prostatic hyperplasia. During a record review of Resident 5's Care Plan on obstructive uropathy, last revised on 11/23/2024, the Care Plan indicated the resident had alteration in urinary elimination and was at risk for UTI secondary to use of suprapubic catheter (a flexible tube inserted directly into the bladder through a small incision in the lower abdomen to drain urine). The Care Plan Interventions indicated to monitor the indwelling urinary catheter, monitor urine for sediment, cloudiness, odor, blood, and amount of output, and to report urine output findings promptly to the MD. The Care Plan Intervention indicated to provide daily treatment to site as ordered, cleanse with normal saline (a mixture of water and salt), pat dry, and apply dry dressing. During a record review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognitive skills for daily decision making were intact. The MDS indicated Resident 5 required moderate assistance on toileting hygiene. The MDS indicated Resident 5 had an indwelling urinary catheter. During a record review of Resident 5's Physician Orders, dated 4/5/2025, the Physician Orders indicated to secure urinary catheter tubing with anchor every day shift to minimize dislodging of catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 5's Treatment Administration Record (TAR), dated 4/1/2025 to 4/30/2025, the TAR indicated to monitor the urinary drainage bag and document presence of signs and symptoms of UTI such as color consistency, odor, hematuria, bladder distention, and burning sensation. The TAR indicated that on 4/5/2025 to 4/9/2025, Resident 5 did not have signs and symptoms of infection. During a concurrent observation and interview on 4/10/2025 at 11:44 a.m. with LVN 3, observed Resident 5 awake and lying on the bed. Resident 5's suprapubic catheter did not have a wound dressing (a bandage or pad placed directly on a wound to help heal and protect it from infection) and was not anchored to Resident 5. LVN 3 stated Resident 5's urinary catheter tubing and drainage bag had yellow and cloudy urine with sediments. LVN 3 stated sediments in the urinary catheter tubing and drainage bag indicated a potential infection. LVN 3 stated sediments in the urine is a COC and should be reported to the MD. During an interview on 4/10/2025 at 2:58 p.m. with the DON, the DON stated sediments and hematuria in the urinary catheter output indicated potential infection. The DON stated Resident 5's visible sediments on the suprapubic catheter tubing was not reported to the MD and may result to the resident's undetected change of condition. The DON stated the facility failed to ensure residents' urinary catheter was anchored. During a record review of the facility's PnP titled, Urinary Catheter Care, last reviewed on 3/21/2025, the PnP indicated the purpose was to prevent urinary catheter- associated complications, including UTI. The PnP indicated to ensure that the catheter remains secured with a securement device to reduce friction and movement at the insertion site. The PnP indicated to observe the resident for complications associated with urinary catheters and to report unusual findings to the physician . if urine had an unusual appearance such as color or blood.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46445 Based on interview and record review, the facility failed to ensure the medical records of one of seven sampled residents (Resident 1) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to ensure Certified Nursing Assistant (CNA) 2 documented Resident 3's percentage of food eaten on the correct time. This deficient practice resulted in inaccurate information on Resident 1's medical records and had the potential for delayed and inaccurate medical interventions. Findings: During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted the resident on 3/24/2025 with diagnoses including unspecified displaced fracture (a piece of broken bone that shifted out of alignment with each other) of the second cervical vertebra (the bone on the neck that allows a person to rotate the head from side to side), epilepsy (a condition that affects the brain and causes frequent seizures [sudden uncontrolled body movements and changes in behavior that occurs because of abnormal electrical activity]), and anemia (condition in which the body does not get enough oxygen -rich blood) in chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/31/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were intact. The MDS indicated Resident 1 required moderate assistance (helper lifts, hold, or supports trunk or limbs, but provides less than half the effort) on eating, oral hygiene, and toileting hygiene. During a record review of Resident 1's change of condition (COC) Interact Assessment Form, dated 4/3/2025, the COC Interact Assessment Form indicated on 4/3/2025 at 11:05 a.m., Resident 1 had a COC and was transferred to General Acute Care Hospital (GACH). During an interview on 4/10/2025 at 12:15 p.m. and concurrent record review of Resident 1's Intervention and Task, dated 3/2025, reviewed with CNA 2, the Nutritional Task section indicated the meal (breakfast, lunch, and dinner) intake amount the resident had eaten in percentage. Resident 1's Nutritional Task indicated the following: a. On 3/26/2025, CNA 2 documented Resident 1's breakfast and lunch meal intakes were 50%, both documented at 1:24 p.m. b. On 3/27/2025, CNA 2 documented Resident 1's breakfast and lunch meal intakes were 50%, both documented at 2:28 p.m. c. On 3/29/2025, CNA 2 documented Resident 1's breakfast meal intake was 50% at 1:55 p.m. and lunch meal intake was 50% at 1:56 p.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. On 4/3/2025, CNA 2 documented Resident 1's breakfast meal intake was 100% at 1:18 p.m. CNA 2 stated the documented time of Resident 1's percentage of breakfast and lunch meal intake was inaccurate. CNA 2 stated Resident 1's meal intake should be documented after the meal had been consumed. During an interview on 4/10/2025 at 2:29 p.m. and concurrent record review of Resident 1's Nutritional Task, dated 3/2025, reviewed with the Director of Staff Development (DSD), the DSD stated Resident 1's documented Nutritional Task on 3/26/2025, 3/27/2025, 3/29/2025, and 4/3/2025 were inaccurate. The DSD stated Resident 1's documented percentage of meal intake should be indicated for each respective meal. The DSD stated inaccurate documentation of Resident 1's Nutritional Task had the potential for delay in the resident's care. During an interview on 4/10/2025 at 2:58 p.m. with the Director of Nursing (DON), the DON stated CNAs should document the residents' amount of meal intake after the resident consumed the meal (breakfast, lunch, or dinner). The DON stated inaccurate documentation of Resident 1's meal intake percentage had the potential for the resident's inaccurate assessment that may lead to resident harm. The DON stated the facility failed to ensure Resident 1's medical record was complete and accurate. During a record review of the facility's policy and procedure (PnP) titled, Charting and Documentation, the PnP indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychological condition shall be documented in the resident's medical record. The PnP indicated the medical record should facilitate communication between the interdisciplinary team (IDT, a team of healthcare professionals from different professional disciplines who work together to manage the physical, psychological and spiritual needs of the patient) regarding the resident's condition and response to care. The PnP indicated documentation in the medical record will be objective, complete, and accurate.