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	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burbank Healthcare & Rehab	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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1) were free of significant medication error when Licensed Vocational Nurse (LVN) 1 failed to follow the doctor's ordered parameters (specific instructions from a doctor on exactly how and when to give a medication) for administering valsartan (a medication used to treat high blood pressure and heart failure [a condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen]) to Resident 1. This failure resulted in LVN 1 administering valsartan to Resident 1 without first assessing Resident 1's blood pressure and heart rate per the doctor's order.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. The admission Record indicated Resident 1's diagnoses included essential hypertension (high blood pressure that is not caused by another medical condition), osteoarthritis (a joint condition where the cartilage between bones wears down, causing pain, stiffness, and decreased movement), and hyperlipidemia (condition in which there are high levels of fats in the blood). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/5/2025, the MDS indicated Resident 1 had severe cognitive impairment (difficulty understanding and making decisions). The MDS indicated Resident 1 was dependent for toilet hygiene and lower body dressing (a helper does all of the effort). The MDS indicated Resident 1 needed partial/moderate assistance for eating and oral hygiene (a helper does less than half the effort of the activity). During a review of Resident 1's Order Summary Report, dated 9/29/2025, the Order Summary Report indicated Resident 1's doctor ordered valsartan 80 milligrams (unit of weight) to be given via one tablet once a day for hypertension. The Order Summary Report indicated to hold (do not administer the medication) valsartan if the systolic blood pressure (the pressure on the arteries when the heart contracts and pumps blood throughout the body) is less than 110 millimeters of mercury (unit of measurement for the force of blood being pumped), or the heart rate is less than 60 beats per one minute. During an observation on 9/25/2025 at 11:29 a.m. inside Resident 1's room, Resident 1 was sitting in a wheelchair at bedside with a tray table across Resident 1's lap. LVN 1 entered Resident 1's room holding a medicine cup with a spoon inside. LVN 1 fed Resident 1 a spoonful of food and then exited the room. During a concurrent observation and interview on 9/25/2025 at 11:30 a.m. with LVN 1 outside of Resident 1's room, LVN 1 was holding an empty medicine cup with a spoon inside. LVN 1 stated she administered to Resident 1 crushed medications mixed with applesauce. LVN 1 stated when she initially communicated to Resident 1 approximately 30 minutes ago that LVN 1 would be administering medications, Resident 1 nodded her head in agreement. LVN 1 stated she then checked [Resident 1's] blood pressure to see if [LVN 1 was] going to hold or give the medications, including valsartan. LVN 1 stated after taking Resident 1's blood pressure, LVN 1 prepared Resident 1's medications at the medication cart by crushing the medications and mixing it in applesauce. LVN 1 stated when she returned to Resident 1, Resident 1 refused the medications. During a concurrent observation and interview on 9/25/2025 at 11:48 a.m. with LVN 1 standing next to her assigned medication cart, LVN 1 stated that when Resident 1 refused her medications, LVN 1 labeled the medicine cup that contained the crush medications mixed with applesauce and placed it inside the locked medication cart. LVN 1 opened the locked medication cart top drawer that was divided into sections and pointed to where the medicine cup was placed. When asked if LVN 1 re-checked Resident 1's vital signs (basic bodily measurements that consist of body temperature, heart rate, breathing rate, and blood pressure) right before spoon feeding the previously prepared crushed medications to Resident 1, LVN 1 stated she took the vital signs approximately 30 minutes ago when she first attempted to administer the medications but Resident 1 had refused. During an interview on 9/26/2025 at 4:20 p.m. with the Director of Nursing (DON), DON stated parameters are special precautions that we look into before giving medications. The DON stated an example of a parameter is to hold a blood pressure medication if the systolic blood pressure is less than 110 millimeters of mercury. The DON stated parameters are part of a doctor's order and is to be checked before medication administration. The DON stated blood pressure and heart rate fluctuates, so before you give medications, you assess the [resident] first. The DON stated the importance of checking parameters prior to administering medications is to avoid adverse side effects for [residents]. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 3/2023, the P&P indicated medications are administered in accordance with prescriber orders. During a review of the facility's P&P titled, Adverse

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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 - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medical record of one of two sampled residents (Resident 2) was complete and accurately documented, when the facility failed to complete their designated form after performing a deep clean (a detailed cleaning process that targets hard-to-reach areas in order to kill germs and prevent the spread of infection) of Resident 2's room. This deficient practice resulted in an incomplete medical record for Resident 2.Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. The admission Record indicated Resident 2's diagnoses included chronic kidney disease (a long-term condition where the kidneys are damaged and gradually lose their ability to filter waste and excess fluid from the blood), muscle weakness, and hyperlipidemia (high levels of fats in the blood). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 8/5/2025, the MDS indicated Resident 2 was able to understand and make decisions. The MDS indicated Resident 2 needed partial assistance (a helper does less than half the effort) with oral hygiene and upper body dressing. The MDS indicated Resident 2 was independent (resident completes activity by themselves without assistance) for eating. During a review of Resident 2's Medication Administration Record (MAR), dated 9/30/2025, the MAR indicated Resident 2's room was placed on contact isolation precautions (a hospital procedure to stop the spread of germs by requiring hand hygiene and the use of gown and gloves before entering a resident's room, followed by its removal when exiting a resident's room) for prophylaxis (a certain action taken to prevent disease). During an interview on 9/26/2025 at 12:57 p.m. with the Housekeeping Supervisor (HS), the HS stated deep cleaning of residents' rooms began on 9/24/2025 related to the rash incidents discussed during a staff meeting with the Director of Nursing (DON). The HS stated when the nursing staff would take a resident to have a shower, housekeeping staff would then enter that resident's room to perform a deep cleaning. During a phone interview on 9/26/2025 at 1:10 p.m. with Housekeeper Staff Member (HSM 1), HSM 1 stated deep cleaning began on 9/24/2025 when she was instructed by the HS and the nursing staff. HSM 1 stated deep cleaning is different from regular cleaning because it includes disinfecting (using chemicals like bleach or alcohol to kill germs on a surface) hard to reach places such as curtains and the residents' beds. Regular cleaning is just dusting and mopping. When asked if there was a checklist that shows what exactly is required for deep cleaning, HSM 1 stated no. During a concurrent interview and record review on 9/26/2025 at 1:21 p.m. with the HS, the HS provided a blank copy of a document titled, Deep Clean Checkoff List: Isolation Rooms, which listed 28 items that were to be cleaned, wiped down, and/or disinfected. The HS stated the Deep Clean Checkoff List: Isolation Rooms was not completed for Resident 2's room. During a concurrent observation and interview on 9/26/2025 at 3:23 p.m. with Resident 2, Resident 2 was lying in bed. Resident 2 stated that her room had a deep cleaning two days ago. Resident 2 stated the following: They worked in teams. When I was taking a hot shower, they cleaned my bed, and then when my neighbor was taking her shower, I saw them clean her side. When asked what housekeeping had cleaned, Resident 2 pointed around her room stated the bed, curtains, floor, bathroom, everything. During an interview on 9/26/2025 at 4:20 p.m. with the DON, the DON stated staff should document accurately and timely. The DON stated that documentation confirms if something was done. The DON stated the consequence of having no documentation related to an action is that the next shift wouldn't know what was done. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 7/2017, the P&P indicated the following: Documentation in the medical record will be objective., complete, and accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their infection control policy for one of three sampled residents (Resident 1) when Licensed Vocational Nurse (LVN) 1: 1. Did not wear gown and gloves prior to entering Resident 1's room, which was placed on contact isolation precautions (a facility procedure to stop the spread of germs by requiring hand hygiene and the use of gown and gloves before entering a resident's room, followed by its removal when exiting a resident's room). 2. Placed a medicine cup, containing crushed medications mixed with applesauce, inside a medication cart next to a glucometer (an electronic device used for multiple residents that measures the amount of sugar in the blood). These deficient practices had the potential to spread infection to Resident 1 and to other residents within the facility. Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. The admission Record indicated Resident 1's diagnoses included essential hypertension (high blood pressure that is not caused by another medical condition), osteoarthritis (a joint condition where the cartilage between bones wears down, causing pain, stiffness, and decreased movement), and hyperlipidemia (condition in which there are high levels of fats in the blood). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/5/2025, the MDS indicated Resident 1 had severe cognitive impairment (difficulty understanding and making decisions). The MDS indicated Resident 1 was dependent for toilet hygiene and lower body dressing (a helper does all of the effort). The MDS indicated Resident 1 needed partial/moderate assistance for eating and oral hygiene (a helper does less than half the effort of the activity). During a review of Resident 1's Order Summary Report, dated 9/29/2025, the Order Summary Report indicated Resident 1's room is to be placed on contact isolation precaution. During an observation on 9/25/2025 at 11:29 a.m. inside Resident 1's room, Resident 1 was sitting in a wheelchair at bedside with a tray table across Resident 1's lap. Resident 1 had a contact isolation sign posted near her name plate outside her room. LVN 1 entered Resident 1's room holding a medicine cup with a spoon inside. LVN 1 fed Resident 1 a spoonful of food and then exited the room. LVN 1 was not wearing a gown and gloves when she entered Resident 1's room. LVN 1 did not wash her hands or use hand sanitizer (an alcohol-based substance that kills germs) before or after entering Resident 1's room. During an interview on 9/25/2025 at 11:30 a.m. with LVN 1 outside of Resident 1's room, LVN 1 stated she entered Resident 1's room to administer crushed medications mixed with applesauce. LVN 1 stated she saw nursing staff place contact isolation signs yesterday, but just forgot to wear a gown and gloves when she entered Resident 1's room. LVN 1 stated contact isolation requires individuals to clean hands with alcohol and wear a gown and gloves before entering a resident's room, followed by removing the gown and gloves and cleaning hands when exiting the room. LVN 1 stated the importance of following contact isolation precautions is to avoid contamination and to avoid spreading germs to residents in the facility. During an interview on 9/26/2025 at 4:20 p.m. with the Director of Nursing (DON), the DON stated contact isolation precautions require staff to wear gown and gloves before entering a resident's room, and to remove the gown and gloves when exiting. The DON stated staff should be washing their hands or using hand sanitizer before entering a resident's room and when leaving the room. The DON stated a consequence of not adhering to contact isolation precautions is the potential for spreading infection to other residents, coworkers, and visitors. During a review of the facility's policy and procedure (P&P) titled, Isolation - Categories of Transmission-Based Precautions, dated 4/2023, the P&P indicated contact precaution requires staff and visitors [to] wear gloves (clean, non-sterile) when entering the room, and gloves are removed and hand hygiene performed when leaving the room. The P&P indicated staff and visitors [are to] wear a disposable gown upon entering the room and remove before leaving the room. 2. During an interview on 9/25/2025 at 11:30 a.m. with LVN 1 outside of Resident 1's room, LVN 1 stated she entered Resident 1's room to administer crushed medications mixed with applesauce. LVN 1 stated when she initially communicated to Resident 1 approximately 30 minutes ago that LVN 1 would be administering medications, Resident 1 nodded her head in agreement. LVN 1 stated she then prepared Resident 1's medications, however when she returned to Resident 1, Resident 1 refused her medications. During a concurrent observation and interview on 9/25/2025 at 11:48 a.m. with LVN 1 standing next to her assigned medication cart, LVN 1 stated that when Resident 1 refused her medications, LVN 1 labeled the medicine cup that contained the crush medications mixed with applesauce and placed it inside the locked medication cart. LVN 1 opened the locked medication cart and