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	12/09/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 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 interview and record review, the facility failed to notify the resident and the resident's representative (RR - a person authorized by State or Federal law including but not limited to agents under power of attorney [POA - a legal document that allows someone else to act on your behalf]) of the transfer or discharge and the reasons for the move in writing for two of three sampled residents (Residents 1 and 2).These failures had the potential for incomplete information conveyed to Residents 1 and 2 or their RR and could have violated residents and RR's rights to appeal (the process in which cases are reviewed by a higher authority) transfer or discharge.Findings: a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 4/29/2025, with diagnoses that included unspecified (unconfirmed) psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), unspecified dementia (a progressive state of decline in mental abilities) and essential hypertension (high blood pressure with no single, identifiable cause). The admission Record indicated Resident 1 was discharged on 9/14/2025. The admission Record indicated RR 1 as the first emergency contact person. During a review of Resident 1's Uniform Statutory Form Power of Attorney (POA), dated 5/27/2022, the POA indicated Resident 1 appointed RR 1 as Resident 1's POA.During a review of Resident 1's Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life), dated 4/24/2025, the POLST indicated RR 1 as the legally recognized decisionmaker.During a review of Resident 1's History and Physical (H&P - a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 8/29/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/31/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 needed maximum assistance from staff for showering and toileting. The MDS indicated Resident 1 was always incontinent (unable to control) of bowel and bladder functions.During a review of Resident 1's Order Summary Report, dated 9/7/2025, the Order Summary Report indicated Resident 1 may be transferred to General Acute Care Hospital (GACH) 1.During a review of Resident 1's Progress Notes, dated 9/7/2025, the Progress Notes indicated Resident 1 was transferred to GACH 1 at 11:53 a.m. due to elevated temperature and vomiting. The Progress Notes indicated RR 1 was notified at 11:41 a.m.During a review of Resident 1's Notice of Proposed Transfer/Discharge (NTD - a written document provided to the resident and their representative, containing specific details about the transfer or discharge and a copy sent to the California Long-Term Care Ombudsman [an advocate for residents of nursing homes, board and care centers, and assisted living facilities] Program, the facility must include the reason for the move, the proposed effective date, the destination, information on the right to appeal, and contact information for the Ombudsman Program and other advocacy agencies), dated 9/7/2025, the NTD indicated Resident 1 was transferred to GACH 1 for elevated temperature and vomiting. The NTD indicated the Departments name, address, telephone and fax number if the resident or RR believes the proposed transfer/discharge was inappropriate and the resident or the RR can file an appeal in writing or by calling the number indicated in the form. The NTD also indicated the state long term care ombudsman's address, telephone and fax number to discuss the proposed transfer and discharge. The NTD did not indicate RR 1's signature.During an interview on 9/30/2025 with RR 1, RR 1 stated she (RR 1) did not receive Resident 1's NTD.During a concurrent interview and record review on 9/30/2025 at 9:46 a.m. with the Assistant Director of Nursing (ADON), Resident 1's NTD, dated 9/7/2025, was reviewed. The ADON stated Registered Nurse (RN) 1 signed the NTD and the NTD should be signed by either Resident 1 or RR 1. The ADON stated staff are not supposed to sign for the resident or the RR.b. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 8/12/2025, with diagnoses that included secondary malignant neoplasm of other digestive organs (cancer cells [body's normal cells become abnormal, grow out of control, and don't die when they should, forming a mass called a tumor] from a primary cancer [the original site] have spread to the digestive organs, but the affected digestive organs are not where the cancer first started), urinary tract infection (UTI - an infection in the bladder/urinary tract) and difficulty in walking. The admission Record indicated Resident 2 was discharged on 9/4/2025. The admission

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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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents received care consistent with professional standards of practice for one of three sampled residents (Resident 1) by failing to notify the physician on 9/1/2025, when Resident 1 had a 20 millimeter of mercury (mmHg - unit of pressure commonly used for blood pressure readings) decrease in systolic blood pressure (sbp - top number of the blood pressure that represents the pressure in your arteries when your heart pumps blood out to the rest of your body).This failure had the potential to place Resident 1 at risk of orthostatic hypotension (a condition where blood pressure drops significantly when a person stands up from a lying or sitting position) and could negatively impact residents' well-being.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 4/29/2025, with diagnoses that included unspecified (unconfirmed) psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), unspecified dementia (a progressive state of decline in mental abilities) and essential hypertension (high blood pressure with no single, identifiable cause).During a review of Resident 1's History and Physical (H&P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 8/29/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/31/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 needed maximum assistance from staff for showering and toileting. The MDS indicated Resident 1 was on antipsychotic (medication used to help people whose brains are having trouble with reality) medication.During a review of Resident 1's Order Summary Report, dated 8/29/2025, the Order Summary Report indicated to monitor for orthostatic hypotension, call the physician if there is a 20 mmHg drop in sbp or a drop of 10 mmHg in diastolic blood pressure (dbp - bottom number of the blood pressure that measures the pressure your blood is pushing against your artery walls while the heart muscle rests between beats) between two readings (lying position and sitting position) every Wednesday for quetiapine (medication used to help people whose brains are having trouble with reality) use. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 9/2025, the MAR indicated on 9/1/2025, Resident 1's blood pressure as follows:1. 156/76 mmHg - lying position2. 136/74 mmHg - sitting positionDuring a concurrent interview and record review on 9/30/2025 with Director of Nursing DON) 1, Resident 1's Physician Order, dated 8/29/2025, MAR, and Progress Notes, dated 9/1/2025, were reviewed. DON 1 stated Resident 1's sbp on 9/1/2025, had a 20 mmHg drop from lying to sitting position. DON 1 stated there was no documentation on 9/1/2025, that physician was notified of the 20 mmHg drop. DON 1 stated Licensed Vocational Nurse (LVN) 1 did not follow the physician order and did not notify the physician of the 20 mmHg drop in sbp. DON 1 stated LVN 1 should have called the physician and monitor Resident 1 for signs of hypotension (low blood pressure). DON 1 stated Resident 1's blood pressure could continue to drop and can lead to further complication like syncope (a brief loss of consciousness caused by a temporary decrease in blood flow to the brain). DON 1 stated the facility's policy was to follow physician order.During a review of facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 3/2023 and last reviewed on 8/15/2025, the P&P indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.1. The nurse will notify the resident's attending physician or physician on call when there has been a(an):a. accident or incident involving the resident;b. discovery of injuries of an unknown source;c. adverse reaction to medication;d. significant change in the resident's physical/emotional/mental condition;e. need to alter the resident's medical treatment significantly;f. refusal of treatment or medications two (2) or more consecutive times);g. need to transfer the resident to a hospital/treatment center;h. discharge without proper medical authority; and/[NAME]. specific instruction to notify the physician of changes in the resident's condition.

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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. (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 0842 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 interview and record review, the facility failed to ensure medical records were complete and accurately documented for two of three sampled residents (Residents 1 and 2), when Resident 1 and Resident 2's Inventory Lists, on the Discharge portion, were left blank.This failure had the potential for Resident 1 and Resident 2's personal belongings to be lost.Findings: a. During a review of Resident 1's admission Record, the admission Records indicated the facility admitted Resident 1 on 4/29/2025, with diagnoses that included unspecified (unconfirmed) psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), unspecified dementia (a progressive state of decline in mental abilities) and essential hypertension (high blood pressure with no single, identifiable cause).During a review of Resident 1's Inventory List (a detailed and organized list of everything a person owns), dated 8/28/2025, the Inventory List indicated the Discharge portion of the Inventory List was blank.During a review of Resident 1's History and Physical (H&P - a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 8/29/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/31/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 needed maximum assistance from staff for showering and toileting.During an interview on 9/30/2025 at 10:12 a.m. with Registered Nurse (RN) 3, RN 3 stated Resident 1 was discharged from the facility on 9/7/2025.b. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 8/12/2025, with diagnoses that included secondary malignant neoplasm of other digestive organs (cancer cells [body's normal cells become abnormal, grow out of control, and don't die when they should, forming a mass called a tumor] from a primary cancer [the original site] have spread to the digestive organs, but the affected digestive organs are not where the cancer first started), urinary tract infection (UTI- an infection in the bladder/urinary tract) and difficulty in walking. The admission Record indicated Resident 2 was discharged on 9/4/2025.During a review of Resident 2's Inventory List, dated 8/12/2025, the Inventory List indicated the Discharge portion of the Inventory List was blank.During a review of Resident 2's H&P, dated 8/13/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions.During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decisions were intact.During a concurrent interview and record review on 9/30/2025 at 10 a.m. with the Medical Records Director (MRD), Residents 1 and 2's Inventory List were reviewed. The MRD stated Residents 1 and 2's Inventory List-at Discharge were left blank. The MRD stated Social Service needs to complete the Inventory List the following day after discharge or transfer. The MRD stated Social Service Department had been audited and still not completing the Inventory List.During an interview on 9/30/2025 at 10:12 a.m. with RN 3, RN 3 stated Resident 2 was discharged from the facility on 9/4/2025. RN 3 stated residents' belongings are packed and kept by Social Services until picked up by family. RN 3 stated there was a potential for resident's belongings to be lost if inventory list was not completed.During an interview on 9/30/2025 at 10:27 a.m. with the Social Service Director (SSD), the SSD stated Certified Nursing Assistants (CNAs) fill up the Inventory List-at Discharge and the Social Services are responsible for checking to make sure the Inventory list was complete the following day of discharge. The SSD stated Medical Records audits the Inventory List, but Social Services was not informed that Inventory List for Resident 1 and Resident 2 was incomplete.During an interview on 9/30/2025 at 10:39 a.m. with Director of Nursing (DON) 1, DON 1 stated Resident 1 and Resident 2's belongings can get lost if not listed in the Inventory List. DON 1 stated family should be called to pick up resident's belongings.During an interview on 9/30/2025 at 11:20 a.m. with the SSD, the SSD stated Resident 2's belongings were picked up on 9/4/2025 but were not listed and were not signed in the Inventory List. During an interview on 9/30/2025 at 11:38 a.m. with the Administrator (ADM), the ADM stated the Social Service Department failed to check the inventory list after the residents were discharged from the facility. The ADM stated the Social Service Department failed to complete the inventory list for Residents 2 and failed to obtain Resident 2 or Resident 2's representative's signature upon picked up on 9/4/2025. The ADM stated missing belongings can result if inventory list was not complete and not signed.During a review of facility's policy and procedure (P&P) titled, Personal Property, dated 3/2023 and last reviewed on 8/15/2025, the P&P