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 01/14/2026

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 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. Based on interview, and record review, the facility failed to develop and implement a person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of three sampled residents (Resident 1) to address Resident 1's refusal of Restorative Nursing Assistance (RNA- provide specialized rehabilitative care, helping residents regain independence with daily activities like walking, bathing, and eating, under the supervision of licensed nurses and therapists) services.This failure had the potential to result in a delay in the delivery of necessary care and services.Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/21/2025, with diagnoses that included unspecified (unconfirmed) acute kidney failure (when the kidneys suddenly cannot filter waste products from the blood), and difficulty in walking and generalized weakness.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 11/25/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 11/28/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required moderate assistance from staff for transfer and walking.During a review of Resident 1's Order Recap Report, dated 12/27/2025, the Order Recap Report indicated an RNA order for ambulation with a front wheeled walker (FWW- a mobility aid used by individuals who can bear some weight but need support with balance and stability) as tolerated five times a week. One time a day every Monday, Tuesday, Wednesday, Thursday and Sunday.During a review of Resident 1's Documentation Survey Report, dated 12/2025, the Documentation Survey Report indicated on 12/30/2025, and 12/31/2025, RNA for ambulation with FWW was noted as not applicable.During an interview on 1/14/2026, at 10:11 a.m., with the Director of Rehabilitation (DOR), the DOR stated Resident 1 was discharged from rehabilitation (the action of restoring someone to health or normal life through training and therapy) on 12/12/2025, because Resident 1 could walk unlimited distances with a FWW. The DOR stated RNA service was started on 12/28/2025, for ambulation with a FWW five times a week.During a concurrent interview and record review on 1/14/2026, at 11:05 a.m., with RNA 1, Resident 1's Documentation Survey Report, dated 12/2025, was reviewed. RNA 1 stated on 12/30/2025, and 12/31/2025, RNA for ambulation indicated NA. RNA 1 stated NA means not applicable. RNA 1 stated they (RNA) document NA if resident is in the General Acute Care Hospital (GACH) or if not in the facility.During an interview on 1/14/2026, at 11:25 a.m., with RNA 2, RNA 2 stated on 12/30/2025, Resident 1 refused as he (Resident 1) waited to be discharged . RNA 2 stated on 12/31/2025, Resident 1 also refused RNA three times as he (Resident 1) waited to be discharged . RNA 2 stated if resident refused, she (RNA 2) should have reported to the Charge Nurse and on both days on 12/30/2025, and 12/31/2025, RNA 2 did not report. RNA 2 stated no RNA was (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

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 01/14/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided on 12/30/2025, and 12/31/2025. RNA 2 stated RNA 2 motivates Resident 1 to get stronger and to be more active, especially when he (Resident 1) would be going home.During an interview on 1/14/2026, at 11:34 a.m., with the Director of Nursing (DON), the DON stated if a resident refused RNA services three times, then RNA 2 should have reported this to the Charge Nurse and the Charge Nurse could have talked to Resident 1, and found out the reason for the refusal and encourage Resident 1 to participate. The DON stated a Care Plan also should have been developed for Resident 1's refusal of RNA services so that the facility could develop interventions to be implemented specifically addressing Resident 1's refusals.During an interview on 1/14/2026, at 11:51 a.m., with the DON, the DON stated that the nurses do not have a guide on how to proceed with the plan of care to address Resident 1's refusal of RNA. The DON stated the nurses might miss (not provide) an intervention if no Care Plan was developed.During a review of facility's policy and procedures (P&P), titled, Comprehensive Person-Centered care Plans, dated 3/2023, and last reviewed on 8/15/2025, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial (the connection between a person's inner thoughts and feelings and their surrounding relationships and environment) and functional needs is developed and implemented for each resident.7. The comprehensive, person-centered care plan:a. includes measurable objectives and timeframes;b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; .c. Includes the resident's stated goals upon admission and desired outcomes;d. Builds on the resident's strengths; ande. Reflects currently recognized standards of practice for problem areas and conditions.10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.13. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on interview, and record review, the facility failed to ensure residents with or without limited range of motion (ROM - movement of the joints) received appropriate treatment and services to increase, prevent, or maintain the ROM mobility for one of three sampled residents (Resident 1) who had a physician's orders for Restorative Nursing Assistance (RNA) ambulation five times a week.This failure resulted in Resident 1 not receiving RNA ambulation and placed Resident 1 at risk for decline in physical function.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/21/2025, with diagnoses that included unspecified (unconfirmed) acute kidney failure (when the kidneys suddenly cannot filter waste products from the blood), difficulty in walking and generalized weakness.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 11/25/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 11/28/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required moderate assistance from staff for transfer and walking.During a review of Resident 1's Order Recap Report, dated 12/27/2025, the Order Recap Report indicated an RNA order for ambulation with a front wheeled walker (FWW- a mobility aid with two wheels on the front legs and gliding tips or legs on the back, allowing it to be rolled forward without lifting, offering stability or balance support) as tolerated five times a week, one time a day every Monday, Tuesday, Wednesday, Thursday and Sunday.During a review of Resident 1's Care Plan Report, dated 12/27/2025, the Care Plan Report indicated Resident 1 had a limitation in gait (walking pattern) with an intervention for RNA ambulation five times a week as tolerated.During a review of Resident 1's Documentation Survey Report dated 12/2025, the Documentation Survey Report indicated on 12/30/2025, (Tuesday) and 12/31/2025, (Wednesday) RNA not applicable.During an interview on 1/14/2026, at 10:11 a.m., with the Director of Rehabilitation (DOR), the DOR stated Resident 1 was on RNA for ambulation using a FWW from 12/28/2025.During a concurrent interview, and record review on 1/14/2026, at 11:05 a.m., with RNA 1, Resident 1's Documentation Survey Report dated 12/2025, was reviewed. RNA 1 stated on 12/30/2025, and 12/31/2025, RNA 2 documented RNA not applicable. RNA 1 stated not applicable means Resident 1 was not in the facility or was out in the General Acute Care Hospital (GACH).During an interview on 1/14/2026, at 11:25 a.m., with RNA 2, RNA 2 stated on 12/30/2025, Resident 1 did not want to walk, as he (Resident 1) waited to be discharged home. RNA 2 stated Resident 1 was not discharged on 12/30/2025. RNA 2 stated on 12/31/2025, Resident 1 was discharged home. RNA 2 stated she (RNA 2) provided RNA ambulation from 7 a.m., to 3:30 p.m. RNA 2 stated she (RNA 2) had offered ambulation three times and Resident 1 refused until Resident 1 was discharged home at 5:10 p.m. RNA 2 stated she (RNA 2) was not sure why she (RNA 2) documented not applicable. RNA 2 stated no RNA ambulation was provided to Resident 1 on 12/30/2025, and 12/31/2025. RNA 2 stated she (RNA 2) should have provided RNA ambulation and since Resident 1 refused, she (RNA 2) should have reported to the charge nurse. RNA 2 stated ambulation helps Resident 1 get stronger especially when he (Resident 1) was about to be discharged .During an interview on 1/14/2026, at 11:51 a.m., with the Director of Nursing (DON), the DON stated providing RNA ambulation helps prevent Resident 1's decline with ROM and ambulation. The DON stated not providing RNA ambulation could possibly result in Resident 1 having weakness and could result in Resident 1 having a fall.During a review of facility's policy and procedure (P&P), titled, Restorative Nursing Services, dated (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/2017, and last reviewed on 8/15/2025, the P&P indicated, Residents will receive restorative nursing care (a patient-centered approach focused on helping individuals regain, maintain, or improve their ability to perform daily activities and live as independently as possible, preventing further decline after illness or injury) as needed to help promote optimal safety and independence.1. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services.2. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care.3. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care.4. The resident or representative will be included in determining goals and the plan of care.5. Restorative goals may include, but are not limited to supporting and assisting the residents in: a. adjusting or adapting to changing abilities; b. developing, maintaining or strengthening his/her physiological (the normal, healthy functioning of a living body) and psychological (referring to things related to the mind, emotions, and behavior) resources; c. maintaining his/her dignity, independence and self-esteem; and d. participating in the development and implementation of his/her plan of care.

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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. Based on interview and record review, the facility failed to maintain an accurate and complete medical record for one of three sampled residents (Resident 1) by failing to document the time of the Physician notification and the Physicians' response after the facility's notification of Resident 1's abnormal (result that falls outside the reference range) blood test result on 12/26/2025.This failure had the potential to result in medication errors, cause confusion in care and the medical records containing inaccurate documentation.Findings:During a review of Resident1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/21/2025, with diagnoses that included unspecified (unconfirmed) acute kidney failure (when the kidneys suddenly cannot filter waste products from the blood), difficulty in walking and generalized weakness. 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 11/25/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 11/28/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required moderate assistance from staff for transfer and walking. During a review of Resident 1's Interact Assessment Form, dated 12/23/2025, the Interact Assessment Form indicated Resident 1 had an abnormal white blood cell count (WBC- a blood cell that helps attack infection or injury in the body) blood result of 15.2 cells per microliter (the number of specific cells found in one-millionth of a liter of blood) and modest (mild to small amount) right lower lobe pneumonia (an infection/inflammation in the lungs). The Interact Assessment Form indicated Licensed Vocational Nurse 1 (LVN 1) notified the Physician and the Physician ordered levofloxacin (medication used to treat infection) and blood test (complete blood count [CBC-measures the three main types of cells that circulate in your blood to ensure they are at healthy levels], complete metabolic panel [CMP-a common blood test that gives doctors a snapshot of your body's overall chemical balance and metabolism by checking 14 substances] and procalcitonin [a blood test marker that helps doctors spot serious bacterial infections]) on 12/26/2025. During a review of Resident 1's Laboratory Test Result dated 12/26/2025, timed at 5:55 p.m., the Laboratory Test Result indicated a low hemoglobin (a protein that carries oxygen) and hematocrit (the percentage by volume of red cells in your blood). The Laboratory Test Result indicated a written note indicating the Physician was notified on 12/26/2025.During a concurrent interview, and record review on 1/14/2026, at 10:55 a.m., with Registered Nurse 1 (RN 1), Resident 1's Laboratory Test Result and Progress Notes dated 12/26/2025, were reviewed. RN 1 stated the Progress Notes did not indicate the Physician was notified. RN 1 stated there was no documentation of the time the nurse notified the Physician, no documentation of who called the physician and no documentation of the response of the Physician. RN 1 stated it is important to notify the Physician of abnormal test results so orders can be obtained to treat the residents. RN 1 stated Resident 1 could develop sepsis (a life-threatening blood infection) or may need blood transfusion (when a person receives donated blood or parts of blood through an intravenous [IV-within the vein] line into a vein, usually in the arm) because of low level of hematocrit and hemoglobin. RN 1 stated the nurse should have documented physician notification and should also document if the Physician gave an order or did not give a new order in the Progress Notes. During a concurrent interview, and record review on 1/14/2026, at 11:34 a.m., with the Director of Nursing (DON), Resident 1's Laboratory Test Result and Progress Notes dated 12/26/2025, were reviewed. The DON stated once the facility receives the resident test (continued on next page)

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	056129	A. Building B. Wing	01/14/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	result, the nurse should notify the physician and document in the Progress Notes the date, time, and the physician's response with new orders or no new orders. The DON stated the Progress Notes did not indicate any documentation of Resident 1's physician notification of the abnormal blood test result on 12/26/2025. The DON stated there were documentation issues on Resident 1's medical record.During an interview on 1/14/2026, at 11:51 a.m. with the DON, the DON stated the nurse should have documented the physician notification of Resident 1's blood test result and if there were any orders or not. The DON stated Resident 1's medical record was incomplete. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation dated 7/2017 and last reviewed on 8/15/2025, the P&P 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 medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.7. Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment; d. How the residents tolerated the procedure/treatment; e. Whether the resident refused the procedure/treatment; f. Notification of family, physician or other staff, if indicated; and g. The signature and title of the individual documenting.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview, and record review, the facility failed to implement its policy for the antibiotic (medication used to treat infection) stewardship (efforts in doctors' offices, hospitals, long-term care facilities, and other health care settings to ensure that antibiotics are used only when necessary and appropriate, means prescribing the right drug, at the right dose, at the right time, for the right duration) program for one of three sampled residents (Resident 1) by failing to monitor Resident 1 for the adverse effects (undesired or harmful effects) of levofloxacin (antibiotic medication used to treat infection) from 12/23/2025 to 12/29/2025.These failures had the potential to increase antibiotic resistance (don't respond to a drug) from unnecessary or inappropriate antibiotic use and had the potential to result in Resident 1 to experience an adverse reaction.During a review of Resident1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/21/2025, with diagnoses that included unspecified (unconfirmed) acute kidney failure (when the kidneys suddenly cannot filter waste products from the blood), urinary tract infection (UTI- an infection in the bladder/urinary tract) and generalized weakness.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 11/25/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 11/28/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 was on antibiotic.During a review of Resident 1's Interact Assessment Form, dated 12/23/2025, the Interact Assessment Form indicated Resident 1 had an abnormal white blood cell count (WBC- a blood cell that helps attack infection or injury in the body) blood result of 15.2 cells per microliter (the number of specific cells found in one-millionth of a liter of blood) and modest (mild to small amount) right lower lobe pneumonia (PNA-an infection /inflammation in the lungs). The Interact Assessment Form indicated Licensed Vocational Nurse 1 (LVN 1) notified the Physician and the Physician ordered levofloxacin.During a review of Resident 1's Order Summary Report, dated 12/23/2025, the Order Summary Report indicated to administer levofloxacin oral tablet 500 milligram (mg-metric unit of measurement, used for medication dosage and/or amount), one tablet by mouth daily for modest right lower lobe pneumonia for seven days.During a record review of Resident 1's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 12/2025, the MAR indicated Resident 1 received levofloxacin from 12/23/2025 to 12/29/2025.During a review of Resident 1's Care Plan, dated 12/24/2025 for Pneumonia, the Care Plan indicated the following interventions:Administer antibiotic therapy as ordered: levofloxacin Oral Tablet 500 mg daily for seven days.Monitor adverse reaction.Monitor for progress of status. Notify the Physician if therapeutic intervention is not effective.Monitor vital signs (body's essential functions like your heart rate, breathing, temperature, and blood pressure) and symptoms associated with infection.During a concurrent interview, and record review on 1/14/2026, at 10:27 a.m., with the Director of Nursing (DON), Resident 1's Physician Order, dated 12/23/2025, and Progress Notes, from 12/23/2025, to 12/29/2025, were reviewed. The DON stated residents who receive antibiotics are monitored for adverse effects every shift (day, evening, night shifts) so if any adverse effects are identified, the physician could be notified and obtain an order to change the antibiotic. The DON stated there was no documented antibiotic monitoring for adverse effects in Resident 1's Progress Notes from 12/23/2025 to 12/29/2025. The DON stated the only documented monitoring was on 12/26/2025 at 6:06 p.m. The DON stated monitoring should be done every shift. The DON stated since there was no documented monitoring for antibiotic adverse effects, the nurses would (continued on next page)

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	056129	A. Building B. Wing	01/14/2026

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not be able to identify if Resident 1 had an adverse effect, that could delay physician notification and potentially result in a delay in care.During an interview on 1/14/2026, at 10:43 a.m., with LVN2, LVN 2 stated Resident 1 was on antibiotics and he (LVN 2) had administered the antibiotic to Resident 1. LVN 2 stated nurses monitor residents on antibiotics for adverse reaction and document in the Progress Notes whether there was an adverse reaction or not.During a concurrent interview, and record review on 1/14/2026, at 11:51 a.m., with the DON, the facility's policy and procedure (P&P), titled, Antibiotic Stewardship dated 12/2016, and last reviewed on 8/15/2025, the P&P indicated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. 1. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents.3. Training and education will include emphasis on the relationship between antibiotic use and: a. gastrointestinal disorders (medical conditions affecting the digestive system causing symptoms like abdominal pain, bloating and nausea.); b. opportunistic infections (an infection caused by germs that typically do not harm healthy people but take advantage of a weakened immune system [body's defense against infections]).c. medication interactions. The DON stated the P&P did not indicate frequency of monitoring for antibiotic adverse effects, but the nurses should monitor and document adverse effects of antibiotics every shift.