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	01/31/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an allegation of a misappropriation of resident property (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent) of one of four sampled residents (Resident 4) to the State Survey Agency (SSA) when Family Member (FM) 1 allegedly took Resident 4's wallet and charged $500 on Resident 1's credit card. This deficient practice had the potential to place Resident 1 at increased risk for further abuse which could have led to additional unreported incidents and delay the SSA's ability to promptly investigate the allegation of a misappropriation of resident property.Findings: During a review of Resident 4's admission Record (AR), the AR indicated the facility originally admitted Resident 4 on 1/10/2026 with diagnoses including muscle weakness and sepsis (a life-threatening medical emergency caused by the body's extreme response to infection). During a review of Resident 1's History and Physical (H&P), dated 1/11/2026, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/17/2026, the MDS indicated Resident 4 had intact cognitive functioning (the ability to think, learn, remember, use judgment, and make decisions). During an interview on 1/26/2025 at 11:15 a.m. with Resident 4, Resident 4 stated that FM 1 came to visit him (Resident 4), took his (Resident 4) wallet, left the facility, charged $500 to Resident 4's credit, and returned back to the facility to give him (Resident 4) back his wallet (with the credit card). Resident 4 stated he cannot remember the exact date and time of the incident. Resident 4 stated he reported the incident to the Social Worker (SW) but cannot remember the date and time he reported it to the SW. During an interview on 1/26/2026 at 1:30 p.m. with SW, the SW stated that Resident 4 reported to him (SW) that FM 1 took Resident 4's wallet and charged $500 to Resident 4's credit card (did not indicate the date and time). During an interview on 1/28/2026 at 2:30 p.m. with the Administrator, the Administrator stated Resident 4 informed the SW that FM 1 took Resident 4's wallet and charged $500 on Resident 4's credit card. The Administrator stated she did not report to the SSA Resident 4's allegation of a misappropriation of property. The Administrator stated she should have reported the incident to the SSA when it happens again in the future. During a review of the facility-provided policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, last reviewed on 8/15/2025, the P&P indicated, All reports of resident abuse, . theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations). If resident abuse, . misappropriation of resident property . is suspected, the suspicion must be reported immediately to the administrator and to the other officials according to the state law. The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/ licensing the facility. ‘Immediately' is defined as: a. within two hours of an allegation involving abuse .

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 01/31/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a person-centered Care Plan (a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) for one of three sampled residents (Resident 2) to address that Resident 2 was immunocompromised (having a weakened immune system that cannot fight infections and diseases as effectively as a healthy one) and had high risk for infection. This failure had the potential to delay provision of necessary care for Resident 2 and placed Resident 2 at risk of developing an infection. Findings:During a review of Resident 2's Face Sheet, undated, the Face Sheet indicated the facility originally admitted Resident 2 on 6/20/2026 and readmitted on [DATE], with diagnoses including diffuse large B-cell lymphoma (is a fast-growing, aggressive type of non-Hodgkin lymphoma [blood cancer] that develops when abnormal B-cell lymphocytes [a type of white blood cell] multiply uncontrollably and frequently causes swollen lymph nodes, fever, and weight loss, and can spread rapidly to other organs), encounter for antineoplastic chemotherapy (the use of medication designed to treat cancer by inhibiting or killing rapidly dividing malignant cells), and acquired absence of kidney. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), the MDS, dated [DATE], the MDS indicated Resident 2's cognitive functioning was intact (the ability to think, learn, remember, use judgment, and make decisions). The MDS indicated Resident 2 needed substantial/maximal assistance (helper does more than half the effort with helper lifting or holding trunk or limbs and providing more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. During a concurrent interview and record review on 1/30/2026 at 3:44 p.m. with the Director of Nursing (DON), Resident 2's Care Plans were reviewed. The DON stated the facility staff failed to initiate and implement a Care Plan for Resident 2 to address that Resident 2 was immunocompromised being diagnosed with diffuse large B-cell lymphoma. The DON stated it was the responsibility of licensed staff or the MDS Coordinator to initiate the Care Plan when Resident 2 was admitted to facility. The DON stated Resident 2's Care Plan should have addressed that Resident 2 could not be cohorted (grouping residents together based on their infection status to prevent the spread of illness to healthy residents) with a resident who had an active infection. The DON stated the Care Plan was a guide to implement the necessary interventions for Resident 2. The DON stated Resident 2's Care Plan was not comprehensive and person centered. The DON stated the failure to develop a comprehensive Care Plan that addressed Resident 2's immunocompromised status placed Resident 2 at risk of acquiring infection, which had the potential to lead to sepsis and other complications such as death. During a review of the facility-provided policy and procedure (P&P) titled, Care plans, Comprehensive Person-Centered, last revised 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 and functional needs is developed and implemented for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.7. The comprehensive, person-centered care plan: .b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being e. reflects currently recognized standards of practice for problem areas and conditions.

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NAME OF PROVIDER OR SUPPLIER Burbank Healthcare & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the comprehensive care plan (a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) was revised for two of three sampled residents (Resident 2 and 3) when facility staff cohorted (grouping residents together based on their infection status to prevent the spread of illness to healthy residents) Residents 2 and 3 with Resident 1 who was suspected with Clostridium Difficile infection (CDI or C. difficile - bacteria that causes severe, diarrhea [loose, watery stools], and inflammation of the colon) on 1/18/2026 and tested positive for CDI on 1/20/2026. This deficient practice had the potential to delay provision of care for Resident 2 and Resident 3. The delay in provision of care to Resident 2 and Resident 3 could result in severe infection, sepsis (a life-threatening medical emergency caused by the body's extreme, overreaction to an infection), hospitalization, or death. Findings:a. During a review of Resident 1's Face Sheet (admission Record), undated, the Face Sheet indicated the facility admitted Resident 1 on 1/17/2026 with diagnoses including other pulmonary embolism without acute cor pulmonale (indicates a blockage in the pulmonary arteries by a blood clot reducing blood flow but not severe enough to cause right heart failure) and sepsis. The Face Sheet indicated Resident 1 had a diagnosis of enterocolitis (is the inflammation of both the small intestines and colon, causing symptoms like severe diarrhea, abdominal pain, fever, vomiting, and dehydration) due to CDI with onset date of 1/20/2026. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/24/2026, the MDS indicated Resident 1's cognitive functioning (the ability to think, learn, remember, use judgment, and make decisions) was intact. The MDS indicated Resident 1 was dependent (helper does all of the effort) with eating, oral hygiene, toileting hygiene, showering/bathing self, upper body dressing, lower body dressing, and putting on/taking off footwear. During a review of Resident 1's Order Summary Report, dated 1/18/2026, the Order Summary Report indicated the physician ordered to collect stool from Resident 1 to test for CDI as soon as possible (ASAP). During a review of Resident 1's Change in Condition (COC - major decline or improvement in a resident's status that will not resolve without intervention) Evaluation form, dated 1/20/2026 timed at 11:30 a.m., the COC indicated Resident 1 had CDI with 1/18/2026 as date of onset of symptoms and meeting the following criteria: Diarrhea: 3 or more liquid or watery stools above what is normal for the resident within a 24-hour period and a stool sample yields a positive laboratory test result for CDI. The COC indicated the facility placed Resident 1 on contact isolation on 1/20/2026. b. During a review of Resident 2's Face Sheet, undated, the Face Sheet indicated the facility originally admitted Resident 2 on 6/20/2019 and readmitted on [DATE], with diagnoses including diffuse large B-cell lymphoma (is a fast-growing, aggressive type of non-Hodgkin lymphoma [blood cancer] that develops when abnormal B-cell lymphocytes [a type of white blood cell] multiply uncontrollably and frequently causes swollen lymph nodes, fever, and weight loss, and can spread rapidly to other organs), encounter for antineoplastic chemotherapy (the use of medication designed to treat cancer by inhibiting or killing rapidly dividing malignant cells), and acquired absence of kidney. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive functioning was intact. The MDS indicated Resident 2 needed substantial/maximal assistance (helper does more than half the effort with helper lifting or holding trunk or limbs and providing more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. c. During a review of Resident 3's Face Sheet, the Face Sheet indicated the facility originally admitted Resident 3 on 11/27/2024 and readmitted on [DATE] (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with diagnoses including other hypertrophic cardiomyopathy (a genetic condition where the heart muscle thickens but does not physically block blood flow out of the heart), chronic kidney disease (long-term, progressive loss of kidney function), type two DM, depression (is a serious, common medical illness characterized by a persistent low mood, sadness, or loss of interest in activities), and anxiety disorders (a group of common mental health conditions characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life, work, or relationships). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had moderately impaired cognitive functioning. The MDS indicated Resident 3 needed substantial/maximal assistance with toileting hygiene, lower body dressing and putting on/taking off footwear.During a concurrent interview and record review on 1/30/2026 at 3:44 p.m. with the Director of Nursing (DON), Resident 2 and Resident 3's Care Plans were reviewed. The DON stated the facility staff failed to update Resident 2 and Resident 3's Care Plans when residents (Resident 2 and 3) were cohorted with Resident 1. The DON stated it was the responsibility of licensed staff and MDS Coordinator to update the Care Plans. The DON stated the Care Plans were guides to implement the necessary interventions for Resident 2 and Resident 3. The DON stated Resident 2 and Resident 3's Care Plans were not comprehensive and not person-centered. The DON stated the failure to revise the Care Plans had the potential to delay care for Resident 2 and Resident 3. The DON stated Resident 2 and Resident 3 were placed at risk of acquiring CDI, which had the potential to lead to sepsis and other complications such as death. During a review of the facility-provided policy and procedure (P&P) titled, Care plans, Comprehensive Person-Centered, last revised 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 and functional needs is developed and implemented for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.7. The comprehensive, person-centered care plan: .b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being e. reflects currently recognized standards of practice for problem areas and conditions.11. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement contact isolation precautions (infection control measures used in the healthcare settings to prevent the spread of infections transmitted by direct or indirect contact with a resident or their environment) for one of three sampled residents (Resident 1) when Resident 1 was suspected and exhibited signs and symptoms (indicators of an illness, injury, or condition) consistent with Clostridiodes (known before as Clostridium) Difficile infection (CDI or C. difficile - bacteria that causes severe, diarrhea [loose, watery stools], and inflammation [swelling] of the colon) on 1/18/2026 and subsequently tested positive for CDI on 1/20/2026, by failing to:1. Ensure Resident 1, who showed signs and symptoms of CDI on 1/18/2026, was not sharing the same room with Resident 2 and Resident 3. Resident 2 was immunocompromised (having a weakened immune system that cannot fight infections and diseases as effectively as a healthy one) due to a diagnosis of diffuse large B-cell lymphoma (a fast-growing, aggressive type of non-Hodgkin lymphoma [blood cancer] that develops when abnormal B-cell lymphocytes [a type of white blood cell] multiply uncontrollably and frequently, causes swollen lymph nodes [small, bean-shaped immune system organs that act as filters throughout the body, trapping bacteria, viruses, and cancer cells to help fight infection], fever [abnormally high body temperature], and weight loss, and can spread rapidly to other organs) and actively undergoing antineoplastic chemotherapy (the use of medication designed to treat cancer by inhibiting or killing rapidly dividing malignant [abnormal] cells).2. Ensure the facility conducted infection risk assessments (assessments of risk factors that place residents at higher risk for infections) for Resident 2 and Resident 3 before cohorting (an infection control strategy that involves grouping residents together based on their infection status to prevent the spread of illness to healthy residents) them with Resident 1 who was suspected with CDI on 1/18/2026 and tested positive for CDI on 1/20/2026.3. Ensure the facility informed and educated Resident 1's roommates, Residents 2 and 3, when the Medical Director suspected Resident 1 of having CDI on 1/18/2026, that they were at risk of acquiring CDI and what proper infection control guidelines Residents 2 and 3 should follow to reduce the risk of transmission. 4. Ensure the facility performed monitoring of Residents 2 and 3 for signs and symptoms of CDI after their roommate, Resident 1, was suspected with CDI on 1/18/2026 and tested positive for CDI on 1/20/2026.5. Follow the facility's policy and procedure (P&P) titled, Clostridium Difficile, with revised date of 10/2018 and last review date of 8/15/2025, indicating, Residents with diarrhea associated with C. difficile (i.e. [an abbreviation for the Latin phrase id est, which translates to namely], residents who are colonized [when someone has germs on or in their body but does not have symptoms of an infection] and symptomatic [exhibiting symptoms]) are placed on contact precautions. Residents with diarrhea and suspected CDI are placed on contact precautions while awaiting laboratory results.6. Follow facility's P&P titled, Isolation (separating residents with contagious or infectious diseases from others to prevent spreading) - Categories of Transmission-Based Precautions (measures implemented in addition to standard precautions [basic level of infection control] for residents known or suspected to be infected with highly transmissible pathogens [tiny organisms that can make you sick if they get inside your body]), revised date of 9/2022 and last review date of 8/15/2025, indicating, The individual on contact precaution is placed in a private room if possible. If a private room is not available, the infection preventionist will assess various risks associated with other resident placement options (e.g. [an abbreviation for the Latin phrase exempli gratia, which means for example], cohorting, placing with a low risk roommate). Staff and visitors wear gloves (clean, non-sterile) when entering the room. Staff and visitors wear a disposable gown upon entering (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the room and remove before leaving the room.This deficient practice had the potential for Resident 1, who was infected with CDI, to transmit the infection (CDI) to Resident 2 (who was immunocompromised) and Resident 3, who were placed in the same room with Resident 1. Transmission of CDI to Resident 2 and Resident 3 could result in serious complications, including severe infection, dehydration (a condition in which the body loses more fluids [like water] than it takes in, and cannot function properly), sepsis (a life-threatening medical emergency caused by the body's extreme response to infection), hospitalization, or death. On 1/30/2026 at 4:58 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility's non-compliance with one or more requirements of participations has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident) in the presence of the Director of Nursing (DON) and the Administrator, due to the facility's failure to implement contact precautions for Resident 1 who continued to share the same room with Resident 2 (who was immunocompromised) and Resident 3, when Resident 1 had signs and symptoms consistent with CDI on 1/18/2026 and subsequently tested positive for CDI on 1/20/2026 which had the potential for Resident 1 to transmit CDI to Residents 2 and 3, placing Resident 2 and Resident 3 at risk for severe infection, dehydration, sepsis, hospitalization, or death.On 1/31/2026 at 4:45 p.m., the Administrator provided an acceptable IJ Removal Plan (a detailed plan that identifies all actions the facility will take to immediately address the non-compliance that has resulted to the IJ situation) for the facility's failure to implement contact precautions for Resident 1.On 1/31/2026 at 5:54 p.m., while onsite at the facility, the SSA verified and confirmed the facility's full implementation of the IJ Removal Plan through observations, interviews, and record reviews, and determined the IJ situation regarding the facility's failure to implement contact precautions for Resident 1 was no longer present. The SSA removed the IJ situation, while onsite, on 1/31/2026 at 5:54 p.m., in the presence of the Administrator and the Director of Nursing (DON).The acceptable IJ Removal Plan included the following summarized actions:1. On 1/29/2026 at 7:20 p.m., the Social Services Director (SSD) moved Resident 2 to Room B with no roommates due to her immunocompromised condition. Effective 1/31/2026, the Registered Nurse (RN) Supervisors on duty will monitor Resident 2 every shift for 40 days for signs and symptoms of CDI infection such as fever, abdominal pain, abdominal spasms (a sudden involuntary muscular contraction), diarrhea, and vomiting.2. On 1/30/2026 at 2:40 p.m., Room A was designated as a single isolation room, and Resident 1 was assigned no roommates.3. On 1/30/2026 at 6 p.m., the DON reviewed and revised Resident 2's care plan to reflect her (Resident 2) immunocompromised condition and that Resident 2 should not share a room with a resident who has an active infection (Resident 1).4. On 1/30/2026 at 6 p.m. and on 1/31/2026 at 6:30 a.m. and 9 a.m., the DON and/or Infection Preventionist Nurse conducted in-services (short teaching sessions designed to update staff on best practices, safety protocols, and regulatory requirements) training for all nursing staff regarding the facility's Infection Control policy. The DON and/or Infection Preventionist Nurse provided a written quiz following each in-service to validate staff understanding of the topic discussed. The topics included in the in-service were the following:a. Policy on Isolation - Categories of transmission-based precautions (second level of infection control in healthcare, implemented in addition to Standard Precautions [the basic level of infection control that should be used in the care of all residents all of the time] to prevent the spread of infections).b. Precautions specific to CDI.c. Procedures for implementing transmission-based precautions.d. Proper hand washing and disinfection (process of using chemical or physical agents to kill or inactivate most disease-causing microorganisms [an organism that is so small it can only be viewed under a microscope and not with the naked eye] on inanimate [having none of the characteristics of life] (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	objects) of environment.e. Enhanced Barrier Precaution (infection control measure that require healthcare workers to wear gowns and gloves during high-contact activities [refers to specific routine care tasks with a high risk of transferring multi-drug resistant organisms {bacteria that have developed resistance to multiple, commonly used antibiotics - medication that fight bacterial infections, to a staff member's clothing or hands] for residents)f. Personal Protective Equipment (PPE - refers to protective clothing, helmets, goggles, or other garments and equipment designed to shield the wearer's body from injury, infection, or occupational hazards [a risk accepted as a consequence of a particular occupation]).g. Cohorting strategies, including placement in a private room when feasible, or cohorting with a low-risk residents, which includes but is not limited to residents who are:Not immunocompromisedHave no open woundsDo not have significant comorbidities (the simultaneous presence of two or more diseases or medical conditions in a resident), such as uncontrolled diabetes mellitus (DM - chronic disorder characterized by high blood sugar caused by the body's inability to produce or effectively use insulin [hormone that regulates blood sugar]), severe Chronic Obstructive Pulmonary Disease (COPD - a condition involving constriction of the airways and difficulty or discomfort in breathing), or similar high-risk conditions.Any facility staff unable to attend the in-service in person will be contacted by phone and provided follow-up training prior to start of their next scheduled shift. Staff who fail to complete the in-service will be temporarily removed from the schedule until the in-service training is completed.5. On 1/30/2026 at 7 p.m. and 8 p.m., the Quality Assurance Nurse Consultant provided one-on-one (1:1) in-service (1:1 in-service - refers to individualized, one-on-one education a staff member or professional provides to a single individual) to the Administrator and the DON regarding the admission process for residents requiring isolation precautions and appropriate cohorting of residents.6. On 1/30/2026 at 7:30 p.m., the Quality Assurance Nurse Consultant provided 1:1 in-service training to the Infection Preventionist Nurse on infection control practices, including proper use of PPE and appropriate cohorting of residents with infection.7. On 1/30/2026, the Medical Records Designee and the DON conducted a record review of all residents with changes in condition, including physician orders and laboratory results, to identify any residents manifesting signs or symptoms consistent with CDI such as fever, abdominal pain/spasm, diarrhea, nausea/vomiting. No other residents were affected.8. On 1/30/2026 at 9 p.m., RN 1 assessed all residents for signs and symptoms of CDI, including fever, abdominal pain or spasms, diarrhea, nausea, and vomiting, No additional residents were affected by the deficient practice.9. Effective 1/30/2026, the DON and Infection Preventionist Nurse will review all incoming admissions to determine the need for isolation or precaution and arrange the appropriate room placement, and if necessary, newly admitted resident will be cohorted with residents who have the same infection or with residents who are not immunocompromised.10. Effective 1/30/2026, the Infection Preventionist Nurse will maintain a tracking log for all residents with active infections, including residents with CDI to prevent spread of infection.11. The Administrator and the Interdisciplinary Team (IDT - a collaborative group of healthcare professionals who work together to create, implement, and evaluate a personalized, comprehensive care plan for residents) consisting of the DON, Infection Preventionist Nurse, Dietary Supervisor, Housekeeping Supervisor, and Medical Director, will conduct monthly infection control meetings to ensure:a. The facility follows the infection control policy in handling residents with transmission-based precautions and follows the PPE policy.b. Any issues related to room placement and cohorting are promptly identified and addressed. 12. The Administrator, DON, and Infection Preventionist Nurse developed a Quality Assurance and Performance Improvement (QAPI - is a data-driven, systematic program to proactively improve resident care and quality of life, combining ensuring standards [QA] with (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	continuous process enhancement [PI] involving all staff, data, and resident/family feedback to prevent issues and achieve optimal outcomes) for Infection Control practices and root cause analysis (RCA - a structured, team-based investigation process used to identify the underlying system-level causes of adverse events) of the problem. This plan will be reviewed and updated during monthly QAPI meetings for three months to ensure the corrective actions are effective and sustained.Non-compliance of F880 remained at the scope and severity of D no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings:During a review of Resident 1's Face Sheet (admission Record), undated, the Face Sheet indicated the facility admitted Resident 1 on 1/17/2026 with diagnoses including other pulmonary embolism without acute cor pulmonale (indicates a blockage in the pulmonary arteries by a blood clot reducing blood flow but not severe enough to cause right heart failure) and sepsis. The Face Sheet indicated Resident 1 had a diagnosis of enterocolitis (is the inflammation of both the small intestines and colon, causing symptoms like severe diarrhea, abdominal pain, fever, vomiting, and dehydration) due to CDI with onset date of 1/20/2026. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/24/2026, the MDS indicated Resident 1's cognitive functioning (the ability to think, learn, remember, use judgment, and make decisions) was intact. The MDS indicated Resident 1 was dependent (helper does all of the effort and resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) on staff for eating, oral hygiene, toileting hygiene, showering/bathing self, upper body dressing, lower body dressing, and putting on/taking off footwear. During a review of Resident 1's Change in Condition (COC - major decline or improvement in a resident's status that will not resolve without intervention) Evaluation form, dated 1/20/2026 timed at 11:30 a.m., the COC indicated Resident 1 had CDI with onset of symptoms on 1/18/2026. The COC form indicated Resident 1 met the following criteria for CDI: Diarrhea: three or more liquid or watery stools above what is normal for the resident within a 24-hour period and a stool sample yields a positive laboratory test result for CDI. The COC indicated the facility placed Resident 1 on contact isolation on 1/20/2026.During a review of Resident 1's Order Summary Report, dated 1/18/2026, the Order Summary Report indicated that the physician ordered a stool sample to be collected from Resident 1 for testing of CDI as soon as possible (ASAP).During a review of Resident 1's Order Summary Report, dated 1/20/2026, The Order Summary Report indicated that the physician ordered Resident 1 to be placed on contact isolation for CDI infection (positive result) for a duration of 21 days.During a review of Resident 1's care plan titled Clostridium Difficile, with date initiated on 1/20/2026, the care plan indicated Resident 1 had CDI infection, and included interventions specifying that facility staff will place Resident 1 on contact isolation precaution.During a review of Resident 1's Laboratory Results Report, dated 1/21/2026, the Laboratory Results Report indicated that a stool sample was collected from Resident 1 on 1/20/2026 at 3:41 a.m., received by the laboratory on 1/20/2026 at 11:56 p.m., and reported on 1/21/2026 at 3:38 a.m. The results indicated that Resident 1 tested positive for CDI.During a review of Resident 2's Face Sheet, undated, the Face Sheet indicated the facility originally admitted Resident 2 on 6/20/2019 and readmitted on [DATE], with diagnoses including diffuse large B-cell lymphoma, encounter for antineoplastic chemotherapy, and acquired absence of kidney (two bean-shaped organs responsible for filtering waste, toxins and excess water from the blood).During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive functioning was intact. The MDS indicated Resident 2 needed substantial/maximal assistance (helper does more than half the effort with helper lifting or holding trunk or limbs and providing more than half the effort) from staff with toileting hygiene, shower/bathe self, lower body dressing and putting (continued on next page)

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on/taking off footwear. During a review of Resident 2's COC, dated 1/27/2026, timed at 6 p.m., the COC indicated Resident 2 was at risk for nosocomial infection (infections acquired in hospitals or healthcare facilities that were not present at the time of admission).During a review of Resident 2's care plan titled Risk for Infection, with date initiated on 1/27/2026, the care plan indicated that Resident 2 is at high risk for infection secondary to immunocompromised status and Resident 2 is at risk for nosocomial infection. The care plan indicated that facility staff will perform hand hygiene (process of cleaning one's hands with soap and water or using alcohol-based hand sanitizers to prevent the spread of infectious diseases), wear gowns and gloves while performing high contact activities.During a review of Resident 3's Face Sheet, undated, the Face Sheet indicated the facility originally admitted Resident 3 on 11/27/2024 and readmitted on [DATE] with diagnoses including other hypertrophic cardiomyopathy (a genetic condition where the heart muscle thickens but does not physically block blood flow out of the heart), chronic kidney disease (long-term, progressive loss of kidney function), type 2 DM, depression (is a serious, common medical illness characterized by a persistent low mood, sadness, or loss of interest in activities), and anxiety disorders (a group of common mental health conditions characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life, work, or relationships).During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had moderate cognitive impairment (involves noticeable memory, language, or thinking problems that exceed normal aging but do not yet severely disrupt daily independence). The MDS indicated Resident 3 needed substantial/maximal assistance from staff with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear.During an observation on 1/26/2026 at 9:30 a.m., in Resident 1's room, observed Resident 1 sharing the same room with Resident 2 and Resident 3, with an isolation cart positioned outside the room and a contact precaution sign posted.During an interview on 1/26/2026 at 10:15 a.m., with Resident 3, Resident 3 stated she (Resident 3) did not understand why her room was on isolation. Resident 3 stated that when she (Resident 3) asked the nursing staff (did not specify) for an explanation, she (Resident 3) was not provided with any information regarding the reason for the isolation. During a concurrent observation and interview on 1/26/2026 at 11:30 a.m., with Resident 2, in Resident 1's (shared) room, observed Resident 1 still sharing the room with Resident 2 and Resident 3. Resident 2 stated that she (Resident 2) was unaware why an isolation sign was posted on the door and was concerned because she (Resident 2) has a tumor (a swelling of a part of the body caused by an abnormal growth of tissue) and is receiving chemotherapy. Resident 2 stated that she asked the nurses and nurse assistants (did not specify) why they were wearing gowns while caring for Resident 1 but was told it had nothing to do with her and not to worry. Resident 2 stated that she continued to express her (Resident 2) concern because she Resident 2) is aware that her immune system (the organs and processes of the body that provide resistance to infection and toxins) is compromised. During an interview on 1/26/2026 at 2 p.m. with the Infection Preventionist Nurse, the Infection Preventionist Nurse stated that the physician (MD 1) ordered a laboratory test for Resident 1 on 1/18/2026 because he (MD 1) had a suspicion that Resident 1 might be positive for CDI infection. The Infection Preventionist Nurse stated Resident 1 was not placed on isolation precautions when the CDI test was ordered on 1/18/2026. The Infection Preventionist Nurse stated that because Resident 1 was not on contact precautions, there was an increased risk of transmitting the infection to other residents and staff. The Infection Preventionist Nurse further stated that Resident 2 should not have been sharing a room with Resident 1, as Resident 2 is immunocompromised and therefore at higher risk for infection. The Infection Preventionist Nurse stated that an infection in Resident 2 could result in severe complications, including hospitalization (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	or death, due to an inability of Resident 2's immune system to effectively respond to infection.During a telephone interview on 1/28/2026 at 12 p.m., with the Medical Director, the Medical Director was asked about Resident 1, who had CDI, sharing a room with Resident 2 and Resident 3. The Medical Director stated that facility staff were aware of the appropriate infection control measures but failed to implement them. The Medical Director further stated that staff should have followed facility policy and Centers for Disease Control and Prevention (CDC - is the nation's leading science-based, data driven, service organization that protects the public's health) guidelines and should not have cohorted Resident 1 with residents who had high-risk conditions and diagnoses, including Resident 2, who was immunocompromised. The Medical Director stated Resident 1 should not have been placed in the same room (cohorted) as Resident 2, who was highly vulnerable, and stated that there was no excuse for this failure. During an interview on 1/30/2026 at 12:45 p.m., with the Infection Preventionist Nurse, the Infection Preventionist Nurse stated that the facility did not follow its policy on CDI because Resident 1, who was positive for CDI, was cohorted with Resident 2, who was immunocompromised.During a concurrent interview and record review on 1/30/2026 at 2:04 p.m., with the DON, Resident 2 and Resident 3's Infection Risk Assessment records from 1/17/2026 to 1/30/2026 were reviewed. The DON stated that there was no documented evidence that infection risk assessments were completed for Residents 2 and 3. The DON stated that the facility should have cohorted residents correctly based on infection risk assessments and the suitability of potential roommates. The DON further stated that the infection risk assessments should have been completed by the Infection Preventionist Nurse or in their absence, by a licensed nurse to determine whether Residents 2 and 3 were appropriate roommates for Resident 1, who had CDI infection, prior to cohorting the residents. The DON stated that the failure to complete these Infection Risk Assessments placed Residents 2 and 3 at increased risk for transmission of CDI. During a concurrent interview and record review on 1/30/2026 at 3:44 p.m., with the DON, Resident 2's care plan titled Risk for Infection, with date initiated on 1/27/2026 was reviewed. The DON stated the facility failed to follow its policy for CDI because Resident 1, who had active CDI, was cohorted with Resident 2, who was immunocompromised and at high risk for infection. The DON stated that facility should not have cohorted Resident 2 with Resident 1. The DON further stated that Resident 2 was at risk for acquiring CDI, which could further compromise her (Resident 2) immune system and result in serious complications such as sepsis, dehydration, and inability to fight the infection, potentially leading to death. The DON stated she (DON) agreed with the deficient practice and stated that it created a risk of CDI transmission to other residents.During an interview on 1/30/2026 at 4:13 p.m., with the DON, the DON stated there was a failure in the facility's system process because an immunocompromised resident (Resident 2) should not be placed in the same room as Resident 1, who had CDI infection. The DON stated that they (the facility) failed to conduct Infection Risk Assessments for Resident 2 and Resident 3. The DON further stated that RNs should have performed the risk assessments whenever there was a COC or new laboratory results, in order to determine whether residents required isolation or room changes based on the needs of the resident identified with an infection. The DON stated there was a lack of staff training regarding isolation precautions and infection risk assessments.During a concurrent interview and record review on 1/31/2026 at 2:01 p.m. with the Infection Preventionist Nurse, Resident 2 and Resident 3's care plans, COCs, IDT, physician orders, and progress notes from 1/17/2026 to 1/30/2026. The Infection Preventionist Nurse stated there was no documented evidence that facility staff notified Residents 2 and 3 of their potential risk for CDI and that Residents 2 and 3 should have received education on proper infection control guidelines. The Infection Preventionist Nurse further stated that no monitoring was conducted for (continued on next page)

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