STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056129	A. Building B. Wing	04/08/2026

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 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 1 and 2) when: 1. On 3/15/2026, Resident 1 was transferred to the general acute care hospital (GACH) for altered level of consciousness (a state of reduced alertness or inability to arouse due to low awareness of the environment) and was diagnosed with opioid intoxication [a class of medication that produce powerful pain-relieving effects and have the potential to cause drowsiness, constipation, and respiratory depression] that overwhelms the body's tolerance). 2. On 3/12/2026, Resident 2 was transferred to the GACH for psychiatric (relating to mental illness) evaluation. This deficient practice had the potential to delay provision of care for Resident 1 and 2.Findings: a. During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 12/1/2025 and readmitted on [DATE] with diagnoses including encephalopathy (any disease, damage, or malfunction that alters brain function), acute kidney failure (the sudden loss of kidney function, occurring within hours or days), type two diabetes mellitus (DM II - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 2/27/2026, the MDS indicated Resident 1 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 required substantial assistance (helper does more than half the effort) from facility with personal hygiene and transferring from bed to chair. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) from facility staff with oral hygiene, upper and lower body dressing. During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 3/20/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Change of Condition (COC - major decline or improvement in a resident's status that will not resolve without intervention) form, dated 3/15/2026, the COC form indicated that on 3/15/2026, Resident 1 was transferred to the GACH for evaluation due to altered level of consciousness. During a review of Resident 1's GACH H&P, dated 3/18/2026, the GACH H&P indicated that Resident 1's had opioid intoxication and Resident 1's urine drug screen was positive for fentanyl (a type of synthetic opioid). During a review of Resident 1's Progress Note, dated 3/18/2026, timed at 5:55 p.m., the Progress Note indicated the facility readmitted Resident 1 from the GACH. During a concurrent interview and record review on 4/8/2026 at 2:17 p.m. with the Director of Nursing (DON), Resident 1's Care Plan was reviewed. The DON stated Resident 1's Care Plan did not address Resident 1's diagnoses of opioid intoxication. The DON stated the admitting licensed nurse should have reviewed Resident 1's GACH records and revised the Care Plan. The DON stated the revision of the Care Plan was necessary to update the guide for Resident 1's plan of care with necessary interventions and monitoring. The DON stated the failure to revise Resident 1's Care Plan had the potential to delay care for Resident 1. b. During a review of Resident 2's admission Record, the (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission Record indicated the facility originally admitted Resident 2 on 3/5/2013 and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), epilepsy (a condition with sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares and loss of consciousness), and depression (mental health illness causing a persistent feeling of sadness, loss of interest). During a review of Resident 2's H&P, dated 3/26/2026, 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 had intact cognitive functioning. The MDS indicated Resident 3 required moderate assistance (helper does less than the effort) from facility staff with oral hygiene, toileting hygiene, personal hygiene, upper and lower body dressing. During a review of Resident 2's COC form, dated 3/11/2026, the COC form indicated on 3/11/2026, at 10 a.m., Resident 2 verbalized wanting to kill another resident. During a review of Resident 2's Progress Note, dated 3/12/2026, the Progress Note indicated on 3/12/2026 at 11 a.m., Resident 2 was transferred to GACH for psychiatric evaluation. During a review of Resident 2's Progress Note, dated 3/24/2026, the Progress Note indicated on 3/24/2026, at 2 p.m., the facility readmitted Resident 2. During a concurrent interview and record review on 4/7/2026 at 3:10 p.m. with the Assistant Director of Nursing (ADON), Resident 2's Care Plan was reviewed. The ADON stated Resident 2's Care Plan did not address Resident 2's change of condition and hospital transfer for psychiatric evaluation on 3/12/2026. The ADON stated Resident 2's Care Plan should have been updated, goals and interventions set. The ADON stated the failure to revise the Care Plan had the potential for Resident 2 to experience decline. During a review of the facility-provided policy and procedure (P&P) titled, Care plans, Comprehensive Person-Centered, last revised 2/20/2026, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition.c. when the resident has been readmitted to the facility from a hospital stay.