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	04/24/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the Resident's Representative (RR- is a person chosen by a resident-or legally authorized-to act on their behalf to manage care, access personal information, or make decisions, particularly if the resident is incapacitated) for one of three sampled residents (Resident 6) who had a Power of Attorney (POA- a legal document that allows someone else to act on your behalf) of Resident 6's changes in conditions on 3/16/2026, and 3/18/2026.This failure had violated Resident 1's and RR's right to be informed and had the potential to increase Resident 1's and RR level of anxiety (an intense, persistent, and often overwhelming feeling of worry, dread, or unease).Findings:During a review of Resident 6?s admission Record, the admission Record indicated the facility admitted Resident 6 on 5/23/2014, with diagnoses that included acute panmyelosis (an abnormal increase in all types of blood-forming cells within the bone marrow [the inside hollow centers of bones, serves as the body's blood cell factory]), multiple sclerosis (MS-a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord) and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs).During a review of Resident 6's Advance Health Care Directive Acknowledgement Form, dated 5/14/2024, the Advance Health Care Directive Acknowledgement Form indicated RR was Resident 6's representative.During a review of Resident 6's Durable Power of Attorney (DPOA), dated 7/23/2014, the DPOA indicated the DPOA effective date was 7/23/2014, and Resident 6 appointed RR as the attorney-in-fact. The DPOA was signed and notarized on 7/23/2014.During a review of Resident 6's Minimum Data Set (MDS-a resident assessment tool) dated 3/19/2026, the MDS indicated Resident 6's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 6 was dependent on staff for all activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 6'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 3/26/2026, the H&P indicated Resident 6 had the capacity to understand and make decisions.During a review of Resident 6's Change of Condition (COC- a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 3/16/2026, the COC indicated Resident 6 had new medication for dermatitis (a common condition that causes swelling and irritation of the skin). The COC indicated Resident 6 was notified.During a review of Resident 6's COC, dated 3/18/2026, the COC indicated Resident 6 had elevated white blood cell count (WBC- (a blood cell that helps attack infection or injury in the body) and platelet (tiny, colorless cell fragments in your blood that act as your body's natural bandage). The COC indicated Resident 6 was notified.During a concurrent interview and record review on 4/24/2026, at 12:25 p.m., with the Director of Nursing (DON), Resident 6's COCs, dated 3/16/2026, and 3/18/2026, were reviewed. The DON stated the COCs on 3/16/2026, and 3/18/2026, indicated RR was not notified. The DON stated the facility was not aware that Resident 6 appointed RR had POA. The DON stated the importance of notifying the RR was to ensure RR was aware of Resident 6's COCs. The DON stated because RR was not informed, the facility may have violated Resident 6 and RR's right to be informed.During an (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056129	A. Building B. Wing	04/24/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 4/24/2026, at 12:44 p.m., with Resident 6 and RR, Resident 6 stated he (Resident 6) had an Advance Health Care Directive, and it was RR.During a review of facility's policy and procedure (P&P), titled, Resident Rights, dated 2/2021, the P&P indicated, Employees shall treat all residents with kindness, respect and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to: . k. Appoint a legal representative of his or her choice, in accordance with state law.During a review of facility's P&P, titled, Change in a Residents Condition or Status, dated 3/2023, 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 (e.g., changes in level of care, billing/payments, resident rights, etc.).4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when:a. the resident is involved in any accident or incident that results in an injury including injuries of an unknown source;b. there is a significant change in the resident's physical, mental, or psychosocial status;c. there is a need to change the resident's room assignment;d. a decision has been made to discharge the resident from the facility; and/ore. it is necessary to transfer the resident to a hospital/treatment center.

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	04/24/2026

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 five sampled residents (Resident 5) regarding skin scraping (a quick, minor medical procedure where a doctor uses a dull blade to gently rub or scrape the top layer of skin to collect a small sample).This failure had the potential for delays in the delivery of necessary care and services and could place Resident 5 at risk for scabies (a contagious skin infestation caused by tiny, eight-legged mites called Sarcoptes scabiei).Findings:During a review of Resident 5?s admission Record, the admission Record indicated the facility admitted Resident 5 on 4/17/2026, with diagnoses that included metabolic encephalopathy (a brain dysfunction caused by chemical imbalances in the body), unspecified (unconfirmed) pruritus (an uncomfortable, irritating sensation that makes you want to scratch your skin) and history of fall.During a review of Resident 5'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 4/20/2026, the H&P indicated Resident 5 had the capacity to understand and make decisions.During a review of Resident 5's Change of Condition (COC- a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 4/22/2026, the COC indicated Resident 5 was placed on contact isolation (a safety measure used in hospitals to prevent the spread of germs that are transferred by touching a patient or items in their room) to rule out scabies.During a review of Resident 5's Order Summary Report, dated 4/23/2026, the Order Summary Report indicated skin scraping.During a review of Resident 5's Minimum Data Set (MDS-a resident assessment tool), dated 4/24/2026, the MDS indicated Resident 5's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 5 required moderate assistance from staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a concurrent interview and record review on 4/24/2026, at 9:46 a.m., with the Infection Preventionist (IP), Resident 5's Care Plans, were reviewed. The IP stated there was no care plan developed for Resident 5's skin scraping to test for the presence of scabies. The IP stated care plan serves as a guide for nurses on what to do when the skin scraping for scabies resulted. The IP stated without care plan it could potentially spread scabies to other residents.During an interview on 4/24/2026, at 12:25 p.m. with the Director of Nursing (DON), the DON stated care plan for skin scraping for scabies should have been developed. The DON stated without a care plan, the nurses will not have a guide on what to do for a suspected scabies resident. The DON stated there is a potential spread of scabies to other residents, staff and visitors.During a review of facility's policy and procedure (P&P), titled, Comprehensive Person-Centered Care Plans, dated 3/2023, and last reviewed on 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 (it describes how your mind and emotions affect your social life, and how your social situation affects your mental health) 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, .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.

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	04/24/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of five sampled residents (Residents 5) by failing to administer clobetasol (medication used to treat severe skin conditions by reducing itching, redness, and swelling) on 4/23/2026, as per physician order.This failure had the potential to result in medication errors and could worsen Resident 5's dermatitis (common condition that causes swelling and irritation of the skin).Findings:During a review of Resident 5?s admission Record, the admission Record indicated the facility admitted Resident 5 on 4/17/2026, with diagnoses that included metabolic encephalopathy (a brain dysfunction caused by chemical imbalances in the body), unspecified (unconfirmed) pruritus (an uncomfortable, irritating sensation that makes you want to scratch your skin) and history of fall.During a review of Resident 5'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 4/20/2026, the H&P indicated Resident 5 had the capacity to understand and make decisions.During a review of Resident 5's Order Summary Report, dated 4/22/2026, the Order Summary Report indicated clobetasol propionate external cream 0.05 percent (%-amount in every hundred), apply to general body, topically (directly to a specific surface area of the body, such as the skin) every day and evening for unspecified dermatitis for four weeks.During a review of Resident 5's Treatment Administration Record (TAR- flowsheet that indicates treatment given to a resident), dated 4/2026, the TAR indicated on 4/23/2026, at evening shift, clobetasol was left blank.During a review of Resident 5's Minimum Data Set (MDS-a resident assessment tool), dated 4/24/2026, the MDS indicated Resident 5's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 5 required moderate assistance from staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a concurrent interview and record review on 4/24/2026, at 9:46 a.m., with the Infection Preventionist (IP), Resident 5's Physician Order, dated 4/22/2026, and TAR, dated 4/23/2026, were reviewed. The IP stated the physician ordered application of clobetasol twice a day for Resident 5's unspecified dermatitis. The IP stated the TAR, dated 4/23/2026, evening was left blank. The IP stated if TAR was blank, it means clobetasol was not given. The IP stated the nurse did not follow the order. The IP stated Resident 5's rashes can worsen because clobetasol was not administered.During an interview on 4/24/2026, at 12:25 p.m., with the Director of Nursing (DON), the DON stated Resident 5's rashes can worsen because clobetasol was not administered. The DON stated Treatment Nurses (TXN) should apply the clobetasol according to the physician order.During a review of facility's policy and procedure (P&P) titled, Administering Medications, dated 3/2023, and last reviewed on 2/20/2026, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required time frame.

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	04/24/2026

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 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 accurate and complete medical record for one of three sampled residents (Resident 3) by failing to document contact isolation (a safety measure used in hospitals to prevent the spread of germs that are transferred by touching a patient or items in their room) monitoring on 4/22/2026, during night shift.This failure had the potential to cause confusion in Resident 3's care and the medical records containing inaccurate documentation.Findings:During a review of Resident 3?s admission Record, the admission Record indicated the facility admitted Resident 3 on 8/15/2024, with diagnoses that included unspecified (unconfirmed) emphysema (a long-term lung condition that causes shortness of breath), unspecified dermatitis (a common condition that causes swelling and irritation of the skin) and history of fall.During a review of Resident 3'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 12/5/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact.During a review of Resident 3's Order Summary Report, dated 4/22/2026, the Order Summary Report indicated contact isolation precaution every shift due to unspecified dermatitis for four weeks until 5/20/2026.During a review of Resident 3's Medication Administration Record (MAR- flowsheet that indicates medication given to a resident), dated 4/2026, the MAR indicated on 4/22/2026, at night shift, the contact isolation was left blank.During a concurrent interview and record review on 4/24/2026, at 9:46 a.m., with the Infection Preventionist (IP), Resident 3's Physician Order, and MAR, dated 4/22/2026, were reviewed. The IP stated the MAR on 4/22/2026, for contact isolation was left blank. The IP stated blank means the contact isolation was not documented as ongoing. The IP stated the nurses did not complete their task of documentation. The IP stated there was no documented evidence that Resident 3 was on contact isolation on 4/22/2026, during night shift and could cause confusion in care.During an interview on 4/24/2026, at 12:25 p.m., with the Director of Nursing (DON), the DON stated without documentation of contact isolation, it could cause spread of scabies to other residents and staff.During a review of facility's policy and procedure (P&P) titled, Charting and Documentation, dated 7/2017, and last reviewed on 2/20/2026, the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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	04/24/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 its infection control measures for seven of eight sampled residents (Residents 3, 4, 2, 7, 8, 6, and 5) while the facility had scabies (a contagious skin infestation caused by tiny, eight-legged mites called Sarcoptes scabiei) outbreak (a sudden, unexpected increase in the number of cases of a disease in a specific area or population). The facility: 1. Failed to ensure Restorative Nursing Assistant 1 (RNA) 1 change gowns before providing care between Resident 3 and Resident 4 who were on contact isolation (infection control procedure used in healthcare to prevent the spread of germs transmitted by direct or indirect contact).2. Failed to ensure Certified Nursing Assistant 2 (CNA 2) wear PPE before delivering breakfast tray to Resident 2 who was on contact isolation.3. Failed to ensure CNA 2 and Licensed Vocational Nurse 1 (LVN 1) was aware of Resident 2's contact isolation precaution.4. Failed to ensure facility's Resident Line Listing was complete, to indicate Resident 7 and Resident 8 who were exposed to Resident 3 who was suspected of scabies infection.5. Failed to ensure Housekeeping Staff 1 (HSK 1) wore gloves when tying a clear plastic bag containing soiled (dirty) isolation linens and isolation trash from Resident 6 who was confirmed positive for scabies and Resident 5 who was suspected of scabies.6. Ensure HSK 1 kept isolation carts with isolation linens and trash inside Residents 6 and 5's room.7. Ensure HSK 1 separated soiled isolation linens from confirmed positive and suspected scabies residents from non-isolation residents.These failures had the potential to spread and expose other residents, staff, and visitors to scabies.Findings:a. During a record review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 12/4/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), dermatitis (skin irritation and inflammation, characterized by itchy, dry, or rash-covered skin), and malignant melanoma (aggressive form of cancer arising from melanocytes).During record review of Resident 3's Minimum Data set [MDS- resident assessment tool), dated 4/2/2026, the MDS indicated that Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated that Resident 3 required maximal assistance from staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a record review of Resident 3's Care Plan initiated 4/22/2026, titled, Contact Isolation: Unspecified Dermatitis. The care plan goal indicated to reduce risk of complications, and infections daily until the next assessment. The care plan intervention indicated will observe contact isolation precautions.During a record review of Resident 4's admission Record, the admission Record indicated that the facility admitted Resident 4 on 11/26/2025, with diagnoses that included dementia and history of falling.During record review of Resident 4's MDS, dated [DATE], the MDS indicated that Resident 4's cognitive skills for daily decisions were severely impaired. The MDS indicated that Resident 4 required supervision assistance from staff for ADLs. During an observation on 4/23/2026, at 12:55 p.m. outside of Resident 3 and Resident 4's room, RNA 1 entered the residents' room wearing personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substance and/or environments) and helped Resident 4 in going to the restroom. Resident 3, who was lying in bed, called for assistance. RNA 1 changed her (RNA 1) gloves and assisted Resident 3, still wearing the same gown used with Resident 4. RNA 1 then helped Resident 3 open food items from the bedside table. RNA 1 returned to assist Resident 4 without removing his gloves or gown.During an interview on 4/23/2026, at 12:58 p.m. with RNA 1, RNA 1 stated that staff must use a gown and gloves when providing care for Resident 3 and Resident 4, as both were on contact isolation. RNA 1 stated that he (RNA 1) only changed his (RNA 1) gloves and not his (RNA 1) gown when providing care to Resident 4 and then continued helping Resident 3 while still wearing the same gown. RNA 1 stated that he (RNA 1) should have changed both gown and gloves to prevent the spread of scabies (a contagious skin infestation caused by the (continued on next page)

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	04/24/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	microscopic mite) infection.During an interview on 4/24/2026, at 12:15 p.m. with the Director of Nursing (DON), the DON stated that nursing staff should put on gowns and gloves before entering a contact isolation room to prevent the spread of scabies. The DON stated that staff should change gloves and gowns between caring for different residents to avoid cross contamination. The DON further stated that staff must use PPE for all residents in contact isolation.b. During a record review of Resident 2's admission Record, the admission Record indicated that the facility admitted Resident 2 on 2/27/2026, with diagnoses including dermatitis and dementia.During a record review of Resident 2's MDS, dated [DATE], the MDS indicated that Resident 2's cognitive skills for daily decisions were severely impaired. The MDS indicated that Resident 2 is dependent on staff for ADLs.During a record review of Resident 2's Order Summary Report, dated 4/22/2026, the Order Summary Report indicated that Resident 2 was on Contact Isolation Precaution due to unspecified (unconfirmed) dermatitis for four until 5/20/2026.During an observation on 4/24/2026, at 8:34 a.m., CNA 2 entered Resident 2's room with breakfast tray placed it in Resident 2's bedside table without wearing proper PPE, left to collect another tray, and returned to set it up for the roommate (Resident 9).c. During an interview on 4/24/2026, at 8:35 a.m. with LVN 1, LVN 1 stated that Resident 2 was not in contact isolation and was on Enhanced Barrier Precaution (EBP- infection control measures for high-risk residents, to reduce the spread of multidrug-resistant organism [MDRO- Bacteria that resist treatment with more than one antibiotic]) due to a wound. LVN 1 stated that she (LVN 1) was not sure who was on EBP or who was on contact isolation. LVN 1 stated that staff must wear a gown and gloves when taking care of residents on contact isolation.During an interview on 4/24/2026, at 2:30 p.m. with CNA 2, CNA 2 stated that staff must wear a gown and gloves before entering the room of any resident on contact isolation. CNA 2 stated that she (CNA 2) was not sure if she (CNA 2) should wear a gown and gloves when delivering food trays and setting them on resident bedside table to resident on contact isolation. CNA 2 stated that she (CNA 2) was not sure if Resident 2 was on contact isolation or on EBP. CNA 2 stated that she (CNA 2) had only worked at the facility for two months and did not know why residents are placed on contact isolation or EBP.During an interview on 4/24/2026, at 12:15 p.m. with DON, the DON stated that nursing staff should put on gowns and gloves before entering a contact isolation room to prevent the spread of scabies. The DON stated that staff should know who the residents on contact isolation are and who is on EBP. The DON stated that staff should wear proper PPE for residents on contact isolation when delivering food tray and proving care.d. During a record review of Resident 7's admission Record, the admission Record indicated that the facility admitted Resident 7 on 4/7/2026, with diagnoses including osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of right ankle and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a record review of Resident 7's MDS, dated [DATE], the MDS indicated that Resident 7's cognitive skills for daily decision was intact.During a record review of Resident 8's admission Record, the admission Record indicated that the facility initially admitted Resident 8 on 2/1/2026, and readmitted on [DATE], with diagnoses including sepsis (a life-threatening blood infection) and dementia.During a record review of Resident 8's MDS, dated [DATE], the MDS indicated that Resident 8's cognitive skills for daily decisions were moderately impaired.During a concurrent interview and record review on 4/24/2026, at 9:45 a.m. with the Infection Preventionist (IP) Nurse, Resident Line Listing was reviewed. The IP nurse stated that she (IP) missed adding Resident 7 and Resident 8 names on the resident line list but Residents 7 and 8 were treated for scabies since they were Resident 3's roommates. The IP nurse stated that Resident 7 and Resident 8 were exposed to scabies and should have been on the resident line list to continue to monitor them.During an interview on 4/24/2026, at 12:22 p.m., with the DON, the DON stated that Resident 7 and Resident 8 should have been included in the resident line list because they were roommates of suspected scabies resident. The DON stated that it was important to include all residents who were affected because the facility can monitor them for signs and symptoms and immediately notify the physician. The DON stated that if affective residents were not added to the (continued on next page)

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	04/24/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident line list the facility would not be able to monitor and provide the care that is needed.During a review of the Acute Communicable Disease Control (ACDC) Program -Scabies Prevention and Control Guidelines for Healthcare Settings (the Guideline) dated 2/2026, the Guideline indicated that a line listing of symptomatic patients/residents and Healthcare Workers (HCW) with a separate line list of their contacts. Identify and prepare a line listing of all patients/residents who were contacts to a patient/resident with scabies or HCW with scabies during the exposure period.During a review of facility's Policy and Procedure (P&P) titled Isolation-Categories of Transmission-Based Precautions revised 2/2026, the P&P indicated that Staff and visitors wear gloves and disposable gowns upon entering the room and remove before leaving the room to avoid touching potentially contaminated surfaces with clothing after gown is removed.During a review of facilities P&P titled Infection Preventionist revised on 9/2022, the P&P indicated that the Infection Preventionist provides education and training on evidence-based infection prevention and control practices.e. During a review of Resident 6?s admission Record, the admission Record indicated the facility admitted Resident 6 on 5/23/2014, with diagnoses that included acute panmyelosis (an abnormal increase in all types of blood-forming cells within the bone marrow [the inside hollow centers of bones, serves as the body's blood cell factory]), multiple sclerosis (MS-a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord) and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs).During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decisions were intact. The MDS indicated Resident 6 was dependent on staff for all ADL.During a review of Resident 6'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 3/26/2026, the H&P indicated Resident 6 had the capacity to understand and make decisions.During a review of Resident 6's Physician Order, dated 4/22/2026, the Physician Order indicated contact isolation precaution due to scabies for four weeks until 5/20/2026.During an observation on the facility's front entrance, on 4/24/2026, at 8 a.m., a notification letter, dated 4/23/2026, was posted by the main sliding entrance door. The notification letter addressed to residents, visitors and staff indicated the facility had scabies infection.During an observation on 4/24/2026, at 8:11 a.m., outside of Resident 6's room, observed contact isolation signage posted outside of Resident 6's room, isolation cart with gloves, gown and mask were at Resident 6's doorway. Observed trash and soiled linen cart inside Resident 6's room.During a concurrent observation and interview on 4/24/2026, at 8:15 a.m., with HSK 1, outside of Resident 6's room, observed HSK 1 without gloves took the trash and isolation soiled cart outside of the room, pushed it along the hallway and tied the clear plastic bag with trash and the clear plastic bag with soiled isolation linen and dropped it off onto the parachute door. Observed HSK 1 returned the empty isolation trash and soiled linen cart back to Resident 6's room. HSK 1 stated the parachute drop off, leading to the laundry room.f. During a review of Resident 5?s admission Record, the admission Record indicated the facility admitted Resident 5 on 4/17/2026, with diagnoses that included metabolic encephalopathy (a brain dysfunction caused by chemical imbalances in the body), unspecified pruritus (an uncomfortable, irritating sensation that makes you want to scratch your skin) and history of fall.During a review of Resident 5's H&P, dated 4/20/2026, the H&P indicated Resident 5 had the capacity to understand and make decisions.During a review of Resident 5's Order Summary Report, dated 4/22/2026, the Order Summary Report indicated contact isolation precaution due to unspecified dermatitis for four weeks until 5/20/2026.During a review of Resident 1's Change of Condition (COC- a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 4/22/2026, the COC indicated resident 5 was placed on contact isolation to rule out scabies.During a review of Resident 5's Order Summary Report, dated 4/23/2026, the Order Summary Report indicated skin scraping (a quick, minor medical procedure where a doctor uses a dull blade to gently rub or scrape the top layer of skin to collect a small sample).During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's (continued on next page)

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	04/24/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 5 required moderate assistance from staff for ADL.During an observation on 4/24/2026, at 8:10 a.m., outside of Resident 5's room, observed contact isolation signage posted outside of Resident 5's room, isolation cart with gloves, gown and mask were at Resident 5's doorway. Observed trash and soiled linen cart inside Resident 5's room.During an observation on 4/24/2026, at 8:18 a.m., outside of Resident 5's room, HSK 1 observed without gloves took the trash and isolation soiled cart outside of the room, pushed it along the hallway and tied the clear plastic bag with trash and the clear plastic bag with soiled isolation linens and drop it off onto the parachute door. Observed HSK 1 returned the empty isolation trash and soiled linen cart back to Resident 5's room.g During a concurrent observation and interview on 4/24/2026, at 8:24 a.m., with HSK 1, in the soiled laundry room, observed tied clear bags of soiled linens on top of a large yellow container. HSK 1 stated he (HSK 1) was not sure which is the isolation linens.During a concurrent observation and interview on 4/24/2026, at 8:26 a.m., with Laundry Staff 1 (LS 1), translated by the Maintenance Supervisor (MS), inside the soiled laundry room, LS 1 stated all the linens currently in the soiled laundry room were from non-isolation rooms. LS 1 stated isolation linens were collected at the same time and placed in a separate location outside and washed separately on the assigned washer and dryer only for isolation linens.During an interview on 4/24/2026, at 8:37 a.m., with the Laundry Staff Supervisor (LSS), the LSS stated the facility's process when collecting isolation linens and trash was to bring the cart only for isolation in front of the isolation room, the LS will don (put on) gloves and gown, go inside isolation room, tie the trash bag and the soiled linen bag inside the room, double bag both trash and soiled linen bag inside the room, place in the cart in the hallway and transport outside of the facility. The LSS stated because HSK 1 dropped off the isolation linens in the parachute drop off, it mixed up with the regular non isolation linens. The LSS stated it could contaminate other linens and could cause spread of infection.During an interview on 4/24/2026, at 9:23 a.m., with CNA 1, CNA 1 stated Resident 5 was on isolation for scabies. CNA 1 stated LS collects soiled trash and linens from the isolation rooms.During an interview on 4/24/2026, at 9:46 a.m. with the IP, the IP stated the facility had scabies outbreak. The IP stated Residents 6 went to his (Resident 6) Oncologist (medical specialists trained to diagnose, treat, and manage care for people with cancer [a group of diseases characterized by uncontrolled, abnormal cell growth that can invade nearby tissues and spread to other parts of the body]) appointment and came back the same day on 4/22/2026, with diagnosis of scabies. The IP stated Resident 5 had symptomatic rashes and was suspected of scabies. The IP stated contact isolation rooms had red hampers for trash and soiled linens. The IP stated the parachute laundry door was for regular soiled linens not from isolation rooms. The IP stated mixing laundry with isolation linens could potentially spread scabies to other residents, staff and visitors.During an interview on 4/24/2026, at 12:25 p.m., with the DON, the DON stated the isolation hampers should stay in the isolation rooms and HSK 1 should have used gloves and gown before collecting the isolation trash and contaminated soiled linens from the isolation rooms. The DON stated HSK 1 should have taken the isolation trash and linens separately and not mix with other non-isolation soiled linens to prevent the spread of scabies.During a review of facility's P&P titled, Scabies Identification, Treatment and Environmental Cleaning, dated 4/2026, was reviewed. The P&P indicated, The purpose of this procedure is to treat residents infected with and sensitized to Sarcoptes scabiei and to prevent the spread of scabies to other residents and staff.12. Individuals who come into contact with the infected resident or with potentially contaminated bedding or clothing should wear a gown and gloves or other protective clothing as established by the facility's infection and exposure control programs.Environmental Control: Typical Scabies (classic scabies-causes intense, night itching and a pimple-like rash, typically affecting few mites): .4. Place bed linens, towels and clothing used by an affected person during the four days prior to initiation of treatment in plastic bags inside the resident's room, handled by gloved and gowned staff without sorting, and washed in hot water for at 10-20 minutes.5. Use the hot cycle of the dryer for at least 10-20 minutes.Environmental Control: (continued on next page)

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	04/24/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Atypical Scabies (crusted/Norwegian-presents with thick, widespread crusts, often lacking itching due to weakened immunity, and harbors thousands of mites): .1. Maintain contact precautions until treatment is complete and/or resident is determined (by Dermatologist [a medical doctor who specializes in treating the health of your skin, hair, and nails] or primary care provider) to be scabies free.5. Bed linens, towels and clothing used by the affected persons during the four days prior to initiation of treatment should be placed in a plastic bag inside the resident's room, handled by gloved and gowned laundry staff without sorting, and laundered in hot water for at least 10 minutes.During a review of ACDC- Scabies Prevention and Control Guidelines for Healthcare Settings, dated 2/2026, the ACDC indicated, Place bed linens, towels and clothing used by an affected person during the three days prior to initiation of treatment in plastic bags inside the patient's/resident's room, handled by gloved and gowned HCW without sorting, and washed in hot water. The hot cycle of the dryer should be used. Non-washable blankets and articles can be placed in a plastic bag for three to seven days, dry cleaned or tumbled in a hot dryer.