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	05/12/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the personal items of clothing of one of three sampled residents (Resident 1), who was cognitively impaired (refers to difficulties with thinking, learning, remembering, and using judgment, among other mental abilities), were not lost.This deficiency practice resulted in Resident 1 being discharged to home in a hospital gown with no shoes. Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the Resident 1 on 4/17/2026 with diagnoses including metabolic encephalopathy (brain dysfunction caused by an underlying systemic or chemical imbalance in the body, rather than a direct physical injury to the brain), cerebral ischemia (occurs when there is insufficient blood flow to the brain to meet its metabolic demands), paroxysmal atrial fibrillation (a type of irregular heartbeat characterized by intermittent episodes of chaotic electrical activity in the heart's upper chambers), myocardial infarction (occurs when blood flow to a part of the heart is blocked, causing heart muscle tissue to die from oxygen deprivation), difficulty in walking, and muscle weakness. During a review of Resident 1's Inventory List: Resident's Clothing and Possessions, dated 4/17/2026, the Inventory List indicated that upon admission Resident 1 had one jacket, two socks, one sweatpants, and one pair of shoesDuring a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 4/24/2026, the MDS indicated the resident's cognitive skills for daily decision making were impaired. The MDS indicated Resident 1 needed partial/moderate assistance (helper does less than half the effort and helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for toileting hygiene, shower/bathe self, upper body dressing, and lower body dressing. During a review of Resident 1's Progress Notes, dated 5/1/2026 timed at 4 p.m., the Progress Notes indicated that Resident 1 was discharged to home with FM 1 and that staff could not find Resident 1's clothes and FM 1 took her (Resident 1) home wearing a hospital gown. During an interview with Family member 1 (FM 1) on 5/6/2026, at 8:30 a.m., FM 1 stated that Social Services Director (SSD) called him on 4/28/2026 to come pick Resident 1 from the facility because insurance would not continue to pay for Resident 1's stay at the facility. FM 1 stated that on 5/1/2026 when he went to pick Resident 1, Resident 1 was missing all her personal items of clothing that she had upon admission on [DATE]. FM 1 stated the SSD stated he could not find them and Resident 1 was discharged to home wearing a hospital gown with no shoes.During an interview with the Social Services Director (SSD) on 5/7/2026 at 4 p.m., the SSD stated Resident 1 was admitted in the facility on a short-term basis. The SSD stated on 5/1/2026 when Resident 1 was being discharged FM 1 informed him that Resident 1's clothing's were missing. The SSD stated he searched for the missing items of clothing in the facility but did not find them. The SSD stated Resident 1 went home wearing a hospital gown. The SSD stated it was inappropriate to discharge Resident 1 home in a hospital gown.During a concurrent interview and record review on 5/8/2026 at 9:20 a.m. with the Director of Nursing (DON), Resident 1's Inventory List was reviewed. The DON stated Resident 1's Inventory List dated 4/17/26 had personal belongings listed. The DON stated that upon discharge Resident 1 did not have her belongings and Resident 1 went home wearing a hospital gown. The DON stated that was a failure on the facility's part that Resident 1 went home without dignity.During a review of the facility-provided policy and (continued on next page)

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedure (P&P) titled, Identifying Exploitation, Theft and Misappropriation of Resident Property, last reviewed on 2/20/2026, the P&P indicated 1. Exploitation, theft and Misappropriation 6. Staff and providers are expected to report suspected exploitation, theft or misappropriation of Residents property.During a review of the facility-provided policy and procedures (P&P) titled, Personal property,' last reviewed 2/20/26 indicated 1. Residents are permitted to retain and use personal possessions including clothes. 2. Residents' belongings are treated with respect by the facility staff regardless of perceived value.

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who was cognitively impaired (refers to difficulties with thinking, learning, remembering, and using judgment, among other mental abilities), had a safe discharge by failing to: 1. Ensure Resident 1 received a 30-day-written notice of discharge.2. Create a discharge care plan upon Resident 1's admission.3. Ensure the Social Services Director (SSD) informed Family Member (FM) 1 during a telephone call about Resident 1's Notice of Medicare Non-Coverage regarding appeal rights and the process to appeal the discharge. 4. Identify Resident 1's discharge needs before the discharge on [DATE].5. Include FM 1 in Resident 1's discharge planning process.6. Conduct an interdisciplinary team (IDT) meeting prior to Resident 1's discharge on [DATE].7. Determine a caregiver's availability and evaluate the caregiver's ability to assist with Resident 1's care.These deficient practices resulted to the facility inappropriately discharging Resident 1 on 5/1/2026 and had the potential to place Resident 1 at risk for health complications. Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the Resident 1 on 4/17/2026 with diagnoses including metabolic encephalopathy (brain dysfunction caused by an underlying systemic or chemical imbalance in the body, rather than a direct physical injury to the brain), cerebral ischemia (occurs when there is insufficient blood flow to the brain to meet its metabolic demands), paroxysmal atrial fibrillation (a type of irregular heartbeat characterized by intermittent episodes of chaotic electrical activity in the heart's upper chambers), myocardial infarction (occurs when blood flow to a part of the heart is blocked, causing heart muscle tissue to die from oxygen deprivation), difficulty in walking, and muscle weakness. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 4/24/2026, the MDS indicated the resident's cognitive skills for daily decision making were impaired. The MDS indicated Resident 1 needed partial/moderate assistance (helper does less than half the effort and helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for toileting hygiene, shower/bathe self, upper body dressing, and lower body dressing.During a review Resident 1's Baseline care plan form, dated 4/22/2026 at 12 p.m., the form indicated the form was not filled and was empty indicating the baseline care plan for discharge was not completed.During a review of Resident 1's Transfer/Discharge summary form, the form indicated Resident 1 was discharged with generalized body dermatitis with excoriation.During a review of Resident 1's Self-Administration of Medication form, the form indicated Resident 1 cannot administer medication to self. During review of Interdisciplinary Team (IDT - a collaborative group of healthcare professionals from various specialties who work together to manage, coordinate, and evaluate a patient's care), the IDT indicated there was no IDT meeting done regarding Resident 1's discharge.During a review of Transfer /Discharge report, the report indicated that Resident 1 was discharged with the following medications:Metropol Tartrate oral Tablet 25 milligrams (mg - unit of measurement). Directions: give one tablet by mouth two times a dayIvermectin oral tablets 3 mg. Directions: give 6 tablets by mouth one time a day every Thursday for unspecified dermatitis for 4 weeks take 6 tablets =18 MGAmiodarone HCL Oral Tablet 200 mg. Directions: Give 1 tablet by mouth one time a dayApixaban Oral Tablet 5 mg. Directions: Give 1 Tablet by mouth tow times a day.Hydroxyzine HCL Tablet 10 mg. Directions: give 1 tablet by mouth one time a day for itching.During an interview with FM 1 on 5/6/2026, at 8:30 a.m., FM 1 stated that the Social Services Director (SSD) called him on 4/28/2026 to come pick Resident 1 from the facility because Resident 1's insurance would not continue paying for her stay at the facility. FM 1 stated the facility did not explain to him the discharge process and was not given an option to appeal the decision to discharging Resident 1 from the facility as he felt Resident 1 was not strong enough to go home. FM 1 stated that when Resident 1 was discharged he was given some of Resident 1's medications from the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility and has not given them to the Resident 1 as he does not know how to give them. FM 1 stated he works 12 hours a day and Resident 1 is left at home all day until he comes back from work. FM 1 stated that Resident 1 spends most of the day in bed until he comes back from work at 6 p.m. FM 1 stated when he comes back home in the evening, that is when he changes the incontinent briefs and feeds Resident 1.During an interview with the Social Services Director (SSD) on 5/7/2026 at 4 p.m., the SSD stated Resident 1 was admitted in the facility on a short-term basis. The SSD stated he received Resident 1's last coverage date notice from the business office on 4/28/2026 and called FM 1 on the same day and informed FM 1 of the Notice of Medicare Non-coverage Notice received from the business office. The SSD stated he informed FM 1 to organize and come to the facility to take Resident 1 home. The SSD stated he did not explain to FM 1 the appeal rights process as FM 1 did not object to the discharge and was willing to come and take Resident 1 home. The SSD stated that by not providing the information regarding the appeal process on discharge FM 1 was denied the opportunity to file for an appeal before Resident 1 was discharged from the facility.During a concurrent interview and record review on 5/8/2026 at 8 a.m. with the Director of Nursing (DON), the policy titled, Transfer of Discharge Documentation, was reviewed. The policy indicated that when a resident is transferred or discharged , details of the discharge will be documented in the medical records, and appropriate information will be communicated to the receiving healthcare facility or provider. The DON stated there was no documentation of the dermatitis (is a broad term for inflammation of the skin) and improvements on discharge. The DON stated there was no documentation that there was discharge planning done for Resident 1 prior to Resident 1's discharge on [DATE]. The DON stated there was no IDT done for Resident 1 and there was no evidence that the care giver (FM 1) was assessed and was able to take care of Resident 1 at home. The DON stated there was no documented evidence that Resident 1's discharge back to the community was feasible. The DON stated the Notice of Medicare Non coverage document is to inform the resident or family member on the non-coverage date. The DON stated the SSD is to provide the family with the appeal process. The DON stated the SSD failed to provide the appeals process to FM 1 and this was against the facility's policy and procedure because it denied FM 1 a chance to appeal the decision of the discharge.During an Interview with Medical Doctor (MD) 1 on 5/8/2026 at 9 a.m., MD 1 stated that if Resident 1 was discharged home on Apixaban and has not taken it since discharge, it is a real risk that can lead to stroke and even death. MD 1 stated if Resident 1 was discharged on Amiodarone Medication interactions: Amiodarone can prolong Apixaban so it can remain anticoagulated (having your blood treated to prevent it from clotting) longer which can lead to the development of blood clots and even death.During an interview with the DON on 5/8/2026 at 9:20 a.m., the DON stated the discharge process starts from admission and to conduct IDT meeting when they meet with the family member and determine the discharge goal and work with the rehabilitation department to be able to get to their prior level of condition before admission. The DON stated the facility's discharge process was not followed for Resident 1 and it placed Resident 1 at risk for unsafe discharge as the facility was not aware of Resident 1's discharge goals prior to discharge. The DON stated FM 1 was not involved in the discharge planning for Resident 1.During a review of the facility-provided policy and procedures (P&P) titled, Discharge Summary and Plan, last reviewed on 1/15/2026, the P&P indicated that when a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. 4. Every resident will be evaluated for his or her discharge needs and will have an individualized post-discharge plan. 5. The post-discharge plan will be developed by the care planning /interdisciplinary team with assistance of the resident and his or her family and will include (c). a description of the residents stated discharge goals. 6. Discharge plan will be r-evaluated based on changes in the resident's condition or needs prior to discharge. 7. The resident representative will be involved in the post-discharge planning process and informed of the final post-discharge plan. 12. A member of the IDT will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is to take place. 13. A copy of the following will be provided to the resident, and a copy will be filed in the resident medical records. (a). An evaluation of the residents' needs (b). post discharge plan and (c). The discharge summary.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a baseline initial comprehensive assessment for functional capacity for one of three sampled residents (Resident 1), who was cognitively impaired (refers to difficulties with thinking, learning, remembering, and using judgment, among other mental abilities). This deficiency practice resulted in Resident 1 being discharged to home without proper assessment to determine Resident 1's needs at home.Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the Resident 1 on 4/17/2026 with diagnoses including metabolic encephalopathy (brain dysfunction caused by an underlying systemic or chemical imbalance in the body, rather than a direct physical injury to the brain), cerebral ischemia (occurs when there is insufficient blood flow to the brain to meet its metabolic demands), paroxysmal atrial fibrillation (a type of irregular heartbeat characterized by intermittent episodes of chaotic electrical activity in the heart's upper chambers), myocardial infarction (occurs when blood flow to a part of the heart is blocked, causing heart muscle tissue to die from oxygen deprivation), difficulty in walking, and muscle weakness. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 4/24/2026, the MDS indicated the resident's cognitive skills for daily decision making were impaired. The MDS indicated Resident 1 needed partial/moderate assistance (helper does less than half the effort and helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for toileting hygiene, shower/bathe self, upper body dressing, and lower body dressing.During an interview with the Social Services Director (SSD) on 5/7/2026 at 4 p.m., the SSD stated Resident 1 was admitted in the facility on a short-term basis. The SSD stated that upon Resident 1's admission on [DATE] he did not do an initial comprehensive assessment of Resident 1. The SSD stated that it was only on 5/1/2026 when Resident 1 was being discharged , that the SSD completed the comprehensive assessment of Resident 1. The SSD stated it is important to do initial baseline comprehensive assessment upon admission to know Resident 1's discharge goals upon discharge. The SSD stated that by not having appropriate care plans and discharge goals it can lead to Resident 1 not receiving services that they need upon discharge. The SSD stated there was no documentation that the care giver (FM 1) was available to take care of Resident 1 at home when discharged . The SSD stated that there was no assessment done on Resident 1 to see if Resident 1 was safe to return home.During a concurrent interview and record review on 5/8/2026 at 9:20 a.m. with the Director of Nursing (DON), Resident 1's assessments were reviewed. The DON stated there was no initial comprehensive assessment done on Resident 1. The DON stated it was important to do an initial comprehensive assessment of residents upon admission to know their discharge goals. The DON stated that the discharge process starts upon admission and for Resident 1 it was not done. The DON stated this failure placed Resident 1 at risk for unsafe discharge as the facility was not aware of Resident 1's discharge goals prior to discharge.During a review of the facility-provided policy and procedures (P&P) titled, Care Plans-Baseline, last reviewed on 2/20/2026, the P&P indicated a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. 2. The baseline care plan includes instructions needed to provide effective, person-centered care of the residents that meet must include. a. initial goals based on admission orders discussion with Residents/representative.