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	06/11/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, the facility failed to ensure a resident who received hemodialysis (a medical treatment that acts as an artificial kidney, filtering waste products and extra fluid from the blood when kidneys are not working well) received treatment in accordance with professional standards of practice for one of three sampled residents (Resident 2) by failing to ensure clear communication between the facility, dialysis center, and the physician for timely administration of Resident 2's medications. This deficient practice had the potential to delay care and negatively affect Resident 2's well-being. Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 5/12/2026 with diagnoses including end stage renal disease (ESRD-irreversible kidney failure), dependence on renal dialysis, unspecified psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality), and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares and loss of consciousness). During a review of Resident 2's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 5/12/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions.During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 5/17/2026, the MDS indicated Resident 2 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 2 required moderate assistance (helper does less than half the effort) from facility staff with oral hygiene and personal hygiene. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) from facility staff with toileting hygiene, showers, and lower body dressing.During a review of Resident 2's Order Summary Report, the Order Summary Report indicated the following physician's order:-5/12/2026: Dialysis days: Monday, Wednesday, and Friday. Chair time: 8 a.m. -5/12/2026: Apixaban (medication used to prevent blood clots from forming) oral tablet 2.5 milligrams (mg.-unit of measurement). Give one tablet by mouth two times a day for deep venous thrombosis prophylaxes (prevention of DVT - a serious medical condition that occurs when a blood clot forms in a deep vein, usually in the legs or pelvis). -5/12/2026: Bumex (medication used to treat swelling and fluid retention) tablet 0.5 mg. Give one tablet by mouth one time a day for ESRD. -5/12/2026: Topiramate (medication used to control certain types of seizures) oral tablet 200 mg. Give one tablet by mouth one time a day for seizures. -5/12/2026: Risperidone (medication used to treat mental health conditions such as psychosis) oral tablet four (4) mg. Give one tablet by mouth two times a day for psychosis manifested by extreme paranoid hallucinations (seeing, hearing, or feeling things that others do not, specifically tied to themes of being watched, threatened, or persecuted) interfering with activities of daily living and causing social isolation. During a review of Resident 2's Medication Administration Record (MAR), dated 5/2026, the MAR indicated that on 5/22/2026, 5/27/2026, and 5/29/2026, for 9 a.m. administration time, there were no licensed staff initials in the box for Resident 2's Apixaban Bumex, Topiramate, and Risperidone to indicate that the medications were administered. The MAR indicated that on 5/22/2026, 5/27/2026, and 5/29/2026, for 9 a.m. administration time, charting code 9 (other/see progress notes) was marked in the box for Resident 2's Apixaban Bumex, Topiramate, and Risperidone indicating to see Resident 2's progress notes for more details. During a (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concurrent interview and record review on 6/10/2026 at 3:11 p.m. with the Director of Nursing (DON), Resident 2's Order Summary Report, dated 5/2026, and Administration Notes, dated 5/22/2026 at 13:08 p.m., 5/27/2026 at 14:46 p.m., and 5/29/2026 at 14:01 p.m. were reviewed. The Administration Notes indicated that on 5/22/2026, 5/27/2026, and 5/29/2026, Resident 2 was out of the facility for dialysis. The DON stated Resident 2's Apixaban Bumex, Topiramate, and Risperidone were not administered on 5/22/2026, 5/27/2026, and 5/29/2026 for 9 a.m. administration time because Resident 2 was out of the facility for dialysis. The DON stated Resident 2's Order Summary Report did not indicate an order from the physician to hold medications prior to dialysis. The DON stated the facility staff should have contacted the physician to clarify which medications should be administered and which medications should be held prior to Resident 2 leaving the facility for dialysis. The DON stated there was a potential for Resident 2 to experience adverse side effects from missing medications. The DON stated Resident 2 was placed at risk to for experiencing seizures, blood clothes, fluid overload, and uncontrolled behaviors. During a review of the facility-provided policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident with, last reviewed on 2/20/2026, the P&P indicated, Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. 2. Education and training of staff includes, specifically. E. timing and administration of medications, particularly those before and after dialysis.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 three sampled residents (Residents 1) by failing to: 1. Ensure the dosage for Resident 1's Ivermectin (an antiparasitic medication [medications used to treat infections caused by parasites, such as worms, mites] used to treat infections and skin conditions like scabies [a highly contagious skin condition caused by mites]. Ivermectin dosing for adults is based on weight: 0.2 milligram [mg-unit of measurement] per kilogram (kg-unit of measurement] of body weight) order was accurate based on Resident 1's weight. 2. Ensure timely reordering of Resident 1's levocarnitine (medication used to treat or prevent carnitine deficiency [a condition where cells cannot properly utilize fats for energy, often resulting in muscle weakness, heart problems, or liver issues]). Findings: During a review of Resident 1?s admission Record, the admission Record indicated the facility originally admitted Resident 1 on 5/13/2024, and readmitted on [DATE] with diagnoses including unspecified (unconfirmed) multiple sclerosis (MS - a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), acute panmyelosis (aggressive form of acute myeloid leukemia [blood cancer] severe bone marrow scarring [a serious condition in which fibrous scar tissue replaces the spongy marrow), dermatitis (skin inflammation with no determined or officially diagnosed cause), and scabies.During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 3/26/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/31/2026, 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 was dependent (helper does all the effort) on facility staff for oral hygiene, toileting hygiene, showers, personal hygiene, upper and lower body dressing. a. During a review of Resident 1's Weights and Vitals Summary, dated 4/12/2026, the Weights and Vitals Summary indicated that on 4/12/2026, Resident 1's weight was 153 pounds (lbs.-unit of measurement). During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following physician's order:-4/22/2026: Ivermectin oral tablet six (6) mg. Give one tablet by mouth one time a day every Thursday for scabies for four weeks. During an interview on 6/11/2026 at 9:42 a.m. with the Dispensing Pharmacist (DP -pharmacist who interprets prescriptions, prepares, packages, labels, and provides medications to the facility for administration), the DP stated Resident 1's order for Ivermectin, dated 4/22/2026, was a weight-based dosage (dosage by weight that uses a person's body mass to determine the precise medication amount) administered once a week. The DP stated the dispensing pharmacy does not have access to resident's weight unless provided by the facility staff. The DP stated that since Resident 1's weight was not provided to the dispensing pharmacy, the dispensing pharmacy would not be able to identify that the Ivermectin dosage was low for Resident 1. During an interview on 6/11/2026 at 9:54 a.m. with the Pharmacy Consultant (PC), the PC stated that Ivermectin dosing was based on residents' body weight (0.2 mg per kg of body weight). The PC stated there was no renal adjustment (the process of modifying a medication dosage or timing to account for reduced kidney function) recommendation for Ivermectin. The PC stated that based on Resident 1's weight, the Ivermectin dosage would be 15 mg. During an interview on 6/11/2026 at 10:22 a.m. with the DP, the DP stated 6 mg. of Ivermectin was a subtherapeutic dose for Resident 1. The DP stated administering low dose of Ivermectin had the potential for the medical indication (medical reason for using a specific therapy) not be successfully treated, required an extension of the treatment. During a concurrent interview and record review on 6/11/2026 at 10:36 a.m. with the Director of Nursing (DON), Resident 1's Progress Notes and Order (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Summary dated 4/2026 were reviewed. The DON stated that once residents returned from an outpatient appointments with new orders, the facility staff should notify the primary physician and place an order with the dispensing pharmacy. The DON stated that on 4/22/2026, Resident 1 returned from an outpatient appointment with Hematologist (a medical doctor who specializes in diagnosing, treating, and managing conditions affecting the blood, bone marrow, and lymphatic system) with an order of 6 mg. Ivermectin once a week for four weeks. The DON stated there was no documented evidence to indicate that facility attempted to clarify Ivermectin dosage with the prescribing physician or Resident 1's Primary Physician. The DON stated the facility staff should have had clear communication with the dispensing pharmacy and the physician for Resident 1's Ivermectin dosage clarification. The DON stated the facility staff should have provided Resident 1's weight to the dispensing pharmacy to ensure the right dosage of Ivermectin was dispensed for Resident 1. The DON stated that administering lower than recommended dose of Ivermectin to Resident 1 had the potential to cause Resident 1's skin condition not to improve. During a review of the facility-provided policy and procedure (P&P) titled, Adverse Consequences, Medication Errors, and Unnecessary Medication, last reviewed on 2/20/2026, the P&P indicated, The interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions (ARDs) and side effects. 5. The staff and practitioner shall strive to avoid the use of unnecessary drug and minimize adverse consequences by: a. following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication.b. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following physician's order:-3/14/2026: Levocarnitine tablet 300 mg. Give two tablets by mouth every 12 hours for carnitine deficiency. During a concurrent interview and record review on 6/10/2026 at 9:36 a.m. with Registered Nurse (RN) 1, Resident 1's Progress Notes dated 6/8/2026 timed at 9:45 a.m. and 9:56 p.m. were reviewed. The Progress Note dated 6/8/2026, timed at 9:45 a.m., indicated that on 6/8/2026 for 9 a.m. administration time, Resident 1 received one tablet of levocarnitine. The Progress Note indicated levocarnitine was on the way from the pharmacy. The Progress Note dated 6/8/2026, timed at 9:56 p.m., indicated that on 6/8/2026 for 9 p.m. administration time, levocarnitine was ordered from the pharmacy. RN 1 stated there was no documented evidence to indicated that the facility reordered Resident 1's levocarnitine prior to 6/8/2026. RN 1 stated the facility staff should have reordered the medication at least 5 days prior to completion of the current supply to make sure Resident 1 did not miss a dose. RN 1 stated failure to reorder levocarnitine on time had the potential to place Resident 1 at risk of experiencing adverse reaction (a harmful, unintended, and undesirable response to a medication or treatment) due to a missed dose. During an interview on 6/10/2026 at 2:56 p.m. with the DON, the DON stated facility staff should have reordered Resident 1's levocarnitine five days prior to finishing the current supply to give enough time for order processing and delivery. The DON stated levocarnitine was reordered on 6/8/2026 and on 6/8/2026 for 9 a.m. administration time Resident 1 did not receive full dose and for 9 p.m. administration time missed the dose. The DON stated Resident 1 was placed at risk of experiencing adverse side effects due to missed medication. During a review of the facility-provided P&P titled, Medication Ordering and Receiving from Pharmacy, last reviewed on 2/20/2026, the P&P indicated, Medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. A. Ordering Medications from the Dispensing Pharmacy. 2) If not automatically refilled by the pharmacy, repeat medications (refills) are written on medication order form/ordered by peeling the bottom part of the pharmacy label and placing it in the appropriate area on the order form provided by the pharmacy for that purpose and ordered as follows: a. Reorder medications five days in advance of need to assure an adequate supply on hand.