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	06/23/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 3) received care in a manner that maintained the resident's dignity and respect when Certified Nurse Assistant (CNA) 1 did not fully close the privacy curtains while providing personal care. This failure had potential to negatively affect the Resident 3 sense of dignity and respect during the care.Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including chronic obstruction pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) and difficult in walking.During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 6/22/2026, the MDS indicated Resident 3 had moderate cognitive skills (ability to think, understand, learn, and remember) for daily decision making and needed maximum assistance (helper does more than half of the efforts) for toileting hygiene, showers, upper body dressing, and personal hygiene.During an observation on 6/22/2026 at 10:18 a.m., outside Resident 3's room, CNA 1 was providing incontinence care and changing the bed linen for Resident 3 without closing the privacy curtain. The privacy curtain was not completely closed and did not provide complete privacy to Resident 3.During an interview on 6/22/2026 at 10:21 a.m., outside Resident 3's room with the Director of Staff development (DSD), the DSD stated that the privacy curtain in Resident 3 room was not closed all the way and did not provide complete privacy to Resident 3. The DSD stated that it is important to have privacy curtains closed completely to protect Resident 3's dignity.During an interview on 6/23/2026 at 3:10 p.m., with the Director of Nursing (DON), the DON stated that nursing staff must always close the privacy curtain when providing care to residents to prevent exposure and to protect their dignity. The DON stated the importance of maintaining privacy for every resident, as it is part of resident's right.During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, revised on 2/20/2026, 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 resident's right to be treated with respect, kindness, and dignity.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent a fall and injury for one of three sampled residents (Resident 1), who was confused, identified as a fall risk, had difficulty in walking, and had repeated falls in the facility. The facility failed to:1. Provide supervision to Resident 1 when staff (unspecified) placed Resident 1 in the hallway unattended.2. Place resident (Resident 1) on areas visible by staff and within easy reach when they (Resident 1) get up in accordance with Resident 1's care plan titled, Actual Fall. with date initiated on 6/1/2026.As a result, Resident 1 fell in the hallway on 6/18/2026 at around 12:50 p.m., sustaining a scalp laceration (a torn, ragged cut or tear in the skin and tissue) with bleeding and severe pain in the left hip. On 6/18/2026 at 1:31 p.m., the facility transferred Resident 1 to the General Acute Care Hospital (GACH) for further evaluation and management, where Resident 1 was admitted with traumatic left periprosthetic shaft of femur fracture (the long bone in the left thigh has broken along its main midsection, right next to or surrounding an existing medical implant [a manufactured device placed inside or on the surface of the body]) and underwent open reduction and internal fixation (ORIF - surgical procedure used to repair severe, displaced, or complex bone fractures). Findings:During a review of Resident 1's undated admission Record (AR), the AR indicated the facility admitted Resident 1 on 5/4/2026 and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), history of falling, and difficulty in walking.During a review of Resident 1's Minimum Data Set (MDS - resident assessment tool), dated 5/9/2026, the MDS indicated Resident 1 had severe impaired cognitive skills (a profound and persistent decline in memory, reasoning, language, and judgment that makes it impossible for a person to manage daily life without substantial help) for daily decision making and needed maximal assistance (helper does more than half the effort) when toileting, showers, lower body dressing, oral hygiene, and for personal hygiene.During a review of Resident 1's History and Physical (H&P - a medical examination that involves a doctor taking a person's medical history, performing a physical exam, and documenting their findings), dated 5/31/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Fall Risk Evaluation, dated 5/4/2026 and timed at 9:38 p.m., the Fall Risk Evaluation History of Falls indicated Resident 1 had one to two falls in the past three months. The Fall Risk Evaluation indicated Resident 1 had balance problems while standing and balance problems while walking. The Fall Risk Evaluation indicated Resident 1 was chairbound (refers to a person who is confined to a chair, typically a wheelchair, due to illness, injury, or physical incapacity). The Fall Risk Evaluation indicated Resident 1 was a risk for fall.During a review of Resident 1's Rehabilitation (Rehab - the process of restoring someone to a normal, healthy, or functional state) Fall Risk Assessment, dated 5/5/2026 and timed at 1:55 p.m., the Rehab Fall Risk Assessment indicated the reason for the review as initial assessment (the first comprehensive evaluation of a resident's health status) and that Resident 1 required extensive assistance (a resident cannot safely move from one surface to another on their own) when transferring and with ambulation (walking). The Rehab Fall Risk Assessment indicated Resident 1 did not demonstrate proper safety techniques during transfers, while using the assistive device (any tool, equipment, or product system used to increase, maintain, or improve a resident's functional abilities and independence), and Resident 1 did not show proper standing balance.During a review of Resident 1's Change of Condition (COC - a decline or improvement that requires assessment, often prompting a revision of the care plan)/Interact (Interventions to Reduce Acute Care Transfers) Assessment (a quality improvement program used in nursing homes to identify, evaluate, and communicate acute changes in a resident's health status) Form, dated 5/9/2026 and timed at 3:51 a.m., the COC/Interact Assessment Form indicated, that on 5/9/2026 at 3:45 a.m. (Resident 1 was) found lying on the floor, parallel (side by side) to the bed. The (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	COC/Interact Assessment Form indicated that Resident 1 was confused and continued to get out of bed all evening.During a review of Resident 1's COC/Interact Assessment Form, dated 5/12/2026 and timed at 12:45 p.m., the COC/Interact Assessment Form indicated that CNA (unspecified) was inside another room when she heard a pad alarm (a pressure-sensitive sensor placed under a resident on a bed or chair that triggers an alert to caregivers when pressure is removed or applied helping staff quickly assist residents art risk for falls) sounding in the hallway, walked out of the room, and noted Resident 1 standing up but was unable to sustain a standing position and went down to the floor, landing on his buttocks. The COC/Interact Assessment Form indicated CNA (unspecified) was unable to reach resident (Resident 1) in time to prevent the fall incident. On 5/12/2026 at 1:45 p.m., a Certified Nursing Assistant (CNA, name not specified) notified Registered Nurse (RN) 1 that Resident 1 was on the floor in the hallway outside his (Resident 1's) room.During a review or Resident 1's Post Fall Evaluation, dated 5/12/2026 and timed at 12:45 p.m., the Post Fall Evaluation indicated the date and time of Resident 1's witnessed fall was on 5/12/2026 at 12:45 p.m., and the reason for the fall was Resident 1 stood up unassisted. During a review of Resident 1's Care Plan (CP) titled, Resident is at risk for fall and injury, initiated on 5/13/2026, the CP indicated a goal to Reduce risk of falls and injury daily. The CP indicated interventions that included to visibly observe resident (Resident 1) frequently and to provide resident with safe clutter free environment.During a review of Resident 1's COC/Interact Assessment Form, dated 6/1/2026 and timed at 3:10 p.m., the COC//Interact Assessment Form indicated that on 6/1/2026 at 3:15 p.m. writer (RN 2) came out of another room across the hallway when resident (Resident 1) was noted on the floor, right outside of his room laying on his right side. Writer (RN 2) called for helped and assessed resident . resident does not recall incident.During a review of Resident 1's Fall Risk Evaluation, dated 6/1/2026 and timed at 3:40 p.m., the Fall Risk Evaluation indicated Resident 1 had three or more falls in the past three months, had intermittent confusion (refers to episodes of disorientation or impaired thinking that come and go), and was chairbound/incontinent (having no or insufficient voluntary control over urination or defecation). The Fall Risk Evaluation indicated Resident 1 had balance problem while standing, balance problem while walking, and decreased muscular coordination (refers to the ability of the body to orchestrate multiple muscles working together in a controlled and purposeful manner, enabling smooth and effective movement in daily activities and complex physical tasks).During a review of Resident 1's CP titled, Actual Fall (found on the floor outside of the room lying on his right side) ., initiated on 6/1/2026, the CP indicated interventions that included to Place resident (Resident 1) in areas visible by staff and within easy reach when they (Resident 1) get up.During a review of Resident 1's COC/Interact Assessment Form, dated 6/18/2026 and timed at 12:50 p.m., the COC/Interact Assessment Form indicated that on 6/18/2026 at approximately 12:50 p.m., writer (RN 1) was notified by a CNA (unspecified) that resident (Resident 1) had sustained a fall. CNA (unspecified) was nearby and heard a thud sound and observed resident (Resident 1) on the floor. RN 1 immediately went to hallway and noted resident (Resident 1) sitting on the floor surrounded by multiple nursing staff (unspecified). According to staff (unspecified) interview, he (Resident 1) was lying on the floor on his left side with wheelchair behind him (Resident 1). The COC/Interact Assessment Form indicated Resident 1 verbalized severe pain to his left hip and left lower extremity (refers to the entire portion of the human body from the hip down to the toes) and was noted with laceration on top of scalp with bleeding. The COC/Interact Assessment Form indicated that on 6/18/2026 at approximately 1:31 p.m., the facility sent Resident 1 to the GACH for further evaluation and management per physician's order. During a review of Resident 1's GACH admission H&P report, dated 6/18/2026 timed at 7:09 p.m., the GACH admission H&P indicated Resident 1 was admitted with traumatic left periprosthetic shaft of femur fracture status post (after) fall at his (Resident 1) skilled nursing facility (SNF). The GACH admission H&P indicated Resident 1 was in his wheelchair in the hallway and got up from it while unattended and then fell forward injuring his head with laceration and his left leg. The GACH admission H&P indicated Resident 1 was in severe pain and his (Resident 1) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	left leg was noted to be shortened and externally rotated (outward rotation of a body segment away from the midline of the body or the center of a joint) suspicious for a fracture. The GACH admission H&P indicated Resident 1's impression (the healthcare provider's professional assessment or working diagnosis) was acute (recent injury) left femur closed (no open wound or surgical incision [a cut made through the skin or soft tissue]) periprosthetic fracture (the fracture occurs around the prosthesis [an artificial device designed to replace a missing part of the human body], meaning it is not through the bone itself but at the interface [at the point where two systems meet and interact] between the implant and the bone) with displacement (bone fragments are not aligned) - preoperative (patient is being evaluated before surgery) for ORIF. The GACH admission H&P indicated the plan was discussed with Resident 1's Family Member (FM) 1 who understood that Resident 1 was a moderate risk patient, that ORIF is a moderate risk surgery, and that there were risks that included significant bleeding, infection, and death.During an interview on 6/23/2026 at 8:30 a.m. with CNA 2, CNA 2 stated that Resident 1 frequently attempted to get up independently from both bed and wheelchair. CNA 2 stated that on 6/18/2026, CNA 2 had been assigned to care for Resident 1 and around lunchtime, Resident 1 should have been seated in the TV room so staff could watch Resident 1. CNA 2 stated an unidentified staff member placed Resident 1 in the hallway. CNA 2 stated that the facility made a mistake by leaving Resident 1 in the hallway rather than in the TV room. CNA 2 stated the fall incident could have been prevented if Resident 1 was in the TV room and was supervised by staff.During an interview on 6/23/2026 at 9:05 a.m. with CNA 3, CNA 3 stated that on 6/18/2026 before lunch, Resident 1 was in the hallway in his wheelchair and CNA 3 observed Resident 1 fell from the wheelchair to the floor. CNA 3 stated that Resident 1 was sitting in the wheelchair when he stood up from the chair and fell forward. CNA 3 stated that Resident 1 should have been in the TV room rather than in the hallway so he can be supervised. CNA 3 stated that Resident 1 was at a high risk for fall due to a history of multiple previous falls.During an interview on 6/23/2026 at 9:50 a.m. with CNA 4, CNA 4 stated that on 6/18/2026, at approximately lunchtime, she was in the hallway and was assisting another resident with lunch with her back to Resident 1 when she heard a loud noise. CNA 4 stated that she turned around and observed Resident 1 lying on the floor on his left side. CNA 4 stated that staff had left Resident 1 in the hallway unattended. CNA 4 stated that she attempted to assist Resident 1 into a sitting position but was unable to do so and she called RN 1 for assistance. CNA 4 further stated that, before observing Resident 1 on the floor, Resident 1 had attempted to rise from the wheelchair by grabbing the medication cart (a mobile workstation used by licensed nurses to securely store, organize, and transport medications directly to residents' rooms) positioned next to him. CNA 4 stated that she did not hear a chair pad alarm activate and did not believe the chair pad alarm on Resident 1's wheelchair was turned on. CNA 4 stated that Resident 1 should have been in the TV room rather than in the hallway. CNA 4 stated that staff closely monitored residents in the TV room and would have been within arm's reach to intervene when Resident 1 attempted to stand. CNA 4 stated that placing Resident 1 in the TV room may have prevented the fall.During an interview on 6/23/2026 at 11:26 a.m. with Licensed Vocational Nurse (LVN 1) stated that on 6/18/2026, around lunchtime, she observed Resident 1 sitting in the hallway. LVN 1 stated that when she was exiting another resident's (unspecified) room, she saw Resident 1 standing up from his wheelchair and attempting to grab the medication cart. LVN 1 stated Resident 1 was unable to reach the medication cart and fell forward onto his left side. LVN 1 stated that Resident 1 struck his head on the corner of the wall or door frame because Resident 1's head was bleeding. LVN 1 stated that she was not within easy reach from Resident 1 to prevent the fall. LVN 1 stated that Resident 1 was at high risk for falls because he frequently attempts to get out of bed.During an interview and concurrent record review on 6/23/2026 at 11:48 a.m. with Physical Therapist Assistant (PTA) 1, Resident 1's Physical Therapy Treatment Note, dated 6/17/2026, was reviewed. PTA 1 stated that Resident 1 required maximum assistance during transfers from sitting to standing, with two people providing 75 percent (per hundred) of the required support. The Physical Therapy Treatment Note indicated, posture remains (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	stooped and stepping mechanism (the body's protective, automatic reflex of taking a quick step to catch yourself and maintain balance when you are pushed, tripped, or begin to fall) is impaired, as the patient ambulates (walks) on the balls of his feet (toe walking). Education and instruction provided for sit-to-stand performance with maximal assistance, as patient displays anxiousness with standing and fails to perform functional push-off (any movement that utilizes your lower body - particularly your glutes, calves, and feet - to propel your center of mass forward or upward) when prompted. PTA 1 stated that Resident 1's level of mobility (movement) fluctuates due to impaired cognition. PTA 1 stated that Resident 1 is on fall risk precautions because he frequently attempts to get up.During an interview and concurrent record review on 6/23/2026 at 1:31 p.m. with RN 1, Resident 1's COC dated 6/18/2026, fall risk evaluations (5/4/2026, 5/12/2026, 5/29/2026, 6/1/2026, and 6/18/2026), and care plan for actual fall (6/1/2026) were reviewed. RN 1 stated that on 6/18/2026, during lunchtime, CNA 4 notified her that Resident 1 had fallen in the hallway. RN 1 stated that when she arrived, Resident 1 was already sitting on the floor with wheelchair positioned on Resident 1's right side, and Resident 1 was bleeding from his head. RN 1 stated that once Resident 1 was placed in bed, she assessed his range of motion (the measurement of how far a specific joint can be comfortably move or rotate in its normal direction) and found that Resident 1 could not move his (Resident 1) left lower extremity. RN 1 stated she contacted Resident 1's physician and received orders to transfer Resident 1 to the GACH. RN 1 stated Resident 1 was a high fall risk because of his history of multiple falls. RN 1 stated that staff did not follow Resident 1's care plan initiated on 6/1/2026 after his previous unwitnessed fall (on 6/1/2026) in the hallway to place Resident 1 on areas visible by staff and within easy reach when they get up. RN 1 stated that staff did not place Resident 1 in a visible location and did not remain within reach when he (Resident 1) attempted to rise from the wheelchair. RN 1 further stated that Resident 1's fall could have been prevented if staff followed the care plan intervention.During an interview on 6/23/2026 at 3:10 p.m. with the Director of Nursing (DON), the DON stated that Resident 1 fell in the hallway on 6/18/2026 at 12:50 p.m. The DON stated that LVN 1 witnessed the fall. The DON stated that LVN 1 left Resident 1 in the hallway to check on another resident (unspecified). The DON stated that Resident 1 attempted to get up without assistance and fell. The DON stated that staff did not follow Resident 1's care plan because LVN 1 was not within reach of Resident 1 when he (Resident 1) attempted to stand. The DON stated that staff could have prevented Resident 1's fall by remaining within Resident 1's reach. The DON stated Resident 1's mental status was confused and fluctuating, Resident 1 was impulsive, and was a high fall risk resident.During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, last reviewed on 2/20/2026, the P&P indicated, Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision.4. Implementing interventions to reduce accidents risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training, as necessary; d. Ensuring the interventions are implemented; and e. documenting interventions. Systems Approach to Safety . 2. Resident supervision is a core component of the system approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. 3. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased . if there is a change in the resident's condition.During a review of the facility's P&P titled, Fall and Fall Risk, Managing, last reviewed on 2/20/2026, the P&P indicated that Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from failing and to try to minimize complications from falling. Resident-Centered Approaches to Managing Falls and Fall Risk . 5. If falling recurs despite (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. Monitoring Subsequent Falls and Fall Risk . 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the physician will help the staff reconsider possible causes that may not previously have been identified.During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, 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 and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 9. Care plan interventions ae chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about resident's and the resident's condition change.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) received their physician-ordered regular diet. Resident 2 was served a soft and bite size (soft, tender, and moist) diet instead of the prescribed regular texture diet. This failure had the potential to result in unnecessary diet restrictions, decreased meal satisfaction, and reduced nutritional intake. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including altered mental status, dysphagia (difficulty swallowing), and aphasia (a disorder that makes it difficult to speak). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 5/28/2026, the MDS indicated Resident 2 had severely impaired cognitive skills (ability to think, understand, learn, and remember) for daily decision making and was dependent (helper does all of the efforts) for eating, toileting hygiene, showers, upper body dressing, and personal hygiene. During a review of Resident 2's Order summary Report (OSR), for the active orders as of 6/23/2026, the OSR indicated NAS (No Added Salt) diet, regular texture, thin consistency, with an order date of 4/22/2026.During an observation on 6/22/2026 at 12:19 p.m. in the dining room, a staff member (name unknown) placed Resident 2's meal tray in front of Resident 2 and Family Member (FM 1). FM 1 removed the lid from Resident 2's tray and stated, This is not the correct tray. He (Resident 2) receives regular texture. Speech Therapist (ST) 1 immediately removed the lunch tray, returned it to the kitchen, and brought Resident 2 a meal tray with the correct regular texture diet. During an interview on 6/23/2026 at 12:16 p.m. with ST 1, ST 1 stated that Resident 2 received an incorrect texture meal tray during lunch on 6/22/2026. ST 1 stated that he (ST 1) immediately returned the tray to the kitchen and replaced it with the correct regular texture tray. ST 1 further stated that providing a diet texture below the resident's prescribed level could cause the resident to refuse the meal or consume less than 100 percent of the meal potentially affecting resident's nutritional intake. During an interview on 6/23/2026 at 12:48 p.m. with Dietary Services Manager (DSM), the DSM stated that Resident 2 received a soft and bite sized diet instead of the prescribed regular texture diet. The DSM stated that staff should verify the diet (food) texture on the tray against the diet order ticket before serving the meal to ensure resident receives the correct diet.During a review of the facility's Policy and Procedure (P&P) titled, Menu, revised on 2/20/2026, the P&P indicated:Twenty-eight-day cycle menus are prepared by the dietitian and modifications of individual resident menus are made as necessary to comply with physician orders and/or resident preferences.

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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 - 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 ensure infection prevention and control practices were followed when Certified Nurse Assistant (CNA) 1 placed soiled linen and soiled brief directly on the floor while providing care for one of three sampled residents (Resident 3). This failure had the potential to contaminate the care environment, increase risk of cross contamination, and place residents at risk for infection.Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including chronic obstruction pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) and difficult in walking. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 6/22/2026, the MDS indicated Resident 3 had moderate cognitive skills (ability to think, understand, learn, and remember) for daily decision making and needed maximum assistance (helper does more than half of the efforts) for toileting hygiene, showers, upper body dressing, and personal hygiene. During an observation on 6/22/2026 at 10:18 a.m., outside Resident 3's room, CNA 1 was providing incontinence care to Resident 3. CNA 1 placed Resident 3's soiled brief on the floor with the soiled linen. During an interview on 6/22/2026 at 10:21 a.m., outside of Resident 3's room with the Director of Staff Development (DSD), the DSD stated that staff should not place soiled briefs or soiled linen on the floor. DSD stated that the staff should place the soiled linen in a linen bag and the soiled diaper in a separate waste bag. The DSD stated that placing soiled items on the floor contaminated the floor and could contribute to the spread of infection. During an interview on 6/23/2026 at 3:10 p.m., with the Director of Nursing (DON), the DON stated that nursing staff must place soiled linen in a bag before placing it in the soiled linen cart. The DON stated that staff must also place soiled briefs in a separate waste bag. The DON stated that placing soiled linen or soiled briefs on the floor could contribute to the spread of infection, and was not consistent with proper infection control practices. During a review of the facility's Policy and Procedure (P&P) titled, Laundry and Bedding, Soiled dated 2/20/2026, the P&P indicated, Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control. Staff handle soiled linen with minimal agitation to avoid the contamination of air, surfaces, and persons.