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	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burbank Healthcare & Rehab	1041 S. Main St. Burbank, CA 91506

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 residents were treated with respect and dignity in a manner that promotes maintenance or enhancement of their quality of life by failing to ensure Certified Nurse Assistants (CNA) did not provide feeding assistance while for three of ten residents (Resident 18, 107, and 67) observed during the Dining task. This deficient practice had the potential to result in a decrease in psychosocial well-being for the residents leading to an overall decline and malnutrition (a serious condition that happens when your diet does not contain the right amount of nutrients). Findings: a. During a review of Resident 18's admission Record (AR), the AR indicated the facility admitted the resident on 10/13/2024, with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), unspecified severe protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function). During a review of Resident 18's Minimum Data Set (MDS - an assessment and care screening tool) dated 2/26/2026, the MDS indicated the resident sometimes was able to understand others and sometimes was able to make himself understood. The MDS indicated the resident required substantial / maximal assistance from staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene. During a review of Resident 18's Care Plan (CP) titled, Resident has self-care deficits: requires extensive to total assistance with Activities of Daily Living. eating: max. initiated 7/8/2025, and last revised 3/8/2026, the CP indicated a goal that the resident would have minimized risk of decline with interventions that included the resident would be provided adequate hydration and nutrition and his rights would be respected. During a Dining observation on 3/9/2026 at 12:37 p.m., observed Resident 18 sitting in a wheelchair at a shared table in the dining room. Observed CNA 2 standing next to Resident 18, CNA 2 picked up Resident 18's spoon with food and placed the spoon in the resident's mouth. Observed CNA 2 continued to assist the resident with eating and drinking. During a Dining observation on 3/9/2026 at 12:42 p.m., observed CNA 3 spoke with CNA 2. Observed CNA 2 left Resident 18's side, walked across the room, and then brought a chair back to the Resident's side and sat while continuing to provide feeding assistance. During a follow up interview on 3/9/2026 at 12:50 p.m., with CNA 2, CNA 2 stated she (CNA 2) did not sit while providing feeding assistance to Resident 18 because it was not comfortable and she (CNA 2) preferred to stand. CNA 2 stated she (CNA 2) was not supposed to stand while assisting residents with feeding, but she (CNA 2) did. CNA 2 stated she (CNA 2) was not sure why she (CNA 2) was supposed to sit while providing feeding assistance to residents. During a follow up interview on 3/9/2026 at 12:59 p.m., with CNA 3, CNA 3 stated he (CNA 3) observed CNA 2 standing while feeding Resident 18 and told CNA 2 to sit down. CNA 3 stated Resident 18 was on a feeding program and needed assistance with feeding and all CNAs should know to sit while providing feeding assistance. CNA 3 stated it was important to sit while providing feeding assistance to provide resident dignity. During a concurrent interview and record review on 3/12/2026 at 12:55 p.m., the Director of Nursing (DON) reviewed the facility policy and procedures (P&P) regarding feeding (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance and dignity. The DON stated CNAs should provide feeding assistance at eye level. The DON stated when CNAs do not sit at eye level with residents then they are looking over or down on the resident. The DON stated it was important to be at eye level to maintain dignity during feeding assistance. The DON stated that when dignity is not maintained it may cause psychosocial effects on residents that can potentially result in the residents eating or drinking less leading to altered nutritional status. The DON stated the P&Ps were not followed.ˆ During a review of the facility P&P titled, Assistance with Meals, last reviewed 2/20/2026, the P&P indicated, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Facility staff will serve resident trays and will help residents who require assistance with eating. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: . a. not standing over residents while assisting them with meals. During a review of the facility policy and procedure titled, Resident Rights, last reviewed 2/20/2026, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity. l. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . a. a dignified existence; . b. be treated with respect, kindness, and dignity. b. During a review of Resident 107's AR, the AR indicated the facility admitted the resident on 7/30/2024, with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), and dementia with behavioral disturbances. During a review of Resident 107's MDS, dated [DATE], the MDS indicated the resident usually was able to understand others and sometimes was able to make herself understood. The MDS indicated the resident was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene. During a review of Resident 107's CP titled, Resident has self-care deficits on her Activities of Daily Living. initiated 4/26/2025, and last revised 6/14/2026, the CP indicated a goal that the resident would have minimized risk of decline with interventions that included the resident would be provided adequate hydration and nutrition and her rights would be respected. During a Dining observation on 3/9/2026 at 1:28 p.m., observed Resident 107 sitting in bed with the lunch meal tray on the rolling bedside table. Observed CNA 4 standing next to Resident 107, CNA 2 pick up Resident 107's spoon and placed the spoon with food in the resident's mouth. Observed CNA 2 continued to assist the resident with eating and drinking while standing. During a follow up interview on 3/9/2026 at 1:32 p.m., with CNA 2, CNA 2 stated she (CNA 2) did not sit while providing feeding assistance to Resident 107 because she (CNA 2) did not like to sit. CNA 2 stated she (CNA 2) knew that she (CNA 2) should sit while providing feeding assistance to residents. Observed CNA 2 retrieved a chair and sat down to continue to provide feeding assistance to Resident 107. During a concurrent interview and record review on 3/12/2026 at 12:55 p.m., the DON reviewed the facility P&P regarding feeding assistance and dignity. The DON stated CNAs should provide feeding assistance at eye level. The DON stated when CNAs do not sit at eye level with residents then they are looking over or down on the resident. The DON stated it was important to be at eye level to maintain dignity during feeding assistance. The DON stated that when dignity is not maintained it may cause psychosocial effects on residents that can potentially result in the residents eating or drinking less leading to altered nutritional status. The DON stated the P&Ps were not followed. During a review of the facility P&P titled, Assistance with Meals, last reviewed 2/20/2026, the P&P indicated, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Facility staff will serve resident trays and will help residents who require assistance with eating. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: . a. not standing over residents while assisting them with meals. During a review of the facility policy and procedure titled, Resident Rights, last reviewed 2/20/2026, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity. l. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . a. a dignified existence; . b. be treated with respect, kindness, and (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dignity. c. During a review of Resident 67's AR, the AR indicated the facility originally admitted the resident on 3/20/2016, and most recently admitted the resident on 1/23/2026, with diagnoses that included dementia, encephalopathy (a change in brain function due to injury or disease), and dysphagia (difficulty swallowing). During a review of Resident 67's MDS, dated [DATE], the MDS indicated the resident usually was able to understand others and was able to make herself understood. The MDS indicated the resident required partial / moderate assistance from staff for eating, upper body dressing, and oral and personal hygiene. During a Dining observation on 3/10/2026 at 7:53 a.m., observed Resident 67 sitting in bed with the breakfast meal tray on the rolling bedside table. Observed CNA 5 standing next to Resident 67, CNA 5 picked up Resident 67's spoon and placed the spoon with food in the resident's mouth. Observed CNA 5 continued to assist the resident with eating and drinking while standing. During a concurrent observation and interview on 3/10/2026 at 7:58 a.m., observed the Director of Staff Development (DSD) entered Resident 67's room and spoke quietly with CNA 5. Observed CNA 5 stopped assisting Resident 67 with feeding assistance and exited the room. The DSD exited the room and stated CNA 5 should not have been standing while assisting Resident 67 with feeding, but she (CNA 5) did. The DSD stated CNAs must sit at eye level while providing feeding assistance to residents to show respect and so residents do not feel rushed while eating. The DSD stated standing while providing feeding assistance was a dignity issue. During a concurrent interview and record review on 3/12/2026 at 12:55 p.m., the DON reviewed the facility P&P regarding feeding assistance and dignity. The DON stated CNAs should provide feeding assistance at eye level. The DON stated when CNAs do not sit at eye level with residents then they are looking over or down on the resident. The DON stated it was important to be at eye level to maintain dignity during feeding assistance. The DON stated that when dignity is not maintained it may cause psychosocial effects on residents that can potentially result in the residents eating or drinking less leading to altered nutritional status. The DON stated the P&Ps were not followed. During a review of the facility P&P titled, Assistance with Meals, last reviewed 2/20/2026, the P&P indicated, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Facility staff will serve resident trays and will help residents who require assistance with eating. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: . a. not standing over residents while assisting them with meals. During a review of the facility policy and procedure titled, Resident Rights, last reviewed 2/20/2026, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity. I. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . a. a dignified existence; . b. be treated with respect, kindness, and dignity.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident medication self-administration was clinically appropriate and failed to honor the resident's right to self-administer medications for one of ten sampled residents (Resident 55) reviewed under the Accidents care area by failing to perform a medication self-administration assessment when staff had knowledge that the resident kept medication at the bed side for self-administration. This deficient practice violated the residents' right to self-administer medications and had potential for the residents to experience adverse effects (an undesired effect of a drug or other type of treatment) of the medication. Cross-reference F689. Findings: During a review of Resident 55's admission Record (AR), the AR indicated Resident 55 was originally admitted to the facility on [DATE], and was most recently readmitted on [DATE], with diagnoses that included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), polyneuropathy (a disorder of the peripheral nervous system that may result in pain, discomfort, and mobility issues), and chronic kidney disease stage three (moderate kidney damage). During a review of Resident 55's History and Physical (H&P) dated 9/12/2025, the H&P indicated Resident 55 had the capacity to understand and make decisions. The H&P further indicated Resident 55 had improved mental status and was awake, alert, and communicative. During a review of Resident 55's Minimum Data Set (MDS - resident assessment tool), dated 2/10/2026, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident was dependent on staff for bathing, required substantial / maximal assistance for toileting, required partial / moderate assistance for oral and personal hygiene, and set up or clean up assistance for eating. During a review of Resident 55's most recent Self Administration of Medication form, dated 12/4/2024, the Self Administration of Medication form indicated Resident 55 was unsafe for self-administration and the resident required additional assistance by the Licensed Vocational Nurses (LVN). During a review of Resident 55's Order Summary Report, the Order Summary Report indicated a physician's order for hydrocortisone external cream (topical medication used to relieve swelling, redness, itching, and allergic reactions), apply to affected areas topically every twelve hours as needed for red spots on forearms and neck, dated 9/2/2025. During a review of Resident 55's Care Plan (CP) titled, (Resident) 55 is at risk for developing pressure sores (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) , and other type of skin breakdown ., initiated on 12/17/2024, the CP indicated weekly body checks. During a review of Resident 55's CP titled, Eye Infection. at risk for eye infection because of left eye redness., initiated on 10/25/2025, and last revised 5/11/2025, the CP indicated interventions that included to administer eye medication as ordered and for staff to assess for signs and symptoms of infection and notify the physician as needed. During a review of Resident 55's CP titled, (Resident 55) has potential for alteration in comfort / pain related to: positioning discomfort ., initiated on 12/17/2024, and last revised 5/11/2025, the CP indicated interventions that included to monitor for signs and symptoms of pain and notify the physician as needed. During an observation on 3/9/2026 at 9:58 a.m., inside Resident 55's room, observed Resident 55 lying in bed. Observed no staff were in the room and a clear plastic medication cup containing white ointment and a used applicator was left on the nightstand. Resident 55 stated the cream in the cup is applied by the nurses to help with itchiness. Observed on the resident's bedside rolling table an open box containing tetrahydrozoline ophthalmic eye drops (over the counter medication that temporarily relieves redness), fluticasone nasal spray (medication that treats allergies), and trolamine salicylate topical cream (topical analgesic used for temporary pain relief). Resident 55 stated the medications in the box belonged to her (Resident 55). During a concurrent observation and interview on 3/9/2026 at 10:12 a.m., observed Certified Nursing Assistant (CNA) 7 entered Resident 55's room and the medication cup containing (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	white ointment, eye drops, nasal spray, and topical cream remained at bedside. CNA 7 stated the Licensed Nurse (LN) applies ointments to Resident 55 for skin redness. CNA 7 stated she (CNA 7) did not know who left the medication cup with ointment in the room, but it was ok to leave the medication and applicator on the nightstand. Observed CNA 7 exited the room and the ointment and used applicator in the cup, eye drops, nasal spray, and topical cream were left unattended at Resident 55's bedside. During an interview on 3/9/2026 at 10:25 a.m., with Treatment Nurse (TN) 1, TN 1 stated any used applicators and medication in cups should not be left on the nightstand in the resident's room because the applicator should not be used more than once for infection control reasons and because there was a chance that Resident 55, or another resident, could ingest the ointment. TN 1 stated even if a resident is alert, no medication should be left at residents' bedside. TN 1 stated she (TN 1) would follow up regarding medication left at Resident 55's bedside. During an observation on 3/10/2026 at 2:21 p.m., observed Resident 55 lying in bed. Observed the ointment and applicator were removed from the nightstand, but the eye drops, nasal spray, and topical cream remained at Resident 55's bedside. During an interview on 3/10/2026 at 2:23 p.m. with CNA 8, CNA 8 stated Resident 55 always had eye drops, nasal spray, and topical cream on the bedside rolling table and her son comes in and helps with the medication. During an interview on 3/10/2026 at 2:23 p.m. with LVN 7, LVN 7 stated she (LVN 7) was assigned to care for Resident 55, and she (LVN 7) had seen medications on and off over the last three weeks on the resident's bedside table. LVN 7 stated she (LVN 7) had not looked at the medications to see exactly what medications were in the box. LVN 7 stated medications should not be kept at bedside, but the resident's son left them there. LVN 7 stated she (LVN 7) did not notify Resident 55's physician that the resident kept medication at bedside for self-administration. During a concurrent interview and record review with Registered Nurse (RN) 3, RN 3 reviewed Resident 55's physician orders. RN 3 stated no medications should be administered without a physician's order, including over the counter medications, because the physician needs to determine if the medications are appropriate for the resident and that resident is not allergic to the medication and that the medication does not interact with other medications. RN 3 stated Resident 55 did not have an order for tetrahydrozoline ophthalmic eye drops, fluticasone nasal spray, and trolamine salicylate topical cream. RN 3 stated that residents have the right to request to self-administer medication, but there is a process to follow including, completing a safety assessment, getting and following a physician's order, and documenting when the medication is administered. RN 3 stated medications should not be left at bedside because residents may not administer the medication in a safe manner and other residents with dementia could possibly obtain the medication from the table and ingest it. During a concurrent interview and record review on 3/10/2026 at 2:50 p.m., with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 55's Self Administration of Medication forms, physician orders, and progress notes. The ADON stated Resident 55 had medications at bedside that were not facility provided. The ADON stated when a resident requests to keep medication to self-administer then the staff should conduct an assessment and notify the physician. The ADON stated it was the resident's right to request to self-administer medications and there was no documented evidence that an assessment was completed or the physician was notified. The ADON stated medications should never be kept at bedside because the resident may over-use the medication resulting in side effects, or other residents may ingest the medication resulting in toxicity or poisoning. The ADON stated any staff that were aware that Resident 55 had medications at bedside should have followed up to ensure the medications were not left there, but they did not. During a concurrent interview and record review on 3/12/2026 at 12:55 p.m., the Director of Nursing (DON) reviewed the facility policy and procedures (P&P) regarding medication self-administration. The DON stated residents have a right to request to self-administer medication, but the medication should not be left at a resident's bedside unless they are kept in a locked box. The DON stated when medications are left unattended at bedside there is the potential the residents could ingest the medication resulting in adverse reactions like poisoning. The DON stated if a resident requests to self-administer medication, then the resident should be assessed (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for safety. The DON stated the facility P&P was not followed when staff knew Resident 55 kept medications at bedside, did not perform a safety assessment, or notify the physician potentially resulting in not respecting resident's rights to self-administer medication. During a review of the facility P&P titled, Self-Administration of Medications, last reviewed 2/20/2026, the P&P indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The IDT considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re?assessed periodically based on changes in the resident's medical and/or decision-making status. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. The IDT evaluates options which allow residents to safely participate in the medication administration process if they wish to do so. Residents who are identified as being able to self-administer medications are asked whether they wish to do so. For self-administering residents, the nursing staff determines who is responsible (the resident or the nursing staff) for documenting that medications are taken. If the resident is able and willing to take responsibility for documenting self-administration of medications, the resident is instructed on how to complete a record indicating the administration of the medication. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room. the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. During a review of the facility P&P titled, Safety and Supervision of Residents, last reviewed 2/20/2026, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities. Safety risks and environmental hazards are identified on an ongoing basis. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for four of five sampled residents (Resident 104, 62, 187, and 78) reviewed for physical restraints, by failing to: 1. Ensure Resident 104 did not have pillows and a rolled towel tucked under the resident's fitted sheet bilaterally (both sides) on 3/9/2026 and 3/11/2026. 2. Ensure a restraint assessment was completed prior to the use of bed placed against the wall for Resident 62. 3. Ensure Resident 62 did not have a pad alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) in use when the resident with capacity verbalized she did not want it and did not consent to its use. 4. Ensure Residents 187's pillows on both sides were not tucked under the fitted sheet. 5. Ensure Resident 187's pad alarm was applied as ordered by the physician and there was a device use or physical restraint assessment completed prior to application of the pad alarm in bed or wheelchair. 6. Ensure there was a physician's order, informed consent, care plan, and device use or physical restraint assessment prior to placement of the bed pad alarm for Resident 78. These deficient practices had the potential to result in the restriction of the residents' freedom of movement, a decline in physical functioning, skin issues, and psychosocial harm. Findings: a. During a review of Resident 104's admission Record (AR), the AR indicated Resident 104 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE] with diagnoses that included metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), dementia (a progressive state of decline in mental abilities), muscle weakness, reduced mobility, and personal history of (healed) traumatic fracture (broken bone). During a review of Resident 104's History and Physical (H&P), dated 9/11/2025, the H&P indicated Resident 104 did not have the capacity to understand and make decisions. During a review of Resident 104's Minimum Data Set (MDS – resident assessment tool), dated 2/9/2026, the MDS indicated the resident was rarely / never able to understand others and rarely / never was able to make herself understood. The MDS further indicated Resident 104 was dependent on staff for eating, oral and personal hygiene, toileting, bathing, dressing, and mobility. During a review of Resident 104's Physician Order Summary, the Physician Order Summary indicated the following orders: - Support and Safety Device - floor mat to decrease potential injury, every shift, dated 1/27/2026. - Support & Safety Device – low bed to decrease potential injury, every shift, dated 1/27/2026. During a review of Resident 104's care plan (CP) titled, Risk for Falls, initiated on 6/3/2024, the CP indicated a goal to reduce risk of falls and injury with interventions that included to provide a safe and clutter-free environment and to provide a low bed and floor mats. During a review of Resident 104's CP titled, Resident is at risk for spontaneous / pathological / stress fractures, initiated on 6/3/2024, the CP indicated interventions that included to position for comfort and to provide a safe and hazard free environment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 104's CP titled, Resident is at risk for skin breakdown secondary to incontinence due to cognitive impairment / dementia, unable to identify urgency feeling to void, initiated on 2/23/2026, the CP indicated a goal that the resident would have no skin breakdown and no falls secondary to attempts to go the bathroom unassisted. During an observation on 3/9/2026 at 9:27 a.m., inside Resident 104's room, observed Resident 104 lying in bed on her back with pillows tucked under the fitted sheet on both sides of the resident that extended from the lower legs up to the upper body. During a concurrent observation and interview on 3/9/2026 at 9:30 a.m., observed Certified Nursing Assistant (CNA) 5 entered Resident 104's room and stood at the resident's bedside to speak with the surveyor, then exited the room and the pillows tucked under the sheets remained in place. During a follow-up interview on 3/9/2026 at 1:37 p.m. with CNA 5, CNA 5 stated the night shift staff put pillows tucked under the sheet on both sides of Resident 104's body because they were afraid the resident would fall. CNA 5 stated pillows should not be placed under the sheet to prevent falls because it is considered a restraint. During an observation on 3/11/2026 at 6:38 a.m., observed Resident 104 lying in bed on her back with a pillow tucked under the sheet on the left side and a rolled towel placed under the tucked sheet on the right side. During a concurrent observation and interview on 3/11/2026 at 6:40 a.m., with Licensed Vocational Nurse (LVN) 6 and CNA 6, LVN 6 entered Resident 104's room and stated there was a rolled towel and pillow tucked under the resident's sheet. CNA 6 then stated she (CNA 6) used the rolled towel because she could not find a pillow. CNA 6 stated she placed the rolled towel and pillow under the sheet to prevent Resident 104 from falling because the resident moves a lot and the sheet prevented the pillow and towel from moving out of place. LVN 6 stated CNA 6 should know not to place pillows and rolled towels under the sheet because it is considered a restraint limiting the resident from turning and reaching for things and potentially resulting in the resident trying to get out of the bed and resulting in a fall from even higher height leading to injury. During an interview on 3/11/2026 at 1 p.m. with the Director of Staff Development (DSD), the DSD stated he had provided in-services to staff regarding restraints. The DSD stated pillows are used on top of the sheets for positioning residents. The DSD stated placing pillows under the sheets on both sides of a resident is considered a restraint because it limits a resident's movement potentially resulting in pressure injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) from not being able to move. During a concurrent interview and record review on 3/12/2026 at 12:55 p.m., the Director of Nursing (DON) reviewed the facility policy and procedures (P&P) regarding restraints. The DON stated a restraint is anything that restricts a resident's freedom of movement that they cannot remove. The DON stated pillows can be used on top of the sheet to position a resident, but when pillows are tucked under the sheet a resident is not able to remove the pillows and freely move. The DON stated pillows placed under the sheets are restraints that can potentially result in PIs and injury from the resident trying to get over the pillows to get out of bed. The DON stated residents can also feel secluded when they are unable to move freely. The DON stated the facility P&P was not followed. b. During a review of Resident 62's AR, the AR indicated that the facility admitted the resident on 2/20/2026 with diagnoses including low back pain, chronic pain, need for assistance with personal care, and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in (continued on next page)

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Burbank Healthcare & Rehab	1041 S. Main St. Burbank, CA 91506

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	breathing). During a review of Resident 62's H&P, dated 2/21/2026, the H&P indicated the resident had the capacity to understand and make decisions and was able to make decisions for activities of daily living. During a review of Resident 62's MDS, dated [DATE], the MDS indicated the resident was able to understand others and able to make herself understood. The MDS indicated Resident 62 was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS further indicated Resident 62 required substantial / maximal assistance (helper does more than half the effort) from staff with lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and walking 10 feet (ft – a unit of measurement). During a review of Resident 62's Order Recap Report (ORR), dated 2/28/2026, the ORR indicated the following orders: - Support & Safety Device – Pad alarm in bed/wheelchair as nursing intervention to alert staff for unassisted transfer, dated 2/20/2026. - Non-restraint. Bed against the wall per resident's preference, dated 3/5/2026. During a review of Resident 62's CP titled, Has sensor pad alarm ., initiated on 2/27/2026, the CP indicated a goal of cooperative and participative during rehab treatment and safety education with interventions that include to respect resident's rights and dignity. During a review of Resident 62's CP titled, Bed against the wall, initiated on 3/5/2026, the CP indicated a goal to be free from complications related to having bed against wall with interventions including review or determine need for bed against wall quarterly and explain reason for bed placement and associated risks. During an observation on 3/9/2026 at 10:10 a.m. with Resident 62, Resident 62's bed pad alarm device wire with sensor pad was disconnected from the monitor with the alarm monitor hanging on the right-side bed side rail and the sensor pad with wire on the floor under the resident's bed by the head of bed. During a concurrent observation and interview on 3/9/2026 at 10:18 a.m. with LVN 1 and Resident 62, inside Resident 62's room, Resident 62 lying in bed, awake. LVN 1 stated Resident 62 has a bed pad alarm, and she will check if Resident 62 has an order for it. LVN 1 checked under where Resident 62 is lying on and asked Resident 62 where her pad alarm went. Resident 62 stated she removed it and placed it by the head of the bed. Resident 62 stated she does not need it, and she uses the call light if she needs help. LVN 1 stated to Resident 62 that the pad alarm is to prevent Resident 62 from falling on the floor. Resident 62 stated she does not fall and she knows how to use the call light and she does not want it. During further interview on 3/9/2026 at 10:20 a.m. with Resident 62, inside Resident 62's room, Resident 62 stated her bed was against the wall, she had two side rails they put up, she had the pad alarm, and one fall mat. Resident 62 stated she does not need all of these. Resident 62 stated she does not need the pad alarm because it is excessive and unnecessary. Resident 62 stated she has (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	told her CNAs, her charge nurses about it and they keep telling her 'okay', but they do not remove it. Resident 62 stated the pad alarm annoyed her, so she removed it. Resident 62 stated they placed all of these since she got admitted to this facility. Resident 62 stated she did not give consent to their use. During an interview on 3/9/2026 at 2:08 p.m. with CNA 1, CNA 1 stated she was the assigned CNA for Resident 62 today, 3/9/2026. CNA 1 stated she took care of Resident 62 sometime last week. CNA 1 stated Resident 62 has restraints bed pad alarm, low bed, side rails, and a fall mat. CNA 1 stated Resident 62 removes her bed pad alarm, and she would tell Resident 62 that she needs it and places it back under Resident 62 while in bed. CNA 1 stated Resident 62 has tried to get up unassisted at the edge of the bed, but Resident 62 would always wait for them before she moves. During a concurrent interview and record review on 3/12/2026 at 10:18 a.m. with Registered Nurse (RN) 1, reviewed Resident 62's AR, H&P, physician orders, informed consents, assessments, RN 1 stated informed consent should be obtained before and at the time of the placing the device. RN 1 stated the bed placed against the wall limits the resident's movement and is a restraint.ˆRN 1 stated a restraint assessment is done to explain the reason why it's needed against the wall or the resident requested their bed to be against the wall.ˆRN 1 stated there was no restraint assessment completed for the use of bed placed against the wall.ˆRN 1 stated when there was no restraint assessment completed and no order for the use of restraints with a potential for injury such as getting their limbs entrapped or stuck between the bed and the fall.ˆRN 1 stated they check the resident's capacity to make decisions under the face sheet/ admission record it would indicate primary decision maker and the H&P would indicate that the resident had capacity to make decisions and Resident 62 was the primary decision maker and had the capacity to make decisions. RN 1 stated Resident 62's informed consent for the use of pad alarm was signed by the resident's family member. RN 1 stated when the resident refused to use the pad alarm the CNA should immediately notify their charge nurse and the LVN will explain the risk and benefits to the resident. RN 1 stated for Resident 62 the CNA should not have placed it back. RN 1 stated for Resident 62 she was notified on 3/9/2026 or 3/11/2026 by LVN 1. RN 1 stated she was not aware of Resident 62's previous refusals for the use of pad alarm. RN 1 stated the pad alarm is a safety device that alerts the staff when the resident gets up unassisted and the resident is reminded to not get up unassisted.ˆ During an interview on 3/12/2026 at 12:56 p.m. with the DON, the DON stated the bed placed against the wall was a restraint. The DON stated if there is no order, we will not be able to determine it is needed, we are not sure if the risk and benefits were explained and we failed to honor the resident's right to self-determination. The DON stated the purpose of the care plan is our guide on how to provide care. The care plan is read by all disciplines. If everybody is aware of caring for the resident care. The DON stated the purpose of the restraint assessment is for us to assess whether the device is appropriate for the resident. The assessment is focused on assessing bed entrapment to the resident. They assess fall risk every quarter. c. During a review of Resident1 187's AR, the AR indicated the facility originally admitted Resident 187 on 4/8/2016 and readmitted in the facility on 2/25/2026 with diagnoses including dementia, generalized muscle weakness, and history of falling. During a review of Resident 187's H&P, dated 2/27/2026, the H&P indicated Resident 187 did not have the capacity to understand and make decisions. During a review of Resident 187's MDS, dated [DATE], the MDS indicated Resident 187 had severely (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impaired cognition (mental action or process of acquiring knowledge and understanding) but was able to understand others and make her needs known. The MDS further indicated Resident 187 required partial or moderate assistance with eating, was totally dependent on staff with toileting hygiene and substantial/maximal assistance with all other activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 187's Order Summary Report, dated 3/12/2026, the Order Summary Report indicated a physician's order dated 2/25/2026 for pad alarm in bed or wheelchair as nursing intervention to alert staff for unassisted transfer. During a review of Resident 187's Physical Restraint Informed Consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) form, dated 2/25/2026, the informed consent indicated that the resident representative gave permission via telephone for the facility to use pad alarm in bed to alert staff for unassisted transfers. During a review of Resident 187's Supportive and Safety/Restraint Physical Assessment form, there was no assessment completed prior to application of the pad alarm in bed or wheelchair. During a review of Resident 187's fall risk evaluation dated 2/25/2026, the fall risk evaluation indicated that Resident 187 was at risk for falls. During a review of Resident 187's CP on risk for falls and injury initiated on 2/25/2026 last revised on 3/3/2026, the CP indicated to provide adequate supervision and frequently cues on safety measures and utilize the safety and supportive devices as ordered as a few of the interventions to reduce the risk for fall or injuries. During a concurrent observation and interview on 3/9/2026 at 1:08 p.m. inside Resident 187's room, observed with CNA 10 Resident 187 trying to get out of bed and there was a yellow star on the wall by the head of the bed with low bed and floor mats marked with a check. CNA 10 stated Resident 187 constantly tried to get out of bed without asking for assistance and had floor mat on both sides of the bed and the bed at a lowest position. CNA 10 stated a yellow star at the head of the bed means that the resident was a risk for falls, and the check mark indicated the interventions in place to prevent the resident from injury in case of a fall. CNA 10 stated Resident 187 did not have a bed alarm. CNA 11 stated Resident 187 did not have the bed alarm marked with a check on the yellow star as one of the interventions to prevent falls or injury. During a concurrent observation and interview on 3/9/2026 at 1:30 p.m. with LVN 2 inside Resident 187's room, LVN 2 stated that the yellow star at the head of Resident 187's bed indicated means the resident is a risk for falls and the check mark indicated the interventions in place for Resident 187 were low bed and floor mats for safety. LVN 2 stated that Resident 187 constantly tries to get out of bed and had bilateral floor mats and low bed in place to minimize injuries in case of a fall. During a concurrent observation and interview on 3/11/2026 at 6:47 a.m. inside Resident 187's room with CNA 11, Resident 187 was observed in bed asleep with pillows tucked under the fitted sheet on both sides of Resident 187's body from the shoulder to the legs and a bed alarm hanging on the left side of the bed. CNA 11 stated that the pillows tucked under the fitted sheets for Resident 187 were already in place when she came in for her shift as the resident rolls over the bed and that the pillows (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tucked under the fitted sheet were placed to protect the resident from rolling over and falling. CNA 11 stated the pillows will not slide out of the bed if tucked under the fitted sheet and Resident 187 is not able to move freely and not able to remove the pillows on her own. During a concurrent observation and interview on 3/11/2026 at 6:58 a.m. inside Resident 187's room with the DSD, the DSD stated Resident 187 had a bed alarm hanging on the left side of the bed. The DSD stated the bed pad alarms are checked for functionality by applying pressure on the bed or moving the resident and the monitor box will alarm. The DSD stated that the nursing staff are not supposed to tuck the pillows under the fitted sheet. The DSD stated the pillows can be placed on top of the fitted sheet. The DSD stated that if the CNAs placed the pillows under Resident 187's fitted sheet, it can be considered a restraint as the resident was unable to move freely and could not remove the pillows on her own. The DSD stated that the pillows on Resident 187's both sides should not have been placed as the pillows restrict the resident's movement which can lead to a decline with her ADLs. During a concurrent interview and record review on 3/12/2026 at 9:30 a.m., Resident 187's physician's order, care plan, fall risk evaluation, and restraint assessments were reviewed with Registered Nurse (RN) 1, RN 1 stated that Resident 187 had a physician's order for pad alarm while in bed/wheelchair dated 2/25/2026, the fall risk evaluation dated 2/25/2026 indicated Resident 187 was a risk for fall, the CP initiated on 2/25/2026 did not indicate the use of pillows tucked under the fitted sheet. RN 1 stated one of the ways the facility makes the staff aware of the current interventions in place for residents on risk for falls is the yellow star on the wall at the head of the bed and the interventions in place are marked off with a check. RN 1 stated there was no restraint or device use assessment prior to application of the pad alarm in bed or wheelchair on Resident 187. RN 1 stated prior to application of a device or physical restraint, a device use or physical restraint assessment should be completed, obtain a physician's order, obtain informed consent, and develop a care plan. RN 1 stated the restraint assessment should have been completed for Resident 187 prior to use of the pad alarm to make sure that the use of the restraint was appropriate and that least restrictive measures were attempted and not effective. RN 1 stated if Resident 187 had a physician's order for pad alarm, the pad alarm on the yellow star should have been marked so the staff would not miss using the pad alarm for Resident 187's safety while in bed as it placed Resident at risk for falls and injury. RN 1 stated that pillows tucked under Resident 187's fitted sheet to prevent the resident from rolling over and fall is not a practice in the facility as it restricts Resident 187's freedom of movement and can be considered a restraint. During an interview on 3/18/02026 at 1:28 p.m. with the DON, the DON stated she was made aware of the issues with Resident 187. The DON stated that pillows tucked under the fitted sheet is not a practice in the facility as Resident 187 was unable to remove the pillows freely and can be considered a restraint as it restricts the resident to move freely in the bed which can lead to decline in functioning. The DON stated staff can put pillows on both sides of the bed but should be placed on top of the sheet. The DON stated that the licensed nurses are supposed to complete a device use or physical restraint prior to application of any restraint or device. The DON stated a device use or restraint assessment should have been completed for Resident 187 prior to application of the bed alarm to ensure that the use of the device or restraint was appropriate and that the least restrictive measures attempted were not effective. The DON stated that the pad alarm should have been applied on Resident 187 as ordered by the physician as it placed Resident 187 at risk for falls and injury. d. During a review of Resident 78's AR, the AR indicated the facility admitted Resident 78 on 1/26/2026 with diagnoses including Parkinson's Disease (a progressive disease of the nervous (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	system marked by tremor, muscular rigidity, and slow, imprecise movements), generalized muscle weakness, and osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 78's H&P dated 1/28/2026, the H&P indicated Resident 78 had the capacity to understand and make decisions. During a review of Resident 78's MDS, dated [DATE], the MDS indicated Resident 78 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) but was able to understand others and make his needs known. The MDS further indicated Resident 78 required partial or moderate assistance with eating, was totally dependent on staff with toileting hygiene, showers/bathing self, upper and lower body dressing, and personal hygiene and substantial/maximal assistance with all other activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 78's Order Summary Report dated 3/12/2026, the Order Summary Report did not indicate a physician's order for pad alarm in bed or wheelchair. During a review of Resident 78's Physical Restraint Informed Consent forms, there was no informed consent obtained from the resident or resident representative for the use of the pad alarm in bed. During a review of Resident 78's Supportive and Safety/Restraint Physical Assessment form, there was no assessment completed prior to application of the pad alarm in bed or wheelchair. During a review of Resident 78's fall risk evaluation dated 1/26/2026, the fall risk evaluation indicated that Resident 78 was at risk for falls. During a review of Resident 78's CP on risk for falls and injury initiated on 2/5/2026, the CP indicated to visibly observe resident frequently, provide a safe and clutter-free environment, and safety devices such as low bed, floor mat, both side rails up and locked while in bed as a few of the interventions in place to reduce Resident 78's risk for falls and injury. During an observation on 3/9/2026 at 12:45 p.m. outside Resident 78's room by the doorway, observed Resident 78 sitting at the edge of the bed on the right-side eating lunch. Observed a bed alarm box hanging on the right side of the bed and Resident 78 sitting directly on a pad under the fitted sheet. During a concurrent observation and interview on 3/9/2026 at 12:56 p.m. inside Resident 78's room with CNA 12, CNA 12 stated Resident 78 had a bed alarm and did not seem to be working. CNA 12 instructed Resident 78 to stand up but the bed alarm did not make an audible alarm. CNA 12 stated the bed alarms were supposed to make an alarm sound when residents move or when they try to get up unassisted. CNA 12 unplugged and plugged the cord from the alarm box but there was no alarm sound. CNA 12 stated that it could be the battery needed to be changed. CNA 12 stated if the battery is low, the box will make a beeping sound. CNA 12 stated they were responsible in ensuring that the pad alarm was functional and replace the battery if needed. CNA 12 stated that if Resident 78's bed alarm was not working, the resident can get up unassisted and fall. During a concurrent interview and record review on 3/9/2026 at 1:15 p.m., reviewed Resident 78's physician's orders, informed consents, care plans, and restraint assessments with Licensed Vocational Nurse (LVN) 8. LVN 8 stated Resident 78 did not have a physician's order for the pad alarm (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in bed, informed consent obtained from the resident or resident representative, device use or restraint assessment, and a care plan. LVN 8 stated if a device or restraint was used on a resident, there should be a physician's order, informed consent, restraint assessment to make sure that the least restrictive interventions were not effective, and include the pad alarm in bed as one of the interventions in the care plan aside from the low bed, floor mat, and both side rails up. LVN 8 stated the use of pad alarm on Resident 78 while in bed can be considered as a restraint as it restricts the resident freedom of movement. During an interview on 3/12/2026 at 1:08 p.m. with the DON, the DON stated that applying a pad alarm on a resident without a physician's order, informed consent, device use or restraint assessment, and care plan is considered a restraint. The DON further stated, if there was no physician's order, the facility would not be able to determine if the pad alarm was needed, the facility was not sure if the risks and benefits were explained to the resident and/or resident representative and failed to honor the resident's right to self-determination. The DON stated the care plan is a guide on how to provide care to the resident and all staff read it. The DON stated if the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) was aware how to properly provide the care to the resident then quality care could not be provided. The DON stated the restraint assessment prior to use of the pad alarm in use ensures that the device use was appropriate and safe for the resident. The DON stated the restraint or device use assessment should have been completed for Resident 78 prior to use, the physician's order and informed should have been obtained, and the intervention should have been included in the risk for fall care plan as it placed Resident 78 at risk for not receiving quality care while in the facility. During a review of the facility provided manufacturer's guideline on Pad Alarm 1, undated, the manufacturer's guideline indicated the device is not a substitute for routine visual monitoring by caregiver. The manufacturer's guideline further indicated: It is the responsibility of the caregiver to ensure that the product is properly installed, tested and functioning correctly before each use. Low battery indicator on the front of the alarm will flash or light up when battery is low and needs to be replaced. Replace battery immediately if indicator flashes or lights. Bench test monitor and sensor pad prior to use. Insert the sensor pad's telephone style plug into the sensor mat jack on the monitor until a click of the plug locking in place is heard or felt. Center the sensor pad under the buttocks of the patient. The monitor will automatically sense the pressure and provide an audible beep to alert caregiver that the system is monitoring the patient. Have the patient attempt to stand to remove the pressure from the sensor pad. The alarm will sound During a review of the facility P&P titled, Use of Restraints, last reviewed 2/20/2026, the P&P indicated, Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom (s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need of restraints will be documented. Policy Interpretation and Implementation. I. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints . 5. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention AND a restraint is required to: a. treat the medical symptom; b. protect the resident's safety; and c. help the resident attain the highest level of his/her physical or psychological well-being. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine pos

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were screened using the Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals are not appropriately placed in nursing homes for long-term care) for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with serious mental illness (SMI) and/or ID/developmental disability (DD)/related conditions (RC) receive the care and services in maintaining his/her highest practicable level in the most appropriate setting for three of three sampled residents (Residents 3, 62, and 17), by: 1. Failing to submit a new Level I PASRR for Residents 3 and 62 who had discrepancy in the previous PASRR Level I Screening. 2. Failing to submit a new Level 1 PASRR screening when Resident 17 was readmitted from the hospital on 4/3/2025 with a new diagnosis of serious mental illness/disorder. These deficient practices had the potential to result in inappropriate placement and unidentified specialized services for Residents 3, 62, and 17. Findings: 1a. During a review of Resident 3's admission Record (AR), the AR indicated that the facility originally admitted the resident on 10/7/2025 and readmitted on [DATE] with diagnoses including mild intellectual disabilities, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), depression, and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 3's History and Physical (H&P), dated 2/11/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 3's PASRR Level I Screening, dated 10/7/2025, the PASRR Level I Screening indicated that the resident did not have a serious diagnosed mental disorder, no suspected mental illness, and has not been prescribed psychotropic (medications capable of affecting the mind, emotions, and behavior) medication. During a review of Resident 3's Minimum Data Set (MDS – a resident assessment tool), dated 10/11/2025, the MDS indicated the resident diagnoses including depression and bipolar disorder. The MDS indicated the resident was taking an antipsychotic (drug used to manage abnormal condition of the mind described as involved a loss of contact with reality) and antidepressant (that helps improve mood by increasing levels of a brain chemical called serotonin) medications. During a concurrent interview and review on 3/10/2026 at 10 a.m. with the Director of Nursing (DON), Resident 3's AR, MDS, and PASRR Level I Screening, dated 10/7/2025, were reviewed. The DON stated the resident's PASRR Level I Screening had discrepancies, and the facility should have submitted a new level 1 screening on admission. The DON stated Resident 3 would not be evaluated and would not receive the appropriate treatment and referral as needed. The DON stated it could result in a delay of care to Resident 3. 1b. During a review of Resident 62's AR, the AR indicated that the facility admitted the resident on 2/20/2026 with diagnoses including anxiety disorder (an abnormal condition characterized by persistent and excessive worries that interfere with daily activities), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to a substance or known physiological condition. (continued on next page)

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Burbank Healthcare & Rehab	1041 S. Main St. Burbank, CA 91506

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 62's H&P, dated 2/21/2026, the H&P indicated that the resident had the capacity to understand and make decisions and was able to make decisions for activities of daily living. During a review of Resident 62's Order Recap Report, dated 2/20/2026, the ORR indicated an order for Ativan oral tablet one (1) milligram (mg – a unit of measurement) to give 1 tablet by mouth three times a day for anxiety manifested by restlessness. During a review of Resident 62's MDS, dated [DATE], the MDS indicated that the resident had active diagnoses including anxiety disorder and psychotic disorder. During a concurrent interview and review on 3/12/2026 at 9:58 a.m. with the DON, reviewed Resident 62's AR, Order Summary Report, MDS, and PASRR Level 1 Screening, dated 2/20/2026, the DON stated that a new Level I Screening should have been completed when the initial PASRR was reviewed. The DON stated that this is to ensure the resident was screened and referred for a level II evaluation as needed. The DON stated that when the submitted PASRR was completed with discrepancies and a new PASRR Level I screening was not done the resident would not be evaluated and not received appropriate treatment and referral as needed. DON stated it could result in a delay of care. DON stated a resident when evaluated for level II the recommendations would be care planned and documented on the resident's record. 2. During a review of Resident 17's AR, the AR indicated that the facility originally admitted the resident on 9/22/2024 and readmitted on [DATE] with diagnoses including schizoaffective disorder, bipolar type (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), psychosis, and mood disorder. During a review of Resident 17's H&P, dated 4/9/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 17's PASRR Level I Screening, dated 9/19/2024, the PASRR Level I Screening indicated that the resident did not have a serious diagnosed mental disorder, no suspected mental illness, and has not been prescribed psychotropic (medications capable of affecting the mind, emotions, and behavior) medication. During a review of Resident 17's MDS, dated [DATE], the MDS indicated resident diagnoses including psychosis and schizophrenia (a mental illness that is characterized by disturbances in thought). The MDS indicated the resident was not taking any antipsychotic (drug used to manage abnormal condition of the mind described as involved a loss of contact with reality) medications. During a concurrent interview and review on 3/12/2026 at 10 a.m., reviewed Resident 17's AR, MDS, and PASRR Level I Screening, dated 9/19/2024 with the DON, the DON stated that the AR indicated that the resident had a new diagnosis of mental disorder during readmission on [DATE], that Resident 17's PASRR Level I Screening was not recent. The DON stated that when residents had a new diagnosis of mental disorder, a new PASRR level 1 screening should be submitted. The DON stated that if a resident was readmitted with a new diagnosis of mental disorder, the admissions department are supposed to require the hospital to submit a new screening. The DON stated that if there was a new diagnosis, the registered nurses (RNs) are supposed to check the PASRR Level 1 screening and submit a new Level 1 screening if needed to ensure the resident was screened and referred for a level II evaluation as needed. The DON stated that if there was no new level 1 screening submitted, the (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident would not be evaluated and would not receive the appropriate treatment and referral as needed. The DON stated it could result in a delay of care. During a review of the facility's policy and procedure (P&P) titled, Preadmission Screening and Resident Review (PASRR), last reviewed 2/20/2026, the policy indicated the purpose of this policy is for the facility to ensure each resident with serious mental illness and/or intellectual/developmental disability/related conditions will have the appropriate setting, as well as if any specialized services and/or rehabilitative services are needed. The procedure indicated that the facility would submit a new Level I PASRR if there is any error/discrepancy in the previous PASRR screening or the MDS does not match the Level I Screening from the GACHs. The P&P further indicated that the facility would submit a new Level I PASRR if there is a significant change in resident's mental or physical condition.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for four of 34 sampled residents (Residents 66, 179, 142, and 97) by failing to ensure: 1. Resident 66 had a care plan on the use of psychotropic medication (prescription drugs that change brain chemistry to alter mood, thoughts, behavior, or perception) Divalproex sodium (a prescription medication used to calm overactive nerves in the brain) and anticoagulant (a type of medicine thatˆprevents blood from clotting (or clumping) too easily) enoxaparin sodium (a prescription medication used to prevent and treat harmful blood clots). 2. Resident 179 had a care plan on the use of anticoagulant heparin (a medication commonly known as aˆblood thinnerˆor anˆanticoagulant with primary purpose to stop blood clots from forming, or to prevent existing clots from getting bigger). 3. Resident142 had a care plan for pain related to chronic arthritis. 4. Resident 97 had a care plan on the use of antibiotic Levofloxacin. These deficient practices had the potential to result in a delay of nursing care and medical interventions for Residents 66, 179, 142, and 97. Findings: 1. During a review of Resident 66's Face Sheet (FS), the FS indicated the facility admitted the resident on 11/8/2019, and readmitted the resident on 1/12/2026, with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life, functioning, or relationships), and functional quadriplegia (the complete inability to move all four limbs, not caused by a spinal cord injury or physical damage, but by severe frailty, advanced disease (like dementia or stroke), or mental disability). During a review of Resident 66's Minimum Data Set (MDS, a resident assessment tool), dated 2/6/2026, the MDS indicated the resident had the ability to make self-understood and usually understands others and had impaired cognition (problems with a person's mental processes—essentially, the way the brain thinks, learns, remembers, and makes decisions). The MDS indicated Resident 66 was on a high-risk drug class antianxiety medication (prescription drugs designed to calm the nervous system, reduce severe fear, and ease panic symptoms by balancing brain chemistry). During a review of Resident 66's Order Summary Report (OSR), dated 1/12/2026, the OSR indicated an order for: - Divalproex Sodium Oral Tablet Delayed Release 500 milligrams (mg, a unit of weight) (Divalproex Sodium). Give 1 tablet by mouth two times a day for bipolar disorder m/b uncontrollable mood swings causing anger and interfering with ADLs. - Enoxaparin Sodium Solution 40 mg/0.4 milliliter (ml, a unit of volume). Inject 0.4 ml subcutaneously (beneath the skin) every 24 hours for deep vein thrombosis (DVT, is a serious condition where aˆblood clot (thrombus) forms in a deep vein, usually in the leg, thigh, or pelvis) prophylaxis (PPX, is a medical term forˆpreventive care—any action, treatment, or medication taken to prevent a disease or infection from happening in the first place). Rotate (following a regular pattern as you move your shots from site to site) injection sites. During a concurrent interview and record review on 3/11/2026, at 8:50 a.m., with Registered Nurse (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(RN) 3, reviewed Resident 66's Medical Diagnoses, OSR, and Care Plans. RN 3 stated there was physician's order for Divalproex Sodium and enoxaparin sodium however, there was no baseline care plan or comprehensive care plan developed and implemented on Resident 66 use of both medications. RN 3 stated that Divalproex Sodium and enoxaparin sodium are significant medications, Divalproex sodium is a mood stabilizer, and the enoxaparin sodium is an anticoagulant. RN 3 stated it was important to monitor for side effects/adverse effects (aˆharmful, unintended, and undesired resultˆthat happens after taking a medication, receiving a treatment, or undergoing a medical procedure) of the medications to ensure its safe use. RN 3 stated that the care plan helps in evaluating the need for the medication and without it there will be possible delay in the provision of care to Resident 66. During an interview on 3/12/2026, at 12:56 p.m., with the Director of Nursing (DON), the DON stated Resident 66 should have a care plan on the use of Divalproex Sodium and Enoxaparin Sodium. The DON stated the purpose of the care plan is our guide on how to provide care to residents with significant medications. The DON stated the care plan is read by all discipline and if everybody is aware on how to care for the resident there will be continuity of care and the resident will receive high quality care. The DON stated if there was no care plan, the quality of care is compromised and can also delay the care to the resident. The DON stated that the care plan is important for both the psychotropic and anticoagulant medications to monitor for its adverse effects and intervene promptly to avoid stress and discomforts to the resident. 2. During a review of Resident 179's FS, the FS indicated the facility admitted the resident on 3/12026, with diagnoses including nondisplaced fracture (aˆbroken or cracked bone that remains in its proper, natural alignment) of fourth metatarsal bone (any of theˆfive long bones in the middle of the footˆthat connect the ankle bones to the toe bonesˆ(phalanges)), left foot, ulcerative colitis (a chronic inflammatory bowel disease (IBD) that causes long-lasting inflammation and ulcers (sores) in the innermost lining of the large intestine (colon) and rectum), and gastro-esophageal reflux disease (GERD, a chronic, more severe form of acid reflux). During a review of Resident 179's History and Physical (H&P), dated 3/2/2026, the H&P indicated the resident was awake, alert, oriented, communicative, non-ambulatory, able to move all extremities, able to test strength and power. The H&P indicated Resident 179 had the capacity to understand and make decisions. During a review of Resident 179's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities—such as thinking, memory, learning, and reasoning—are working properly without significant decline or impairment). The MDs indicated Resident 179 was on a high-risk drug class anticoagulant. During a review of Resident 179's OSR, dated 3/1/2026, the OSR indicated an order for Heparin Sodium (Porcine) Injection Solution 5000 unit per milliliter (unit/ml, refers to theˆconcentrationˆor strength of the blood-thinning medicine) (Heparin Sodium (Porcine)). Inject 1 ml subcutaneously every 8 hours for DVT PPX. Rotate injections. During a concurrent interview and record review on 3/11/2026, at 7:16 a.m., with RN 1, reviewed Resident 179's Medical Diagnoses, OSR, and Care Plans. RN 1 stated there was a physician's order for heparin sodium, however, there was no baseline or comprehensive care plan developed and implemented on the use of heparin to Resident 179. RN 1 stated that heparin sodium is a significant (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication, and heparin sodium is an anticoagulant. RN 1 stated it was important to monitor for side effects/adverse effects of the medication to ensure its safe use. RN 1 stated that the care plan helps in evaluating the need for the medication and without it there will be possible delay in the provision of care to Resident 179. During an interview on 3/12/2026, at 12:56 p.m., with the DON, the DON stated Resident 179 should have a care plan on the use of heparin sodium. The DON stated the purpose of the care plan is to guide us on how to provide care to residents with significant medications. The DON stated the care plan is read by all discipline and if everybody is aware on how to care for the resident there will be continuity of care and the resident will receive high quality care. The DON stated if there's no care plan, the quality of care is compromised and can also delay the care to the resident. The DON stated that the care plan is important for anticoagulant medications to monitor for its adverse effects and intervene promptly to avoid stress and discomforts to the resident. 3. During a review of Resident 142's Face Sheet (FS), the FS indicated Resident 142 was admitted on [DATE] to the facility with diagnoses including bullous pemphigoid (skin condition that causes large, fluid-filled blisters), acute chronic systolic congestive heart failure(a long-term weak heart that suddenly gets worse and cannot pump blood properly, causing fluid buildup in the body), and other specified arthritis, unspecified site (joint inflammation or pain is present but the exact place in the body is not specified). During a review of Resident 142's H&P, dated 1/21/2026, the H&P indicated resident can make needs known but cannot make medical decisions. During a review of Resident 142's MDS, dated [DATE], indicated Resident 142 was usually able to make self- understood and usually able to understand others. The MDS further indicated that Resident 14 had an impaired cognition (difficulty with thinking). The MDS indicated the resident required extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a concurrent interview and record review for Resident 142 on 3/12/2026 at 1:30 p.m., with Registered Nurse (RN) 3, Care plans were reviewed. RN 3 stated there was no care plan for pain in Resident 142's chart. RN 3 stated it is important to have a care plan for Resident 142's pain related to arthritis to see if pain management is effective and to track if the current regimen is effective and if not then need to contact provider to see if any medication adjustments need to be made. During an interview on 3/12/2026 at 4 p.m. with the Director of Nursing (DON), the DON stated that an assessment and care plan needed to be done for pain for Resident 142. The DON stated that if there was no care plan for pain for Resident 142 then the healthcare workers do not know how to address the pain based on interventions, and also everyone can be aware on how to provide care for the resident. DON stated that yes, the resident needs a care plan for pain, and the policy titled, Care Plans, Comprehensive Person- Centered, was not followed. 4. During a review of Resident 97's admission Record, the admission Record indicated the facility originally admitted the resident on 7/22/2025 and readmitted in the facility on 10/1/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), history of falling, UTI. During a review of Resident 97's H&P, dated 10/2/2025, the H&P indicated Resident 97 did not have the capacity to understand and make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 97's MDS, dated [DATE], the MDS indicated Resident 97 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was usually able to understand and make her needs known. The MDS further indicated Resident 97 required set up or clean-up assistance from staff with eating; supervision or touching assistance with walking; total assistance with toileting; partial/moderate assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 97 was frequently incontinent with bowel and bladder. During a review of Resident 97's physician's order dated 3/12/2026, the physician's order indicated the following: - 11/25/2026: levofloxacin oral tablet 750 milligrams (mg – a unit of measurement) give 1 tablet by mouth 1 time a day for UTI for five (5) days - 11/28/2025: discontinue levofloxacin oral tablet 750 mg give 1 tablet by mouth 1 time a day for UTI for 5 days - 11/28/2026: levofloxacin oral tablet 750 mg give 1 tablet by mouth 1 time a day for UTI until 12/1/2025. During a review of Resident 97's care plans (CP), the CP did not indicate there was a care plan developed and implemented that Resident had UTI and was on levofloxacin. During a concurrent interview and record review on 3/11/2026 at 11:05 a.m., Resident 97's physician's orders and care plans were reviewed with the Infection Preventionist (IP). The IP stated that Resident 97 had a physician's order for levofloxacin 750 mg oral tablet one time a day for UTI for 5 days dated 11/25/2025. The IP stated there was no care plan developed and implemented to address Resident 97's UTI and the use of levofloxacin. The IP stated that if a resident had a change in condition such as UTI and the use of any antibiotics, a care plan should be developed and implemented by the licensed nurse who received the order from the physician within 24 hours of receiving the order. The IP stated that Resident 97's CP should have been developed and implemented for the UTI and use of levofloxacin for the staff to know or be aware of the current plan of care for the resident and for them to know how to properly care for Resident 97 to meet her needs. The IP stated that if there was no care plan developed and implemented for the UTI and levofloxacin, it placed Resident 97 at risk worsening of the UTI and delay in providing the care to the resident. During an interview on 3/12/2026 at 1:28 p.m. with the DON, the DON stated a care plan serves as a guide for the staff on how to provide care for the residents. The DON further stated that all members of the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) have access to the care plan. If the IDT was aware on how to properly provide care to the resident, then the residents will receive quality care. The DON stated that Resident 97's CP should have been developed and implemented for the UTI and use of levofloxacin for the staff to know or be aware of the current plan of care for the resident and for them to know how to properly care for Resident 97 to meet her needs. The DON stated that if there was no care plan developed and implemented for the UTI and levofloxacin, it placed Resident 97 at risk for a delay in providing and receiving the care the resident needs. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 2/26/2026, the P&P indicated: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 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. - The IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. - The care plan interventions are derived from a thorough analysis of the information gathered. - The comprehensive, person-centered care plan: a. Includes measurable objective 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, including (1) Services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her right, including the right to refuse treatment; (2) Which professional services are responsible for each element of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to ensure the environment was free of accident hazards for twelve of 14 sampled residents (Residents 180, 72, 179, 12, 1, 104, 55, 9, 21, 183, 22, and 78) reviewed for accidents by failing to ensure: 1. Residents 180, 72, 179, and 12 did not have a furniture or equipment on top of the floor mat (specially designed mats provide cushioning and support to patients who are at risk of falling, helping to prevent serious injuries). 2. Residents 180, 1, 72, 104, and 55 did not have medications or biologicals (medicines derived from living organisms-such as humans, animals, or microorganisms-rather than being created from chemicals) left at the bedside. 3. Residents 1, 9, and 78's tab/pad alarm (a type of^fall-management monitor^used in hospitals, nursing homes, and home care settings to alert caregivers when a person at risk of falling is attempting to get out of bed or a chair without assistance) was connected to the alarm console and was working properly. 4. Ensure Licensed Vocational Nurse (LVN) 9 followed the facility policy and procedures (P&P) regarding falls when one of ten sampled residents (Resident 121) reviewed during the Accidents care area had movement from the bed to the fall mat on 2/21/2026. 5. Failing to ensure the floor mats were in place for Resident 183 as ordered by the physician. 6. Failing to ensure that Resident 22's bed was in a low position. These deficient practices increased the risk of accidents such as falls with injuries, and ingestion poisoning on residents. Findings: 1. During a review of Resident 180's Face Sheet (FS), the FS indicated the facility admitted the resident on 3/5/2026, with diagnoses including nontraumatic intracerebral hemorrhage (a sudden, spontaneous brain bleed caused by blood vessels bursting inside the brain without any external head injury or trauma) and drug-induced hypoglycemia (a dangerous drop in blood sugar levels (typically below 70 mg/dL) caused by medications, most commonly diabetes treatments like insulin or sulfonylureas). During a review of Resident 180's History and Physical (H&P), dated 3/6/2026, the H&P indicated the resident was awake, alert, oriented, communicative, able to move all extremities, reduced test strength and power. The H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 180's Minimum Data Set (MDS, a resident assessment tool), dated 3/12/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities, such as thinking, memory, learning, and reasoning, are working properly without significant decline or impairment). The MDS indicated Resident 180 was independent to needing partial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident had a fall within the last 2 to 6 months. During a review of Resident 180's Order Summary Report (OSR), dated 3/5/2026, the OSR indicated an order for [Support & Safety Device]- Floor mat to decrease potential injury. During a review of Resident 180's Fall Risk Evaluation (FRE), dated 3/5/2026, the FRE indicated the resident was at risk for falls. During a review of Resident 180's Care Plan (CP) Report titled, Risk for fall/injury related to other nontraumatic intracerebral hemorrhage, chronic respiratory failure (a long-term condition where the lungs cannot properly exchange gases, resulting in persistently low oxygen or high carbon dioxide levels in the blood)., last revised on 3/6/2026, the CP indicated a goal of resident will have reduced (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risk for fall or injuries daily and an intervention to provide adequate supervision and frequently cues on safety measures and utilize the safety and supportive devices as ordered. During a concurrent observation and interview on 3/9/2026, at 10:23 a.m., with Licensed Vocational Nurse (LVN) 2, inside Resident 180's room, observed Resident 180's floor mat at the right side of the bed had an oxygen concentrator (a medical device thatˆtakes in room air, removes nitrogen from it, and provides a continuous supply of concentrated, high-purity oxygen (90-95%)ˆto people who need extra oxygen due to breathing-related conditions) on top of them. LVN 2 stated there should be no oxygen concentrator on top of the fall mat because when the resident rolls down or fall onto the fall mat, the resident will hit the hard objects on top of the floor mat and cause injuries such as bruises, cuts, or fracture (break in bone). During a concurrent interview and record review on 3/11/2026, at 7:16 a.m., with Registered Nurse (RN) 1, reviewed Resident 180's Medical Diagnoses, OSR, FRE, and CP. RN 1 stated there should be no furniture or equipment on top of the floor mat of Resident 180 because it defeats the purpose of the floor mat to provide a safe, soft-landing space for the resident. RN 1 stated the purpose of the floor mat was to prevent injury to the resident. RN 1 sated if they fall, they land on the soft surface of the mat. RN 1 stated it is not preventing the resident from having a safe space to land on because of the objects on top of them that can cause bruising and fracture to the resident. RN 1 stated that it was a protocol for devices applied to have consent in their facility. During an interview on 3/12/2026, at 12:56 p.m., with the Director of Nursing (DON), the DON stated the floor mat is used for fall prevention to reduce injury if there is an incidence of fall. The DON stated it is not appropriate to have equipment and furniture on top of Resident 180's floor mat because they can fall on them and sustain an injury. The DON stated all staff is responsible for checking for objects on top of the floor mat frequently when they provide care to the residents. 2. During a review of Resident 72's FS, the FS indicated the facility admitted the resident on 10/30/2025, and readmitted the resident on 1/12/2026, with diagnoses including metabolic encephalopathy (a broad term for temporary or permanent brain dysfunction caused by chemical imbalances in the body, rather than a direct physical injury), muscle weakness, and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right ankle. During a review of Resident 72's H&P, dated 1/15/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 72's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had impaired vision. The MDS indicated that the resident had impaired cognition (having trouble with mental processes that allow a person to think, learn, remember, concentrate, and make decisions) and was dependent on mobility and ADLs. During a review of Resident 72's OSR, dated 3/11/2026, the OSR did not indicate an order for a floor mat. During a review of Resident 72's Fall Risk Evaluation (FRE), dated 1/12/2026, the FRE indicated the resident was at risk for falls. During a review of Resident 72's CP Report titled, Safety/supportive devices: Low bed (a bed frame designed to sit much closer to the ground than a traditional bed), side rails (metal or rigid plastic (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	barriers attached to the sides of a bed) times (X) 2, floor mat, bed alarm (is a safety device used primarily for seniors, patients with dementia, or those at high risk of falling), and wheelchair alarm (is a safety device used primarily for seniors, patients with dementia (a progressive state of decline in mental abilities), or those at high risk of falling), last revised on 10/31/2025, the CP indicated a goal of reducing risk for fall or injuries daily and an intervention to provide adequate supervision and frequently cues on safety measures and utilize the safety and supportive devices as ordered. During a concurrent observation and interview on 3/9/2026, at 10:36 a.m., with LVN 2, inside Resident 72's room, observed Resident 72's floor mat at the right side of the bed had a side table on top of them. LVN 2 stated there should be no side table on top of the fall mat because when the resident rolls down or fall onto the fall mat, the resident will hit the hard objects on top of the floor mat and cause injuries such as bruises, cuts, or fracture. During a concurrent interview and record review on 3/11/2026, at 7:16 a.m., with RN 1, reviewed Resident 72's Medical Diagnoses, OSR, FRE, and CP. RN 1 stated there should be no furniture or equipment on top of the floor mat of Resident 72 because it defeats the purpose of the floor mat to provide a safe, soft-landing space for the resident. RN 1 stated the purpose of the floor mat was to prevent injury to the resident. RN 1 sated if they fall, they land on the soft surface of the mat. RN 1 stated it is not preventing the resident from having a safe space to land on because of the objects on top of them that can cause bruising and fracture to the resident. RN 1 stated that it was a protocol for devices applied to have consent in their facility. During an interview on 3/12/2026, at 12:56 p.m., with the DON, the DON stated the floor mat is used for fall prevention to reduce injury if there is an incidence of fall. The DON stated it is not appropriate to have equipment and furniture on top of Resident 72's floor mat because they can fall on them and sustain an injury. The DON stated all staff is responsible for checking for objects on top of the floor mat frequently when they provide care to the residents. 3. During a review of Resident 179's FS, the FS indicated the facility admitted the resident on 3/1/2026, with diagnoses including difficulty in walking, muscle weakness, and dizziness. During a review of Resident 179's H&P, dated 3/2/2026, the H&P indicated the resident was awake, alert, oriented, communicative, non-ambulatory, able to move all extremities, able to test strength and power. The H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 179's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition. The MDS indicated the resident was needing substantial to setup assistance on mobility and ADLs. The MDS indicated the resident had a fall in the las t month and had a fracture related to fall in the last 6 months. During a review of Resident 179's OSR, dated 3/1/2026, the OSR indicated an order for [Support & Safety]- Floor mat to decrease potential injury. Every shift. During a review of Resident 179's FRE, dated 3/1/2026, the FRE indicated the resident was at risk for falls. During a review of Resident 179's CP Report regarding the resident being at risk for falls/injury related to history of falling., last revised on 3/11/2026, the CP indicated a goal of reduce risk of falls and injury daily until the next assessment and an intervention to provide resident with a safe and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clutter-free environment. During a concurrent observation and interview on 3/9/2026, at 10:11 a.m., with LVN 2, inside Resident 179's room, observed Resident 179's floor mat at the left side of the bed had a side table on top of them. LVN 2 stated there should be no side table on top of the fall mat because when the resident rolls down or fall onto the fall mat, the resident will hit the hard objects on top of the floor mat and cause injuries such as bruises, cuts, or fracture. During a concurrent interview and record review on 3/11/2026, at 7:16 a.m., with RN 1, reviewed Resident 179's Medical Diagnoses, OSR, FRE, and CP. RN 1 stated there should be no furniture or equipment on top of the floor mat of Resident 179 because it defeats the purpose of the floor mat to provide a safe, soft-landing space for the resident. RN 1 stated the purpose of the floor mat was to prevent injury to the resident. RN 1 sated if they fall, they land on the soft surface of the mat. RN 1 stated it is not preventing the resident from having a safe space to land on because of the objects on top of them that can cause bruising and fracture to the resident. RN 1 stated that it was a protocol for devices applied to have consent in their facility. During an interview on 3/12/2026, at 12:56 p.m., with the DON, the DON stated the floor mat is used for fall prevention to reduce injury if there is an incidence of fall. The DON stated it is not appropriate to have equipment and furniture on top of Resident 179's floor mat because they can fall on them and sustain an injury. The DON stated all staff is responsible for checking for objects on top of the floor mat frequently when they provide care to the residents. 4. During a review of Resident 12's FS, the FS indicated the facility admitted the resident on 10/31/2025, with diagnoses including the presence of artificial hip joint (a man-made device surgically implanted to replace a damaged or diseased natural hip joint), contracture of the right and left hips, and contracture of the right and left knees. During a review of Resident 12's H&P, dated 11/2/2025, the H&P indicated the resident was alert, oriented to person and does not have the capacity to understand and make decisions. During a review of Resident 12's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had impaired cognition. The MDS indicated the resident was dependent to requiring partial assistance on mobility and ADLs. During a review of Resident 12's OSR, dated 10/31/2025, the OSR indicated an order for Support & Safety Device- Low bed with floor mat to decrease potential injury. Every shift. During a review of Resident 12's FRE, dated 10/31/2025, the FRE indicted the resident was at risk for falls. During a review of Resident 12's CP Report titled, Risk for fall/injury related to frequent falls, altered mental status (AMS, any sudden or significant change in a person's normal thinking, awareness, or behavior)., last revised on 11/1/2025, the CP indicated a goal of resident will have reduced risk for fall or injuries daily and an intervention to provide adequate supervision and frequently cues on safety measures and utilize the safety and supportive devices as ordered. During a concurrent observation and interview on 3/9/2026, at 10:11 a.m., with LVN 2, inside Resident 12's room, observed Resident 12's floor mat at the left side of the bed had a side table on top of them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 2 stated there should be no side table on top of the fall mat because when the resident rolls down or fall onto the fall mat, the resident will hit the hard objects on top of the floor mat and cause injuries such as bruises, cuts, or fracture. During a concurrent interview and record review on 3/11/2026, at 7:16 a.m., with RN 1, reviewed Resident 12's Medical Diagnoses, OSR, FRE, and CP. RN 1 stated there should be no furniture or equipment on top of the floor mat of Resident 12 because it defeats the purpose of the floor mat to provide a safe, soft-landing space for the resident. RN 1 stated the purpose of the floor mat was to prevent injury to the resident. RN 1 sated if they fall, they land on the soft surface of the mat. RN 1 stated it is not preventing the resident from having a safe space to land on because of the objects on top of them that can cause bruising and fracture to the resident. RN 1 stated that it was a protocol for devices applied to have consent in their facility. During an interview on 3/12/2026, at 12:56 p.m., with the DON, the DON stated the floor mat is used for fall prevention to reduce injury if there is an incidence of fall. The DON stated it is not appropriate to have equipment and furniture on top of Resident 12's floor mat because they can fall on them and sustain an injury. The DON stated all staff is responsible for checking for objects on top of the floor mat frequently when they provide care to the residents. 5. During a review of Resident 180's FS, the FS indicated the facility admitted the resident on 3/5/2026, with diagnoses including nontraumatic intracerebral hemorrhage and drug-induced hypoglycemia. During a review of Resident 180's H&P, dated 3/6/2026, the H&P indicated the resident was awake, alert, oriented, communicative, able to move all extremities, reduced test strength and power. The H&P indicated Resident 180 had the capacity to understand and make decisions. During a review of Resident 180's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition. The MDS indicated Resident 180 was independent to needing partial assistance on mobility and activities of daily living (ADLs). The MDS indicated Resident 180 had a fall within the last 2 to 6 months. During a review of Resident 180's OSR, dated 3/11/2026, the OSR did not indicate an order for urea cream (is a topical, skin-softening medication used to treat dry, rough, or thickened skin conditions.). During a review of Resident 180's Self-Administration of Medication (SAM), dated 3/5/2026, the SAM indicated the resident was not a candidate for self-administration and licensed nurses to administer prescribed medications. During a concurrent observation and interview on 3/9/2026, at 10:29 a.m. with LVN 2, inside Resident 180's room, observed Resident 180 had a tube of urea cream at the bedside of the resident. LVN 2 stated there should be no medications or biologicals left at the bedside of Resident 180 for safety. During a concurrent interview and record review on 3/11/2026, at 7:16 a.m., with RN 1, reviewed Resident 180's Medical Diagnoses, OSR and SAM. RN 1 stated there was no order for the resident to have urea cream at the bedside and the SAM indicated the resident cannot self-administer medications. RN 1 stated there should be no medications or biologicals left at the bedside to prevent accidental ingestion poisoning on residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/2026, at 12:56 p.m., with the DON, the DON stated it is not appropriate to leave medications at the bedside of Resident 180 to self-administer medications because the resident was not a candidate for self-administration of medications. The DON stated if the resident was deemed capable, they provide lock boxes at the bedside to prevent other residents from accessing them. The DON stated if the resident is not capable to self-administer medications, it should be kept at the medication carts. The DON stated all staff should check for medications left at the bedside and notify the charge nurse and RN sup when they find one. The DON stated leaving medications or biologicals at the bedside of Resident 180 had a potential for ingestion of the medication of the residents that can lead to poisoning and other adverse reactions. 6. During a review of Resident 1's FS, the FS indicated the facility admitted the resident on 10/30/2025, and readmitted the resident on 11/24/2025, with diagnoses including acute respiratory failure (a life-threatening, sudden-onset medical emergency where your lungs cannot properly get enough oxygen into the blood or remove carbon dioxide from it), pneumonitis (inflammation (swelling and irritation) of the lung tissue, specifically the tiny air sacs (alveoli) responsible for oxygen exchange), and dependence on supplemental oxygen (a medical treatment that provides extra, concentrated oxygen to people who cannot get enough oxygen on their own from normal air). During a review of Resident 1's H&P, dated 1/11/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 1's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition. During a review of Resident 1's OSR, dated 3/11/2026, the OSR did not indicate an order for A&D ointment (is a thick, medicated skin protectant designed to soothe, heal, and protect irritated skin) at the bedside. During a review of Resident 1's Self-Administration of Medication (SAM), dated 1/11/2026, the SAM indicated the resident was not a candidate for self-administration. Licensed Nurses to administer prescribed medications. During a concurrent observation and interview on 3/9/2026, at 9:38 a.m., with Treatment Nurse (TN) 2, inside Resident 1's room, observed packets of A&D ointments was left at the bedside of the resident. TN 2 stated there should be no medications or biologicals left at the bedside of Resident 1 to prevent the resident or other confused residents from ingesting them causing poisoning. During a concurrent interview and record review on 3/11/2026, at 7:16 a.m., with RN 1, reviewed Resident 1's Medical Diagnoses, OSR and SAM. RN 1 stated there was no order for the resident to have urea cream at the bedside and the SAM indicated the resident cannot self-administer medications. RN 1 stated there should be no medications or biologicals left at the bedside to prevent accidental ingestion poisoning on residents. During an interview on 3/12/2026, at 12:56 p.m., with the DON, the DON stated it is not appropriate to leave medications at the bedside of Resident 1 to self-administer medications because the resident was not a candidate for self-administration of medications. The DON stated if the resident was deemed capable, they provide lock boxes at the bedside to prevent other residents from accessing them. The DON stated if the resident is not capable to self-administer medications, it should be kept at the medication carts. The DON stated all staff should check for medications left at the bedside and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notify the charge nurse and RN sup when they find one. The DON stated leaving medications or biologicals at the bedside of Resident 1 had a potential for ingestion of the medication of the residents that can lead to poisoning and other adverse reactions. 7. During a review of Resident 72's FS, the FS indicated the facility admitted the resident on 10/30/2025, and readmitted the resident on 1/12/2026, with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and dysphagia (difficulty swallowing). During a review of Resident 72's H&P, dated 1/15/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 72's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had impaired cognition. During a review of Resident 72's OSR, dated 3/11/2026, the OSR did not indicate an order for A&D ointment at the bedside. During a review of Resident 72's Self-Administration of Medication (SAM), dated 1/12/2026, the SAM indicated the resident was not a candidate for self-administration. All medications to be given as ordered by licensed nurses due to polypharmacy (the routine use of multiple medications—typically five or more—by a single person, including prescriptions, over-the-counter drugs, and supplements) and safety. During a concurrent observation and interview on 3/9/2026, at 10:47 a.m. with LVN 2, inside Resident 72's room, observed Resident 72 had multiple A&D ointment packets at the bedside of the resident. LVN 2 stated there should be no medications or biologicals left at the bedside of the resident for safety. During a concurrent interview and record review on 3/11/2026, at 7:16 a.m., with RN 1, reviewed Resident 72's Medical Diagnoses, OSR and SAM. RN 1 stated there was no order for the resident to have A&D ointment at the bedside and the SAM indicated the resident cannot self-administer medications. RN 1 stated there should be no medications or biologicals left at the bedside to prevent accidental ingestion poisoning on residents. During an interview on 3/12/2026, at 12:56 p.m., with the DON, the DON stated it is not appropriate to leave medications at the bedside of Resident 72 to self-administer medications because the resident was not a candidate for self-administration of medications. The DON stated if the resident was deemed capable, they provide lock boxes at the bedside to prevent other residents from accessing them. The DON stated if the resident is not capable to self-administer medications, it should be kept at the medication carts. The DON stated all staff should check for medications left at the bedside and notify the charge nurse and RN sup when they find one. The DON stated leaving medications or biologicals at the bedside of Resident 72 had a potential for ingestion of the medication of the residents that can lead to poisoning and other adverse reactions. During a review of the facility-provided Curad Vitamin A&D, last updated 12/25/2025, the Information indicated a WARNING/CAUTION: Even though it may be rare, some people may have very bad and sometimes deadly side effects when taking a drug. Tell your doctor or get medical help right away if you have any of the following signs or symptoms that may be related to a very bad side effect: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Signs of an allergic reaction, like rash; hives; itching; red, swollen, blistered, or peeling skin with or without fever; wheezing; tightness in chest or throat; trouble breathing, swallowing, or talking; unusual hoarseness; or swelling of the mouth, face, lips, tongue, or throat. -Very bad skin irritation. How do I store and/or throw out Curad Vitamin A&D? -Keep all drugs in a safe place. Keep all drugs out of the reach of children and pets. -Throw away unused or expired drugs. Do not flush down a toilet or pour down a drain unless you are told to do so. Check with your pharmacist if you have questions about the best way to throw out drugs. There may be a drug take-back programs in your area. 8. During a review of Resident 104's admission Record (AR), the AR indicated Resident 104 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE] with diagnoses that included metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), dementia (a progressive state of decline in mental abilities), muscle weakness, reduced mobility, and personal history of (healed) traumatic fracture (broken bone). During a review of Resident 104's H&P, dated 9/11/2025, the H&P indicated Resident 104 did not have the capacity to understand and make decisions. During a review of Resident 104's MDS, dated [DATE], the MDS indicated the resident was rarely / never able to understand others and rarely / never was able to make herself understood. The MDS further indicated Resident 104 was dependent on staff for eating, oral and personal hygiene, toileting, bathing, dressing, and mobility. During a review of Resident 104's Self Administration of Medication form, dated 1/28/2026, the Self Administration of Medication form indicated Resident 104 was not capable of administering topical medications and the resident was not approved for self-administration of medications. During a review of Resident 104's CP titled, Resident is at risk for skin breakdown secondary to incontinence due to cognitive impairment / dementia, unable to identify urgency feeling to void, initiated on 2/23/2026, the CP indicated a goal that the resident would have no skin breakdown. During an observation on 3/9/2026 at 9:27 a.m., inside Resident 104's room, observed Resident 104 lying in bed. Observed no staff were in the room and a clear plastic medication cup containing white ointment and a used applicator was left on the nightstand. During a concurrent observation and interview on 3/9/2026 at 9:30 a.m., observed Certified Nursing Assistant (CNA) 5 entered Resident 104's room and the clear plastic medication cup containing white ointment and a used applicator remained on the nightstand. CNA 5 stated the Licensed Nurse (LN) applies ointments to Resident 104 for skin redness from incontinence. CNA 5 stated she did not know who left the medication cup with ointment in the room, but it should not have been left at bedside. CNA 5 placed the cup from the nightstand into the trash. During an interview on 3/9/2026 at 10:25 a.m., with Treatment Nurse (TN) 1, TN 1 stated the LNs apply zinc oxide to Resident 104 for a skin protectant because the resident is incontinent. TN 1 stated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	any used applicators and medication in cups should not be left on the nightstand in the resident room because the applicator should not be used more than once for infection control reasons and because there was a chance that Resident 104, or another resident, could ingest the ointment. TN 1 stated even if a resident is alert, no medication should be left at a resident's bedside. During a concurrent interview and record review on 3/12/2026 at 12:55 p.m., the Director of Nursing (DON) reviewed the facility policy and procedures (P&P) regarding medication administration. The DON stated residents have right to request to self-administer medication, but the medication should not be left at a resident's bedside unless there was a locked box to hold the medications when not in use. The DON stated if a resident requests to self-administer medication, then the resident should be assessed for safety. The DON stated when medications are left unattended at bedside there is the potential the residents could ingest the medication resulting in adverse reactions like poisoning. The DON stated the facility P&P was not followed when topical ointment was left at Resident 104's bedside. 9. During a review of Resident 55's AR, the AR indicated Resident 55 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE] with diagnoses that included dementia, polyneuropathy (a disorder of the peripheral nervous system that may result in pain, discomfort, and mobility issues), and chronic kidney disease stage three (moderate kidney damage). During a review of Resident 55's H&P dated 9/12/2025, the H&P indicated Resident 55 had the capacity to understand and make decisions. During a review of Resident 55's MDS dated [DATE], the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident was dependent on staff for bathing, required substantial / maximal assistance for toileting, required partial / moderate assistance for oral and personal hygiene, and set up or clean up assistance for eating. During a review of Resident 55's most recent Self Administration of Medication form, dated 12/4/2024, the Self Administration of Medication form indicated Resident 55 was unsafe for self-administration and the resident required additional assistance by the Licensed Vocational Nurses (LVN). During a review of Resident 55's Order Summary Report, the Order Summary Report indicated a physician's order for hydrocortisone external cream (topical medication used to relieve swelling, redness, itching, and allergic reactions), apply to affected areas topically every twelve hours as needed for red spots on forearms and neck, dated 9/2/2025. During a

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory care provided to residents was consistent with professional standards of practice for three (3) of 3 sampled residents (Resident 128, Resident 1, and Resident 66) reviewed for respiratory care by failing to ensure: 1. Resident 128's oxygen (O2) via nasal cannula (NC - a simple, two-pronged device that delivers extra oxygen to the nose) tubing was not touching the floor. 2. Resident 1's nebulizer (device that transforms liquid medicine into a fine, breathable mist) mask and tubing, dated 2/22/2026, was discarded and replaced with a new nebulizer mask and tubing. 3. Resident 66's nebulizer tubing and mouthpiece, dated 2/23/2026, was discarded and replaced with a new nebulizer tubing and mouthpiece. These deficient practices placed the residents at risk for acquiring infections due to contaminated tubing and develop complications such as shortness of breath and desaturation (low levels of oxygen in the blood). Findings: 1. During a review of Resident 128's admission Record, the admission Record indicated the facility admitted Resident 128 on 2/10/2026 with diagnoses including acute respiratory failure (a condition that happens when the lungs cannot get enough oxygen into the blood causing shortness of breath), malignant neoplasm (a tumor [abnormal growth of tissue] that can invade surrounding normal tissue and/or spread to other parts of the body) of breast, bone, and brain, and generalized muscle weakness. During a review of Resident 128's History and Physical (H&P), dated 2/12/2026, the H&P indicated Resident 128 did not have the capacity to understand and make decisions. During a review of Resident 128's Minimum Data Set (MDS - a resident assessment tool), dated 2/17/2026, the MDS indicated Resident 128 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was sometimes able to understand and make her needs known. The MDS further indicated Resident 128 required partial/moderate assistance from staff with eating; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 128 oxygen therapy while in the facility. During a review of Resident 128's Order Summary Report dated 3/12/2026, the Order Summary Report indicated the following: 2/10/2026: Administer O2 at two (2) liters per minute (LPM – a unit of measurement) via NC or facemask may titrate up to 3 LPM for O2 saturation (concentration of O2 in the blood) less than 92 percent (% - a unit of measurement) as needed for shortness of breath. 2/10/2026: Change O2 tubing as needed. 2/10/2026: Change nasal cannula/mask as needed when soiled. During a concurrent observation and interview on 3/9/2026 at 12:23 p.m. inside Resident 128's room with Licensed Vocational Nurse (LVN) 8, LVN 8 stated that Resident 18's NC tubing was touching the floor. LVN 8 stated the NC tubing should be placed inside a plastic storage bag and should not be touching the floor. LVN 8 stated that the floor is contaminated and bacteria can travel up to the tubing leading to Resident 128 inhaling the bacteria and cause respiratory infection. During an interview on 3/12/2026 at 3:02 p.m. with the Director of Nursing (DON), the DON stated that (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the staff have to ensure that any tubing, including the NC tubing, should be off the floor at all times. The DON stated that if there is extra tubing hanging, it should be placed inside a plastic storage bag. The DON stated the floor is contaminated and bacteria can go up the tubing. The DON stated that Resident 128 can inhale the bacteria and get respiratory infection. 2. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 10/30/2025, and readmitted the resident on 11/24/2025, with diagnoses including acute respiratory failureˆwith hypoxiaˆ(a dangerous condition where your body tissues and organs do not receive enough oxygen to function properly), pneumonitisˆ(inflammation (swelling and irritation) of the lung tissue, specifically the tiny air sacs (alveoli)), and dependence on supplemental oxygenˆ(a prescribed medical treatment that provides extra oxygen to people who cannot get enough through normal breathing).ˆ During a review of Resident 1's H&P, dated 1/11/2026, the H&Pˆindicatedˆthe resident does not have the capacity to understand and make decisions.ˆ During a review of Resident 1's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition.ˆThe MDS indicated the resident was on oxygen therapy/supplemental oxygen.ˆ During a review of Resident 1's Order Summary Report (OSR), dated 1/10/2026, the OSR indicated orders for:ˆ Levalbuterol HCl inhalation nebulization solution 0.63ˆmilligram (mg - a unit of weight)/3ˆmilliliters (ml - a unit of volume)ˆ(Levalbuterol HCl). 3 ml inhale orally via nebulizer every 6 hours for wheezingˆ(a high-pitched, whistling sound produced when breathing, caused by narrowed or obstructed airways in the lungs).ˆ Pulmicort inhalation suspension 0/25 mg/2 ml (Budesonide (Inhalation)). 2 ml inhale orally via nebulizer two times a day for wheezing.ˆ During a review of Resident 1's Care Plan (CP) Report titled, Enhanced Barrier Precautionsˆ(EBP -ˆan infection control strategy in nursing homes requiring staff to use gowns and gloves during high-contact care (e.g., dressing, bathing, transferring) to prevent the spread of multidrug-resistant organisms [MDROs - bacteria or other germs that have developed resistance to multiple classes of common medication used to treat infections, making infections difficult or impossible to treat]), last revised on 1/14/2026, the CP indicated an intervention to clean and disinfect equipment as indicated.ˆ During a concurrent observation and interview on 3/9/2026 at 9:43 a.m. withˆCertified Nursing Assistant (CNA)ˆ1, inside Resident 1's room,ˆobservedˆResident 1's nebulizer mask and tubing placed inside a transparent plastic bag labeled with the name of the resident with a date of 2/22/2026. CNA 1 does not know when to discard the mask and nebulizer tubing and she will ask her charge nurse.ˆ During an interview on 3/11/2026 at 7:16 a.m. withˆRegistered Nurse (RN)ˆ1, RN 1ˆstatedˆthe nebulizer mask and tubing of Resident 1 should be changed weekly andˆif needed (prn)ˆto prevent infection or exposure to infection on residents. RN 1ˆstatedˆthe nebulizerˆmaskˆand tubing could develop bacteria and viruses if used for a longerˆperiod of timeˆthat can cause the resident to get (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sick. RN 1ˆstatedˆthe licensed nursesˆare responsible forˆreplacing the old nebulizer mask and tubing.ˆ During an interview on 3/12/2026, at 12:56 p.m., with the DON, the DONˆstatedˆthe nebulizer mask and tubing of Resident 1 should have been replaced weekly to prevent and reduce the risk of pneumoniaˆ(an infection/inflammation in the lungs)ˆor other respiratory infection to the resident. The DONˆstatedˆthat the licensed nursesˆare responsible forˆreplacing the mask and tubing weekly. The DONˆstatedˆpolicy and procedure (P&P) titled,ˆAdministering Medications through a Small Volume (Handheld) Nebulizer,ˆfor nebulizer tube and mask changing was not followed.ˆ 3. During a review of Resident 66's admission Record, the admission Record indicated the facility admitted the resident on 11/8/2019, and readmitted the resident on 1/12/2026, with diagnoses including parainfluenza virus pneumoniaˆ(a lung infection caused by human parainfluenza viruses (HPIV), leading to inflammation, fluid buildup, and breathing difficulty), pleural effusionˆ(an abnormal buildup of excess fluid between the thin layers of tissue (pleura) lining the lungs and the inside of the chest cavity), and anxiety disorderˆ(a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life, functioning, or relationships).ˆ During a review of Resident 66's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and usually understands others and had impaired cognition.ˆ During a review of Resident 66's OSR, dated 3/10/2026, the OSR indicated an order for:ˆ Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg/ 3 ml (Ipratropium-Albuterol). 3 ml inhale orally every 12 hours forˆshortness of breath (SOB), wheezing.ˆ Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg/ 3 ml (Ipratropium-Albuterol). 3 ml inhale orally every 6 hours for SOB, wheezing.ˆ During a review of Resident 66's CP Report titled, Resident is at risk for infection secondary to recent history of pneumonia., last revised on 2/24/2026, the CP indicated an intervention to provide indwellingˆ(residing, existing, or being placed inside something else)ˆdevice care.ˆ During a concurrent observation and interview on 3/9/2026, at 11:03 a.m., withˆLVNˆ5, inside Resident 66's room,ˆobservedˆResident 66's nebulizer tubing and mouthpiece inside a plastic bag dated 2/23/2026.ˆLVN 5ˆstatedˆthe licensed staff should have changed the nebulizer tubing and mouthpiece weekly and prn for infection control.ˆLVN 5ˆstatedˆthe nebulizer tubing and mouthpiece can grow bacteria and viruses when used for a longerˆperiod of timeˆand can cause the resident to get respiratory infections.ˆ During an interview on 3/11/2026 at 8:50 a.m. with RN 3, RN 3ˆstatedˆthe nebulizer tubing and mouthpieceˆshould have been changedˆonˆ3/4/2026, toˆpreventˆrespiratory infectionˆto Resident 66. RN 3ˆstatedˆthe nebulizer tubing and mouthpiece should be changed weekly and prn. RN 3ˆstatedˆall licensed staffˆwere responsible forˆensuring all the nebulizer tubing mouthpiece is up to date, nor more than a week old.ˆ During an interview on 3/12/2026 at 12:56 p.m. with the DON, the DONˆstatedˆthe nebulizerˆtubingˆandˆmouthpieceˆof Residentˆ66ˆshould have been replaced weekly to prevent and reduce the risk of pneumonia or other respiratory infection to the resident. The DONˆstatedˆthat the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	licensed nursesˆare responsible forˆreplacing theˆnebulizer maskˆandˆmouthpieceˆweekly. The DONˆstatedˆthe P&P titled,ˆAdministering Medications through a Small Volume (Handheld) Nebulizer,ˆfor nebulizer tube and mask changing was not followed.ˆ During a review of the facility's P&P titled, Infection Prevention and Control Program, last reviewed on 2/20/2026, the P&P indicated an infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. During a review of the facility's recent P&P titled, Administering Medications through a Small Volume (Handheld) Nebulizer, last reviewed on 220/2026, the P&Pˆindicatedˆthe purpose of this procedure is toˆsafely and aseptically administer aerosolized particles of medicationˆinto the resident's airway.ˆ Steps in the Procedureˆ 25. Change equipment and tubing every seven days, or according to facility protocol.ˆ

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review the facility failed to: 1. Have Trelegy (a medication used to treat chronic obstructive pulmonary disease [COPD - a disease causing shortness of breath and chest congestion) oral inhalation for Resident 33 available in the facility between 8/1/2025 and 3/9/2026, observed during Medication Administration Task. 2. Reconcile (the process of comparing transactions and activity to supporting documentation) six (6) medication emergency kits (eKIT - storage container for emergency use medications) containing Controlled Substances (CS- medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as Controlled Medications [CM]) and document on the CS accountability log for March 2026, in two (2) of 2 inspected Medication Rooms (Medication room [ROOM NUMBER] and 2). As a result, control and accountability of CSs did not follow state and federal regulations and facility policy and procedures (P&P). These deficient practices increased the opportunity for CS diversion (the transfer of medications from a lawful to an unlawful channel of distribution or use), the risk that residents in the facility could have accidental exposure to harmful medications and delayed medication treatments during emergencies. In addition these practices had the potential to compromise the health and well-being of Resident 33 by omitting the administration of critical medications, and for Resident 33 to experience potential adverse consequences (also known a side-effect [unwanted, uncomfortable, or dangerous effects]), harm, impairment, and complications such as exacerbation of COPD, difficulty breathing resulting in physical and psychosocial harm, hospitalization and/or death. Cross-reference F759, F760, and F842. Findings:ˆ During a review of Resident 33's admission Record (a document containing demographic and diagnostic information), dated 3/9/2026 the admission Record indicated Resident 33 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including glaucoma (a group of eye diseases that damage the optic nerve connecting the eye to the brain, often caused by high fluid pressure inside the eye) and COPD. During a review of Resident 33's Order Summary Report (a report listing the physician order for the resident,) dated 3/8/2026, the report indicated Resident 33 was prescribed: 1. brimonidine 0.1% to give one (1) drop in both eyes three (3) times a day for glaucoma, starting 1/31/2025. 2. Trelegy to inhale 1 puff orally once a day for congestion, starting 7/16/2025. During a review of Resident 33's ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record]), for March 2026, the MAR indicated Resident 33 was prescribed: 1. brimonidine 0.1% 1 drop in both eyes 3 times a day for glaucoma, to give at 9 a.m., 1 p.m. and 5 p.m. 2. Trelegy 1 puff oral inhalation once a day for congestion, to give at 9 a.m. During an observation on 3/9/2026 at 9:10 a.m., in Medication Cart Station 2, Licensed Vocational Nurse (LVN) 4 was observed administering dorzolamide with timolol (a combination medication used for glaucoma) drops in the eye, and omega-3 (a supplement) tablet, Saccharomyces boulardii (a supplement) capsule, vitamin d3 (a supplement) tablet, gabapentin (a medication used for neuropathy [nerve damage]) tablet, and polyethylene glycol (a medication used for constipation) liquid orally to Resident 33. LVN 4 was not observed administering brimonidine eye drops and Trelegy oral inhalation. During an interview on 3/9/2026 at 12:35 p.m. with LVN 4, LVN 4 stated LVN 4 administered dorzolamide with timolol, omega-3, Saccharomyces boulardii, vitamin d3, and gabapentin to Resident 33, and did not administer brimonidine eye drops and Trelegy oral inhalation that day (3/9/2026) at 9:10 a.m. to Resident 33, as prescribed by Resident 33's physician. During the same interview, LVN 4 stated Trelegy oral inhalation was not available in Medication Cart 2 or in the facility. LVN 4 stated that the facility must keep medications readily available to ensure timely administration at scheduled times. LVN 4 stated that medication refills should be ordered from the pharmacy 3 to five (5) days in advance of last dose, and followed up as needed, to ensure timely availability of medications. LVN 4 stated Trelegy was a (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication used for COPD and not administering and/or missing a dose could harm Resident 33 by causing breathing difficulty leading to potential hospitalization. LVN 4 stated facility failed to ensure Trelegy was readily available in the facility at time of scheduled dose, resulting in Resident 33 not receiving a dose on 3/9/2026. LVN 4 stated LVN 4 will follow up with the pharmacy to expedite the refill of Trelegy and call the physician to inform the morning dose was not administered. During an interview on 3/9/2026 at 12:45 p.m., with the Director of Nursing (DON), the DON stated that on 3/9/2026 during morning medication administration, LVN 4 failed to administer brimonidine to Resident 33 by failing to prepare the administration and failed to administer Trelegy to Resident 33 since the medication was not available in the facility. The DON stated that according to facility policy, there should be adequate supply of medications on hand. The DON stated that LVN's are expected to re-order medications timely and follow-up on the refills to ensure medications are available to residents. The DON stated these failures resulted in unavailability and interruption of medication administration and continuity of care for Resident 33, increasing the risk of worsening congestion, COPD, and potential hospitalization. During a concurrent observation and interview on 3/9/2026 at 2:45 p.m. with LVN 5 and in the presence of Registered Nurse (RN) 3, in Medication room [ROOM NUMBER], there was: 1. 1 medication eKIT containing CSs stored in the refrigerator and labeled REF120, without a CM accountability log for the reconciliation of CS inventory count at every shift change for March 2026. RN 3 stated that all CSs, including medication eKITs containing CSs should be reconciled and counted at every shift and documented on a CM accountability log.ˆ RN 3 stated the eKIT labeled REF120 containing CSs in Medication room [ROOM NUMBER] was not reconciled with an inventory count at every shift in March 2026 and were not documented on a CM accountability log. RN 3 stated it was important to account for all CSs to ensure accountability and prevent CS diversion.ˆ During a concurrent interview and record review on 3/9/2026 at 3:15 p.m. with the DON, the Manifest records from pharmacy for the delivery of Trelegy, dated 7/16/2025, and Resident 33's Notice of Prescription Denial Drug Coverage form for Trelegy, dated 9/20/2025, were reviewed. The DON stated the Manifest indicated Trelegy for Resident 33 was last delivered to the facility on 7/16/2025 with a quantity 28. The DON stated the Notice of Prescription Denial Drug Coverage form for Trelegy for Resident 33 indicated the pharmacy denied the refill of the medication because it was non-formulary (prescription medication not included on the health insurance plan's approved drug list) and if the facility agreed to pay by signing the form, the pharmacy will bill the facility $361.11 for quantity 28 / 14 day supply. The DON acknowledged the form was not signed, and that the DON had not seen or overlooked the form. The DON stated there were no additional Manifests or Notice of Prescription Denial Drug Coverage forms for Trelegy for Resident 33. The DON stated the facility received a quantity 28 (14-day supply) of Trelegy for Resident 33 on 7/16/2025. The DON acknowledged the facility had not received Trelegy and the pharmacy had not delivered Trelegy since 7/16/2025. The DON stated as a result, Resident 33 did not have a supply of Trelegy for administration after the 14-day supply finished on 7/31/2025. The DON stated that the DON and several licensed nurses failed to re-order and follow-up from pharmacy on the status of Trelegy, since 8/1/2025. The DON stated that there was no consistent system in place to ensure timely re-ordering and follow-up of medications. The DON stated these failures resulted in unavailability and interruption of medication administration and continuity of care for Resident 33, increasing the risk of worsening congestion, COPD, and potential hospitalization. During a concurrent observation and interview on 3/10/2026 at 10:11 a.m. with RN 1, in Medication room [ROOM NUMBER], there was: 1. One (1) medication eKIT containing CSs stored in the refrigerator and labeled REF60 without a CM accountability log for the reconciliation of CS inventory count at every shift change for March 2026. 2. Four (4) medication eKITs containing CSs stored at room temperature and labeled 122, 490, PO283, and PO598, without a CM accountability log for the reconciliation of CS inventory count at every shift change for March 2026. RN 1 stated that all CSs, including medication eKITs containing CSs, should be reconciled at every shift and documented on a CM accountability log.ˆ RN 1 stated the eKITs (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Three (3) medication errors out of 32 total opportunities contributed to an overall medication error rate of 9.38% affecting two (2) of four (4) residents observed for medication administration (Resident 33 and 184). The medication errors were as follows: 1. Resident 33 did not receive brimonidine (a medication used for glaucoma [a condition of increased pressure in the eyeball]) drops and Trelegy (a medication used to treat chronic obstructive pulmonary disease [COPD - a disease causing shortness of breath and chest congestion due to mucus) oral inhalation as ordered by Resident 33's physician. 2. Resident 184 did not receive Systane (a medication used for dry eyes) drops as ordered by Resident 184's physician. These failures had the potential to result in Resident 33 and 184 to experience adverse effects (unwanted, uncomfortable, or dangerous effects) and health complications such as increased eye pressure, blindness, worsening dry eyes, and difficulty breathing resulting in Resident 33's and 184's health and well-being to be negatively impacted. Cross-reference F755 and F842. Findings: During a review of Resident 33's admission Record (a document containing demographic and diagnostic information,) dated 3/9/2026 the admission Record indicated Resident 33 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including glaucoma and COPD. During a review of Resident 33's Order Summary Report (a report listing the physician order for the resident,) dated 3/8/2026, the report indicated Resident 33 was prescribed: 1. brimonidine 0.1% to give one (1) drop in both eyes 3 times a day for glaucoma, starting 1/31/2025. 2. Trelegy to inhale 1 puff orally once a day for congestion, starting 7/16/2025. During a review of Resident 33's ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record,]) for March 2026, the MAR indicated Resident 33 was prescribed: 1. brimonidine 0.1% 1 drop in both eyes 3 times a day for glaucoma, to give at 9 a.m., 1 p.m. and 5 p.m. 2. Trelegy 1 puff oral inhalation once a day for congestion, to give at 9 a.m. During a review of Resident 184's admission Record dated 3/9/2026 the admission Record indicated Resident 184 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including glaucoma. During a review of Resident 184's MAR for March 2026, the MAR indicated Resident 184 was prescribed: 1. Systane 1 drop in both eyes twice a day for dry eyes, to give at 9 a.m. and 6 p.m. During an observation on 3/9/2026 at 9:10 a.m., in Medication Cart Station 2, Licensed Vocational Nurse (LVN) 4 was observed administering dorzolamide with timolol (a combination medication used for glaucoma) drops in the eye, and omega-3 (a supplement) tablet, Saccharomyces boulardii (a supplement) capsule, vitamin d3 (a supplement) tablet, gabapentin (a medication used for neuropathy [nerve damage]) tablet, and polyethylene glycol (a medication used for constipation) liquid orally to Resident 33. Resident 33 was observed swallowing the oral medications with a glass of juice. Resident 33 refused the polyethylene glycol. LVN 4 was not observed administering brimonidine eye drops and Trelegy oral inhalation. During an observation on 3/9/2026 at 9:55 a.m., in Medication Cart 3, LVN 13 was observed administering tamsulosin (a medication used for urinary retention) capsule, digoxin (a medication used for atrial fibrillation [a heart condition causing irregular heart rate]) tablet, eliquis (a medication used atrial fibrillation) tablet, prednisone (a medication used for inflammation) tablet, cyproheptadine (a medication used for allergies) tablet, multivitamin with minerals (a supplement), docusate (a medication used for constipation), magnesium oxide (a supplement), and cephalexin (a medication used for urine infections) capsule orally to Resident 184. Resident 184 was observed swallowing the medications with glass of water. LVN 13 was not observed administering Systane to Resident 184. During an interview on 3/9/2026 at 12:30 p.m. with LVN 13, LVN 13 stated LVN 13 administered tamsulosin, Eliquis, prednisone, cyproheptadine, multivitamin with minerals, docusate, magnesium oxide cephalexin orally to Resident 184, and failed to prepare and administer Systane that day (continued on next page)

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Burbank Healthcare & Rehab	1041 S. Main St. Burbank, CA 91506

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(3/9/2026) at 9:55 a.m. to Resident 184. LVN 13 acknowledged Resident 184's physician's order specified to administer Systane at 9 a.m. LVN 13 stated per facility Policy and Procedures (P&P), there was a 60-minute window before and after the scheduled time for medication administration, and that Resident 184 did not receive Systane during that window. LVN 13 stated Systane was a medication used for dry eyes and not administering and/or missing a dose would not alleviate Resident 184's condition. LVN 13 stated that LVN 13 failed to follow 5 rights of medication administration and failed to administer Systane as prescribed to Resident 184 that day at 9 a.m. LVN 13 stated this was considered a medication error. During an interview on 3/9/2026 at 12:35 p.m. with LVN 4, LVN 4 stated LVN 4 administered dorzolamide with timolol, omega 3, Saccharomyces boulardii, vitamin d3, and gabapentin to Resident 33, and did not administer brimonidine eye drops and Trelegy oral inhalation that day (3/9/2026) at 9:10 a.m. to Resident 33, as prescribed by Resident 33's physician. LVN 4 stated that LVN 4 documented the MAR that brimonidine and Trelgey were administered to Resident 33 at 9 a.m. knowing that both medications were not administered. LVN 4 stated per facility P&P, there was a 60-minute window before and after the scheduled time for medication administration. LVN 4 acknowledged the physician's order specified to administer brimonidine at 9 a.m. to Resident 33. LVN 4 stated brimonidine was a medication used for glaucoma and not administering and/or missing a dose could harm Resident 33 by not controlling the pressure in the eyes, causing increased pressure and worsening glaucoma leading to potential blindness. LVN 4 stated brimonidine eye drops were stored in the refrigerator in the medication room and LVN 4 forgot to obtain from the medication room. During the same interview, LVN 4 stated Trelegy oral inhalation was not available in Medication Cart 2 or in the facility. LVN 4 acknowledged the physician's order specified to administer Trelegy at 9 a.m. to Resident 33. LVN 4 stated that the facility must keep medications readily available to ensure timely administration at scheduled times. LVN 4 stated that medication refills should be ordered from the pharmacy 3 to 5 days in advance of last dose, and followed up as needed, to ensure timely availability of medications. LVN 4 stated Trelegy was a medication used for COPD and not administering and/or missing a dose could harm Resident 33 by causing breathing difficulty leading to potential hospitalization. LVN 4 stated facility failed to ensure Trelegy was readily available in the facility at time of scheduled dose, resulting in Resident 33 not receiving a dose on 3/9/2026. LVN 4 stated LVN 4 will follow up with the pharmacy to expedite the refill of Trelgy and call the physician to inform the morning dose was not administered. LVN 4 stated that LVN 4 failed to maintain an accurate clinical record, follow 5 rights of medication administration and administer brimonidine and Trelegy to Resident 33, 1 hour before to 1 hour after the 9 a.m. scheduled dose. LVN 4 stated were considered medication errors and falsification of resident records. During an interview on 3/9/2026 at 12:45 p.m. with the Director of Nursing (DON), the DON stated that on 3/9/2026 during morning medication administration, LVN 4 failed to administer brimonidine to Resident 33 by failing to prepare the administration and failed to administer Trelegy to Resident 33 since the medication was not available in the facility. The DON acknowledged brimonidine and Trelegy were prescribed by Resident 33's physician at 9 a.m. The DON stated that according to facility policy, medications should be administered within a 60-minute window from the time scheduled by the physician and there should be adequate supply of medications on hand. The DON stated these failures placed Resident 33 at risk of worsening glaucoma, congestion and COPD and increasing the potential for hospitalization. The DON stated that LVN 4 failed to follow the 5 rights of medication administration and facility medication administration guidelines, and that these were considered medication errors. During an interview on 3/10/2026 at 2:20 p.m., with the DON, the DON stated that LVN 13 failed to administer Systane to Resident 184 on 3/9/2026 during morning medication administration, increasing the risk of exacerbating (making worse) dry eyes for Resident 184. The DON acknowledged Systane was prescribed by Resident 184's physician at 9 a.m. The DON stated that according to facility P&P, medications should be administered within a 60-minute window from the time scheduled by the physician. The DON stated that LVN 13 failed to follow the 5 rights of (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication administration and facility medication administration guidelines, resulting in a medication error for Resident 184. During a review of the facility's P&P titled, Medication Administration-General Guidelines, last reviewed 2/20/2026, the P&P indicated that Medications are administered as prescribed. 2. Medications are administered in accordance with written orders of the attending physician. 10. Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after). During a review of the facility's P&P titled, Administering Medications, last reviewed 2/20/2026, the P&P indicated that 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. 7. Medications are administered within 1 hour of their prescribed time . During a review of the facility's P&P titled, Adverse consequences, Medication Errors and Unnecessary Medication, last reviewed 2/20/2026, the P&P indicated: 6. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 7. Examples of medications errors include: a. Omission - a drug is ordered but not administered; g. Wrong time.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free of any significant medication errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) by not: 1. Administering Trelegy (a medication used to treat chronic obstructive pulmonary disease [COPD - a disease causing shortness of breath and chest congestion]) to Resident 33 between 8/1/2025 and 3/9/2026. This deficient practice resulted in Resident 33 to not receive Trelegy daily between 8/1/2025 and 3/9/2026 in accordance with the physician's orders and standards of practice and had the potential to cause Resident 33 to experience adverse effects (unwanted, unintended results) and serious health complications such as exacerbation of COPD, difficulty breathing resulting in physical and psychosocial harm, hospitalization and/or death. 2. Administering levofloxacin (a medication used to treat infection)ˆfor one (1) of two (2) sampled residentsˆ(Resident 97)ˆreviewed for antibiotic therapyˆas ordered by the physician.ˆ This deficient practice placed Resident 97 at riskˆto experience significant side adverse effect and serious health complications due to improper managementˆof infectionˆwhich could result to progression of infection.ˆ 3. Rotating (a method to ensure repeated injections are not administered in the same area) subcutaneousˆ(sq, beneath the skin) heparinˆ(an injectable prescription medicine that acts as a powerful blood thinnerˆ[anticoagulant])ˆ administration sitesˆfor two of three sampled resident (Residents 1 and 179) reviewed for heparin use. 4. Rotating sqˆinsulinˆ(a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication administration sitesˆfor one of one sampled resident (Resident 140) reviewed for insulin use. These deficient practicesˆhad the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin and heparin for Resident 1, Resident 140, and Resident 179 such as excessive bruising, lipodystrophy (abnormal distribution of fat)ˆand cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin).ˆ Findings: 1. During a review of Resident 33's admission Record (a document containing demographic and diagnostic information), dated 3/9/2026, the admission Record indicated Resident 33 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including glaucoma (a group of eye diseases that damage the optic nerve—the vital nerve connecting the eye to the brain—often caused by high pressure buildup inside the eye) and COPD. During a review of Resident 33's Order Summary Report (a report listing the physician order for the resident), dated 3/8/2026, the report indicated Resident 33 was prescribed: 1. Trelegy to inhale 1 puff orally once a day for congestion, starting 7/16/2025. During a review of Resident 33's Medication Administration Record (MAR - a document of the medications administered to a resident that is part of the resident's permanent medical record), for March 2026, the MAR indicated Resident 33 was prescribed: 1. Trelegy 1 puff oral inhalation once a day for congestion, to give at 9 a.m. During a review of Resident 33's MARs, between 8/1/2025 and 3/9/2026, the MARs indicated Trelegy was documented as administered daily at 9 a.m. by several licensed vocational nurses. During an observation on 3/9/2026 at 9:10 a.m., in Medication Cart Station 2, Licensed Vocational (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse (LVN) 4 was observed administering dorzolamide with timolol (a combination medication used for glaucoma,) drops in the eye, and omega-3 (a supplement,) tablet, Saccharomyces boulardii (a supplement,) capsule, vitamin d3 (a supplement,) tablet, gabapentin (a medication used for neuropathy [nerve damage]) tablet, and polyethylene glycol (a medication used for constipation) liquid orally to Resident 33. LVN 4 was not observed administering brimonidine eye drops and Trelegy oral inhalation. During an interview on 3/9/2026 at 12:35 p.m. with LVN 4, LVN 4 stated LVN 4 administered dorzolamide with timolol, omega-3, Saccharomyces boulardii, vitamin d3, and gabapentin to Resident 33, and did not administer Trelegy oral inhalation that day (3/9/2026) at 9:10 a.m. to Resident 33, as prescribed by Resident 33's physician. LVN 4 stated Trelegy oral inhalation was not available in Medication Cart 2 or in the facility. LVN 4 stated that the facility must keep medications readily available to ensure timely administration at scheduled times. LVN 4 stated that medication refills should be ordered from the pharmacy three (3) to five (5) days in advance of last dose, and followed up as needed, to ensure timely availability of medications. LVN 4 stated Trelegy was a medication used for COPD and not administering and/or missing a dose could harm Resident 33 by causing breathing difficulty leading to potential hospitalization. LVN 4 stated facility failed to ensure Trelegy was readily available in the facility at time of scheduled dose, resulting in Resident 33 not receiving a dose on 3/9/2026. LVN 4 stated LVN 4 will follow up with the pharmacy to expedite the refill of Trelegy and call the physician to inform the morning dose was not administered. LVN 4 stated that LVN 4 failed to maintain an accurate clinical record, follow 5 rights of medication administration and administer Trelegy to Resident 33, 1 hour before to 1 hour after the 9 a.m. scheduled dose. LVN 4 stated these deficient practices were considered medication errors and falsification of resident records. During an interview on 3/9/2026 at 12:45 p.m. with the Director of Nursing (DON), the DON stated that on 3/9/2026 during morning medication administration, LVN 4 failed to administer Trelegy to Resident 33 since the medication was not available in the facility. The DON stated that according to facility policy, there should be adequate supply of medications on hand. The DON stated that LVNs are expected to re-order medications timely and follow-up on the refills to ensure medications are available to residents. The DON stated these failures resulted in unavailability and interruption of medication administration and continuity of care for Resident 33, increasing the risk of worsening congestion, COPD and potential hospitalization. During a concurrent interview and record review on 3/9/2026 at 3:10 p.m. with LVN 4, Resident 33's MARs, between August 2025 and March 2026, were reviewed. LVN 4 stated Resident 33's Trelegy inhaler was never received from pharmacy and that LVN 4 was unaware of the reason. LVN 4 stated the checkmarks on the MAR with her initials between 8/1/2025 and 3/9/2026 indicated that Trelegy was successfully administered to Resident 33. LVN 4 stated if a medication was unavailable, it should not have a checkmark on the MAR. LVN 4 stated if she was unable to complete a medication administration, the MAR should indicate it was not given. LVN 4 stated not administering Trelegy daily to Resident 33 between 8/1/2025 and 3/9/2026 were considered significant medication errors. During a concurrent interview and record review on 3/9/2026 at 3:15 p.m. with the DON, the Manifest records from the pharmacy for the delivery of Trelegy, dated 7/16/2025, and Resident 33's Notice of Prescription Denial Drug Coverage form for Trelegy, dated 9/20/2025, were reviewed. The DON stated the Manifest indicated Trelegy for Resident 33 was last delivered to the facility on 7/16/2025 with a quantity 28 (14 day supply). The DON stated the Notice of Prescription Denial Drug Coverage form for Trelegy for Resident 33 indicated the pharmacy denied the refill of the medication because it was non-formulary (prescription medication not included on the health insurance plan's approved drug list) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and if the facility agreed to pay by signing the form, the pharmacy will bill the facility $361.11 for another quantity 28/14 day supply. The DON acknowledged the form was not signed, and that the DON had not seen or overlooked to sign the form. The DON acknowledged the pharmacy had not provided additional Manifests or Notice of Prescription Denial Drug Coverage forms for Trelegy for Resident 33. The DON acknowledged the facility had not received and pharmacy had not delivered Trelegy since 7/16/2025. The DON stated as a result, Resident 33 did not have a supply of Trelegy for administration after the 14-day supply finished on 7/31/2025. The DON stated not administering Trelegy since 8/1/2025 was considered a significant medication error. The DON stated that the DON and several licensed nurses failed to re-order and follow-up from pharmacy on the status of Trelegy, since 8/1/2025. The DON stated that there was no consistent system in place to ensure timely re-ordering and follow-up of medications. The DON stated these failures resulted in unavailability and interruption of medication administration and continuity of care for Resident 33, increasing the risk of worsening congestion, COPD and potential hospitalization. During a review of the facility's recentˆpolicy and procedure (P&P)ˆtitled, Adverse Consequences and Medication Errors, 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 (ADRs) and side effects. Adverse consequences shall be reported to the attending physician and pharmacist, and to federal agencies asˆappropriate.ˆ Policy Interpretation and Implementationˆ 5. A medication error is defined as the preparation of drugs or biological which is notˆin accordance withˆphysician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services.ˆ 6. Examples of medication errors include:ˆ h. failure to follow manufacturer's instruction and/or accepted professional standards (e.g., failure to shake medications that is labeled shake well crushing a medication on the do not crush list without an order).ˆ During a review of the facility's P&P titled Medication Administration-General Guidelines, last reviewed 2/20/2026, the P&P indicated that Medications are administered as prescribed. 2. Medications are administered in accordance with written orders of the attending physician. 10. Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after). During a review of the facility's P&P titled Administering Medications, last reviewed 2/20/2026, the P&P indicated that 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. 7. Medications are administered within one (1) hour of their prescribed time . During a review of the facility's P&P, titled Adverse consequences, Medication Errors and Unnecessary Medication, last reviewed 2/20/2026, the P&P indicated: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 7. Examples of medications errors include: a. Omission - a drug is ordered but not administered; g. Wrong time. 13. In the event of a significant medication-related error or adverse consequence, immediate action is taken, as necessary, to protect the resident's safety and welfare. Significant is defined as: b. requiring hospitalization f. life threatening g. resulting in death. 2. During a review of Resident 97's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted the resident on 7/22/2025 and readmitted in the facility on 10/1/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), history of falling, Urinary Tract Infection (UTI - infection caused by bacteria invading any part of the urinary system, including the kidneys, bladder, ureters, or urethra).ˆ During a review of Resident 97's History and Physical (H&P) dated 10/2/2025, the H&PˆindicatedˆResident 97 did not have the capacity to understand and make decisions.ˆ During a review of Resident 97's Minimum Data Set (MDS - a resident assessment tool), dated 12/18/2025, the MDS indicated Resident 97 had severely impaired cognition (mental action or process ofˆacquiringˆknowledge and understanding) and wasˆusually ableˆto understand and make her needs known. The MDS further indicated Resident 97 required set up or clean-up assistance from staff with eating; supervision or touching assistance with walking; total assistance with toileting; partial/moderate assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for anˆindividual to thrive). The MDS furtherˆindicatedˆResident 97 wasˆfrequentlyˆincontinent with bowel and bladder.ˆˆ During a review of Resident 97's physician's order dated 3/12/2026, the physician's orderˆindicatedˆthe following:ˆ - 11/25/2026: levofloxacin oral tablet 750 milligrams (mg – a unit of measurement) give 1 tablet by mouth 1 time a day for UTI for 5 daysˆ - 11/28/2025:ˆdiscontinueˆlevofloxacin oral tablet 750 mg give 1 tablet by mouth 1 time a day for UTI for 5 daysˆ - 11/28/2026: levofloxacin oral tablet 750 mg give 1 tablet by mouth 1 time a day for UTI until 12/1/2025.ˆ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 97'sˆMAR, for 11/2025 and 12/2025, the MAR indicated that Resident 97's levofloxacin was not marked as given on 11/27/2025 and 12/1/2025.ˆ During aˆconcurrent interview and record review on 3/11/2026 at 11:05ˆa.m. with the Infection Preventionist (IP), Resident 97's physician's order andˆMAR, for 11/2025 and 12/2025, were reviewed. The IPˆstatedˆthat Resident 97 had a physician's orderˆfor levofloxacin dated 11/25/2025 for 5 days for UTI. The IPˆstatedˆthat on 11/28/2025, the order wasˆdiscontinuedˆand reordered on the same dayˆto continue administration of the medication until 12/1/2025. The IPˆstatedˆthat Resident 97's MARˆindicatedˆthatˆon 11/27/2025 and 12/1/2025 were not marked as given asˆthere was no check mark and theˆinitials of theˆlicensed nurse'sˆinitialsˆwhich means that the medication was notˆadministered.ˆThe IPˆstatedˆall medications mustˆbe administeredˆas ordered by the physicianˆand marked as given in the MAR with a check and initials. The IPˆstatedˆthat Resident 97's levofloxacin should have been administered as ordered by the physicianˆas it placed Resident 97 at risk from improper treatment of the infectionˆand delay in receiving the care and services the resident needsˆwhich can lead to worsening of Resident 97's UTI.ˆ During a review of the facility's P&Pˆtitled, Medication Administration – General Guidelines, last reviewed on 2/20/2026, the P&P indicated that medications are administered as prescribed in accordance with good nursing principlesˆand practices and only by persons legally authorizedˆto do so. Personnel authorized toˆadministerˆmedicationsˆdo so onlyˆafter they haveˆfamiliarized themselves with the medication.ˆTheˆfacility has sufficient staff to allow administering of medications without unnecessary interruptions.ˆˆ During a review of the facility's P&P titled, Charting and Documentation, last reviewed onˆ2/20/2026, the P&Pˆindicatedˆthat all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical record. The medical record shouldˆfacilitateˆcommunication between the interdisciplinary teamˆregardingˆthe resident's condition and response to care.ˆThe P&P furtherˆindicatedˆthat documentation of proceduresˆand treatments will include care-specific details, including theˆdate and time the treatment/procedure was provided and the signature and titleˆof the individual documenting. 3. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 10/30/2025, and readmitted the resident on 11/24/2025, with diagnoses includingˆlong term use of anticoagulantsˆ(medicines that prevent or reduce the risk of dangerous blood clots forming in the blood vessels and heart), gastrostomyˆ(a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and perforation of intestineˆ(a hole or tear that develops through the wall of the stomach, small intestine, or large bowel).ˆ During a review of Resident 1's H&P, dated 1/11/2026, the H&Pˆindicatedˆthe resident did not have the capacity to understand and make decisions.ˆ During a review of Resident 1's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognitionˆ(a person's mental abilities—such as thinking, memory, learning, and reasoning—are working properly without significant decline or impairment).ˆThe MDS indicated the resident was on a high-risk drug class anticoagulant.ˆˆ During a review of Resident 1's Order Summary Report (OSR), dated 1/10/2026, the OSR indicated an (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burbank Healthcare & Rehab	1041 S. Main St. Burbank, CA 91506

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order for heparin sodium (Porcine) Injection Solution 5000ˆunits per milliliter (unit/ml -ˆrepresentsˆtheˆconcentrationˆor strength of the medication)ˆ(Heparin Sodium (Porcine)). Inject 1 ml subcutaneously two times a day forˆdeep vein thrombosis (DVT -ˆis a serious medical condition that occurs when aˆblood clot (thrombus) forms in a deep vein, usually in the lower leg, thigh, or pelvis)ˆprophylaxis (PPX,ˆis a medical term forˆpreventive careˆor actions taken to stop a disease or infection before it happens). Rotate sites.ˆ During a review of Resident 1's Location of Administration Report (LAR) for Heparin from 1/1/2026 to 1/31/2026, the LARˆindicatedˆheparin sodium (Porcine) Injection Solutionˆ5000 unit/ml on:ˆ 1/11/2026 at 11:45 a.m. on the Arm-leftˆ 1/11/2026 at 5:54 p.m. on the Arm-leftˆ 1/26/2026 at 9:51 a.m. on the Abdomen-Left Lower Quadrant (LLQ)ˆ 1/26/2026 at 5:08 p.m. on the Abdomen-LLQˆ During a review of Resident 1's Care Plan (CP) Report titled, Risk for complications such as excessive bleeding, bruises and skin breakdown related to use of anticoagulant medication heparin, last revised on 10/31/2025, the CPˆindicatedˆan intervention to administer medication as ordered.ˆ During a concurrent interview and record review on 3/11/2026 at 7:16 a.m. withˆRegistered Nurse (RN)ˆ1, Resident 1's Medical Diagnoses, OSR, LAR, and CP were reviewed. RN 1 stated there were multiple instances that the licensed nurses did not rotate the insulin administration sites to the resident and the physician's order indicated to rotate sites of administration.ˆRN 1ˆstatedˆthe failure of the licensed staff to rotate sites of administration predisposes the resident to bruises and bleeding. RN 1 stated heparin has a Blackbox warningˆ(the most stringent safety alert mandated by the U.S. Food and Drug Administration (FDA) for prescription drugs and medical devices)ˆmeaning the drug can cause higher potential adverse reactions. RN 1ˆstatedˆnot rotating heparin administration site per physician's order was a medication error.ˆ During an interview on 3/12/2026, at 12:56 p.m., with theˆDON, the DONˆstatedˆthe heparin administration sites for Resident 1 should have been rotated per physician's order to prevent adverse effects such as muscle atrophy, bruising, and bleeding at the injection sites. The DONˆstatedˆthe staffˆfailed toˆrotated injection sites of heparin and follow physician's order whichˆconstitutesˆa medication error.ˆ During a review of the facility's recent P&P titled, Adverse Consequences and Medication Errors, last reviewed on 2/20/206, 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 (ADRs) and side effects. Adverse consequences shall be reported to the attending physician and pharmacist, and to federal agencies asˆappropriate.ˆ Policy Interpretation and Implementationˆ 5. A medication error is defined as the preparation of drugs or biological which is notˆin accordance withˆphysician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services.ˆ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Examples of medication errors include:ˆ h. failure to follow manufacturer's instruction and/or accepted professional standards (e.g., failure to shake medications that is labeled shake well crushing a medication on the do not crush list without an order).ˆ During a review of the facility-provided Highlights of Prescribing Informationˆ(HPI)ˆon the use of Heparin Sodium injection, for intravenous or subcutaneous use, withˆinitialˆapproval in 1939, the HPI indicated for deep subcutaneous (intrafat) injection use a different site for each injection.ˆ 4. During a review of Resident 179's admission Record, the admission Record indicated the facility admitted the resident on 3/1/2026, with diagnoses including nondisplaced fractureˆ(a broken or cracked bone where the pieces remain perfectly aligned and have not shifted out of place)ˆof fourth metatarsal boneˆ(the five long, slender bones located in the middle of the foot between the ankle bones (tarsals) and the toe bones (phalanges)), left foot, ulcerative colitisˆ(a chronic inflammatory bowel disease that causes long-lasting inflammation and tiny, open sores (ulcers) in the innermost lining of your large intestine, specifically the colon and rectum), and gastro-esophageal reflux disease (GERD -ˆa chronic, more severe form of acid reflux (or heartburn) where stomach contents—including acid—regularly flow backward into the esophagusˆ(the tube connecting the mouth to the stomach)).ˆˆ During a review of Resident 179's H&P, dated 3/2/2026, the H&Pˆindicatedˆthe resident is awake, alert, oriented, communicative, non-ambulator, able to move all extremities, able to test strength and power. The H&Pˆindicatedˆthe resident had the capacity to understand and make decisions.ˆˆ During a review of Resident 179's OSR, dated 3/1/2026, the OSR indicated an order for heparin sodium (Porcine) Injection Solution 5000 unit/ml (Heparin Sodium (Porcine)). Inject 1 ml subcutaneously every 8 hours for DVTˆPPX. Rotate injections.ˆ During a review of Resident 179's LAR for Heparin from 3/1/2026 to 3/31/2026, the LARˆindicatedˆheparin sodium (Porcine) Injection Solution 5000 unit/ml was administered on:ˆ 3/6/2026 at 9:01 p.m. on the Abdomen-LLQˆ 3/7/2026 at 6:10 a.m. on the Abdomen-LLQˆ During a concurrent interview and record review on 3/11/2026, at 7:16 a.m. with RN 1, Residentˆ179's Medical Diagnoses, OSR, and LAR were reviewed. RN 1ˆstatedˆthere were multiple instances that the licensed nurses did not rotate the insulin administration sites to the resident and the physician's orderˆindicatedˆto rotate sites of administration. RN 1ˆstatedˆthe failure of the licensed staff to rotate sites of administration predisposes the resident to bruises and bleeding. RN 1 stated heparin has a Blackbox warning meaning the drug can cause higher potential adverse reactions. RN 1ˆstatedˆnot rotating heparin administration site per physician's order was a medication error.ˆ During an interview on 3/12/2026, at 12:56 p.m., with the DON, the DONˆstatedˆthe heparin administration sites for Resident 179ˆshould have been rotated per physician's order to prevent adverse effects such as muscle atrophy, bruising, and bleeding at the injection sites. The DONˆstatedˆthe staffˆfailed toˆrotated injection sites of heparin and follow physician's order whichˆconstitutesˆa medication error.ˆ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recentˆP&Pˆtitled, Adverse Consequences and Medication Errors, last reviewed on 2/202.206, 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 (ADRs) and side effects. Adverse consequences shall be reported to the attending physician and pharmacist, and to federal agencies asˆappropriate.ˆ Policy Interpretation and Implementationˆ 5. A medication error is defined as the preparation of drugs or biological which is notˆin accordance withˆphysician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services.ˆ 6. Examples of medication errors include:ˆ h. failure to follow manufacturer's instruction and/or accepted professional standards (e.g., failure to shake medications that is labeled shake well crushing a medication on the do not crush list without an order).ˆ During a review of the facility-provided HPIˆon the use of Heparin Sodium injection, for intravenous or subcutaneous use, withˆinitialˆapproval in 1939, the HPI indicated for deep subcutaneous (intrafat) injection use a different site for each injection.ˆ 5. During a review of Resident 140's admission Record, the admission Record indicated the facility admitted the resident on 5/12/20265, and readmitted the resident on 8/19/2025, with diagnoses including type 2 diabetes mellitusˆ(DM -a disorder characterized by difficulty in blood sugar control and poor wound healing)ˆwith hyperglycemiaˆ(high blood sugar), and chronic kidney disease stage 3ˆ(CKD3 -ˆindicates mild to moderate kidney damage, where kidneys filter waste inefficiently).ˆ During a review of Resident 140's H&P, dated 8/20/2025, the H&Pˆindicatedˆthe resident was alert and oriented to person and does not have the capacity to understand and make decisions.ˆˆ During a review of Resident 140's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairmentˆ(a noticeable, slight decline in memory or thinking skills that is greater than normal aging but not severe enough to interfere with daily independence). The MDS indicated the resident was on a high-risk drug classˆhypoglycemic medicationˆ(a type of medicine used toˆlower blood sugar levelsˆin people with diabetes, specifically Type 2).ˆ During a review of Resident 140's OSR, the OSR indicated an order for:ˆ 9/24/2025ˆAdmelogˆInjection Solution 100ˆunit per milliliters (unit/ml,ˆin insulin defines theˆconcentrationˆor strength of the insulin, telling you exactly how much medication is packed into a liquid volume)ˆ(Insulin Lispro). Inject as per sliding scaleˆ(a method of determining how much fast-acting insulin to inject before a meal or at bedtime, based on a person's current blood sugar reading): if 150 - 200 = 1; 201 - 250 = 2; 251 - 300 = 3; 301 - 350 = 4; 351 - 400 = 5 [give 6 unitsˆifˆblood sugar (BS)ˆgreater than 400 and notify MD], subcutaneously before meals [hold if BS less than 70 and notify MD];ˆ 1/5/2026ˆBasaglarˆKwikPenˆSubcutaneous Solution Pen-injector 100ˆunit/mlˆ(Insulin Glargine). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inject 15 units subcutaneously at bedtime forˆdiabetes mellitus (DM). Rotate injection site.ˆ During a review of Resident 140's CP Report titled, Resident is at risk for hypoglycemiaˆ(low blood sugar)ˆand hyperglycemia related to DM, last revised on 9/8/2025, the CPˆindicatedˆan intervention to administer medications as ordered.ˆ During a review of Resident 140's LAR of Insulin from 1/2026 to 2/2026, the LARˆindicatedˆinsulin were given on:ˆ BasaglarˆKwikPenˆSubcutaneous Solution Pen-injector 100ˆunit/mlˆ 1/11/2026ˆat 8:56ˆp.m. on theˆAbdomen - LLQˆˆ 1/12/2026ˆat 8:50ˆp.m. on theˆAbdomen – LLQˆ 2/14/2026ˆat 8:42ˆp.m. on theˆAbdomenˆ–ˆRight Lower Quadrant)ˆRLQˆˆ 2/16/2026ˆat 9:39ˆp.m. on theˆAbdomen - RLQˆ AdmelogˆInjection Solution 100 UNIT/MLˆ 1/12/2026ˆat 5:02ˆp.m. on theˆAbdomen - LLQˆˆ 1/13/2026ˆatˆ11:45ˆa.m. on theˆAbdomen – LLQˆ 1/24/2026ˆat 5:23ˆp.m. on theˆAbdomen - LLQˆˆ 1/25/2026ˆat 4:47ˆp.m. on theˆAbdomen - LLQˆˆ 1/27/2026ˆatˆ11:30ˆa.m. on theˆAbdomen – LLQˆ 2/13/2026ˆat 4:53ˆp.m. on theˆAbdomen - LLQˆˆ 2/14/2026ˆatˆ12:17ˆp.m. on theˆAbdomen – LLQˆ 2/14/2026ˆat 4:28ˆp.m. on theˆAbdomenˆ–ˆLeft Upper Quadrant (LUQ)ˆˆ 2/15/2026ˆatˆ12:07ˆp.m. on theˆAbdomen – LUQˆ 2/24/2026ˆatˆ11:49ˆa.m. on theˆAbdomen - LLQˆˆ 2/24/2026ˆat 5:10ˆp.m. on theˆAbdomen – LLQˆ 2/27/2026ˆat 4:05ˆp.m. on theˆArm - rightˆˆ 2/28/2026ˆatˆ11:56ˆa.m. on theˆArmˆ–ˆrightˆ During a concurrent interview and record review on 3/11/2026, at 8:50 a.m., with RN 3, Resident 140's Medical Diagnoses, OSR, CP, and LAR were reviewed. RN 3ˆstatedˆthereˆwereˆtimes they did not (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rotate theˆinulin injectionˆsites to Resident 140ˆto prevent lipodystrophy.ˆRN 3 stated that insulinˆis not effective when you administer them on the siteˆlipodystrophy,ˆthe absorption will not be effective.ˆRN 3ˆstatedˆtheˆresidentˆcould suffer from hypo/hyperglycemia.ˆRN 3 stated that insulin is a significant medication and not rotating insulin administration sites to Resident 140 isˆconsideredˆa medication error.ˆ During an interview on 3/12/2026, at 12:56 p.m. with the DON, the DONˆstatedˆthe insulin administration sites for Resident 140 should have been rotated per physician's order to prevent adverse effects such as muscle atrophy,ˆbruisingˆand lipodystrophy. The DONˆstatedˆthe staffˆfailed toˆrotated injection sites of insulinˆadmelogˆandˆbasaglarˆand follow physician's order whichˆconstitutesˆa medication error.ˆ During a review of the facility-provided Highlights of HPI on the use ofˆBasaglarˆ(insulin glargine) injection, for subcutaneous use, with initial U.S. approval in 2015, the HPI indicated to rotate injection sites into the abdominal area, thigh, or deltoid to reduce the risk of lipodystrophy and localized cutaneous amyloidosis.ˆ During a review of the facility-provided HPI on the use ofˆAdmelogˆ(insulin lispro) injection, for subcutaneous or intravenous use, withˆinitialˆU.S.ˆapproval in 2017, the HPI indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis.ˆ

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to store medications in accordance with manufacturer specifications, professional principles and facility policy and procedures (P&P) by failing to: 1. Remove and discard from use one (1) open Aplisol (also known as Tubersol - medication used to diagnose tuberculosis [infection in the lungs]) vial for facility stock, in accordance with manufacturer's requirements and facility policy and procedures in 1 of two (2) inspected Medication Rooms (Medication room [ROOM NUMBER]). 2. Store one lorazepam (a medication used to treat anxiety and restlessness) oral concentrate (a solution with increased strength) bottle in the refrigerator for Resident 128 in accordance with the manufacturer's requirements in one of three inspected medication carts (Medication Cart 1 Station 1.) 3. Ensure orally administered medications were stored separately from injectable medications, in 1 of six (6) inspected medication carts (Medication Cart 2 Station 1.) 4. Label one (1) Trelegy (a medication used to treat chronic obstructive pulmonary disease [COPD - a disease causing shortness of breath and chest congestion due to mucus) oral inhalation with a date indicating when use began for Resident 105, in accordance with manufacturer's requirements and facility P&P, in 1 of 6 inspected medication carts (Medication Cart 2 Station 2). These deficient practices increased the risk for Residents 105, Resident 128, and other residents to receive medication that had become ineffective or toxic due to improper storage or labeling and increase the risk of infections and receiving medications via the wrong route possibly leading to adverse health consequences resulting in hospitalization or death. Cross-reference F755, F759, F760, F842. Findings: During an observation on [DATE] at 10:11 a.m., in Medication room [ROOM NUMBER], with Registered Nurse (RN) 1, the following medications were found either expired and not discarded, or stored contrary to their respective manufacturer's specifications and facility's P&P: 1. One (1) open Aplisol multi-dose vial for facility stock was found stored in the refrigerator and not labeled with a date indicating when use began. According to the manufacturer's product storage and labeling, Aplisol vials should be stored in the refrigerator between 36 and 46 degrees Fahrenheit (a unit of measure for temperature) and used or discarded from use within 30 days of opening the vial. During a concurrent interview, RN 1 stated the Aplisol vial stored in the refrigerator in Medication room [ROOM NUMBER] was opened and used and not labeled with a date indicating when use began. RN 1 stated usually open Aplisol vials were good for 30 days. RN 1 stated Aplisol vials needed to be labeled with a date when first used to know when to discard and not administer expired Aplisol to residents in error. RN 1 stated administering expired Aplisol to residents may result in inaccurate results (either false negative or false positive) and therefore lead to providing the incorrect treatment to residents. RN 1 stated the vial was considered expired and needed to be removed from the refrigerator and placed in the expired medication bin to be disposed of and not accidentally used for residents. During an observation on [DATE] at 12 p.m., in Medication Cart 1 Station 1, with Licensed Vocational Nurse (LVN) 2 the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, or stored and labeled contrary to facility policies: 1. 1 opened Lorazepam oral concentrate bottle for Resident 128 was found stored at room temperature with a blue label affixed to the bottle indicating to refrigerate. According to the manufacturer's product storage and labeling, lorazepam oral concentrate bottles should be stored in the refrigerator between 36 and 46 degrees Fahrenheit and to discard opened bottles after 90 days. During a concurrent interview with LVN 2, LVN 2 stated the Lorazepam oral concentrate bottle for Resident 128 was opened and stored at room temperature. LVN 2 stated according to the label on the Lorazepam bottle, the bottle should be stored in the refrigerator to maintain potency (effectiveness). LVN 2 stated this bottle is now considered expired should not use due to storage conditions against (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the manufacturer recommendations. LVN 2 stated if the Lorazepam is used in error, it will be ineffective and will not treat Resident 128's anxiety and restlessness further escalating the condition. During a concurrent observation and interview on [DATE] at 12:15 p.m., in Medication Cart 2 Station 2, with LVN 7, the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: 1. 1 open Trelegy inhaler for Resident 105 was found stored at room temperature without a date indicating when the inhaler was first opened. According to manufacturer guidelines, the Trelegy inhaler should be discarded 6 weeks after opening. LVN 7 stated the Trelegy inhaler for Resident 105 was opened and not labeled with a date when it was first used. LVN 7 stated according to facility policy multi-use medications like inhalers should be labeled with the date when first opened to know when they expire and should be discarded, and that according to the manufacturer guidelines printed on the Trelegy medication box, once the Trelegy was opened to be discarded 6 weeks later. LVN 7 stated the facility failed to label the Trelegy inhaler with a date indicating when use first began. During a concurrent observation and interview on [DATE] at 12:40 p.m., in Medication Cart 2 Station 1, with LVN 1, the following medications were found stored in a manner contrary to facility policies: 1. 1 heparin (a blood thinner) intravenous (administered directly into the vein) solution stored with alendronate (a medication used to build bone density) oral tablet, ondansetron (a medication used for nausea) oral tablets and Advil (also known as ibuprofen, a medication used for pain or fever) oral caplets in the same bin of the medication cart. LVN 1 stated that orally administered medications and intravenous medications should be stored separately in their own sections/bins, not together, to prevent errors in wrong route administration and possible infections. LVN 1 acknowledged heparin was stored with alendronate, ondansetron and Advil in the same bin in Medication Cart 2 Station 1. LVN 1 stated the facility failed not to separate and store oral medications from intravenous medications. During an interview on [DATE] at 2:20 p.m. with the Director of Nursing (DON), the DON stated the Aplisol vial stocked in the refrigerator for facility use in Medication room [ROOM NUMBER] was opened and not labeled with a date when use began. The DON stated multi-dose vials (used more than once) usually expire 28 days after opening the vials and should be discarded beyond that date to prevent accidental use. The DON stated the Aplisol vial was considered expired and needed to be removed from the medication room and be discarded to prevent accidental use. The DON stated using Aplisol vials beyond the expiration date in error may potentially provide inaccurate results for tuberculosis leading to inaccurate treatment for residents. During the same interview, the DON stated the Lorazepam oral concentrate for Resident 128 was not stored in the refrigerator as indicated on the bottle. The DON stated that inappropriate storage can cause the medication to lose its potency and be ineffective, causing Resident 128 to experience anxiety and restlessness. The DON stated several LVN's failed to store Lorazepam in the refrigerator. The DON added per facility policy, multi-dose medications, such as inhalers, need to be labeled with the date when opened to know when they expire and should be discarded. The DON stated several LVNs failed to label Trelegy for Resident 105 with the date when opened. In addition, the DON stated orally and externally administered medications should be stored separately from intravenously administered medications to prevent wrong route administration, infections, and contaminations. The DON stated the facility failed to store Heparin in Medication Cart 2 Station 1 separate from Advil, alendronate and ondansetron. During a review of the facility's P&P titled, Storage of Medications, last reviewed on [DATE], the P&P indicated that Medications and biologicals are stored safely, and properly, following manufacturer's recommendations or those of the supplier. C. Intravenously administered medications are kept separate from orally administered medications. During a review of facility's P&P titled, Vials and ampules of injectable medications, last reviewed on [DATE], the P&P indicated that Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal. B. The date opened and the initials of the first person to use the vial are (continued on next page)

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Burbank Healthcare & Rehab	1041 S. Main St. Burbank, CA 91506

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recorded on multi-dose vials. During a review of facility's P&P titled, Administering Medications, last reviewed on [DATE], the P&P indicated: When opening a multi-dose container, the date opened is recorded on the container. During a review of manufacturer's guide Highlights of Prescribing Information for Trelegy, dated 1/2019, the guide indicated Discard TRELEGY ELLIPTA 6 weeks after opening the foil tray or when the counter reads 0 (after all blisters have been used), whichever comes first. During a review of manufacturer's guide for Aplisol, dated 11/2013, the guide indicated Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. During a review of manufacturer's guide for Lorazepam oral concentrate, dated 11/2019, the guide indicated Store at cold temperature. Refrigerate at 2 to 8 C (36 to 46 F).

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen reviewed during the Kitchen task by failing to:ˆ 1. Ensure perishable items, hotdogs, were disposed of by the best by date of 2/3/2026. 2. Ensure six (6) plates of salad were labeled with a prepared date. 3. Ensure 10 prepared bowls of ice cream were labeled with a prepared date. These deficient practices had the potential to result in harmful bacterial growth and cross- contamination (the process by which bacteria, chemicals, or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs). Findings:ˆ During a concurrent observation and interview on 3/9/2026 at 7:50 a.m. with the Dietary Supervisor Assistant (DSA), inside the walk-in refrigerator, one (1) opened container of hotdogs, opened date 1/27/2026 and best by date 2/3/2026. The DSA stated he will dispose the hotdogs because it is past the best by date.ˆ During a concurrent observation and interview on 3/9/2026 at 7:50 a.m. with the DSA, the DSA stated inside the refrigerator for milk and side orders, 6 salad plates did not have a label of date when it was prepared.ˆThe DSA stated it should be labeled with a date right when it was prepared. During a concurrent observation and interview on 3/9/2026 at 7:55 a.m. with the DSA, the DSA stated inside the standing freezer, the facility stores ice cream. The DSA stated that 10 prepared bowls of ice cream did not have a label of date when it was prepared. The DSA stated the bowls of ice cream contained rainbow sherbet and there was no open rainbow sherbet in the freezer. During an interview on 3/12/2026 at 12:22 p.m. with the Dietary Service Supervisor (DSS), the DSS stated the prepared foods should have been labeled with the date of when it was prepared and best by date. The DSS stated the reason for labeling with a date is because those foods are time/temperature controlled. The DSS stated this is the facility's way of tracking that the foods are good and not old and keep track of when it was made. The DSS stated when foods are not labeled and disposed of it could lead to foodborne illness and sickness among residents. During a review of the facility's policy and procedure (P&P) titled, Dating and Labeling, last reviewed 2/20/2026, the P&P indicated that this policy is to ensure food safety and prevent contamination within the facility, all food items should be properly covered, dated, and labeled in dry storage and refrigerator/freezer areas. The P&P indicated: 1. Dietary staff will check food items upon delivery to ensure for safety. Items that are damaged or spoiled should be discarded. 4. All items should be properly covered, dated, and labeled. Food items have the following appropriate dates: a. Delivery date - upon receipt b. Open date - opened containers of PHF [potentially hazardous food]. 6. No food item that is expired or beyond the best buy date are in stock.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication administration record (MAR - a record of all active physician orders and medications administered to a resident) was not falsified by documenting Trelegy (a medication used to treat chronic obstructive pulmonary disease [COPD - a disease causing shortness of breath and chest congestion due to mucus]) was administered once a day between 8/1/2025 to 3/9/2026 when it was unavailable in the facility for one (1) of four (4) residents observed for medications administration (Resident 33). This deficient practice increased the risk that Resident 33 could have experience worsening COPD, causing difficulty in breathing and possibly resulting in hospitalization and/or death. Cross-reference F755, F759, and F760. Findings: During a review of Resident 33's admission Record (a document containing demographic and diagnostic information), dated 3/9/2026, the admission Record indicated Resident 33 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including COPD. During a review of Resident 33's Minimum Data Set (MDS - a resident assessment tool), dated 2/4/2026, indicated Resident 26 was cognitively intact and able to understand others. During a review of Resident 33's Order Summary Report (a report listing the physician order for the resident,) dated 3/8/2026, the report indicated Resident 33 was prescribed: 1. Trelegy to inhale one (1) puff orally once a day for congestion, starting 7/16/2025. During a review of Resident 33's for March 2026, the MAR indicated Resident 33 was prescribed: 1. Trelegy one (1) puff oral inhalation once a day for congestion, to give at 9 a.m. During a review of Resident 33's MARs between 8/1/2025 and 3/9/2026, the MARs indicated Trelegy was documented as administered daily at 9 a.m. by several licensed vocational nurses. During an observation on 3/9/2026 at 9:10 a.m., at Medication Cart Station 2, Licensed Vocational Nurse (LVN) 4 was observed administering dorzolamide with timolol (a combination medication used for glaucoma [a group of eye diseases that damage the optic nerve-the cable connecting the eye to the brain-often due to high fluid pressure inside the eye]) drops in the eye, omega-3 (a supplement) tablet, Saccharomyces boulardii (a supplement) capsule, vitamin d3 (a supplement) tablet, gabapentin (a medication used for neuropathy [nerve damage]) tablet, and polyethylene glycol (a medication used for constipation) liquid orally to Resident 33. LVN 4 was not observed administering Trelegy oral inhalation. During an interview on 3/9/2026 at 12:35 p.m. with LVN 4, LVN 4 stated LVN 4 administered dorzolamide with timolol, omega-3, Saccharomyces boulardii, vitamin d3, and gabapentin to Resident 33, and did not administer Trelegy oral inhalation that day (3/9/2026) at 9:10 a.m. to Resident 33, as prescribed by Resident 33's physician. LVN 4 stated Trelegy oral inhalation was not available in Medication Cart 2 or in the facility. LVN 4 stated Trelegy was a medication used for COPD and not administering and/or missing a dose could harm Resident 33 by causing breathing difficulty leading to potential hospitalization. LVN 4 stated that LVN 4 documented in the MAR that Trelegy was administered to Resident 33 at 9 a.m. that day (3/9/2026) knowing that Trelegy was not administered. During a concurrent interview and record review on 3/9/2026 at 3:10 p.m. with LVN 4, Resident 33's MARs, between August 2025 and March 2026, were reviewed. LVN 4 stated Resident 33's Trelegy inhaler was never received from the pharmacy and that LVN 4 was unaware of the reason. LVN 4 stated the checkmarks on the MAR with her initials between 8/1/2025 and 3/9/2026 indicated that Trelegy was successfully administered to Resident 33. LVN 4 stated LVN 4 knowingly marked the MAR that Trelegy was administered thirty three times at 9 a.m. on 9/28/2025, 10/5/2025, 10/11/2025, 12/5/2025, 12/17/2025, 12/18/2025, 12/22/2025, 12/24/2025, 12/25/2025, 12/30/2025 and 1/4/2026, 1/8/2026, 1/10/2026, 1/11/2026, 1/17/2026, 1/26/2026, 1/27/2026, 1/28/2026, 2/4/2026, 2/15/2026, 2/18/2026, 2/20/2026, 2/22/2026, 2/23/2026, 2/26/2026, 2/27/2026, 2/28/2026, 3/3/2026, 3/4/2026, 3/5/2026, 3/6/2026, 3/8/2026, and 3/9/2026. LVN 4 stated if a medication was unavailable, it should not have a checkmark on the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MAR. LVN 4 stated if she was unable to complete a medication administration, the MAR should indicate it was not given. LVN 4 stated that marking the MAR that Trelegy was administered when it was not created an inaccurate clinical record for Resident 33. During an interview on 3/9/2026 at 3:15 p.m. with the DON, the DON acknowledged the facility had not received and the pharmacy had not delivered Trelegy since 7/16/2025. The DON stated as a result, Resident 33 did not have a supply of Trelegy for administration after the 14-day supply finished on 7/31/2025. The DON stated when a medication is unavailable to administer, the LVNs must notify the pharmacy, the resident's physician, and let the DON know about the missing medication as it will be treated as a medication error. The DON stated none of the LVNs contacted her about missing medications for Resident 33. The DON stated it was unacceptable to sign the MARs between 8/1/2025 and 3/9/2026 that Trelegy was administered when it was not available in the facility. The DON stated not administering Trelegy could result in worsening congestion, COPD, and potential hospitalization During an interview on 3/9/2026 at 3:39 p.m. with Resident 33, Resident 33 stated that Resident 33 received an inhaler (Resident 33 was unable to recall the medication name) for her bronchitis (inflammation of the tubes in the lungs that cause mucus and cough) last summer (between June to August of 2025) and has not received it since. During a concurrent interview and record review on 3/10/2026 at 10:52 a.m, with LVN 5, Resident 33's MARs, between September 2025 and November 2025, were reviewed. LVN 5 stated the checkmarks on the MAR with her initials between 9/1/2025 and 11/2/2025 indicated that Trelegy was successfully administered to Resident 33. LVN 5 stated Resident 33's Trelegy inhaler was not available in the facility and that LVN 5 had not followed up with pharmacy for the status of the refill. LVN 5 stated if a medication was unavailable, it should not have a checkmark on the MAR. LVN 5 stated LVN 5 knowingly marked the MAR that Trelegy was administered 21 times at 9 a.m. on 9/17/2025, 9/22/2025, 9/23/2025, 9/24/2025, 9/29/2025, 9/30/2025, 10/1/2025, 10/6/2025, 10/7/2025, 10/13/2025, 10/15/2025, 10/18/2025, 10/19/2025, 10/20/2025, 10/24/2025, 10/25/2025, 10/26/2025, 10/27/2025, 10/30/2025, 10/31/2025, and 11/2/2025. LVN 5 stated that marking the MAR that Trelegy was administered when it was not created inaccurate clinical record for Resident 33. During a concurrent interview and record review on 3/10/2026 at 11:06 a.m. with LVN 7, Resident 33's MARs between November 2025 and February 2026 were reviewed. LVN 7 stated the checkmarks on the MAR with her initials between 11/22/2025 and 2/25/2026 indicated that Trelegy was successfully administered to Resident 33. LVN 7 stated Resident 33's Trelegy inhaler was not available in the facility and that LVN 7 failed to re-order from pharmacy on several occasions. LVN 7 stated if a medication was unavailable, it should not have a checkmark on the MAR. LVN 7 stated LVN 7 knowingly marked the MAR that Trelegy was administered five (5) times at 9 a.m. on 11/22/2025, 1/21/2026, 1/22/2026, 2/16/2026, 2/25/2026. During a concurrent interview and record review on 3/10/2026 at 11:26 a.m. with LVN 13, Resident 33's MARs, between August 2025 and February 2026, were reviewed. LVN 13 stated the checkmarks on the MAR with her initials between 8/5/2025 and 2/24/2026 indicated that Trelegy was successfully administered to Resident 33. LVN 13 stated Resident 33's Trelegy inhaler was not available in the facility and that LVN 13 failed to inform the DON, assistant DON, Registered Nurse (RN) supervisors, and the physician and failed to re-order the medication from pharmacy. LVN 13 stated if a medication was unavailable, it should not have a checkmark on the MAR. LVN 13 stated LVN 13 marked the MAR possibly in error that Trelegy was administered 11 times at 9 a.m. on 8/5/2025, 8/18/2025, 11/5/2025, 11/12/2025, 11/17/2025, 11/24/2025, 2/3/2026, 2/6/2026, 2/12/2026, 2/17/2026, and 2/24/2026. During a concurrent interview and record review on 3/10/2026 at 11:40 a.m. with LVN 14, Resident 33's MARs, between November 2025 and January 2026, were reviewed. LVN 14 stated the checkmarks on the MAR with her initials between 11/18/2025 and 1/7/2026 indicated that Trelegy was successfully administered to Resident 33 five (5) times at 9 a.m. on 11/18/2025, 11/20/2025, 12/25/2025, 1/5/2026, and 1/7/2026. LVN 14 stated Resident 33's Trelegy inhaler was not available in the facility and LVN 14 stated if a medication was unavailable, it should not have a checkmark on the MAR. LVN 14 stated (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	due to high workload LVN 14 likely marked them in error because LVN 14 checked off the resident's entire MAR at the end of the pass and did not check to see which medications were actually administered and which were not. LVN 14 stated as a result LVN 14 failed to identify which medications to re-order or follow-up for with pharmacy. During a review of the facility's Policy and Procedures (P&P) titled, Medication Administration-General Guidelines, last reviewed 2/20/2026, the P&P indicated that Medications are administered as prescribed in accordance with good nursing principles and practices. 1. The individual who administers the mediation dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. 4. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. During a review of the facility's P&P titled Administering Medications, last reviewed 2/20/2026, the P&P indicated: 20. The individual administering the medication initials on the resident's MAR on the appropriate line after giving each medication and before administering the next dose. 21. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. date and time the medication was administered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to ensure: 1. Resident 182's call light (a button, cord, or remote device in a hospital or nursing home room that allows a resident to electronically alert nurses or staff that they need assistance) was not inside the trash can and was sanitized before handing it off to the resident for use during random resident screening.ˆ 2. The mobile linen carts on the units were not covered with a permeable (material that allows liquid to pass through)/mesh material observed during infection control task. These deficient practices had the potential to cause cross-contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect a mechanical device used by caregivers to safely move people with limited mobility from one place to another) of infection among residents and staff. Findings: 1. During a review of Resident 182's Face Sheet (FS), the FS indicated the facility admitted the resident on 1/13/2026, and readmitted the resident on 3/2/2026, with diagnoses including muscle weakness, difficulty in walking, and history of traumatic fracture (aˆbroken or cracked bone caused by a sudden, high-force impact). During a review of Resident 182's History and Physical (H&P), dated 3/4/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 182's Minimum Data Set (MDS - a resident assessment tool), dated 3/7/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a stage of decline between normal aging and dementia, where memory or thinking problems are noticeable to others and interfere with complex daily tasks). The MDS indicated the resident was independent to needing partial assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview on 3/9/2026 at 10:47 a.m. with Licensed Vocational Nurse (LVN) 2, observed Resident 182's bed remote control was on the left side of the bed inside the trash can. LVN 2 stated the bed remote control should be always within easy reach of the resident so the resident can adjust the bed according to her comfort and also should not be inside the trash for infection control purposes. LVN 2 stated she should have sanitized the call light before placing them on the bed of the resident. During an interview on 3/12/2026 at 12:56 p.m. with the Director of Nursing (DON), the DON stated the bed remote should not be inside the trash can as it can cause spread of infection to the resident. The DON stated LVN 2 should have sanitized the bed remote control prior to placing it back in bed. During a review of the facility's recent policy and procedure (P&P) titled, Infection Prevention and Control Program, last reviewed on 2/20/2026, the P&P indicated an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help the development and transmission of communicable diseases and infections. During a review of the facility's recent P&P titled, Safety and Supervision of Residents, last reviewed on 2/20/2026, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. 4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents. 2. During an observation on 3/9/2026 at 10:51 a.m., during resident screening, observed multiple mobile carts in Station 1, with clean linens covered with blue loosely woven/permeable mesh material. During a concurrent interview and record review on 3/12/2026 at 9:31 a.m. with the Infection Preventionist (IP), a photo of the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mobile linen carts taken on 3/9/2026, at 10:51 a.m., in Station 1 of the facility, was reviewed. The IP stated the covers for the mobile linen cart were covered with mesh material and it was permeable to air, water, and dust. The IP stated the linens inside the cart were not protected from the environmental elements that can cause contamination of the linens that can cause the residents to get sick. During a concurrent observation and interview on 3/12/2026 at 12:10 p.m. with the Housekeeping Supervisor (HKS), on the Laundry Department hallway, observed three mobile linen racks with clean linens inside of them protected by a blue colored mesh/permeable material. The HKS stated the material that they used to cover the clean linens were loosely woven and can allow air and water to go through. The HKS stated he will consult with the MS about the issue and will get back to the surveyor why they were using the loosely woven material to cover the clean linens. During a concurrent observation and interview on 3/12/2026 at 12:15 p.m. with the Maintenance Supervisor (MS), with the presence of the HKS, the MS stated they initially do not use mobile linen carts to store their clean linens. The MS stated they have closets in each unit where they stack the linens but the corporate office sent them the mobile linen carts to use. The MS stated the linens were protected by a loosely woven, permeable material that can let air and water pass through, like when he sneezes the virus can come into the carts because the cover is not protecting the linens. The MS stated viruses can be carried by air and pass through the cover causing infections to residents. Both the MS and the HKS stated that the current covers for the mobile linen carts were not protecting the clean linens from environmental contaminants due to the loosely woven, permeable material used for covering the linens. During a review of the facility's recent P&P titled, Linen Cart Use and Management Policy, last reviewed on 2/20/2026, the P&P indicated to ensure the safe, sanitary handling, transport, and storage of clean and soiled linens in order to reduce the risk of cross-contamination and maintain infection prevention standards within the facility. Procedure 1. Clean Linen Carts - Clean linen carts must be covered or enclosed at all times when transporting or storing clean linens. During a review of the facility's recent P&P titled, Infection Prevention and Control Program, last reviewed on 2/20/2026, the P&P indicated an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help the development and transmission of communicable diseases and infections.

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Burbank Healthcare & Rehab	1041 S. Main St. Burbank, CA 91506

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that essential equipment was maintained in a safe and working condition when: 1. One (1) of 1 sampled walk-in freezer reviewed during the Kitchen task had ice build-up inside the freezer. This deficient practice had the potential to result in an injury among staff and cross-contamination (the process by which bacteria, chemicals, or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) of food items. 2. 1 of 1 sampled resident (Resident 33) Resident 33's call light (a button or device a resident uses to get help from staff) was not properly connected to the wall panel during an observation on 3/9/2026. Findings: a. During a concurrent observation and interview on 3/9/2026 at 7:52 a.m. with the Dietary Service Assistant (DSA), inside the walk-in freezer, the walk-in freezer temperature reading indicated negative one (1) degree Fahrenheit (ˆF – a unit of measurement). The DSA stated there is ice build-up and the should be no ice build-up. The DSA stated he will inform maintenance about it.ˆ During an interview on 3/12/2026 at 12:25 p.m. with the Dietary Service Supervisor (DSS), the DSS stated ice build-up is cleaned as needed and to ensure ice is not building up further. The DSS stated the maintenance department helps them with the ice build-up because the maintenance department uses a tool that can reach the back of the walk-in freezer. The DSS stated ice build-up occurs due to staff frequent door openings, going in and out of the walk-in freezer throughout the day. The DSS stated this affects the temperature increasing and then dropping throughout the day and in that area moisture builds up and freezes. The DSS stated ice build-up should be removed and when not removed it can become a safety/danger issue with her staff, pieces could fall from the ceiling, and they could trip and could fall onto food items which potential for cross-contamination. During a review of the facility's policy and procedure (P&P) titled, Refrigerator/Freezer Storage, last reviewed 2/20/2026, the P&P indicated that dietary staff will check and record temperatures of all refrigerators and freezers to ensure the equipment is within appropriate temperature for food storage and handling. The P&P indicated that Freezers must be maintained free of excessive ice or frost buildup to ensure proper air circulation and temperature control. Dietary staff will report any ice buildup to the Dietary Supervisor and Maintenance. b. During a review of Resident 33's Face Sheet (FS), the FS indicated Resident 33 was originally admitted on [DATE] and readmitted on [DATE] to the facility with a diagnosis of chronic obstructive pulmonary disease with acute exacerbation (COPD - a chronic lung disease causing difficulty in breathing); type 2 diabetes mellitus without complications (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing); paraplegia, unspecified (loss of movement and/sensation, to some degree, of the legs). During a review of Resident 33's History and Physical (H&P), dated 1/31/2025, the H&P indicated resident has the capacity to understand and make decisions. During a review of Resident 33's Minimum Data Set (MDS – a resident assessment tool), dated 12/26/2025, indicated Resident 33 was able to make self- understood and able to understand others. The MDS further indicated that Resident 33 is cognitively intact (able to understand and make decisions). The MDS indicated the resident required extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/9/2026 at 9:48 a.m., with Resident 33, Resident 33 stated staff takes a few minutes to answer call light. Resident 33 stated it can take hours if the call light is not working and the resident needs to wave someone down. Resident 33 pressed the pad call light and light outside the door from resident's room did not turn on. During a concurrent observation and interview on 3/9/2026 at 10:20a.m., with Certified Nursing Assistant (CNA) 13, Resident 33 pressed the pad call light and CNA 13 looked at the light outside the door and the light did not light up. CNA 13 checked twice and stated the call light is not working. CNA 13 checked the wall panel where pad call light cable is plugged in and it was not plugged in all the way. CNA 13 asked the resident to press pad call light again and it worked. CNA 13 stated that the plug should have been pushed all the way into the wall. ˆCNA 13 stated if the pad call light is not working properly, then staff would not be able to know if Resident 33 needs something and it could have been an emergency. During an interview on 3/12/2026 at 4:23 p.m. with the Director of Nursing (DON), the DON stated the practice for call light includes all staff should check if the call light is properly connected. The DON stated the nurse should have connected the call light because if not Resident 33 would not be able to call. The DON stated the policy for Call Lights was not followed. During a review of the facility's P&P titled, Call Lights, last reviewed 2/20/2026, the P&P indicated, to assure residents receive prompt assistance. Monitoring the lights and making sure that lights are answered promptly, regardless of who is assigned to each.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to honor the resident's right to be informed in advance by the physician or other practitioner or professional, of the risks and benefits of proposed care, treatment and treatment alternative or option for one of one sampled resident (Resident 66) reviewed for informed consents (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) by failing to ensure Resident 66's informed consent on the use of psychotropic medication (a drug or other substance that affects how the brain worksˆand causes changes in mood, awareness, thoughts, feelings, or behavior) (Buspirone, a prescription medication used to treat chronic anxiety and manage daily anxiety symptoms, such as irritability and restlessness) matches the physician's order. This deficient practice violated the residents' right to make an informed decision regarding the use of psychotropic medications. Findings: During a review of Resident 66's Face Sheet (FS), the FS indicated the facility admitted the resident on 11/8/2019, and readmitted the resident on 1/12/2026, with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life, functioning, or relationships), and unspecified symptoms and signs involving cognitive functions (the brain's specialized, mental processes for acquiring, storing, manipulating, and retrieving information) and awareness. During a review of Resident 66's Minimum Data Set (MDS, a resident assessment tool), dated 2/6/2026, the MDS indicated the resident had the ability to make self-understood and usually understand others and had severe cognitive impairment (a significant decline in mental abilities-memory, thinking, and reasoning-that makes it impossible for a person to live independently). The MDS indicated the resident was on a high-risk drug class antianxiety medication. The MDS indicated that the resident and the family participated in the assessment and goal setting. During a review of Resident 66's Order Summary Report (OSR), dated 3/2/2026, the OSR indicated an order of buspirone HCl tablet five (5) milligrams (mg, a unit of weight) (Buspirone HCl). Give one (1) tablet by mouth one time a day for anxiety, monitor for behavior (m/b) inability to relax or stay still causing exhaustion or self-harm. During a review of Resident 66's Psychotherapeutic Drug Informed Consent Form (ICF), undated, the ICF indicated buspirone five (5) mg tablet orally (PO) twice a day (BID) for anxiety, m/b inability to relax, stay still causing exhaustion, self-harm. During a concurrent interview and record review on 3/11/2026, at 8:50 a.m., with Registered Nurse (RN) 3, reviewed Resident 66's Medical Diagnoses, OSR, and ICF. RN 3 stated the consent in the medical chart indicated buspirone to be administered BID, however, the physician`s order indicates that the administration is once a day. RN 3 stated it was important to make sure the consent matches the order to ensure the resident was agreeing to the right medication and right dose of the antianxiety medication. RN 3 also stated it can also potentially cause medication error affecting residents. During an interview on 3/12/2026, at 12:56 p.m., with the Director of Nursing (DON), the DON stated the consent should match the physician's order for Resident 66's use of buspirone. The DON stated the ICF and physician's order should match to ensure the resident and their representative were aware if the medication was reduced and also to prevent adverse side effects (a harmful, unintended, and undesired result of a medical treatment) of the medications. The DON stated facility`s policy and procedure (P&P) titled Informed Consent was not followed. During a review of the facility's recent P&P titled, Policy: Informed Consent, last reviewed on 2/20/2026, the P&P indicated to ensure that residents and/or their representatives are fully informed of the benefits, risks, frequency/duration, and alternatives before initiating the administration of psychotherapeutic drugs or physical restraints. Procedure: 2. Prior to obtaining Informed Consent, the attending physician and/or prescriber must provide the residents or their representatives with information on the following topics, including but are not limited to: - Treatment Details: Nature of procedures involved in the proposed treatment, (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including the probable frequency and duration. 7. A licensed nurse will verify the informed consent information and sign it to confirm its accuracy and completeness. During a review of the facility's recent P&P titled, Resident Rights, last reviewed on 2/20/2026, the P&P indicated employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation p. be informed, and participate in, his or her care planning and treatment. During a review of the facility's recent P&P titled, Charting and Documentation, last reviewed on 2/20/2026, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. During a review of the facility's recent P&P titled, Psychotropic Medication Use, last reviewed on 2/20/2026, the P&P indicated residents will not receive medications that are not clinically indicated to treat a specific condition.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) and bed remote control within reach of the resident for two of six sampled residents (Residents 182 and 140) reviewed under environment task. This deficient practice had the potential for Residents 182 and 140 unable to summon health care worker for help and to adjust the bed for comfort as needed. Findings: 1. During a review of Resident 182's Face Sheet (FS), the FS indicated the facility admitted the resident on 1/13/2026, and readmitted the resident on 3/2/2026, with diagnoses including muscle weakness, difficulty in walking, and history of traumatic fracture (aˆbroken bone caused by a sudden, high-energy impactˆor injury). During a review of Resident 182's History and Physical (H&P), dated 3/4/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 182's Minimum Data Set (MDS, a resident assessment tool), dated 3/7/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (it involves noticeable memory or thinking problems (like frequently forgetting appointments or losing trains of thought) that go beyond typical aging, yet the person can still manage daily life independently without significant disruption). The MDS indicated Resident 182 was independent to needing partial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 182's Fall Risk Evaluation (FRE), dated 3/2/2026, the FRE indicated the resident was not at risk for fall. During a review of Resident 182's Care Plan (CP) Report titled, Resident is at risk for falls/injury, last revised on 3/12/2026, the CP indicated an intervention to keep frequently used personal items within easy reach. During a concurrent observation and interview on 3/9/2026, at 10:47 a.m., with Licensed Vocational Nurse (LVN) 2, observed Resident 182's bed remote control was on the left side of the bed inside the trash can. LVN 2 stated the bed remote control should be always within easy reach of the resident so the resident can adjust the bed according to her comfort. LVN 2 also stated the resident can fall while reaching for the bed remote control inside the trash can and sustain an injury. During an interview on 3/12/2026, at 12:56 p.m., with the Director of Nursing (DON), the DON stated the call light and bed remote should be within the resident's reach to ensure they can easily access the remote control and the call light. The DON stated the failure of the staff to keep the bed remote control of Resident 182 within reach can lead to the resident not being able to reposition the bed for comfort and can fall while reaching for it. The DON stated the policy and procedure (P&P) titled, Safety and Supervision of Residents, was not followed. 2. During a review of Resident 140's FS, the FS indicated the facility admitted the resident on 5/12/2025, and readmitted the resident on 8/19/2025, with diagnoses including muscle weakness, history of traumatic fracture, and history of falling. During a review of Resident 140's H&P, dated 8/20/2025, the H&P indicated the resident was fairly weak and debilitated (severely weakened, exhausted, or drained of strength and energy, often caused by illness or injury) after multiple falls with muscle injuries, he had been on pain medications and gradually improved. The H&P indicated that the resident is alert and oriented to person only and does not have the capacity to understand and make decisions. During a review of Resident 140's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment. The MDS indicated the resident was dependent to needing supervision assistance on mobility and activities of daily living (ADLs). During a review of Resident 140's FRE, dated 1/8/2026, the FRE indicated the resident was at risk for falls. During a review of Resident 140's CP Report titled, Resident is at risk for falls/injury related to difficulty walking., initiated on 8/28/2025, the CP indicated an intervention to keep call light within easy reach and encourage resident to use it to get assistance. During a concurrent observation and interview on 3/9/2026, at 11:02 a.m., with LVN 5, observed Resident 140's call light was on the left (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	side of the bed resting on the floor. LVN 5 stated the call light should be always within easy reach of the resident so the resident can call for assistance when needed. LVN 5 also stated the resident can fall while reaching for the call light on the floor and sustain an injury. During an interview on 3/12/2026, at 12:56 p.m., with the DON, the DON stated the call light and bed remote should be within the resident's reach to ensure they can easily access the remote control and the call light. The DON stated the failure of the staff to keep the call light of Resident 140 within reach can lead to the resident not being able to call for help when needed and can fall while reaching for it. The DON stated the P&P titled, Policy: Call Lights, was not followed. During a review of the facility's recent P&P titled, Policy: Call Lights, last reviewed on 2/20/2026, the P&P indicated to assure residents receive prompt assistance.ˆ Nursing & Care Duties: 2. Ensuring that the call light is within the resident's reach when in his/her room or when on the toilet. During a review of the facility's recent P&P titled, Safety and Supervision of Residents, last reviewed on 2/20/2026, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. 4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents. During a review of the facility's recent P&P titled, Residents Risks and Environmental Hazards, last reviewed on 2/20/2026, the P&P indicated due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. bed safety c. falls f. poison control During a review of the facility's recent P&P titled, Accident/Incident Prevention, last reviewed on 2/20/2026, the P&P indicated this facility strives to prevent accidents by providing an environment that is free from accident hazards over which the facility has control, as well as identification of each resident at risk for accidents/incidents and the provision of adequate care plans with procedures to prevent accidents.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the Advanced Directive Acknowledgement Form (a form that shows a person was given information about their medical wishes and rights) was complete for one of three sampled residents (Resident 14). This deficient practice had the potential to result in Resident 14's healthcare wishes not being known or followed, placing the resident at risk of receiving unwanted or inappropriate treatment. Findings: During a review of Resident 14's Face Sheet (FS), the FS indicated Resident 14 was originally admitted on [DATE] and re-admitted on [DATE] to the facility with a diagnosis of fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing(the upper part of the thigh bone is broken but didn't go through the skin and is healing normally without complications); encephalopathy, unspecified (a disease affecting how the brain works); type 2 diabetes mellitus without complications (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 14's History and Physical (H&P) dated 10/4/25, the H&P indicated resident does not have the capacity to understand and make decisions. During a review of Resident 14's Minimum Data Set (MDS- a resident assessment tool), dated 12/26/2025, indicated Resident 14 was usually able to make self- understood and usually able to understand others. The MDS further indicated that Resident 14 had an impaired cognition (difficulty with thinking). The MDS indicated Resident 14 required extensive assistance from staff with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a concurrent interview and record review on 3/11/2026 at 9:03 am with Social Services Director (SSD), the Advance Directive Acknowledgement form was reviewed. The SSD stated that Advance Directive is done within 72 hours after admission.ˆSSD stated that for Resident 14 the Advance Directive Acknowledgement form was not completed correctly because it did not show any specifications marked off and was only showing signatures. SSD stated the policy was not being followed. During a concurrent interview and record review on 3/12/2026 at 4:23 pm, Resident 14's Advance Directive Acknowledge Form was reviewed with the Director of Nursing (DON). The DON stated that upon admission the advance directive should be reviewed with resident and responsible party. The DON stated Resident 14's Advance Directive Acknowledge Form was incomplete because it only had signatures and nothing was checked off. The DON stated that without an advance directive staff would not know what to follow in case of emergency when the resident is unable to decide for herself regarding healthcare decisions. The DON stated the policy titled Advanced Directive was not followed. During a review of the facility's policy and procedure (P&P) titled, Advance Directives last reviewed on 2/20/2026, the P&P indicated, if the resident does not have an advanced directive: 1. if the resident or representative indicates that he or she has not established advanced directives, the facility staff will offer assistance in establishing advanced directives. a. The resident or representative is giving the option to accept or decline assistance, and care will not be contingent on either decision. b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. 2. Information about whether or not the resident has executed an advanced directive is displayed prominently in the medical records in a section of the record that is retrievable by any staff. 3. The attending physician provides information to the resident and legal representative regarding the residents health status, treatment options and expected outcomes during the development of the initial comprehensive assessment and care plan.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure residents were free from unnecessary psychotropic medication (medications that affect the mind, emotions, and behavior) and the use of chemical restraints (any drug that is used for discipline or staff convenience and not required to treat medical symptoms) for one of five sampled residents (Resident 9) reviewed for unnecessary medications by failing to ensure quetiapine fumarate (an atypical antipsychotic drug [treats symptoms of psychosis-such as hallucinations, delusions, and severe agitation]) was prescribed and monitored for specific, measurable behavioral manifestations. This deficient practice had the potential to result in the administration of unnecessary psychotropic medication and placed Resident 9 at increased risk for adverse effects related to psychotropic medication therapy, such as drowsiness, dizziness, or increased risk of fall, possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 9's admission Record (AR), the AR indicated the facility admitted the resident on 1/22/2025 and most recently readmitted the resident on 12/4/2025 with diagnoses that included unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), unspecified dementia (a progressive state of decline in mental abilities) with behavioral disturbance, unspecified mood disorder, and alcohol dependence in remission. During a review of Resident 9's Minimum Data Set (MDS - resident assessment tool), dated 12/19/2025, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated that the resident required substantial / maximal assistance from staff for bathing and personal hygiene, required partial / moderate assistance for toileting and oral hygiene, and set-up assistance for eating. During a review of Resident 9's Order Summary Report, the Order Summary Report indicated the following orders: - Quetiapine fumarate tablet 25 milligrams (mg, a unit of measurement), give one tablet by mouth at bedtime for psychosis manifested by inability to process internal stimuli causing stress manifested by agitation, dated 12/4/2025. - Quetiapine fumarate tablet 25 mg, give 12.5 mg by mouth one time a day for psychosis manifested by inability to process internal stimuli causing stress manifested by agitation, dated 12/4/2025. - Monitor episodes of inability to process internal stimuli causing stress manifested by agitation, record the number of episodes for quetiapine use every shift, dated 12/4/2025. During a review of Resident 9's Care Plan (CP) titled, (Quetiapine fumarate) . Resident has episodes of: psychosis manifested by inability to process internal stimuli causing stress manifested by agitation. initiated on 12/4/2025, the CP indicated the resident was at risk for side effects of medication usage and to monitor and record episodes per policy. During a concurrent interview and record review on 3/11/2025 at 11:38 a.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 reviewed Resident 9's physician orders. LVN 5 stated she cared for Resident 9. LVN 5 stated Resident 9 had an order for quetiapine fumarate for inability to process internal stimuli causing stress manifested by agitation. LVN 5 stated agitation was not a specific behavior manifestation, and different nurses could interpret agitation behavior differently. LVN 5 stated Resident 9 has behaviors of attempting to hit staff and screams. During a concurrent interview and record review on 3/11/2026 at 11:40 a.m., with LVN 3, LVN 3 reviewed Resident 9's physician orders and medication administration record (MAR- a record of all medications taken by a resident on a day-to-day basis) for 3/2026. LVN 3 stated antipsychotic medications are high-risk medications that can cause adverse effects that can be harmful to residents. LVN 3 stated the goal for psychotropic medication administration is to gradually reduce the dose (GDR - structured process of slowly lowering a patient's medication dose) to reduce the potential for adverse effects. LVN 3 stated behavioral manifestations are included in the physician's order and documented in the MAR each shift by the LN to monitor for effectiveness. LVN 3 stated Resident 9 received quetiapine fumarate for behavioral manifestations of agitation. LVN 3 stated agitation is not a behavior (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manifestation. LVN 3 stated agitation is manifested in behaviors like striking or lashing out at people. LVN 3 stated when Resident 9 was not monitored for specific behaviors there was the potential to keep the resident on the medication for longer than necessary. LVN 3 stated the unnecessary administration of psychotropic medication can potentially result in black box warning side effects (most stringent safety advisory for prescription medications signaling serious, severe, or life-threatening risks, such as potential death). During a concurrent interview and record review on 3/12/2026 at 12:55 p.m., the Director of Nursing (DON) reviewed the facility policy and procedures (P&P) regarding psychotropic medication administration. The DON stated psychotropic medications are high risk medications with potential side effects including tardive dyskinesia (a movement disorder that causes a range of repetitive muscle movements in the face, neck, arms, and legs) and parkinsonism (a term that refers to brain conditions that cause unintended or uncontrollable movements). The DON stated psychotropic medications need to be accurately monitored for measurable behaviors to know if the medication can be decreased with a GDR. The DON stated that when psychotropics are not accurately monitored for specific measurable behaviors it may result in the unnecessary administration of psychotropics and be considered a chemical restraint. The DON stated agitation is not a specific measurable behavior. The DON stated the facility P&P was not followed when Resident 9's quetiapine fumarate was ordered and monitored for behavioral manifestations of agitation. During a review of the facility P&P titled, Psychotropic Medication Use, last reviewed 2/20/2026, the P&P indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition. A psychotropic medi9ation is any mediation that affects brain activity associated with mental processes and behavior. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications. anti-psychotics. Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes: . indications for, use; . adequate monitoring for efficacy and adverse consequences. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications. During a review of the facility policy and procedure titled, Resident Rights, last reviewed 2/20/2026, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity. l. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . be free from . chemical restraints not required to treat the resident's symptoms .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely submission of a completed Minimum Data Set (MDS - a resident assessment tool) for two of three sampled residents (Residents 21 and 50) reviewed for Resident Assessment task, by failing to: 1. Transmit (electronic submission of MDS to the Centers of Medicare & Medicaid Services [CMS - a federal agency that administers major healthcare programs]) the Quarterly MDS Assessment timely for Resident 21. 2. Transmit the admission MDS Assessment timely for Resident 50. These deficient practices had the potential to negatively affect the provision of necessary care and services needed by Residents 21 and 50. Findings: a. During a review of Resident 21's admission Record (AR), the AR indicated that the facility admitted the resident on 6/13/2025 with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), anemia (a condition where the body does not have enough healthy red blood cells), and hyperlipidemia (a condition where the body has abnormally high levels of fat in the blood). During a review of Resident 21's History and Physical (H&P), dated 7/7/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a concurrent interview and review on 3/11/2026 at 11:24 a.m. with the MDS Coordinator (MDSC), Resident 21's MDS Assessments with the Final Validation Report (facility's documentation of successful MDS file submission) was reviewed. The MDSC stated the Final Validation Report indicated a submission date of 3/10/2026 and was submitted late because it was missed. The MDSC stated it should have been submitted within 14 days by 12/19/2025 and they submitted after that date which was considered late. b. During a review of Resident 50's AR, the AR indicated that the facility admitted the resident on 10/26/2025 with diagnoses including urinary tract infection (UTI - an infection in the bladder/urinary tract), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), and dysphagia (difficulty swallowing). During a review of Resident 50's H&P, dated 10/28/2025, the H&P indicated that the resident did not have the capacity to understand and make decisions. During a concurrent interview and review on 11:24 a.m. with the MDSC, Resident 50's MDS Assessments with the Final Validation Report was reviewed. The MDSC stated the admission MDS, dated [DATE], was submitted late on 11/18/2025. The Final Validation Report indicated that the MDS Assessment was completed more than 14 days later. The MDSC stated it should have been submitted by the 14th day, 11/16/2025 to be considered on time. The MDSC stated they submitted Resident 21's admission MDS Assessment after 11/16/2025 on 11/18/2025 and it was late. During an interview on 3/11/2026 at 11:55 a.m. with the MDSC, the MDSC stated that the MDS assessments should be submitted timely because it contains data about the residents' diagnosis, functional abilities, and care needs.^The MDSC stated when the admission and quarterly are not submitted on time the data would not be accurate. During an interview on 3/12/2026 at 3:09 p.m. with the Director of Nursing (DON), the DON stated the purpose of transmitting MDS Assessments timely, so it shows the overall picture of the residents. The DON stated that when the MDS Assessments are not submitted timely they may fail to identify if there is a change in the residents' condition in between assessment timeframe and result in a delay of care. During a review of the facility's policy and procedure (P&P) titled, MDS Completion and Submission Timeframes, last reviewed 2/20/2026, the P&P indicated the timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument (RAI) Manual. During a review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2025, the RAI manual indicated providers must transmit all sections of the MDS 3.0 required for their State-specific instrument and all tracking or correction information. The MDS must be transmitted electronically no later than 14 calendar days after the MDS completion date.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS-a resident assessment tool) by failing to ensure the MDS assessment of one of three sampled residents (Resident 189) was transmitted accurately when a discharge assessment was submitted on 2/20/2026 and remained discharged from the facility. Resident 189 returned to the facility at 1:30 p.m. on 2/21/2026. This deficient practice had the potential to cause confusion and delay in the delivery of necessary care and services to Resident 189. Findings: During a review of Resident 189's admission Record (AR), the AR indicated Resident 189 was originally admitted in the facility on 9/11/2024 and readmitted in the facility on 11/12/2025 with diagnoses including malignant neoplasm (a tumor [abnormal growth of tissue] that can invade surrounding normal tissue and/or spread to other parts of the body) of left kidney, bone, and left lung, moderate protein-calorie malnutrition (a condition that occurs when there is a lack of protein and calories in the diet which can lead to weight loss, weakened immune system, and increased risk of infection), and paraplegia (inability to move the lower parts of the body). During a review of Resident 189's History and Physical (H&P), dated 7/13/2025, the H&P indicated Resident 189 had the capacity to understand and make decisions. During a review of Resident 189's most recent MDS assessment, dated 2/20/2026, the MDS assessment indicated that the type of the MDS assessment was discharged with return anticipated. The MDS further indicated that Resident 189 was discharged to an acute hospital. During a review of Resident 189's physician's order dated 2/20/2026, the physician's order indicated to transfer Resident 189 to the hospital via non-emergency transport or ambulance for blood transfusion (a medical procedure where blood or parts of blood from a donor are given to a patient thru the vein to replace lost blood and improve health). During a review of Resident 189's progress notes dated 2/20/2026, the progress notes indicated the ambulance arrived and transferred the resident to the hospital in stable condition and returned at 1:30 p.m. on 2/21/2026. During a concurrent interview and record review on 3/9/2026 at 1 p.m., Resident 189's AR, MDS assessment, and progress notes were reviewed with Licensed Vocational Nurse (LVN) 8. LVN 8 stated that Resident 189's last readmission date was 11/12/2025, the MDS assessment dated [DATE] indicated the resident was discharged to the acute hospital on 2/20/2026, the progress notes indicated Resident 189 left the faciity on 2/20/2026 at 8:40 p.m. and returned 2/21/20256 at 1:30 p.m. LVN 8 stated residents who did not come back to the facility within 24 hours are discharged from the system or electronic health record (EHR) and new records are created upon coming back if more than 24 hours had passed. LVN 8 stated that Resident 189 only went to the hospital for blood transfusion and came back within 24 hours. LVN 8 stated he is not familiar with the MDS assessments but Resident 189's last MDS assessment in the EHR indicated that the resident was discharged and has not come back yet. During a concurrent interview and record review on 3/12/2026 at 9:11 a.m., Resident 189's AR, MDS assessments, and progress notes were reviewed with the MDS Coordinator (MDSC). The MDSC stated that Resident 189's last readmission date was 11/12/2025, the MDS assessment dated [DATE] indicated the resident was discharged to the acute hospital on 2/20/2026, the progress notes indicated Resident 189 left the faciity on 2/20/2026 at 8:40 p.m. and returned 2/21/20256 at 1:30 p.m. The MDSC stated they just submit a discharge assessment if the residents were discharged from the facility for more than 24 hours. The MDSC stated that submission of resident assessments should be accurate. The MDSC stated that the MDS assessment submitted for Resident 189 dated 2/20/2026 was not accurate and was a data entry error. The MDSC stated they should not have submitted a discharge assessment as the records indicated that Resident 189 was no longer a resident in the facility since 2/20/2026. The MDSC stated Resident 189's MDS assessment should be accurate as it presents the clinical picture of the resident including diagnosis and the type of care the resident is receiving in the facility. The MDSC stated that if the assessment was not accurate, it can cause a delay in the care of (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident. During an interview on 3/12/2026 at 3:10 p.m. with the Director of Nursing (DON), the DON stated that the discharge MDS assessments are only completed and submitted if the resident was gone for more than 24 hours. The DON stated that all members of the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) have access to the MDS and it is a way of making the IDT members aware of the resident's clinical picture and the type or types of care the resident is receiving in the facility. The DON stated if the EHR is showing that Resident 189's most recent assessment showed that the resident was discharged and no longer in the facility, it could cause a delay in the care of Resident 189. During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, last reviewed on 2/2/0/2026, the P&P indicated that the resident assessment coordinator is responsible in ensuring that the IDT conducts timely and appropriate resident assessment and reviews according to the following requirements: OBRA required assessments - conducted for all residents in the facility: (7) Discharge Assessment (return anticipated and return not anticipated) During a review of the Centers for Medicare and Medicaid Services (CMS, a federal agency that administers the nation's major healthcare programs) Long-Term Care Resident Assessment Instrument (RAI, a means of ensuring that residents receive the highest quality of care and can maintain the highest quality of life) Version 3.0 Manual, last updated 10/2025, Chapter 1, Section 1.3, indicated the RAI process requires that the assessment accurately reflects the resident's status.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure injury (also called pressure ulcer, the breakdown of skin integrity due to pressure) for one of one sampled resident (Resident 128) reviewed under pressure injury by failing to ensure Resident 128's low air loss mattress (LALM, a special type of air mattress that uses a constant, gentle flow of air through microscopic holes to keep the skin dry and prevent pressure wounds) was replaced timely when the LALM was beeping indicating low pressure with an orange light and the resident appeared sunken into the bed. This deficient practice placed Resident 128 at risk for the development and worsening of pressure injuries. Findings: During a review of Resident 128's admission Record, the admission Record indicated the facility admitted Resident 128 on 2/10/2026, with diagnoses including pressure ulcer of sacral (bottom of the spine) region and right heel, malignant neoplasm (a tumor [abnormal growth of tissue] that can invade surrounding normal tissue and/or spread to other parts of the body) of breast, bone, and brain, and generalized muscle weakness. During a review of Resident 128's History and Physical (H&P) dated 2/12/2026, the H&P indicated Resident 128 did not have the capacity to understand and make decisions. During a review of Resident 128's Minimum Data Set (MDS, a resident assessment tool), dated 2/17/2026, the MDS indicated Resident 128 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was sometimes able to understand and make her needs known. The MDS further indicated Resident 128 required partial/moderate assistance from staff with eating; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 128 had a pressure-reducing device for bed, received PI care, and application of nonsurgical dressings. During a review of Resident 128's Order Summary Report dated 3/12/2026, the Order Summary Report indicated the following physician's orders: - 2/11/2026: LALM at setting per resident weight or comfort for pressure redistribution and wound care management. - 2/11/2026 and last revised 3/11/2026: right heel PI cleanse with normal saline (NS - a salt water solution), pat dry, apply betadine (a solution which contains iodine applied to the skin to help prevent infection in wounds, cuts, and scrapes), then cover with dry dressing every day shift for 30 days - 2/11/2026 and last revised 3/11/2026: Topical Ointment 1 250 unit per gram (unit/gm - a unit of measurement) apply to sacrococcyx (bottom of the spine up to the tailbone) extending to buttocks topically every day shift for PI management for 30 days. Cleanse with NS pat dry then apply Topical Ointment 1 and Wound Dressing (WD) 1 then cover with dry dressing. During a review of Resident 128's care plan (CP) on use of LALM initiated on 2/12/2026 and last revised on 2/16/2026, the CP indicated to ensure the LALM is inflated and recommended as one of the interventions. During a review of Resident 128's Braden Scale for Predicting Pressure Ulcer Risk Evaluations dated 2/10/2026, 2/17/2026, 2/24/2026, and 3/2/2026, the Braden Scale for Predicting Pressure Ulcer Risk Evaluations indicated that Resident 128 was a moderate to high risk for developing PI. During a concurrent observation and interview on 3/9/2026 at 12:23 p.m., inside Resident 128's room with Licensed Vocational Nurse (LVN) 8, LVN 8 stated that Resident 128's LALM had been beeping indicating low pressure with an orange light since 10 a.m. and was reported to the maintenance department. LVN 8 stated that Resident 128's LALM was getting softer compared from 10 a.m. when it first started beeping and that Resident 128 appeared sunk in bed from the middle part up to the head. LVN 8 stated he followed up again with the maintenance department at 12 p.m. During a follow up interview and record review on 3/10/2026 at 2:30 p.m., Resident 128's care plan on LALM, Order Summary Report, and Braden Scale for Predicting Pressure Ulcer Risk Evaluations were reviewed with LVN 8. LVN stated that Resident 128 was a moderate to high risk for falls and that the CP for the LALM indicated to ensure that the LALM is inflated. LVN 8 stated Resident 128 had PI on the right heel and sacrococcyx area and received treatment as ordered by the physician daily. LVN 8 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the facility should have ensured the Resident 128's LALM was properly functioning as the soft mattress can affect the resident's comfort, can sink in bed further touching the base of the bedframe, and worsen the PI on the right heel and sacrococcyx area. During an interview on 3/12/2026 at 3:03 p.m. with the Director of Nursing (DON), the DON stated the licensed nurses including the treatment nurses and the maintenance department personnel are responsible for ensuring that the LALM were properly functioning as it defeats the purpose of LALM use. The DON stated that if a LALM was not functioning, the licensed nurses will notify the maintenance department and should be checked as soon as possible to ensure the resident affected do not sink in the LALM which can cause discomfort and could worsen the resident's PI. The DON stated that more than 2 hours before Resident 128's LALM to be fixed is too long. The DON stated Resident 128's LALM should have been fixed immediately as the soft mattress can cause discomfort and also placed Resident 128 at risk for worsening of her PI. During a review of the facility's policy and procedure (P&P) titled, Pressure-Reducing Mattresses, last reviewed on 2/20/2026, the P&P indicated the facility provides mattress that prevent and/o minimize pressure on the skin, and to offer enhanced comfort. The P&P further indicated: - Follow the manufacturer's instruction and adjust the LALM to a desired firmness based on the following: A. Resident's weight. For LALM 1, refer to the setting guidelines. B. Residents comfort using the hand check method. During a review of the facility provided manufacturer's guideline for LALM 1, undated, the manufacturer's guideline indicated the following: - Operating Instructions: - Turn on the control unit power. The indicator of the power switch will come on. The control unit will start to blow air into the mattress. - The low-pressure indicator (orange) will come on as inflation is underway. - When the pressure reaches the preset level, within approximately 30 minutes, the normal pressure indicator will come on, and the low-pressure indicator will turn off.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received services and assistance for two of four sampled residents (Resident 38 and Resident 180) reviewed for urinary tract infection (UTI, a common infection that occurs when bacteria enters and multiplies in the urinary system, which includes the kidneys, bladder, and urethra) by failing: 1. To ensure Resident 90's urinal bottle (a handheld container designed for collecting urine) was not hanging on the side of the trash can. 2. To ensure Resident 180's urinal bottle was labeled. These deficient practices had the potential for the residents' urinal bottle to be contaminated which may lead to development of urinary tract infection. Findings: 1. During a review of Resident 38's admission Record (AR), the AR indicated the facility admitted the resident on 1/15/2026, with diagnoses including history of falling, generalized muscle weakness, and difficulty in walking. During a review of Resident 38's History and Physical (H&P), dated 1/16/2026, the H&P indicated that Resident 38 had the capacity to understand and make decisions. During a review of Resident 38's Minimum Data Set (MDS, a resident assessment tool), dated 1/22/2026, the MDS indicated Resident 38 had an intact cognition (mental action or process of acquiring knowledge and understanding) but was able to understand others and make his needs known. The MDS further indicated Resident 38 was independent with eating; partial/moderate assistance with oral and personal hygiene, and upper body dressing; substantial/maximal assistance with all other activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 38 was continent of bowel and bladder. During a review of Resident 38's care plan (CP) on risk for alteration in elimination patterns with the bladder initiated on 2/5/2026 and last revised on 2/15/2026, the CP indicated to assess resident's ability to participate with bladder/[NAME] program and monitor for signs and symptoms of UTI. During a concurrent observation and interview on 3/9/2026, at 9:58 a.m., inside Resident 38's room with Certified Nursing Assistant (CNA) 19, CNA 19 stated Resident 38's urinal was hanging on the side of the trash can. CNA 12 stated that the facility uses a urinal holder that can be hung on the side of the bed frame for easy access and maintain cleanliness of the urinal. CNA 19 stated she was not familiar with the resident and hanging the urinal on the side of the trash could be Resident 38's preference. CNA 19 stated that resident 38's urinal should have been placed on the urinal holder as the trash can is contaminated and when the resident uses the urinal it placed the resident at risk for getting infection due to the contaminated urinal. During an interview on 3/9/2026 at 10:15 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1, stated that the facility has a urinal holder to keep the urinal clean and at easy reach all the time. LVN 1 stated that the urinal should not be placed on the trash can as the trash is contaminated. LVN 1 stated that placement of urinal in a place other than the holder, it should be care planned as non-compliance. LVN 1 stated that Resident 38's urinal should have been on the urinal holder instead of the trash can as the trash can is contaminated and placed Resident 38 for acquiring infection such as UTI from using the contaminated urinal. During an interview of 3/12/2026 at 1:23 p.m. with the Director of Nursing (DON), the DON stated that (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility has urinal that can be hung on the side of the bed frame and the CNAs and licensed nurses are supposed to monitor and remind the residents that the urinals should be placed on the holder to keep it clean. The DON stated the urinals are not supposed to be hung on the side of the trash can as it is contaminated, not a good practice and not sanitary which could lead to the resident's acquiring infection. The DON stated that if placing the urinal on the side of the trash can is a patient preference, it should be documented and explained the risks and consequences and addressed in the care plan to respect the resident's right. The DON stated that Resident 38's urinal should have been hung on the side of the bed with a urinal holder not on the trash can as the trash can is contaminated and placed Resident 38 at risk for acquiring infection such as UTI. 2. During a review of Resident 180's Face Sheet (FS), the FS indicated the facility admitted the resident on 3/5/2026, with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease, stage 4 (it is the final stage before kidney failure, requiring urgent management to slow progression and prepare for potential^dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) or^transplant (a medical operation where a failing or damaged organ or tissue is removed from a person's body and replaced with a healthy one)), and acquired absence of kidney. During a review of Resident 180's History and Physical (H&P), dated 3/6/2026, the H&P indicated the resident was awake, alert, oriented, communicative, able to move all extremities, and had reduced test strength and power. The H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 180's Care Plan (CP) Report titled, Impaired skin integrity., last revised on 3/6/2026, the CP indicated an intervention of incontinence care and keeping skin dry and clean. During a concurrent observation and interview on 3/9/2026, at 10:29 a.m., with Licensed Vocational Nurse (LVN) 2, inside Resident 180's room, observed Resident 130's unlabeled urinal bottle on top of the side table at the right side of the bed. LVN 2 stated the staff should have labeled the urinal bottle with the name of the resident, room number, and the date it was provided to prevent switching of urinals among residents that can cause cross-contamination (the unintentional transfer of harmful bacteria, viruses, or allergens from one surface, food, or person to another). During an interview on 3/11/2026, at 7:16 a.m., with Registered Nurse (RN) 1, RN 1 stated the practice in the facility when providing urinals to the resident was to place the name and room number of the resident to prevent switching of urinals among residents that can cause urinary tract infections. RN 1 stated the Certified Nursing Assistants (CNAs) were responsible to make sure the urinal bottles were labeled. During an interview on 3/12/2026, at 12:26 p.m., with the Director of Nursing (DON), the DON stated the urinal bottle should be labeled with the resident's initial and the date it was provided. The DON stated they change the urinal only when it appears dirty and as needed. The DON stated the purpose of labeling the urinal with the initials of the resident and the date it was provided was to ensure they did not mix each resident's urinal that can potentially cause UTI on the residents. The DON stated the staff did not follow the policy and procedure (P&P) titled Giving and removing Urinal. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, last reviewed on 2/20/2026, the P&P indicated and infection prevention and control program (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. During a review of the facility's recent P&P titled, Giving and removing Urinal, last reviewed on 2/202/2026, the P&P indicated to provide resident with a container for urine.^ For a Dependent Resident Steps: 13. Label as indicated.

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Burbank Healthcare & Rehab	1041 S. Main St. Burbank, CA 91506

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure the staff providing care and services to the resident who has a feeding tube (soft plastic tubes through which liquid nutrition travels through the gastrointestinal tract [the series of organs that food and liquids pass through as they are digested, absorbed, and leave the body as feces]) are aware of, competent in, and utilize facility protocols regarding feeding tube nutrition and care for one of ten sampled residents (Resident 1) observed during Dining Observation by failing to ensure Licensed Vocational Nurse (LVN) 1 checked the gastrostomy tube (g-tube - a small tube placed through the skin directly into the stomach to deliver nutrition, fluids, and medications) placement prior to administering Jevity 1.5 (aˆhigh-calorie, liquid nutrition formulaˆdesigned for people who cannot eat enough food by mouth, typically used through a feeding tube) bolus feeding (a method of delivering liquid nutrition (formula) directly into the stomach through a feeding tube, usually using a large syringe, 3-6 times a day to mimic normal meal times). This deficient practice had the potential to administer the feeding in the peritoneum (a thin, smooth, and slippery membrane that acts as a lining inside the abdomen and wraps around organs like the stomach and intestines) that can lead to peritonitis (a serious, often life-threatening inflammation of theˆperitoneum, which is the thin, slick lining that covers the inside of your belly (abdomen) and wraps around your internal organs) on residents. Findings: During a review of Resident 1's Face Sheet (FS), the FS indicated the facility admitted the resident on 10/30/2025, and readmitted the resident on 11/24/2025, with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), perforation of intestine (a serious medical emergency where a hole or tear develops in the wall of the stomach, small intestine, or large bowel), and severe protein-calorie malnutrition (a life-threatening condition caused by a critical lack of food, protein, and nutrients). During a review of Resident 1's History and Physical (H&P), dated 1/11/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2026, the MDS indicated the resident had the ability to male self-understood and understand others and had intact cognition (means that a person's mental abilities are working normally, without any significant decline, impairment, or damage). The MDS indicated the resident was dependent to needing supervision assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident has a feeding tube. During a review of Resident 1's Order Summary Report (OSR), the OSR indicated an order for: 2/28/2026 Enteral Feed (often referred to asˆtube feeding, isˆa method of delivering liquid nutrition directly into the stomach or small intestine) Order: (Jevity 1.5) at 237 milliliters (ml - a unit of volume) at 9 a.m., 1 p.m., 5 p.m. and 500 ml at 9 p.m. via bolus to provide 1611 cubic centimeter (cc, a tiny unit of volume, equal to the space inside a cube measuring 1 cm X 1 cmˆX 1 cm)/2417 kilocalorie (kcal, a unit of energy equal to 1,000 small calories) per day. 1/10/2026 Enteral Feed Order every shift [Enteral]. Check tube placement every (q) shift. During a review of Resident 1's Care Plan (CP) Report titled, Resident is on g-tube feeding, last revised on 1/12/2026, the CP indicated an intervention to check and maintain placement and patency of g-tube. During an observation on 3/9/2026 between 12 p.m. and 12:10 p.m., outside Resident 1's room, Licensed Vocational Nurse (LVN) 1 did not enter Resident 1's room. During a concurrent observation and interview on 3/9/2026 at 1:01 p.m. with LVN 1, inside Resident 1's room, observed LVN 1 prepare for bolus feeding of Jevity 1.5 via g-tube to Resident 1. LVN 1 donned gown because resident is on enhanced barrier precaution (EBP - infection-control measures in nursing homes requiring staff to wear gowns and gloves during high-contact care [e.g., dressing, bathing, changing linens] for residents with wounds, tubes, or known dangerous germs). LVN 1 communicated with the resident what she was doing and checked (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the name of the resident with the ID band. LVN 1 elevated head of bed (HOB) and checked for residual (the amount of liquid-formula, water, and stomach juices-that is still sitting in the stomach from a previous feeding when it is time for the next one) on the g-tube, no residual was noted. LVN 1 flushed tubing with 30 ml of water and poured the contents of Jevity 1.5 in the piston syringe (is a simple, handheld medical device used to inject, measure, or withdraw fluids, liquids, or gases. It operates like a tiny, manual pump, consisting of a hollow, marked cylinder [the barrel] and a sliding inner rod [the plunger] that creates suction or pressure), the Jevity had 237 ml of fluid. LVN 1 flushed 30 ml of water after pouring all the contents of Jevity 1.5. LVN 1 repositioned the resident in bed and removed the gloves and gown. LVN 1 washed hands. During an interview on 3/9/2026 at 1:11 p.m. with LVN 1, LVN 1 stated she checked Resident 1's g-tube placement around 12 p.m. Informed LVN 1 she was not observed between 12 p.m. to 12:10 p.m. entering Resident 1's room to check g-tube placement. Informed LVN 1 staff was requested to find Resident 1's LVN. LVN 1 stated the facility's practice on checking for g-tube patency and placement was through injecting air in the g-tube and listening for bubbling gurgling sounds in the abdomen using a stethoscope (a handheld medical tool used by doctors and nurses to listen to sounds inside the body, primarily the heart, lungs, and intestines). During an interview on 3/12/2026 at 10:04 a.m. with Registered Nurse (RN) 1, RN 1 stated they check for placement of g-tube using a stethoscope and syringe and inject air and they listen for bowel bubbling/gurgling sounds on the abdomen. RN 1 stated LVN 1 should have checked for placement of the g-tube before administering the formula. LVN 1 stated checking for the placement earlier than the administration time of the Jevity 1.5 bolus feed, like an hour before administering the formula was not a good practice because the tube could have been dislodged and the formula will not be administered properly. During an interview on 3/12/2026 at 12:26 p.m. with the Director of Nursing (DON), the DON stated LVN 1 should have checked the g-tube placement on the moment she was giving the bolus feeding because the tubing can be dislodged anytime it has to be current. The DON stated checking the placement of the g-tube an hour before you administer the bolus feeding was not acceptable. The DON stated the failure of LVN 1 to check for placement of the g-tube on the time of administration of the bolus feeding can potentially lead to administration of the feeding formula on the other parts of the stomach or peritoneum that can lead to peritonitis. The DON stated the policy and procedures (P&P) titled Administering Medications through an Enteral Tube, and Enteral Tube Feeding via Syringe (Bolus), provided by the facility was not followed. The DON stated for verification of tube placement in the facility they use a stethoscope and syringe, injecting air and listening to gurgling sounds on the abdomen when air is injected. During a review of the facility's recent P&P titled, Administering Medications through an Enteral Tube, last reviewed on 2/20/2026, the P&P indicated the purpose of this procedure is to provide guidelines for the safe administration of medications through the enteral tube. Steps in the Procedure 7. Verify placement of feeding tube. During a review of the facility's recent P&P titled, Enteral Tube Feeding via Syringe (Bolus), last reviewed on 2/20/2026, the P&P indicated the purpose of this procedure is to provide nutritional support to residents unable to obtain nourishment orally. Steps in the Procedure 7. Verify placement of tube. Documentationˆ 2. Verification of tube placement.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure parenteral fluids (liquids, such as medication or nutrition, that are administered to the body by bypassing the digestive system) were administered consistent with professional standards of practice to one of one sampled resident (Resident 179) reviewed for hydration by failing to ensure the Resident 179's peripheral intravenous (IV - within a vein) line (a small, flexible plastic tube (catheter) inserted through the skin into a small vein-usually in the hand, arm, or foot-to deliver fluids and medications directly into the bloodstream) had the date and initials of the licensed nurse who inserted the IV line or changed the IV dressing.ˆ This deficient practice had the potential for complications associated with intravenous therapy (a medical technique that delivers fluids, medication, or nutrients directly into a person's bloodstream through a vein) and catheter-related infections. Findings: During a review of Resident 179's Face Sheet (FS), the FS indicated the facility admitted the resident on 3/1/2026 with diagnoses including elevated white blood cell (WBC) count (occur when you have infection or inflammation in the body), anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life, functioning, or relationships), and polyneuropathy (a condition whereˆmany nerves outside the brain and spinal cord (the peripheral nervous system) are damaged simultaneously). During a review of Resident 179's History and Physical (H&P), dated 3/2/2026, the H&P indicated the resident was awake, alert, oriented, communicative, non-ambulatory, able to move all extremities and able to test strength and power. The H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 179's Minimum Data Set (MDS - a resident assessment tool), dated 3/8/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (means that a person's mental abilities are working normally, without any significant decline, impairment, or damage). The MDS indicated the resident was on a high-risk drug class antibiotic medication (medications that treat bacterial infections by killing bacteria or stopping them from growing and multiplying) and had a peripheral IV access. During a review of Resident 179's Order Summary Report (OSR), dated 3/5/2026, the OSR indicated an order for: - Peripheral site care as needed for complications. May extend IV site for poor venous access if no complications are present. Change dressing with site change and if needed (PRN). - Peripheral site care every 72 hours for site care, restart IV and subcutaneous site (additional MD order required for insertion of IV catheter into lower extremities). - Site check every shift. Site without signs and symptoms of complications and no adverse reactions (any harmful, unintended, or unwanted result that happens after taking a medication or using a medical product, even when it is used correctly) from IV therapies unless addressed in nurse's notes. Every shift. During a review of Resident 179's Care Plan (CP) Report titled, Resident requires special treatment/procedures such as: IV antibiotic therapy for elevated WBC, peripheral IV line site, last revised on 3/9/2026, the CP indicated a goal of the resident's IV access will be maintained and be free of complications within the nest review date and an intervention for peripheral IV: Restart IV site every 96 hours and PRN but may extend for poor venous access site, flush IV site as ordered, monitor for complications and intake and output (I/O). During a concurrent observation and interview on 3/8/2026 at 10:11 a.m. with Licensed Vocational Nuse (LVN) 2, inside Resident 179's room, observed Resident 179's peripheral IV on the left-hand gauge 24 (a very small, thin intravenous catheter, commonly color-coded yellow) with no date and initial of the licensed nurse who inserted the line or changed the dressing covered with a net dressing. LVN 2 stated it should be labeled with the date and the initials of the licensed nurse who inserted the line or changed the dressing to know how long the peripheral line was inserted and when to change the IV site to prevent infection to the resident. During a concurrent interview and record review on 3/11/2026 at 7:16 a.m. with Registered Nurse (RN) 1, Resident 179's Medical Diagnoses, H&P, MDS, OSR, and CP were reviewed. RN 1 stated there was an order for peripheral IV site care and to restart IV every 72 (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours but may extend IV site for poor venous access. RN 1 stated RNs are responsible for making sure the IV site was up to date. RN 1 stated they place the date of insertion and initials of the nurse who inserted the line. RN 1 stated when they change the dressing, they are supposed to place the date and initial of the nurse who changed the dressing so they know when to change them and for infection control. During an interview on 3/12/2026 at 12:56 p.m. with the Director (DON), the DON stated the licensed staff should have labeled the IV site with the date and initials of the nurse who inserted the line or changed the dressing. The DON stated the purpose of labeling was to know when the dressing and insertion was done. The DON stated the Peripheral IV line is good for 96 hours and keeping them, more than that time had potential for infection at the During a review of the facility's recent policy and procedure (P&P) titled, Peripheral and Midline IV Dressing Changes, last reviewed on 2/20/2026, the P&P indicated the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. General Guidelines 4. Change the dressing if it becomes damp, loosened or visibly soiled and: a. at least every seven (7) days for transparent semipermeable membrane (TSM - sterile, adhesive, and transparent dressings used to cover IV insertion sites)dressing; b. at least every two (2) days for sterile gauze dressing (including gauze under a TSM unless the site is not obscured); or c. immediately if the dressing or site appears compromised. 6. Assess the peripheral/midline access device at least every four (4) hours (every 1-2 hours for residents with cognitive impairment. b. Check expiration dates of the infusion, dressing and administration set. Steps in the Procedure 9. Place new dressing (TSM or gauze) over insertion site. Label with the date and time of dressing change, and initials.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pain management consistent with professional standards of practice and the residents' goals and preferences for two of two sampled residents (Resident 62 and 142) reviewed for Pain care area, by failing to: 1. Follow the physician order for pain consult referral for Resident 62. This deficient practice had the potential to result in mismanagement of resident pain resulting in limited resident participation in activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily) and mobility. 2. Ensure Licensed Vocational Nurse (LVN) 4 assessed Resident 142's pain level prior to administrating the pain medication and to accurately document Resident 142's pain in the Medication Administration Record (MAR). This deficient practice has the potential to result in ineffective pain management, which may negatively impact Resident 142's comfort, safety, and overall well-being. Findings: a. During a review of Resident 62's admission Record (AR), the AR indicated that the facility admitted the resident on 2/20/2026 with diagnoses including low back pain, chronic pain, need for assistance with personal care, and chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing). During a review of Resident 62's History and Physical (H&P), dated 2/21/2026, the H&P indicated that the resident has the capacity to understand and make decisions and is able to make decisions for activities of daily living. During a review of Resident 62's Clinical Admission, dated 2/20/2026, the Clinical admission indicated that the resident had vocal complaints of pain and was identified as a new issue on her cervical region (referring to the area around the neck) that is severe, constant, aching pain, and worse with movement. During a review of Resident 62's Minimum Data Set (MDS – a resident assessment tool), dated 2/25/2026, the MDS indicated the resident was able to understand others and able to make herself understood. The MDS indicated the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS further indicated the resident required substantial / maximal assistance (helper does more than half the effort) with lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and walking 10 feet (ft – a unit of measurement). During a review of Resident 62's Order Recap Report (ORR), dated 2/28/2026, the ORR indicated an order for pain consult. During a review of Resident 62's Care Plan (CP) titled, Potential for Alteration in Comfort/Pain related to chronic pain, muscle spasm., initiated date 2/27/2026, the CP indicated a goal that the resident would reduce episodes of pain or discomfort with interventions that included for pain consultation if indicated. During an interview on 3/9/2026 at 10:20 a.m. with Resident 62, inside Resident 62's room, Resident 62 stated that she has pain in her left knee and she feels frustrated. Resident 62 stated she has spoken to the nursing staff and has requested to be seen by a pain specialist for her pain management because nothing is working. Resident 62 stated she just got her pain medication an hour ago and her current pain level is five (5) out of 10 and it is not tolerable. Resident 62 stated she is (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grinding on her gums to ignore the pain. Resident 62 stated she wants her pain specialist to be followed up. During a concurrent interview and record review on 3/12/2026 at 1:05 p.m. with the Assistant Director of Nursing (ADON), Resident 62's physician orders and nursing progress notes, dated 2/28/2026 timestamped at 2:23 p.m., were reviewed. The ADON stated the nursing note is confusing to him (ADON) if the orders were carried out or not. The nursing notes indicated MD notified with new orders: pain consult. Orders carried out. The ADON stated the orders would show that a referral was made when the appointment was scheduled with a date and time, the name of the provider and should be made immediately or the same day. The ADON stated he does not know if there was a pain referral prior to 3/11/2026. During an interview on 3/12/2026 at 2:53 p.m. with the Medical Records Director (MRD), the MRD stated she checked and there was no pain referral prior to 3/11/2026. During an interview on 3/12/2026 at 2:26 p.m. with the Director of Nursing (DON), the DON stated the licensed nurse will try to schedule the appointment as soon as possible. The DON stated Registered Nurse (RN) receives the order from the doctor, schedule the appointment and document in the resident's clinical chart under progress notes. The DON stated once the appointment has been scheduled it will be entered under the physician order. The DON stated this is to ensure that the resident will be seen by the pain specialist and her pain addressed. The DON stated that when the pain referral is not done the resident will not receive the care she is supposed to get and the resident's pain is not managed and potentially can affect her participation in daily activities and mobility. During a review of the facility's policy and procedures (P&P) titled, Pain Assessment and Management, last reviewed 2/20/2026, the P&P indicated that the purpose of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. The P&P indicated that the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. 'Pain management' is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. Defining Goals and Appropriate Interventions: 1. The pain management interventions shall be consistent with the resident's goals for treatment. Such goals will be specifically defined and documented. b. During a review of Resident 142's AR, the AR indicated Resident 142 was admitted on [DATE] to the facility with a diagnosis of Bullous Pemphigoid (skin condition that causes large, fluid-filled blisters); acute chronic systolic congestive heart failure (a long-term weak heart that suddenly gets worse and can't pump blood properly, causing fluid buildup in the body); other specified Arthritis, unspecified site (joint inflammation or pain is present but the exact place in the body isn't specified). During a review of Resident 142's H&P, dated 1/21/26, the H&P indicated resident can make needs known but cannot make medical decisions. During a review of Resident 142's MDS, dated [DATE], indicated Resident 142 was usually able to make self- understood and usually able to understand others. The MDS further indicated that Resident 14 had an impaired cognition (difficulty with thinking). The MDS indicated the resident required (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a concurrent observation and interview on 3/9/2026 at 10:30 am with Resident 142 inside the resident's room. Resident 142 was lying in bed and stated that since last night has been having pain and requested pain medication, but no one has given her pain medication. Resident 142 stated that from a scale 1-10, currently her pain level is 9/10 on her legs and back and she has not been able to sleep all night from the pain. Resident 142 pressed the call light and a staff member answered the call light and Resident 142 told staff member that she was in pain and staff member went to look for her nurse. LVN 4 came in with a pink tray and a medicine cup that had two pills. LVN 4 told the resident that LVN 4 was going to give her Tylenol but did not ask resident for the pain level. During a review of Resident 142's Order Summary Report (OSR), dated 1/20/2026, the OSR indicated an order for Acetaminophen 325 milligrams (mg – a unit of measurement) Give 2 tablet by mouth two times a day for mild pain (1-3). During a concurrent interview and record review on 3/9/2026 at 11:12 a.m. with LVN 4, Resident 142's physician's orders were reviewed and LVN 4 stated Resident 142 was ordered Acetaminophen 325 mg, give two (2) tablets by mouth two times a day for mild pain (1-3). During an interview on 3/9/2026 at 2:10 p.m. with LVN 4, LVN 4 stated there is no order for as needed (PRN) pain medication for Resident 142. LVN 4 stated that if the resident's pain level is higher than three (3) then LVN 4 would have to notify the doctor and do progress note, especially if severe pain is consistent. LVN 4 stated that other alternatives that could have been done are nonpharmaceutical interventions, for example reposition or distraction. LVN 4 stated that she did not offer Resident 142 nonpharmaceutical interventions. During a concurrent interview and record review on 3/11/2026 at 1:45p.m. with LVN 4, Resident 142's Medication Administration Record (MAR - document used by healthcare professionals to track, verify, and log all medications given to a resident) was reviewed. LVN 4 stated that Resident 142's pain level on 3/9/2026 for the morning was entered in MAR as 2/10 pain level because LVN 4 assumed pain level was 2/10 instead of asking Resident 142 for the pain level. LVN 4 stated that instead of 2/10 pain level, the MAR should indicate 9/10 pain level since that was the pain level the resident verbalized. LVN 4 stated it is important to see if medications are not effective because it can lead to something more severe and there can be a change of condition which needs to be communicated to the doctor. During a concurrent interview and record review on 3/12/26 1:30 p.m. with RN 3, Resident 142's OSR, dated 1/20/2026, and medical records were reviewed. RN 3 stated that when residents are in pain and before giving pain medication, the licensed nurse needs to assess the resident and ask them to rate their pain on a scale from zero to 10, what is the quality, and the location of pain. RN 3 stated that depending on residents' pain, give pain medication and reassess after 30 minutes of medication being administered. RN 3 reviewed Resident 142's medical records and stated that diagnosis with arthritis would require pain medication. RN 3 stated that the only order she sees on 3/9/2026 is for Tylenol twice a day for mild pain (1-3). RN 3 stated that the RN should notify the provider that there was no medication ordered for a higher pain scale more than 3/10. During an interview on 3/12/2026 at 4:23 p.m. with the DON, the DON stated that LVN 4 should have assessed the pain level, check doctor's order and a change of condition should have been created if pain was not controlled with medication given. The DON stated what can occur is that Resident 142's (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain would not be controlled and Resident 142 would remain in pain and discomfort. The DON stated the policy titled Pain- Clinical Protocol was not followed.ˆ During a review of the facility's P&P titled, Pain-Clinical Protocol, last reviewed 2/20/26, the P&P indicated, 1. The physician and staff will identify individuals who have pain or who are at risk for having pain. a. This includes reviewing non diagnosis and conditions that commonly cause pain . b. It also includes a review for any treatments that the resident currently is receiving for pain, including complementary and Nonpharmacological treatments. 2. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is an onset of new pain or worsening of existing pain. 3. The staffing physician will identify the characteristics of the pain such as location, intensity, frequency, pattern, and severity. a. Staff will use a consistent approach and a standardized pain assessment instrument appropriate to the residents cognitive level. 4. The nursing staff will identify any situations or interventions where an increase in the residence pain may be anticipated; for example, wound care, ambulation, or repositioning. 5. The staff will evaluate how pain is affecting mood activities of daily living, sleeping, and the resident's quality of life, as well as how pain may be contributing to complications such as gait disturbances social isolation and false. During a review of the facility's P&P titled, Charting and Documentation, last reviewed 2/20/26, the P&P indicated, all services provided to the resident, progress toward the care plan goals, and any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective (not opinionated or speculated), complete, and accurate.

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Burbank Healthcare & Rehab	1041 S. Main St. Burbank, CA 91506

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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 residents who received hemodialysis (HD - also known as dialysis, process of removing waste products and excess fluid from the body) received treatment consistent with professional standards of practice for one of one sampled resident (Resident 59) reviewed under the Dialysis care area by failing to ensure communication with the HD Center (a specialized outpatient facility that provides HD) when Licensed Vocational Nurse (LVN) 4 failed to follow-up with the HD Center when the Dialysis Communication Record form was not completed on 3/6/2026 and 3/9/2026. This deficient practice placed the resident at risk for a delay in care and services related to HD. Findings: During a review of Resident 59's admission Record (AR), the AR indicated the facility originally admitted the resident on 4/5/2016 and most recently admitted the resident on 12/3/2024 with diagnoses that included End Stage Renal Disease (ESRD - irreversible kidney failure), dependence on renal (kidney) dialysis, hypertensive heart and chronic Kidney disease (a combined condition where long-term high blood pressure causes structural heart and simultaneous, progressive loss of kidney function), and diabetes mellitus (DM -a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 59's Minimum Data Set (MDS - resident assessment tool), dated 2/12/2026, the MDS indicated the resident was able to understand others and to make herself understood. The MDS further indicated that the resident was dependent on staff for bathing, required partial / moderate assistance from staff for toileting, and supervision for oral and personal hygiene. During a review of Resident 59's Care Plan (CP) titled, HD.I, (Resident 59) have ESRD . I am at risk for chronic anemia (low level of red blood cells) because I have inadequate iron intake / absorption. I may exhibit poor tissue perfusion / insufficient oxygen., initiated 2/14/2018 and last reviewed 2/24/2026, the CP indicated interventions that included HD Center to administer medications as ordered, to communicate with HD center as indicated, and follow protocol for labs as ordered. During a review of Resident 59's CP titled, Weight variance is expected due to fluid retention secondary to ESRD / HD), ., initiated 3/5/2020 and last reviewed 2/24/2026, the CP indicated interventions that included post HD dry weights will be utilized that are identified on the Pre/Post HD form and to notify the attending physician of HD Center orders. During a review of Resident 59's Physician Order Summary, the Physician Order Summary indicated the following orders: - Use post HD weights for weight management purposes, dated 11/5/2025. - HD Center (HDC) 1, HD days Monday, Wednesday, Friday, chair time 4:30 a.m., pick up time 4 a.m., return time 8 a.m., dated 1/6/2026. During an interview on 3/9/2026 at 10 a.m. with Resident 59, Resident 59 stated she goes to HDC 1 on Monday, Wednesday, and Friday and communicates with the facility. During a concurrent interview and record review on 3/11/2026 at 12:02 p.m., with LVN 3, Resident 59's HD Communication Record forms, dated 3/6/2026 and 3/9/2026, were reviewed. LVN 3 stated the HD Communication Record form is used for the facility and HDC 1 to communicate. LVN 3 stated when the resident returns from HD, the LVN assesses the resident and reviews the form for the resident's pre and post HD weight to know if there are any weight changes, and any other important notes from the HD center. LVN 3 stated if the form is not completed by the HD center then the LVN should call the HD center and follow up. LVN 3 stated the HD Communication Record forms dated 3/6/2026 and 3/9/2026 were not completed by HDC 1. During a concurrent interview and record review on 3/11/2026 at 12:07 p.m. with LVN 4, Resident 59's HD Communication Record forms, dated 3/6/2026 and 3/9/2026, were reviewed. LVN 4 stated she was caring for Resident 59 on 3/6/2026 and 3/9/2026 and she completed the post HD assessment and signed the forms. LVN 4 stated she did not notice the HD Communication Record forms were not completed by HDC 1 on 3/6/2026 and 3/9/2026. LVN 4 stated when the forms were not completed, she should have followed the procedure and called HDC 1 to follow up, but she did not. LVN 4 stated when she did not follow up there was the potential of complications resulting in Resident 59 because she (LVN 3) may not have been aware of follow-up labs ordered, weights, or (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	even if the resident did or didn't receive HD. During a concurrent interview and record review on 3/12/2026 at 12:55 p.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) regarding HD was reviewed. The DON stated the facility process is to complete the HD Communication Record form with the LVN's assessments and monitor HDC 1's communication like any medications that were administered and the pre and post HD weight. The DON stated the form is a communication tool between the facility and the HD center and if the form is not completed then the LVN should follow up to have the facility fax over pertinent information and document that communication. The DON stated when LVN 4 did not follow up there was the potential of the plan of care not being followed for Resident 59. The DON stated the facility P&P was not followed. During a review of the facility P&P titled, End-Stage Renal Disease, Care of a Resident with, last reviewed 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. 1. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. 2. Education and training of staff includes, specifically : . b. the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis; . 4. Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: a. how the care plan will be developed and implemented; b. how information will be exchanged between the facilities. 5. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. During a review of the facility provided contract with HDC 1 titled, SNF OUTPATIENT DIALYSIS SERVICES AGREEMENT, dated 3/5/2019, the contract indicated, Interchange of information, The Nursing Facility shall provide for the interchange of information useful or necessary for the care of the ESRD Residents. Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Nursing Facility and ESRD Dialysis Unit.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on interview and record review, the facility failed to ensure a resident receive treatment and care in accordance with professional standards of practice for one of one sampled resident (Resident 153), by failing to arrange Resident 153's transportation to their Oncology (the specialized branch of medicine dedicated to the diagnosis, treatment, and prevention of cancer [a group of diseases characterized by the uncontrolled proliferation of cells]) appointment. This deficient practice resulted in a missed Oncology visit on 3/10/2026 for Resident 153. Findings: During a review of Resident 153's admission Record (AR), the AR indicated that the facility admitted the resident on 12/15/2025 with diagnoses including acute kidney failure (also known as acute kidney injury, condition in which the kidneys suddenly cannot filter waste from the blood), elevated white blood cell count, and disorder of bone. The AR indicated Resident153 as the primary decision maker. During a review of Resident 153's History and Physical (H&P), dated 12/17/2025, the H&P indicated the resident had immunodeficiency due to conditions classified elsewhere. During a review of Resident 153's Minimum Data Set (MDS - a resident assessment tool), dated 12/20/2025, the MDS indicated the resident made self understood and had the ability to understand others. The MDS indicated Resident 153 was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS indicated Resident 153 required partial / moderate assistance from staff with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. During a review of Resident 153's physician order, the physician order indicated the following: - dated 2/26/2026 timestamped at 11:21 a.m., an appointment with Oncology on 3/10/2026 at 1:30 p.m. Social Services Department to schedule transportation. - dated 3/10/2026 timestamped at 8:21 a.m., appointment with Oncology on 3/10/2026 at 12 p.m. Social Services Department to schedule transportation. - dated 3/10/2026 timestamped at 8:22 a.m., an appointment with Oncology on 3/10/2026 at 1:30 p.m. Social Services Department to schedule transportation. Discontinued reason: per doctor's office request. During a review of Resident 153's Care Plan (CP) titled, has self-care deficits, initiated on 12/15/2025, the CP indicated the goal of minimizing risk of decline with interventions to allow resident to be active in decision-making process involving care. During a concurrent interview and record review on 3/11/2026 at 10:24 a.m. with Registered Nurse (RN) 2, reviewed Resident 153's physician orders and Appointment Notification Form (ANF), dated 2/27/2026. RN 2 stated Resident 153 missed his Oncology appointment that was scheduled yesterday, 3/10/2026 at 12 p.m. because there was an issue with transportation and Resident 153 was not picked up to go to his appointment. RN 2 stated the ANF is filled out upon receipt of new appointment order and the ANF was signed by Social Services Assistant (SSA) 1. RN 2 stated she will call the Oncology clinic to reschedule Resident 153's Oncology clinic appointment. During a concurrent interview and record review on 3/11/2026 10:33 a.m. with SSA 1 and SSA 2, reviewed Resident 153's physician orders and ANF, dated 2/27/2026. SSA 1 stated this was her signature to acknowledge that she received the appointment for Resident 153. SSA 1 statedˆSSA 2, also a social services assistant, takes care of Station 1 - SSA 2 takes care of long-term residents. SSA 1 stated she works together with SSA 2, but primarily SSA 2 is assigned to Station 1. SSA 2 stated Resident 153's ANF did not need to be filled out because Resident 153 was going to be picked up by the facility van. SSA 2 stated she was not aware that Resident 153 had an appointment scheduled yesterday, 3/10/2026 at 1:30 p.m. and was then moved to 12 p.m. SSA 1 stated Resident 153's ANF form was not filled out under social services section including the transportation name, pick up time, and if Resident 153 would be accompanied by family or an escort. During a follow-up interview on 3/11/2026 at 10:48 a.m. with RN 2, RN 2 stated the social services section of the ANF needed to be filled out so they, licensed nurses, would know that the transportation had been set-up and make sure Resident 153 is ready at the time of pick up. RN 2 (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that section was not completed and Resident 153 missed his appointment. RN 2 stated yesterday, 3/10/2026 at 8 a.m. she received a call from the Oncology clinic to change Resident 153's appointment time to an earlier time at 12 p.m., but it was not set up.ˆ During an interview on 3/11/2026 at 2:29 p.m. with the Director of Nursing (DON), the DON stated the licensed nurses receive the order for a resident's appointment date and time; they will enter the order and fill out the ANF form to notify the Social Services Department that the resident needs transportation and social services will arrange the transportation. The DON stated the ANF form should contain the name of transportation, including facility-provided van transportation, the name of transportation and pick up time. The DON stated the details are important so the nursing staff know and the resident know what time the resident will be picked up. The DON stated that when the transportation details are not filled out, it means it was not done, and the resident missed their appointment. The DON stated for Resident 153, who missed their appointment, Resident 153 was not seen by his Oncology specialist, and the specialist would not be able to provide treatment and orders. During a review of the facility's policy and procedures (P&P) titled, Transportation, Diagnostic Services, last reviewed on 2/20/2026, the P&P indicated that the facility would assist residents in arranging transportation to/from diagnostic appointments when necessary. The P&P indicated that should it become necessary for the facility to provide transportation, the social service designee, will be responsible for arranging the transportation through the business office.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adaptive feeding equipment (specialized tools and utensils designed to assist individuals with limited motor skills, strength, or coordination in eating independently and safely) or one (1) out of 1 sampled resident (Resident 160) observed during dining observation facility task on 3/9/2026, lunch time. This deficient practice had the potential for Resident160 to have a decline in function and loss of independence. Findings: During a review of Resident 160's Face Sheet (FS), the FS indicated Resident 160 was admitted on [DATE] to the facility with diagnoses including type 2 diabetes mellitus without complications (a disorder characterized by difficulty in blood sugar control and poor wound healing); hydrocephalus, unspecified (too much fluid builds up in the brain); presence of cerebrospinal fluid drainage device (a small tube is placed in the body to remove extra fluid from the brain). During a review of Resident 160's History and Physical (H&P), dated 11/24/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 160's Minimum Data Set (MDS - a resident assessment tool), dated 1/21/2026, the MDS indicated Resident 160 was usually able to make self- understood and usually able to understand others. The MDS further indicated that Resident 160 had impaired cognition (difficulty with thinking). The MDS indicated the resident required extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a review of Resident 160's Order Summary Report (OSR), dated 9/24/2025, the OSR indicated an order for Adaptive Feeding Equipment to provide divided plate and built-up weighted utensils for all meals while sitting supported in wheelchair. During a concurrent observation and interview on 3/9/2026 at 12:41 p.m. with Restorative Nurse Assistant (RNA) 2, observed RNA 2 sitting down feeding Resident 160 in the dining area. RNA 2 stated Resident 160 can move his arms, but his hands shake a lot and RNA 2 assists him with meals. RNA 2 stated build-up utensil weighted handles were special utensils used to make it easier for Resident 160 to eat.ˆRNA 2 stated that she did not see the build-up utensils in the tray and only saw the plate with divided compartments. RNA 2 stated that Resident 160 used to get build-up utensils before but is not sure why the resident does not receive them anymore. RNA 2 stated that Friday (3/6/2026) was the last time RNA 2 assisted Resident 160 and saw the build-up utensils. RNA 2 stated she did not report to anyone that the resident did not receive the build-up utensils on the tray. RNA 2 reviewed the resident's meal ticket and stated Resident 160 should have build-up utensils in his tray because they were written on the meal ticket. During a concurrent interview and record review on 3/11/2026 at 1:50 p.m. with Licensed Vocational Nurse (LVN) 12, Resident 160's Order Summary Report (OSR), dated 9/24/2025, was reviewed. LVN 12 stated that Resident 160 has an order for build-up utensils and was unable to find an order for feeding program. LVN 12 stated the resident should have been feeding himself and Certified Nursing Assistant (CNA) or RNA can assist the resident, if needed, to eat. LVN 12 stated build-up utensils make it easier for residents to eat on their own because the build-up utensils have a grip and is easier to get food. LVN 12 stated that build-up utensils are used so residents can aid themselves with eating and for motor function. LVN 12 stated if the resident does not use the buildup utensils, then the resident has the potential to lose the motor function ability they had. A photo taken on 3/9/2026 of Resident 160's tray with utensils and plate was reviewed. LVN 12 stated the resident does not have the build-up utensils on the tray. LVN 12 stated no one has notified her of the resident not receiving the build-up utensils. LVN 12 stated if she had been notified, she would have made the kitchen staff, Director of Staff Development (DSD), and supervisor aware of the situation. During an interview on 3/12/2026 at 4:23 p.m. with the Director of Nursing (DON), the DON stated that the protocol for build-up utensils should have a doctor's order, immediately provide build-up utensils, and develop a care plan on its use. The DON stated that it is important to allow the residents to eat by themselves to promote independence. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated that the failure of the staff to provide the build-up utensils during meals had the potential for decline in function for eating. The DON stated the policy titled Adaptive Equipment was not followed. During a review of the facility's policy and procedure (P&P) titled, Adaptive Equipment, last reviewed on 2/20/2026, the P&P indicated the Dietary Service Supervisor will provide staff with a list of residents on adaptive equipment. The dietary department will be responsible for sanitizing, storing and assuring that the adaptive equipment is provided at each meal.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its antibiotic stewardship program (a coherent set of actions which promote using antimicrobials responsibly) that includes antibiotic (ATB, a medicine that fights bacterial infections by killing bacteria or stopping them from multiplying) use protocols and a system to monitor antibiotic use for two of two sampled residents (Residents 179 and 1) reviewed for antibiotic use by failing to ensure: 1. Resident 19's use of antibiotic Ertapenem Sodium had monitoring for adverse effects (aˆharmful, undesired, or unexpected symptomˆthat happens after taking a medication, having a medical procedure, or being exposed to a substance). 2. Resident 2's Linezolid (a type of medication that is used to treat different types of infection) was started timely. 3. Resident 2 was monitored for adverse side effects for Resident 2 while receiving the Linezolid. These deficient practices had the potential to increase antibiotic resistance (when bacteria develop the ability to withstand the effects of antibiotics, making it difficult or impossible to treat infections) from unnecessary or inappropriate antibiotic use and had the potential for the residents to experience an unmonitored adverse reaction. Findings: 1. During a review of Resident 179's Face Sheet (FS), the FS indicated the facility admitted the resident on 3/1/2026, with diagnoses including ulcerative colitis (a chronic, long-term inflammatory bowel disease (IBD) that causes lasting inflammation and small sores, or ulcers, in the innermost lining of the large intestine (colon) and rectum), elevated white blood cell (WBC) count (indicates underlying infection, inflammation, tissue damage, or certain blood disorders. Common symptoms include fever, fatigue, and pain, and cholangitis (swelling [inflammation] of the bile duct system [a network of tubes carrying digestive fluid essential for breaking down fats and removing waste] that results from infection). During a review of Resident 179's History and Physical (H&P), dated 3/2/2026, the H&P indicated the resident is awake, alert, oriented, communicative, non-ambulatory, able to move all extremities, and able to test strength and power. The MDS indicated the resident had the capacity to understand and make decisions. During a review of Resident 179' Minimum Data Set (MDS - a resident assessment tool), dated 3/8/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities—such as thinking, memory, learning, and reasoning—are working properly without significant decline or impairment). The MDS indicated the resident was on a high-risk drug class antibiotic. During a review of Resident 179's Order Summary Report (OSR), dated 3/7/2026, the OSR indicated an order for Ertapenem Sodium Solution Reconstituted 1 gram (gm - a unit of measurement for weight). Use 1 gm intravenously (via a vein) every 24 hours for elevated WBCs for seven (7) days (first dose to be taken from e-kit [emergency kit or comfort kit in a Skilled Nursing Facility (SNF) - a secured, pre-stocked box of essential, fast-acting medications kept on-site to immediately treat sudden symptoms or medical crises]), start once blood cultures (a laboratory test that checks blood samples for bacteria or fungus to diagnose serious, bloodstream-wide infections) are drawn. During a review of Resident 179's Care Plan (CP) Report titled, Risk for infection secondary to any open wound, last revised on 3/2/2026, the CP indicated a goal to reduce the risk for MDRO transmission daily until the next assessment. The CP did not indicate any intervention to monitor for the adverse effect on the use of Ertapenem. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/11/2026 at 7:16 a.m., with Registered Nurse (RN) 1, Resident 179's Medical Diagnoses, OSR, and CP were reviewed. RN 1 stated there was no order for monitoring for adverse effects on the use of antibiotic Ertapenem and the CP did not indicate an intervention to monitor for adverse effects on the use of the antibiotic. RN 1 stated the use of antibiotic Ertapenem on Resident 179 should have been monitored for adverse effects to capture the delayed reaction for the antibiotics and to intervene appropriately. During an interview on 3/12/2026 at 12:56 p.m. with the Director of Nursing (DON), the DON stated Resident 179's use of antibiotic Ertapenem should have been monitored for adverse side effects and should have been documented in the progress notes. The DON stated it was important to monitor for adverse effects so they can intervene as soon as possible, relieving the resident any discomfort it can bring. The DON stated the policies and procedures (P&P) for Antibiotic Stewardship were not followed. During a review of the facility's recent P&P titled, Antibiotic Stewardship- Orders for Antibiotics, last reviewed on 2/20/2026, the P&P indicated all antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program and in conjunction with the facility's general policy for medication utilization and prescribing. Policy Interpretation and Implementation 9. When a resident is discharged home, the nurse will review complete antibiotic orders with the resident, including: c. possible side effects. During a review of the facility's recent P&P titled, Antibiotic Stewardship- review and Surveillance of Antibiotic Use and Outcomes, last reviewed on 2/20/2026, the P&P indicated antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The Data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. Policy Interpretation and Implementation 4. All resident antibiotic regimens will be documented on the facility-approved antibiotics surveillance tracking form. The information gathered will include: d. name of antibiotic (see approved surveillance list). i. adverse events. During a review of the facility's recent P&P titled, Antibiotic Stewardship- Staff And Clinician Training and Roles, last reviewed on 2/20/2026, the P&P indicated the facility will educate and train staff and practitioners about the facility antibiotic stewardship program, including appropriate prescribing, monitoring, and surveillance of antibiotic use and outcomes. Policy Interpretation and Implementation 4. The IP will monitor over time and report to the IPCC: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. negative outcomes or events related to antibiotic use, for example: (1) C. difficile (also known as Clostridioides difficile, a bacterium causing severe diarrhea, abdominal pain, and colitis, often linked to antibiotic use that destroys good gut bacteria infections; (2) adverse drug events; and (3) antibiotic resistance rates. During a review of the facility-provided Highlights of Prescribing Information (HPI) regarding the use of Invanz (ertapenem for injection), for intravenous or intramuscular use, with initial U.S. approval in 2001, the HPI indicated: Adverse Reactions The following are described in greater detail in the Warnings and Precautions section. - Hypersensitivity Reactions - Seizure Potential - Interaction with Valproic Acid - Clostridioides difficile-Associated Diarrhea (CDAD) - Caution with intramuscular Administration - Development of Drug-Resistant Bacteria - Laboratory Tests 2. During a review of Resident 2's FS, the FS indicated the facility admitted the resident on 2/15/2026 with diagnoses including urinary tract infection (UTI - an infection in the bladder/urinary tract), sepsis (a life-threatening blood infection), and generalized muscle weakness. During a review of Resident 2's H&P, dated 2/18/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had an intact cognition and was able to understand and make her needs known. The MDS further indicated Resident 2 was independent with eating; supervision or touching assistance with oral hygiene; partial/moderate assistance with upper body dressing; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 97 had an indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine). During a review of Resident 2's physician's order, dated 3/12/2026, the physician's order indicated a physician's order, dated 3/10/2026, for Linezolid oral tablet 600 milligrams (mg – a unit of measurement) give 1 tablet by mouth every 12 hours for UTI for 7 days. The physician's order (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	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burbank Healthcare & Rehab	1041 S. Main St. Burbank, CA 91506

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated a start date of 3/11/2026 and end date of 3/18/2026. During a review of Resident 2's care plan (CP) on UTI initiated on 3/10/2026, the CP indicated to administer antibiotic therapy as ordered, monitor for adverse reactions, and monitor for progress of status and notify the physician if therapeutic intervention is not effective as a few of the interventions to resolve Resident 2's infection. During a review of Resident 2's medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 3/2026, the MAR indicated the first dose of Linezolid was administered on 3/11/2026 at 9 a.m. During a review of Resident 2's progress notes from 3/10/2026 to 3/11/2026, the progress notes did not specify any monitoring for the adverse side effects of Linezolid use. During a concurrent interview and record review on 3/11/2026 at 11:17 a.m., reviewed Resident 2's physician's orders, care plans, MAR, and progress notes with the Infection Preventionist (IP). The IP stated that Resident 2 had a physician's order for Linezolid oral tablet 600 mg give one (1) tablet by mouth every 12 hours for UTI for 7 days and the MAR indicated Resident 2 received the first dose on 3/11/2026 at 9 a.m. as indicated by a check mark. The IP stated the CP indicated to administer the medication as ordered and to monitor the resident for adverse effects. The IP stated Resident 2's progress notes indicated that the resident was being monitored for abnormal urine test result and was on Linezolid for UTI for 7 days but did not specify if Resident 97 had any adverse side effects or what adverse side effects to monitor for. The IP stated new antibiotic orders are supposed to be started within four (4) of receiving the order as a standard of practice. The IP stated that residents are supposed to be monitored for adverse side effects every shift and documented in the progress notes, and documentation should include the specific adverse effects to be monitored. The IP stated that Resident 2's first dose of Linezolid should have been started within 4 hours of receiving the order as it was the standard of practice which can lead to delay in treatment of the UTI and may worsen the resident's symptoms. The IP stated that the licensed nurses should have monitored Resident 2 for specific adverse side effects on the use of Linezolid such as diarrhea, nausea and vomiting, and headache which can lead to not notifying the physician timely and delay in the necessary services or treatment Resident 2 needed. During an interview on 3/12/2026 at 1:45 p.m. with the DON, the DON stated that antibiotic orders are supposed to be started within 4 hours of receiving the physician's order as it was a standard of practice to immediately treat the infection such as UTI and delay in worsening of symptoms. The DON stated that when a resident is on antibiotic therapy, the licensed nurses are supposed to monitor the resident for specific adverse side effects and should be documented in the progress notes for the nurses to know if the resident was having adverse effect form the medication so proper interventions can be provided such as calling the physician immediately. The DON stated that Resident 2's Linezolid should have been started within 4 hours as it placed Resident 2 at risk for a delay in treating the UTI and may worsen the symptoms. The DON stated that Resident 2's monitoring for adverse side effects should have been specific and documented in the progress notes so the physician can be notified immediately, and proper interventions can be provided timely to prevent delay in care. During a review of the facility provided manufacturer's specifications for Linezolid, last revised 2018, the manufacturer's specifications indicated that the most common adverse reactions include diarrhea, vomiting, headache, and nausea. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Antibiotic Stewardship- Staff and Clinician Training and Roles, last reviewed on 2/20/2026, the P&P indicated the facility will educate and train staff and practitioners about the facility antibiotic stewardship program, including appropriate prescribing, monitoring, and surveillance of antibiotic use and outcomes. The P&P further indicated that the IP will1 monitor over time and report to the Infection Prevention Control Committee the negative outcomes or events related to antibiotic use, for example adverse drug events and antibiotic resistance rates. During a review of the facility's P&P titled, Adverse Consequences and Medication Errors, last reviewed on 2/20/2026, the P&P indicated the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reaction and side effects. Adverse consequences shall be reported to the attending physician and pharmacist, and to federal agencies as appropriate. The P&P further indicated: Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported. An adverse consequence is defined as an unpleasant symptom or event that is due to or associated with a medication, such as impairment or decline in an individual's mental or physical condition or functionals or psychosocial status. And adverse consequence may include: Adverse drug/medication reaction; Side effect; Medication-medication interaction; or Medication-food interaction.

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide at least 80 square feet (sq ft - unit of measurement) per resident in 41 of 72 rooms (Rooms 101, 103, 105, 106, 116, 119, 120, 121, 122, 123, 125, 126, 128, 130, 131, 133, 135, 201, 202, 203, 204, 205, 208, 209, 210, 211, 214, 216, 217, 218, 219, 220, 221, 222, 224, 225, 228, 229, 230, 231, and 232). The room size for these rooms had the potential to have inadequate space for resident care and mobility. Findings: During observations from 3/9/2026 to 3/12/2026, observed a sufficient amount of space for residents to move freely inside the rooms with an application for room variance. There was adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided by nursing staff for the residents. During a review of the facility Room Waiver Request Letter for 41 resident rooms submitted by the Administrator, dated 3/9/2026, the letter indicated that the following rooms did not meet the 80 sq ft per resident requirement per federal regulation: room [ROOM NUMBER], 209 sq ft, three (3) bed capacity, 69.67 sq ft per resident. room [ROOM NUMBER], 209 sq ft, 3 bed capacity, 69.67 sq ft per resident. room [ROOM NUMBER], 209 sq ft, 3 bed capacity, 69.67 sq ft per resident. room [ROOM NUMBER], 209 sq ft, 3 bed capacity, 69.67 sq ft per resident. room [ROOM NUMBER], 294 sq ft, four (4) bed capacity, 73.5 sq ft per resident. room [ROOM NUMBER], 154 sq ft, two (2) bed capacity, 77 sq ft per resident. room [ROOM NUMBER], 154 sq ft, 2 bed capacity, 77 sq ft per resident. room [ROOM NUMBER], 209 sq ft, three (3) bed capacity, 69.67 sq ft per resident. room [ROOM NUMBER], 209 sq ft, 3 bed capacity, 69.67 sq ft per resident. room [ROOM NUMBER], 209 sq ft, 3 bed capacity, 69.67 sq ft per resident. room [ROOM NUMBER], 209 sq ft, 3 bed capacity, 69.67 sq ft per resident. room [ROOM NUMBER], 209 sq ft, 3 bed capacity, 69.67 sq ft per resident. room [ROOM NUMBER], 209 sq ft, 3 bed capacity, 69.67 sq ft per resident. room [ROOM NUMBER], 154 sq ft, 3 bed capacity, 51.33 sq ft per resident. room [ROOM NUMBER], 209 sq ft, 3 bed capacity, 69.67 sq ft per resident. room [ROOM NUMBER], 209 sq ft, 3 bed capacity, 69.67 sq ft per resident. room [ROOM NUMBER], 209 sq ft, 3 bed capacity, 69.67 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 154 sq ft, 2 bed capacity, 77 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 154 sq ft, 2 bed capacity, 77 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 220 sq ft, 3 bed capacity, 73.33 sq ft per resident. room [ROOM NUMBER], 209 sq ft, 3 bed capacity, 69.67 sq ft per resident. room [ROOM NUMBER], 154 sq ft, 2 bed capacity,77 sq ft per resident. The minimum requirement for a 2-bed room should be at least 160 sq ft. The minimum requirement for a 3-bed room should be at least 240 sq ft. The minimum requirement for a 4-bed room should be at least 320 sq ft. The letter further indicated, The space provided in these multiple resident rooms is sufficient to (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	provide access and freedom of movement, does not have adverse effects on the residents' health and safety, and does not impede the ability of the residents in those rooms from reaching his/her highest practicable well-being. During an interview on 3/12/2026 at 3:14 p.m. with the Director of Nursing (DON), the DON stated that the residents' rooms should have enough space between residents' beds to ensure they have enough space to move. The DON stated the room waiver request letter is for regulation to meet the required square footage for each resident. The DON stated all facility staff checks to ensure there are no environmental hazards and no clutters in-between residents for all rooms especially for rooms with room waiver. The DON stated the room size not meeting the required space requirement potential for residents to not have enough space to move around, risk for falls and potential for injury.^ During a review of the facility policy and procedures (P&P) titled, Bedrooms, last reviewed 2/20/2026, the P&P indicated that All residents are provided with clean, comfortable, and safe bedrooms that meet federal and state requirements. Bedrooms measure at least 80 square feet of space per resident in double rooms, and at least 100 square feet of space in single rooms. (Note: Individual variations on this may be permitted by federal authorities if it is demonstrated that the variation is in accordance with special needs of the resident and will not adversely affect the resident's health and safety.