STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056326	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Convalescent Hospital	845 S.Burlington Avenue Los Angeles, CA 90057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify the physician regarding a significant change in condition for one of three sampled residents (Resident 1), who refused to continue dialysis (treatment to clean one's blood by removing waste and extra fluid when the kidneys are unable to) treatment and verbalized a desire to die.This failure resulted in delayed physician evaluation, psychiatric intervention, and implementation of medically necessary treatment and safety measures.During a review of Resident 1's admission Record, dated 5/21/2026 indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including end-stage renal disease (ESRD-Condition in which the kidneys cease functioning on a permanent basis leading to the need for regular course of long-term dialysis or kidney transplant to maintain life) requiring dialysis and depression (a mood disorder that may cause persistent sadness or loss of interest in activities).During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool) dated 3/9/2026, indicated Resident 1 had severely impaired cognition (ability to think, remember and reason, the mental action or process of acquiring knowledge and understanding through thought, experience, and senses). The MDS indicated Resident 1 was dependent on staff for activities of daily living (ADLs) such as toileting, dressing, putting on and taking off footwear, rolling left and right, sit to lying, lying to sitting in bed, sit to stand, and chair to bed transfers. Resident 1 required maximal assistance for upper body dressing, oral hygiene, and personal hygiene. Resident 1 required supervision for eating.During a review of Resident 1's nursing progress notes dated 5/20/2026, indicated the dialysis center reported to the facility that on 5/20/2026 Resident 1 refused to finish his dialysis treatment and verbalized statements indicating a desire to die. The progress note indicated that the facility nurse made physician aware of the resident's refusal of dialysis treatment.During a concurrent observation and interview on 5/21/2026 at 11:19 AM, Resident 1 lay down in his room wearing a gown, covered with blankets, had a flat affect, made poor eye contact, and had limited verbal engagement. Resident 1 appeared lethargic, stated he was sleepy and did not care about anything anymore. When I tried to engage with him and ask him questions his response was I don't care.During an interview on 5/21/2026 at 11:48 AM with Licensed Vocational Nurse 1 (LVN1), the LVN1 stated Resident 1 had a history of depression, refused to eat breakfast and lunch, and refused to take his medications in the morning.During an interview on 5/21/2026 at 12:55 PM with the Minimum Data Set (MDS) nurse, the MDS nurse verified Resident 1 had a diagnosis of depression upon admission to the facility. The MDS nurse stated antidepressant medication had been ordered; however, the medication was being held because Resident 1 was unable to provide consent and refused medications. The MDS nurse stated Resident 1 did not have a responsible party who could make health care decision for him; however in such cases the facility's Medical Director and Interdisciplinary Team members could sign off on providing necessary treatment. The MDS nurse verified there was no active Care Plan or new Physician orders in place since Resident 1's return from the hospital on 5/18/2026, to address Resident 1's depression or non-pharmacological interventions to address the resident's psychosocial needs and depressive symptoms.During a phone interview on 5/21/2026 at 1:54 PM with the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attending Physician (AP), the AP stated he was not notified that Resident 1 had refused dialysis or verbalized a desire to die. The AP stated that if he had been notified, he would have ordered a psychiatric consultation, ordered a repeat dialysis treatment, and considered transfer to the hospital for further evaluation and treatment.During an interview on 5/21/2026 at 2:33 PM with the Director of Nursing (DON), the DON stated failure to notify the AP placed Resident 1 at risk for complications related to his dialysis in depression, such as fluid overload and weight loss. The DON stated it is the responsibility of the licensed nurses to update the Care Plan as needed and when residents have a change in condition.During a review of the facility's policy and procedure titled Change in a Resident's Condition or Status dated 2/2021, indicated the nurse will notify the resident's attending physician when there has been a significant change in the resident's physical, emotional, and mental condition. A significant change of condition is a major decline in the residents' health that will not normally resolve itself without intervention by staff or by implementing clinical interventions. A significant change of condition requires interdisciplinary review and revision of the Care Plan.

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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 - Few	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 observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for one of three sampled residents (Resident 1) to address diagnosis of depression (a mood disorder that may cause persistent sadness or loss of interest in activities), refusal of treatment, and non-pharmacological interventions for mood and behavioral symptoms.This failure had the potential to place the resident at risk for worsening depression, psychosocial decline, nutritional compromise, and lack of appropriate mental health interventions.During a review of Resident 1's admission Record, dated 5/21/2026 indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including end-stage renal disease (ESRD-Condition in which the kidneys cease functioning on a permanent basis leading to the need for regular course of long-term dialysis or kidney transplant to maintain life) requiring dialysis and depression.During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool) dated 3/9/2026, indicated Resident 1 had severely impaired cognition (ability to think, remember and reason, the mental action or process of acquiring knowledge and understanding through thought, experience, and senses). The MDS indicated Resident 1 was dependent on staff for activities of daily living (ADLs) such as toileting, dressing, putting on and taking off footwear, rolling left and right, sit to lying, lying to sitting in bed, sit to stand, and chair to bed transfers. Resident 1 required maximal assistance for upper body dressing, oral hygiene, and personal hygiene. Resident 1 required supervision for eating. The MDS indicated Resident 1 had little interest or pleasure in doing things and was feeling down, depressed, or hopeless.During a concurrent observation and interview on 5/21/2026 at 11:19 AM, Resident 1 lay down in his room wearing a gown, covered with blankets, had a flat affect, made poor eye contact, and had limited verbal engagement. Resident 1 appeared lethargic, stated he was sleepy and did not care about anything anymore. When I tried to engage with him and ask him questions his response was I don't care.During an interview on 5/21/2026 at 11:48 AM with Licensed Vocational Nurse 1 (LVN1), the LVN1 stated Resident 1 had a history of depression, refused to eat breakfast and lunch, and refused to take his medications in the morning.During an interview on 5/21/2026 at 12:55 PM with the Minimum Data Set (MDS) nurse, the MDS nurse verified Resident 1 had a diagnosis of depression upon admission to the facility. The MDS nurse stated antidepressant medication had been ordered; however, the medication was being held because Resident 1 was unable to provide consent and refused medications. The MDS nurse stated Resident 1 did not have a responsible party who could make health care decision for him; however in such cases the facility's Medical Director and Interdisciplinary Team members could sign off on providing necessary treatment. The MDS nurse verified there was no active Care Plan or new Physician orders in place since Resident 1's return from the hospital on 5/18/2026, to address Resident 1's depression or non-pharmacological interventions to address the resident's psychosocial needs and depressive symptoms.During an interview on 5/21/2026 at 2:33 PM with the Director of Nursing (DON), the DON stated it is the responsibility of the licensed nurses to update the Care Plan as needed to provide residents with interventions to manage their health problems.During a review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered dated 3/2023, indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The IDT team reviews and updates the care plan when there is a significant change in the resident's condition, when the desired outcome is not met, when resident has been readmitted to the facility from a hospital stay and at least quarterly in conjunction with the required MDS assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services for one of three residents (Resident 1) by failing to obtain timely psychiatric evaluation and intervention for Resident 1 exhibiting depression (a mood disorder that may cause persistent sadness or loss of interest in activities), refusal of dialysis (treatment to clean one's blood by removing waste and extra fluid when the kidneys are unable to), and verbalizations indicating a desire to die.This failure placed Resident 1 at risk for worsening mental health status, self-neglect, decline in medical condition, and avoidable harm.During a review of Resident 1's admission Record, dated 5/21/2026 indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including end-stage renal disease (ESRD- Condition in which the kidneys cease functioning on a permanent basis leading to the need for regular course of long-term dialysis or kidney transplant to maintain life) requiring dialysis and depression (a mood disorder that may cause persistent sadness or loss of interest in activities).During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool) dated 3/9/2026, indicated Resident 1 had severely impaired cognition (ability to think, remember and reason, the mental action or process of acquiring knowledge and understanding through thought, experience, and senses). The MDS indicated Resident 1 was dependent on staff for activities of daily living (ADLs) such as toileting, dressing, putting on and taking off footwear, rolling left and right, sit to lying, lying to sitting in bed, sit to stand, and chair to bed transfers. Resident 1 required maximal assistance for upper body dressing, oral hygiene, and personal hygiene. Resident 1 required supervision for eating.During a review of Resident 1's nursing progress notes dated 5/20/2026, indicated the dialysis center reported to the facility that on 5/20/2026 Resident 1 refused to finish his dialysis treatment and verbalized statements indicating a desire to die. The progress note indicated that the facility nurse made physician aware of the resident's refusal of dialysis treatment.During a review of Resident 1's Order Summary, no active orders were found to address Resident 1's depression.During a concurrent observation and interview on 5/21/2026 at 11:19 AM, Resident 1 lay down in his room wearing a gown, covered with blankets, had a flat affect, made poor eye contact, and had limited verbal engagement. Resident 1 appeared lethargic, stated he was sleepy and did not care about anything anymore. When I tried to engage with him and ask him questions his response was I don't care.During an interview on 5/21/2026 at 11:48 AM with Licensed Vocational Nurse 1 (LVN1), the LVN1 stated Resident 1 had a history of depression, refused to eat breakfast and lunch, and refused to take his medications in the morning due to being depressed.During an interview on 5/21/2026 at 12:55 PM with the Minimum Data Set (MDS) nurse, the MDS nurse verified Resident 1 had a diagnosis of depression upon admission to the facility. The MDS nurse stated antidepressant medication had been ordered; however, the medication was being held because Resident 1 was unable to provide consent and refused medications. The MDS nurse stated Resident 1 did not have a responsible party who could make health care decision for him; however, in such cases the facility's Medical Director and Interdisciplinary Team members could sign off on providing necessary treatment. The MDS nurse verified there was no active Care Plan or new Physician orders in place since Resident 1's return from the hospital on 5/18/2026, to address Resident 1's depression or non-pharmacological interventions to address the resident's psychosocial needs and depressive symptoms. The MDS nurse verified Resident 1 had not been monitored sinceDuring a phone interview on 5/21/2026 at 1:54 PM with the Attending Physician (AP), the AP stated he was not notified that Resident 1 had refused dialysis or verbalized a desire to die. The AP stated that if he had been notified, he would have ordered a psychiatric consultation, ordered a repeat dialysis treatment, and considered transfer to the hospital for further evaluation and treatment.During an interview on 5/21/2026 at 2:33 PM with the Director of Nursing (DON), the DON stated failure to notify the AP placed Resident 1 at risk for complications related to his dialysis in depression, such as fluid overload (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and weight loss. The DON stated it is the responsibility of the licensed nurses to update the Care Plan as needed and when residents have a change in condition.During a review of the facility's policy and procedure titled Depression dated 3/2023, indicated the nurse shall assess and document reports of suicidal ideation, whether mood decline is associated with anorexia, crying, sleeplessness. The physician will evaluate underlying causes of mood disorder, depression, and contributing factors. The physician will identify the need for additional testing or psychiatric consultation. The staff will provide pertinent individualized non-pharmacological interventions for the individual with depression addressing psychological, spiritual, and family issues. The physician will identify and order appropriate non-pharmacological and pharmacological interventions based on preceding assessments. The staff and physician will monitor the resident/patient