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	05/14/2026

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 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 and interview, the facility failed to ensure kitchen staff labeled all foods stored in the refrigerator and freezer with the correct food name, date of food delivery, date the food container was opened, and best by date. This deficient practice of not correctly labeling all foods stored in the refrigerator and freezer had the potential for residents who consume food from the kitchen to suffer from foodborne illnesses (refer to illnesses such as nausea, vomiting, and diarrhea, caused by the ingestion of contaminated food or beverages) and hospitalization Findings: During an observation in the kitchen on 5/11/2026 at 7:55 AM, several food items and drinks in the refrigerator and freezer were not labeled as follows:Iceberg lettuceClear drinks (appeared to be water)CilantroFrozen food in red color in dessert cups (unable to identify what it is)White colored drinks (appeared to be milk). During a concurrent observation and interview on 5/11/2026 at 8:12 AM with the Dietary Services Supervisor (DSS - manages daily food service operations, ensuring safe, nutritious, and appealing meals while supervising staff, controlling budgets, and upholding health regulations), when asked why several food items and drinks in the kitchen refrigerator and freezer were not labeled, DSS stated, I don't know. I gave them (staff) in-service on labeling. I told them (staff) over and over about labeling. But they still did not label all the foods. DSS stated the food labeling is important so staff will know if the food is still good to consume and to prevent infection, and risk of food poisoning. According to DSS, the potential harm that may come to all residents is risk of choking likely lead to death and risk of poison and infection. During an interview on 5/12/2026 at 8:47 AM with the dishwasher (DI), DI stated, it is important to have labels on all foods so we know if food is okay to eat or to throw away because it's bad to eat it. DI also stated that when residents consume unlabeled food, the residents are at risk to have tummy ache.might get diarrhea, vomiting, they might to go the hospital if the illness is very bad. During an interview on 5/12/2026 at 9:52 AM with the dietary cook (DC), DC stated food labels are important because, we don't want to give the residents expired foods because it's bad for their stomach, they will get sick. DC also stated that the potential harm that may come to the residents, they will go to the bathroom a lot, you know to poop. They will have stomach pains. They will vomit. A review of the facility's in-service education (a professional development for workers aimed to enhance their skills, knowledge, and competence to improve job performance) on Dating and Labeling dated 1/22/2026, 2/25/2026 and 4/16/2026 indicated all kitchen staff were in-serviced when to date and label each food item. A review of the facility's policy and procedure (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Dating and Labeling with a revision date of 4/2025, indicated, all items should be properly covered, dated, and labeled and that food items should have the delivery date, open date, and thaw date labeled on each food item. The P&P also indicated that the staff should be trained on the importance of food labeling.to maintain food safety.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 ensure that two out of two residents (Resident 5 and Resident 45) did not sign Advanced Directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor). Resident 5 and Resident 45 had severe cognitive (the mental ability to make decisions of daily living) impairment. This deficient practice violated Resident 5 and Resident 45's rights with the potential to cause conflict with the residents healthcare wishes.Findings: During a review of Resident 5's admission Record, the admission record indicated the facility admitted the resident on 1/10/2018 with diagnoses that included but not limited to cerebral infarction (loss of blood flow to a part of the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool) dated 4/2/2026, the MDS indicated Resident 5 had severe cognitive) impairment. The MDS indicated Resident 5 needed supervision/touching assistance for eating, maximum staff assistance with activities of daily living (ADL) including, personal hygiene, upper body dressing and oral hygiene, dependent on staff for toileting hygiene, showering, upper body, sitting to lying and lying to sitting). During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had severe cognitive impairment. The MDS indicated Resident 5 needed limited staff assistance with personal hygiene, toilet use dressing, bed mobility and transfer bed/chair/wheelchair and supervision for eating and oral hygiene. During a review of Resident 5's Advanced Directive dated 7/25/20245, the Advanced Directive indicated, Resident not capable to make decisions at this time. Advanced Directive indicated to refer to Physician Orders for Life-Sustaining Treatment (POLST - a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST form is not an Advance Directive). During a review of Resident 5's POLST dated 1/16/2018, the POLST indicated Resident 5 signed the POLST on 1/17/2018. The POLST indicated Do attempt Resuscitation (Not to attempt an emergency life-saving procedure used when someone is not breathing or heartbeat stopped, allowing natural death), Comfort Focused Treatment (in case of emergency focus on pain relief and reduce suffering instead of using any drastic life saving measures)primary goal is to prolong life), no long term artificial nutrition including feeding tubes (medical device used to deliver nutrition and medications in liquid form). During a review of Resident 45's admission Record, the admission record indicated the facility admitted the resident on 1/26/2016 and readmitted on [DATE] with diagnoses that included but not limited to hemiplegia and aphasia (a disorder that makes it difficult to speak).During a review of Resident 45's MDS dated [DATE], the MDS indicated Resident 45 had severe cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 45 needed limited staff assistance with eating and moving around in room and in facility corridor, extended assistance for bed mobility, transfer bed/chair/wheelchair, personal hygiene and toileting. During a review of Resident 45's MDS dated [DATE], the MDS indicated Resident 45 had severe cognitive impairment. The MDS indicated Resident 45 needed maximum staff assistance with personal hygiene, toileting and shower, partial/moderate assistance with ADL of, lower body dressing, oral hygiene, sit to stand and chair/bed transfer, walking 50-150 feet and supervision/touching assistance for eating, upper body assist, sitting to stand, lower body dressing and putting/taking off footwear. During a review of Resident 45's Advanced Directive dated 1/14/2025, the Advanced Directive indicated, Resident not capable to make decisions at this time. Advanced Directive stated to refer to Physician Orders for Life-Sustaining Treatment (POLST - a portable medical order form that records patients' treatment (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST form is not an Advance Directive). During a review of Resident 45's POLST dated 8/17/2017, the POLST indicated Resident 45 signed the POLST on.9/21/2016. POLST indicated, attempt Resuscitation (an emergency life-saving procedure used when someone is not breathing or heartbeat stopped), Full Treatment (in case of emergency provide all medically effective means to prolong life, primary goal is to prolong life), long term artificial nutrition including feeding tubes (medical device used to deliver nutrition and medications in liquid form). During a concurrent interview and record review with Medical Data Sheet Nurse (MDS - nurse responsible to complete a resident assessment tool for all residents in the facility on 05/14/2026 at 10:19 am, Resident 5 and Resident 45's the Advanced Directive and POLST were reviewed). MDS stated and confirmed that both Resident 5 and Resident 45 didn't have capacity to understand the Advanced Directive and POLST upon admission. MDS stated that Resident 45 didn't have any family member that could have been contacted and that Resident 5 has a family member listed as an emergency contact. MDS stated that the POLST for Resident 5 and Resident 45 signed a few years ago and could not remember if the facility contacted the residents' family members. During a concurrent interview and record review with MDS on 05/14/2026 at 11:14 am Resident 5 and Resident 45's Advance Directive and POLST was reviewed, MDS stated, We would follow this POLST in emergencies. We really don't know what is their (resident's) choice or not. Family member can back up what resident's wishes are. It's not appropriate for residents to sign a consent when they don't have capacity [NAME] make decisions., We (facility) should make sure if resident has power of attorney (POA - a legal document that authorizes a trusted person to make decision or act on behalf of someone)) or any other legal document when they are admitted before having them sign anything, or any relative or emergency contact is available to help with signing POLST or other forms if resident is not able to due to cognitive impairment. During an interview on 05/14/2026 at 12:37 pm, Director of Nursing (DON) stated that Resident 5 and Resident 45 didn't have the capacity to make decisions or sign a POLST. DON stated that, Its not a good standard of practice, it effect resident's rights and preferences, we didn't give them right. According to our process, we get POLST signed as soon as resident is admitted , we involve family if resident not cognitive capable of signing. We need to have a family meeting and resident to see their POLST. If resident's family not there then social services should find a legal guardian or conservative. During a review of the facility's policy and procedures (P&P) titled, Advance Directive, reviewed 3/17/2026, P&P indicated, If the resident is incapacitated and unable to receive information about his or her rights to formulate an advance directive, the information may be provided to the resident's legal representative.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to securely store and dispose off personal health identifiable (PHI - any health-related data that can directly or indirectly trace back to a specific individual) information was stored securely and disposed after admission from a general acute care hospital (GACH) visit for one of one (Resident 129). The deficient practice had the potential to result in a breach protected PHI and medical identity theft, targeted financial fraud, and alterations to personal medical records for Resident 129's. Findings: A review of Resident 129's admission record indicated Resident 129 was admitted to the facility on [DATE], with diagnoses that include end stage renal disease (severe phase of kidney (organ that filters bodily waste) disease where your kidneys permanently lose about 85 percent (%- unit of measurement) to 90% of their function, leaving them unable to filter waste and excess fluid from the blood), fracture (crack or break in one of the bones) of left pubis (bone of the hip), hypertension (high blood pressure), cognitive communication deficit (communication impairment affecting memory, attention, or executive function), toxic encephalopathy (brain dysfunction, damage, or malfunction caused by exposure to poisonous or neurotoxic substances), history of falling and dependence on dialysis (medical treatment that filters waste products, toxins, and excess fluid from the blood when the kidneys are no longer functioning properly). A review of Resident 129's history and physical (H&P) dated 5/11/2026 indicated Resident 129 has the capacity to understand and make decisions. During a tour on 5/11/2026 at 11:06 a.m., a bracelet with Resident 129's identifiable health information (name, age, sex, date of birth , date of admission, medical record number, visitation number) from the GACH visit was observed on top of Resident 129's bedside drawer. During an interview on 5/11/2026 at 11:09 a.m., infection prevention nurse (IPN) stated the patient identification bracelet was from Resident 129's recent acute care visit prior to admission to the facility. IPN stated leaving a Residents personal information at bedside could result in a medical data breach (unauthorized actors access, steal, or disclose sensitive PHI and violation of Health Insurance Portability and Accountability Act (HIPAA- a federal law passed in 1996 that sets the national standard to protect sensitive patient medical information and dictates how healthcare organizations must handle, store, and share that data). During an interview on 5/14/2026 at 3:29 p.m., the Director of Nursing (DON) stated patient personal identifiable information must be kept confidential, secured and is used only through authorized access as part of medical records. DON stated unsecured access to personal health information (PHI) can result in nefarious breach (unethical violation of patient privacy or data security). The facility's policy and procedures (P&P) titled Protected Health Information (PHI), Management and Protection of dated 3/17/2026, indicated, it is the responsibility of all personnel who have access to Resident and facility information t ensure that such information is managed and protected to prevent unauthorized release or disclosure. The facility's P&P titled Resident Rights dated 3/17/2026, indicated, the unauthorized release, access, or disclosure of resident information was prohibited and must be in accordance with current laws governing privacy information issues.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to maintain a clean, sanitary, and homelike environment for one out of one resident (Resident 110). This deficient practice had the potential for Resident 110 to experience low self esteem and not appreciated. Findings: During a review of Resident 110's admission Record, the admission record indicated the facility admitted the resident on 3/25/2026 with diagnoses that included but not limited to schizophrenia (a mental illness that is characterized by disturbances in thought) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 110's Minimum Data Set (MDS - a resident assessment tool) dated 3/5/2026, the MDS indicated Resident 110 had moderate cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 110 needed partial/moderate staff assistance with activities of daily living (ADL- including upper body assist and personal hygiene, set up/cleaning assistance for eating and dependent on staff for toileting lower body dressing, hygiene, showering). During an observation on 5/11/2026 at 12:13 pm, Resident 110 was observed lying in bed. An uneven brown splash stain observed on the wall right in front of the resident's bed and within Resident 110's line of sight. Resident 110 not aware the origin of stain and how long stain has been on the wall. During a concurrent observation and interview on 5/12/2026 at 2:05 pm with Infection Prevention Nurse (IPN) in Resident 110's room, the uneven brown splash stain was observed on the wall right in front of the resident's bed. IPN stated, I don't know what this stain is from, it could be anything. Yes, the stain is right in front of the resident. This is resident's home, with her room not being clean resident wouldn't feel like it her home.During a concurrent interview on 5/14/2026 at 12:55 pm with Director of Nursing (DON), DON stated, This stain could be anything, blood, bowel (stool/feces), feeding, coke or anything. It can make resident not feel like at home. This is resident's home so they should feel like a clean home. During a review of the facility's policy and procedures (P&P) titled Homelike Environment revised on 3/17/2026, the P&P indicated, The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. Those characteristics may include clean, sanitary and orderly environment.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure facility staff provided an accurate medical concern description to an optometrist (OPT - a primary healthcare professional who specializes in eye and vision care) when Resident 101's eyeglasses were missing for of one of four residents' (Resident 101) . This deficient practice resulted in Resident 101 complaining that without his eyeglasses, his eyes would get wet, it was very hard to see or do anything, he could not read and loves to read. Findings: During a review of Resident 101's admission record (face sheet - a document containing demographic and diagnostic information) indicated Resident 101 was admitted to the facility on [DATE] with the following diagnoses: hypercapnia (a condition where there is an abnormally high level of carbon dioxide in the bloodstream), hypercalcemia (a condition where the calcium level in your blood is abnormally high that can lead to weakened bones, kidney stones, and severe heart or neurological complications if left untreated), pressure ulcer of left buttock, stage 2, hypertensive heart disease with heart failure (heart problems that occur because of high blood pressure that is present over a long time with heart muscle not able to pump enough blood for the body's needs), reduced mobility (any temporary or permanent physical, sensory, or cognitive condition that limits a person's ability to move, travel, or navigate environments freely), generalized muscle weakness (lack of physical or muscle strength), hyperparathyroidism (a condition where one or more of the parathyroid glands [regulate the body's calcium levels, which are critical for nerve and muscle function, bone health, and blood clotting] become overactive and produce too much parathyroid hormone [PTH - primary function is to strictly regulate and maintain the balance of calcium and phosphorus in your blood, which is essential for healthy bones, nerves, muscles, and heart function], asthma (a lung disease that causes the airways to swell, narrow, and fill with mucus, leading to difficulty breathing, wheezing, coughing, and chest tightness), and metabolic encephalopathy (a general term that describes a brain disease, damage or malfunction; brain function is disturbed). During a review of Resident 101's history and physical (H&P - a physician's complete patient examination) dated 11/22/2205 indicated, Resident 101 did not have the capacity to make medical decisions and could not make needs known. The H&P also indicated Resident 101's overall vision and eye health was normal. During a review of the facility's In-Service Education (a professional development for workers aimed to enhance skills, knowledge, and competence to improve job performance) sign-in sheet dated 2/10/2026 indicated, an in-service education course on Special Needs of Resident: Blindness and Deafness was provided. The in-service course content included common challenges for blindness and visually impaired residents were mobility, personal care, navigating the environment and communication. During a review of Resident 101's optometry exam (comprehensive test that includes visual exams, diagnoses, and treatment plans) dated 2/13/2026 indicated, an OPT conducted a visual exam one Resident 101 and that the OPT recommended reading glasses for Resident 101. During a review of Resident 101's Minimum Data Set (MDS - a resident assessment tool) dated 2/26/2026, indicated, Resident 101 was cognitively intact (a person's thinking and reasoning abilities are functioning properly and are not significantly impaired). The MDS indicated, Resident 101 had impaired vision, sees large print but not regular print in newspapers or books, and wore corrective lenses (eyeglasses). The MDS also indicated, Resident 101 needed substantial or maximal assistance with toileting hygiene (maintaining cleanliness before and after using the toilet) due to urinary and bowel incontinence (lack of voluntary control over urination or bowel movement). During a review of Resident 101's Acknowledgement of Receipt of Eyeglasses dated 4/07/2026, glasses were received and signed for by Social Services Assistant (SSA). During a review of Resident 101's physician progress notes (a doctor's written record that documents a patient's health status, treatment, and care plan) dated 5/04/2026, indicated, Resident 101's overall vision and eye health was normal. During a review of SSA's email dated 5/11/2026 at 10:05 AM (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	addressed to OPT, indicated, [Resident 101] lost the glasses and that the resident's prescribed eye glasses were received on 4/07/2026. SSA email further indicated that Resident 101 stated that the eye glasses are too blurry and unable to see with the eye glasses. During a review of SSA's notes dated 5/11/2026 at 3:49 PM, the SSA notes indicated that Resident 101 visited SSA's office and notified SSA that her (Resident 101's) eyeglasses were missing. The SSA note also indicated that on 5/08/2026, the OPT's office was notified of the missing eye glasses via email. During a review of Resident 101's SSA notes dated 5/14/2026 at 9:41 AM, the SSA notes indicated that SSA called the OPT's office to inquire about a scheduling exam appointment for a vision Resident 101 because Resident 101's previous eyeglasses got lost. The SSA notes indicated that Resident 101 visual exam appointment was scheduled between 5/25/2026 and 5/29/2026, and Resident 101 was notified of the appointment date. During a review of Resident 101's care plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) on impaired ambulation (act of walking) initiated on 11/24/2025 and with a target date of 5/27/2026, indicated, Resident 101 has impaired visual functioning related to aging and resident wears glasses. The CP goal indicated Resident 101 will minimize the risk of injury related to visual impairment daily. The CP interventions included optometrist/ophthalmologist consult as needed. During an interview on 5/12/2026 at 1:24 PM with Resident 101, Resident 101 stated, my eyeglasses are bifocal (distance and reading) and transition (lens tinting- changing from clear to dark in the sun) which he has had for 2.5 years. This is my only glasses. I wear it on a regular basis, every day, all day until I go to bed. I cannot see well without them. Resident 101 stated he noticed that the eyeglasses were missing on 5/07/2026. Resident 101 stated he tried to notify SSA on the same da 5/07/2026y, but SSA was not working on that day. Resident 101 stated that on 5/08/2026, he visited SSA in SSA's office and told SSA that his eyeglasses were missing. Resident 101 stated that his eyeglasses were never found after an exhaustive search. Resident 101 stated I can see a little bit without my glasses but it's very hard to see anything and then after a while, my eyes get wet that's why I need my glasses. It's difficult to do anything without it (eyeglasses). I love reading and now I cannot read. Resident 101 stated a pair of reading glasses was made available to her around April 2026 was no good. They are too blurry for me. They are only for reading. I can't read my books with those [glasses]. During a concurrent interview and record review with SSA on 5/13/2026 at 2:47 PM, SSA email dated 5/11/2026 timed at 10:05 a.m. was reviewed. SSA stated Resident 101 told SSA that Resident 101's eyeglasses were lost (missing). SSA stated Resident 101's eyeglasses were in Resident 101's nightstand and which disappeared on Thursday, 5/07/2026. SSA stated that SSA told Resident 101 that SSA will call the OPT office to schedule an visual exam appointment. SSA stated that per SSA's email to OPT dated 5/11/2026 at 10:05 a.m. indicated Resident 101 needed a replacement eyeglasses because [Resident 101] stated they (eyeglasses are too blurry she is unable to see with. SSA re-read SSA's email again and then stated, I think I got it mixed up with the other one. SSA explained that Resident 1 had two glasses: one eyeglasses that was missing and uses that every day and the other eyeglasses [Resident 101] cannot use because it's too blurry for Resident 101. SSA stated that SSA did not accurately communicate with OPT about the reason for replacing eyeglasses, SSA stated that Resident 101, cannot see, could fall and get fractured hands, legs, head, could hurt self while transferring to the bed or going to the restroom, and trouble seeing staff. During a phone interview on 5/14/2026 at 9:26 AM with the OPT office Receptionist (REC), REC stated and confirmed that Resident 101's visual exam appointment will be between 5/2/2026 and 5/29/2026. REC also stated and confirmed that the facility received Resident 101's reading glasses on 4/07/2026 and that Resident 101 was seen by the optometrist on 2/13/2026. During a follow up interview on 5/14/2026 at 10 AM with SSA, SSA Resident 101's quality of life while waiting for the replacement eyeglasses to arrive would be difficult.because [Resident 101] likes to read.eyes become watery.difficult to be around activities, move around the bed, use the phone to play games, [Resident 101] likes playing games on the phone. During an interview on 5/14/2026 at 4:21 PM with the Director of Nursing (DON), the DON stated SSA (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have included in SSA's email about Resident 101's eyeglasses were missing, and not blurry. DON stated Resident 101 was unable to see the surroundings well without eyeglasses, which might limit Resident 101's movement around the facility for fear of falling or getting hurt and that the facility are not meeting Resident 101's psychosocial needs. During a review of the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Visually Impaired Resident, Care of with a revision date of 3/17/2026, indicated, It is the facility's responsibility to assist the resident.in scheduling appointments and ensuring arrangements to obtain needed services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to supervise and monitor and immediately attend to residents' meal carts to ensure that one of one sample resident (Resident 54) did not access meal carts that had left over foods and drinks. Resident 54 has a history of dysphagia (difficulty swallowing). This deficient practice placed Resident 54 at increased risk for aspiration (accidentally inhaling food or liquids which can lead to infection), hospitalization, and death.Findings: During a review of Resident 54's admission Record, the admission record indicated the facility admitted the resident on 3/2/2026 with diagnoses that included but not limited to severe protein-calorie malnutrition (potentially life-threatening condition caused by an inadequate intake of protein, calories and other macronutrients) and dysphagia.During a review of Resident 54's Minimum Data Set (MDS-a resident assessment tool) dated 4/2/2026, the MDS indicated Resident 54 had moderate cognitive impairment. The MDS indicated Resident 54 needed partial/moderate assistance for activities of daily living (ADL) including, personal hygiene, upper body dressing, oral hygiene, toileting hygiene, showering, upper body, sitting to lying and lying to sitting. During an observation and concurrent interview on 05/11/2026 at 1:32 pm, two meal tray carts (with multiple meal trays in it) were observed in the hallway outside the facility kitchen, the kitchen doors were closed, and no staff was present/seen in the around/near the kitchen hallway and where the meal carts were located. The meal carts had residents' eaten leftover food on the meal trays. Resident 54 who was ambulating (walking) in the hallway outside the kitchen area, picked up cup of 4 ounces of milk (cover with a lid) from one of the meal carts. Resident 54 then walked towards his room. When the writer asked Resident 54 regarding the milk, the resident didn't respond and kept walking towards resident's room. The writer informed Certified Nurse Assistant (CNA) 3 who then stopped Resident 54 and asked Resident 54 about the cup of milk that resident had, Resident 54 gave the cup of milk back to CNA 3.During an interview on 05/11/2026 at 2 pm, with CNA 3, CNA 3 stated that Resident 54's intention was possibly to drink the 4 ounces of milk. CNA 3 stated, it is not safe for residents to have access to the leftover food from the meal cart outside of kitchen. During an interview on 5/13/2026 at 1:07 pm, Interviewed Speech Therapist (ST - a licensed health care professional who diagnose and treat patients with problems like speech difficulties, cognitive and swallowing disorders), ST stated, Resident (Resident 54) is nil per oral (NPO -no eating or drinking by mouth), has diagnosis of dysphagia. If residents had drunk the milk, he would have aspirated. I educated the resident about aspiration precautions. ST stated that Resident 54 has a gastric tube (G tube -flexible tube that is used to provide food/nutrition/hydration and medication in liquid form) which was placed around 1/26. ST stated that Resident 54 was agreeable to NPO status. ST stated that Resident 54, told me he was hungry; I told Registered dietician (RD) to adjust his G-tube feeding. ST stated that RD increased the G-tube feeding to 65 milliliters (ml-unit of measurement) per hour (ml/hour). ST stated that Resident 54 is at risk of silent aspiration (aspiration without typical aspiration symptoms like coughing or any kids of discomfort) and pneumonia (lung infection) because the milk/food would enter into Resident 54's lungs, and the resident would be hospitalized .During an interview on 5/13/2026 at 12:50 pm with RD, RD stated, (Resident 54) is NPO, on G-tube diet. He has a history of dysphagia. If resident with dysphagia drinks milk, he can aspirate. RD stated that the nursing staff bring the dirty food trays/carts and leave them outside the kitchen after residents are done with their meals. RD stated that dietary staff then bring the meal trays/carts inside the kitchen area right after the meal carts are brought to the kitchen by the facility staff and then start cleaning them. Food is not safe in dirty trays for any resident to eat. Residents shouldn't have access to the leftover food in meal trays.During an interview on 5/14/2026 at 12:59 pm with Director of Nursing (DON), DON stated that since Resident 54 can't swallow (dysphagia), the resident is at risk of aspiration and hospitalization due to aspiration pneumonia. DON stated that if residents have access to leftover food in the (continued on next page)

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	056326	A. Building B. Wing	05/14/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unsupervised trays, residents can ingest food they are allergic to which can cause allergic reactions in residents. During a review of the facility's policy and procedures (P&P) titled Dysphagia - Clinical Protocol revised on 3/17/2026, the P&P indicated, In conjunction with the resident/ patient and family, the physician must carefully consider the clinical and ethical appropriateness of any recommendation that the resident/patient should not be allowed to eat it all or should be tube fed because of aspiration risk.During a review of the facility's P&P titled Safety and Supervision of Residents revised on 3/17/2026, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Residents safety and supervision and assistance to prevent accidents or facility wide priorities.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 remove expired medication prescribed for two out of eight sampled residents (Resident 6 and Resident 64) from the medication cart (is a mobile workstation used in healthcare facilities to store, transport, and dispense medicines, medical equipment, and supplies). This deficient practice had the potential to result in the administration of expired medications to residentsFindings: A review of Resident 6's admission record indicated Resident 6 was admitted to the facility on [DATE], with medical diagnoses that included: Hypertension (high or raised blood pressure), Acute Kidney Failure (a condition in which the kidneys suddenly can't filter waste from the blood), and Depression (a constant feeling of sadness and loss of interest). A review of Resident 6's Minimum Data Set (MDS - a resident screening tool) dated 4/23/2026, indicated Resident 6's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS indicated Resident 6 required total care with eating and oral hygiene, and required substantial to maximum assistance for toileting hygiene, shower bathing and upper and personal hygiene, and was non-ambulatory. A review of Resident 6's Physician Order dated 11/28/2026 timed at 3:17 pm, Loratadine (medication used to relieve allergy symptoms such as sneezing, runny nose, itchy or watery eyes, and an itchy throat)10 milligrams (mg-unit dose measurement) give 1 tablet by mouth every 24 hours as needed for allergies. A review of Resident 6's Medication Administration Record (MAR) for 5/2026 indicated Resident 6 did not receive Loratadine A review of Resident 64's admission Record indicated Resident 64 was admitted to the facility on [DATE], with medical diagnoses that included: Hypertension (high or raised blood pressure), Depression (a constant feeling of sadness and loss of interest) and Anxiety (a condition characterized by constant, excessive, and uncontrollable worry about everyday things like work, health, or finances). A review of Resident 64's Physician Order dated 8/17/2024 timed at 12:06 pm, indicated Resident 64 to receive Loratadine 10 mg give 1 tablet by mouth every 24 hours as needed for allergies. A review of Resident 64's MDS dated [DATE], indicated Resident 64's cognition was intact. The MDS indicated Resident 64 required minimal assistance with eating and oral hygiene, and required minimal assistance for toileting hygiene, shower bathing and upper and personal hygiene, and was able to walk at least 10 feet in a room. A review of Resident 64's MAR for 5/2026 indicated Resident 6 did not receive Loratadine. During a concurrent observation/inspection and interview with licensed vocational nurse (LVN) 4 on 5/14/2026 at 12:21 pm, the facility medication cart was inspection/observed. A bottle of Loratadine 10 mg tablets with an expiration date of 4/2026 was observed in the top drawer of the medication cart. LVN 4 stated the nurse in charge of the medication cart is responsible to make sure that there are no expired medications in the medication cart. LVN 4 stated that another LVN checks all the medication carts for any outdated or cancelled medications left in all medication carts. LVN 4 stated she will dispose the expired Loratadine left in the cart. LVN 4 stated that if expired medication is left in the cart there is the possibility that the medication can be administered to residents which is considered medication in error. LVN 4 stated that all expired medications should be removed from the medication carts to prevent medication error involving expired medications. During an interview on 5/14/2026 at 12:42 pm, Registered Nurse Supervisor (RNS) 2 stated every Sunday, a licensed nurse checks all the facility's medication carts for any expired medications, especially the Over the Counter (OTC) medications (medications sold without a prescription in stores or pharmacies). RNS 2 stated that the licensed nurse assigned to check for expired medication removes all expired and discontinued/cancelled prescription medications from the medication carts, destroys and logs the expired and discontinued/cancelled medications. RNS 2 stated that licensed nurse assigned to (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administer medication is responsible in making sure that expired and or cancelled prescriptions medications are removed from the medication carts During an interview on 05/14/2026 at 12:49 pm, LVN 5 stated once a month a pharmacy consultant checks the medication carts for expired medications and makes no expired medications are left in any of the facility's medication carts. During an interview on 05/14/2026 at 12:25 pm Director of Nursing (DON) stated that every nurse that administers medication to residents must make sure that there are no expired medications. DON stated that a licensed nurse comes to the facility once a week to check the carts for any expired medications. DON stated that for additional, for safety, a consultant comes once a month to the facility to check the carts for expired medications. DON stated that, it is the charge nurse assigned to administer medications is responsible in making sure that there are no expired medications in the medication cart. DON stated expired medications left in the medication cart increases the risk of the medications to be administered to a resident and the medication would not be beneficial (the medication may not work as intended when it is expired). A review of the facility's policy and procedures titled, Storage of Medications dated reviewed 3/17/2026, indicated the following:PolicyThe facility stores all drugs and biologicals in a safe, secure, and orderly manner.Policy Interpretation and ImplementationDrugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications.Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers.The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destructed as indicated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for two of two sampled residents (Resident 4 and Resident 54) the facility failed to:1. Ensure staff provide Resident 4 with a clean urinal (a portable, reusable or disposable container into which a resident can urinate without getting out of bed) This deficient practice placed Resident 4 at increased risk for infections due to contamination (unintentional transfer of bacteria/germs or other contaminants from urinal to the resident).2. Ensure Resident 54 did not have access to meal carts with left over foods and drinks already consumed by residents. This deficient practice placed Resident 54 at increased risk to suffer from food borne illness/ infections due to contaminated (unintentional transfer of bacteria/germs or other contaminants from urinal to the resident) food and drinks Findings: 1. During a review of Resident 4's admission Record, the admission record indicated the facility admitted the resident on 3/25/2026 with diagnoses that included but not limited to dementia (a progressive state of decline in mental abilities) and cerebral infarction (loss of blood flow to a part of the brain) and hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s - are organs that filter blood, remove waste and excess water to produce urine, and regulate the body's chemical, fluid, and hormone balance) have failed).During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 4/1/2026, the MDS indicated Resident 4 had severe cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 4 needed partial/moderate staff assistance with activities of daily living (ADL-, toileting, upper body assist, sitting to lying, lying to sitting, personal hygiene, lower body dressing, putting/taking off footwear, sitting to standing and tub/shower transfer, set up/cleaning assistance for eating and maximum assistance for showering.) During an observation on 5/11/2026 at 12:22 pm, Resident 4 was observed in a wheelchair in Resident 4's room. Resident 4's urinal which was placed at the side rail of the bedside had the date 4/10/26. During another observation on 5/12/2026 at 1:56 pm, Resident 4 was observed in a wheelchair in resident's room. Resident 4's urinal which was placed at the bedside had the date 4/10/26. During an interview on 5/12/2026 at 1:56 pm with Certified Nursing Assistant (CNA) 2, CNA 2 stated, I change the urinal when it looks dirty, it has yellow some color in it or a ring in it , well it kind of looks dirty.During an interview on 5/12/2026 at 2:05 pm with Infection Prevention Nurse (IPN), IPN stated, Urinal for all residents should be changed once a week or as needed. Urinal not changed for every week can cause bacteria to grow, residents can get UTI (urinary tract infection - UTI- an infection in the bladder/urinary tract) and it can get progress if not cured, can get sepsis.During an interview on 5/14/2026 at 12:52 pm with Director of Nursing (DON), DON stated that if a urinal is not changed for a month or longer, the resident can get Infection in bladder (the organ that stores urine) or any kind of infection. It can potentially progress to sepsis or hospitalization. Urinals should be changed weekly or earlier if needed to.During a review of the facility's policy and procedures (P&P) titled Infection Prevention and Control Program revised on 3/17/2026, 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. 2. During a review of Resident 54's admission Record, the admission record indicated the facility admitted the resident on 3/2/2026 with diagnoses that included but not limited to severe protein-calorie malnutrition (potentially life-threatening condition caused by an inadequate intake of protein, calories and other macronutrients) and dysphagia (difficulty swallowing).During a review of Resident 54's MDS dated [DATE], the MDS indicated Resident 54 had moderate cognitive impairment. The MDS indicated Resident 54 needed partial/moderate assistance for ADL including, personal hygiene, upper body dressing, oral hygiene, toileting hygiene, showering, upper body, sitting to lying and lying to sitting. During an observation and concurrent interview on 5/11/2026 at 1:32 pm, two meal tray carts (with multiple meal trays in it) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were observed in the hallway outside the facility kitchen, the kitchen doors were closed and no staff was present/seen in the hallway. The meal carts had residents' eaten leftover food on the meal trays. Resident 54 who was ambulating (walking) in the hallway outside the kitchen area, picked up cup of 4 ounces of milk (cover with a lid) from the meal carts. Resident 54 then walked towards his room. When the writer asked Resident 54 regarding the milk, the resident didn't respond and kept walking towards resident's room. The writer informed Certified Nurse Assistant (CNA) 3 who then stopped Resident 54 and asked Resident 54 about the cup of milk that resident had. Resident 54 gave the cup of milk back to CNA 3.During an interview on 5/11/2026 at 2 pm, with CNA 3, CNA 3 stated that Resident 54's intention was possibly to drink the 4 ounces of milk. CNA 3 stated, it is not safe for residents to have access to the leftover food from the meal cart outside of kitchen. During an interview on 5/13/2026 at 2:35 pm, Interviewed Infection Prevention nurse (IP). IP stated, it's not safe for residents to have access to the leftover food from the resident's meal trays. IP stated, It is an infection issue. We don't know who that tray belongs to, so no resident should be touching another resident's food or belongings. There could be transmission of potential infection.During an interview on 5/14/2026 at 12:59 pm, Director of Nursing (DON). DON stated, Dirty trays don't have clean food. Its leftover food from other residents. There is potential for resident to get infection by eating food from unsupervised dirty trays. It's not safe.During a review of the facility's policy and procedures (P&P) titled Infection Prevention and Control Program revised on 3/17/2026, 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.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations and interview, the facility failed to maintain an insect free building according to its facility's policy and procedures (P&P) titled Pest Control with review date 3/17/2026, for one of one sampled resident room (Resident 14). This deficient practice had the potential to significantly compromise the resident's safety, health leading to infection and possibly hospitalization.Findings: A review of Resident 14's admission Record indicated the facility admitted Resident 14 on 4/7/2026 with diagnoses including hypertension (HTN-high blood pressure) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and anemia (a condition where the body does not have enough healthy red blood cells). A review of Resident 14's Minimum Data Set (MDS - a resident assessment tool) dated 4/14/2026, indicated Resident 14 is cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 14 was dependent on staff with Activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) care. During a concurrent observation and interview on 5/14/2026, at 10:24 A.M., with Certified Nursing Assistant (CNA) 1, in Resident 14's room, nightstand, three alive cockroaches were seen in the top drawer of the nightstand, one alive cockroaches on the right hind corner of the nightstand and two alive on the left front corner of the nightstand. CNA 1 stated that she saw the two alive cockroaches on the left front corner of the nightstand drawer. CNA 1 stated that alive cockroaches in the residents' rooms may cause infection, get into the open orifices of the residents such as the nose, ears, any opening on the resident and cause infection. During an interview, on 5/14/2026, at 10:45 A.M., with the Maintenance Supervisor (MS), the MS stated that last week, he saw two alive cockroaches in two different residents' room. MS stated he called the pest control company that the facility is contracted with, the technician came and placed small traps in the two resident rooms including three additional residents' room but did not treat the entire facility for cockroaches. MS stated the facility should not have cockroaches in the residents' rooms as they may affect the resident's health causing infection and may end up on the resident's food and inside the ears. During a concurrent interview and record review, on 5/14/2026, at 11:16 A.M., with the Director of Nursing (DON), the facility's pest control report dated 4/27/2026 was reviewed. The report indicated that the pest control company provided treatment in only five rooms in the facility and not the entire facility. The DON stated if treatment is done in some rooms, cockroaches may move from one room to the next and the whole facility needs to receive treatment for it to be effective. The DON stated that cockroaches are pests which can transmit infection, bite the residents, enter residents open areas which may lead to affecting the resident's psychosocial health may adversely be affected. A review of the facility's P&P, titled, Pest Control with review date 3/17/2026, indicated,Policy StatementOur facility shall maintain an effective pest control program.Policy Interpretation and Implementation1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.2. Pest control services are provided by Orkin.3. Only approved FDA and EPA insecticides and rodenticides are permitted in the facility and all such supplies are stored in areas away from food storage areas.4. Garbage and trash are not permitted to accumulate and are removed from the facility daily.5. Maintenance services assist, when appropriate and necessary, in providing pest control services.