

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 056129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/10/2020
NAME OF PROVIDER OF SUPPLIER BURBANK HEALTHCARE & REHAB		STREET ADDRESS, CITY, STATE, ZIP 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 0609 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an injury of unknown source to the State Agency (SA) for one of two sampled residents (Resident 1). On 0[DATE], Resident 1 was diagnosed with [REDACTED]. This deficient practice resulted in the SA not receiving a timely notification for the needed investigation. Findings: A review of Resident 1's Admission Record (face sheet) indicated the facility admitted Resident 1 on 07/04/2019 with a re-admitted d 01/05/2020. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-screening tool) dated 1[DATE]19 indicated Resident 1 had memory problems and needed extensive assistance with bed mobility, transfer, toilet use, and personal hygiene. A review of Resident 1's Nursing Notes dated [DATE], timed at 7:50 a.m. Resident 1 complained of left hip. Resident 1's physician was notified and ordered STAT (urgent) hip x-rays (type of diagnostic procedure that used for checking for fractures). On the same day, the x-ray report indicated Resident 1 had an acute fracture femoral neck (fracture of top of thigh bone) and osteopenia (reduced bone mass). Resident 1's physician ordered transferring Resident 1 to a general acute care hospital. On 0[DATE] at 3 p.m. during an interview, the administrator stated the Director of Nursing (DON) and her (administrator) investigated the incident. Resident did not have an incident of fall or trauma, and they concluded the injury was related to the resident's [DIAGNOSES REDACTED]. A review of the undated facility's policy and procedure on Abuse Allegation Reporting indicated the facility is to report to the Department (SA) any injuries of unknown origin to the Department.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE (X6) DATE	

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.