Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	054536	01/11/2024
Name of Provider or Supplier	**Street Address, City, State**	
La Mesa Rehab	8380 Center Drive, # E, La Mesa, CA	

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

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
E0000	The following reflects the findings of the California Department of Public Health during a concurrent EMERGENCY PREPAREDNESS and RECERTIFICATION survey for a Change of Service (to add Occupational Therapy) and Change of Ownership. Representing the California Department of Public Health: Surveyor 35704, HFEN, Rehabilitation Consultant. The surveyor entered the facility located at 8380 Center Drive, #E, La Mesa, CA on 1 /11/24 at 0800 hours. There were 2 Standards not met for Emergency Preparedness Requirements 42 CFR §485.68, Condition of Participation for Comprehensive Outpatient Rehabilitation Facilities (CORFs).
E0006	Plan Based on All Hazards Risk Assessment CFR(s): 485.68(a)(1)-(2) 403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 460.84(a)(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 483.475(a)(1)-(2), 484.102(a)(1)-(2), 485.68(a)(1)-(2), 485.542(a)(1)-(2), 485.625(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at 418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-

	based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at 483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at 483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is not met as evidenced by: Based on interview and document review, the CORF failed to develop and maintain an emergency preparedness plan that was based on and included a documented facility-based and community-based risk assessment, utilizing an all hazards approach and addressed the emergency events identified by the risk assessment. This placed the safety of the patients, staff, and visitors at risk during an emergency. Findings: On 1/11/24 at 1400 hours, a request was made to the Administrator for the emergency preparedness plan. Review of the plan did not contain a risk assessment based on the community of La Mesa. During an interview with the Administrator at 1440 hours, the Administrator was unaware of the regulatory requirement of the Emergency Plan being based on facility-based and community-based risk assessments, utilizing an all-hazards approach and verified it was not completed.
E0030	Names and Contact Information CFR(s): 485.68(c)(1) 403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 460.84(c)(1), 482.15(c)(1), 483.73(c)(1), 483.475(c)(1), 484.102(c)(1), 485.68(c)(1), 485.542(c)(1), 485.625(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at 482.15(c) and CAHs at 485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at 403.748(c):] The communication plan must include all

	of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at 416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at 418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at 484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at 486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on interview and document review, the CORF failed to develop and maintain an emergency preparedness plan that included contact information for staff, patient's physicians and contract personnel. This placed the safety of the patients, staff, and visitors at risk during an emergency. Findings: During document review on 1/11/24 at 1400 hours, with the Administrator, the communication plan was requested and reviewed. The communication plan did not contain staff contact information as required. The Administrator acknowledged the finding and was not aware of the requirement in Appendix Z for Emergency Preparedness.
I0000	The following reflects the findings of the California Department of Public Health during a concurrent RECERTIFICATION and EMERGENCY PREPAREDNESS survey for a Change of Service (add Occupational Therapy) and Change of Ownership. Representing the California Department of Public Health: Surveyor 35704, HFEN, Rehabilitation Consultant. The surveyor entered the facility located at 8380 Center Drive, #E, La Mesa, CA on 1/11/24 at 0800 hours. There were 4 Standards found not in compliance for a Comprehensive Outpatient Rehabilitation Facility (CORF). 42 CFR §485.51 - 485.66.
I0511	ADMINISTRATOR CFR(s): 485.56(b)(4) The governing body must appoint an administrator who retains professional and administrative responsibility for all personnel providing facility services.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to maintain complete and accurate employee health files for 2 of 3 employees. The deficient practice had the potential to affect the safety and provision of patient care.

Findings:

During a review of personnel files for Staff 1 (Assistant), Staff 2 (Respiratory Therapist) and PT 1 (Physical Therapist) TB screening forms were present at the time of hire. None of the files contained evidence of TB Testing.

During a concurrent interview and policy review with the Administrator on 1/11/24 at 1300 hours, the Administrator stated employees are not required to be TB tested and only TB screening is required.

Review of the facility's Infection Control Policy IC-2 showed the following:

Tuberculosis (TB) testing requirements :

1) All clinical staff at La Mesa Rehab including but not limited to (group A):

Physical Therapist (PT),

Physical Therapist Assistant(PTA),

Social Worked(SW) and

Respiratory Therapist (RT)

Members of group B will complete a TB screening form to determine the need for additional action.

Hired Employee TB screening form will be stored in their personnel file.

2) All Office staff at La Mesa Rehab including but not limited to (group B):

Administrator,

Aids

Billing and Front Desk Receptionist

Medical Director

CEO

Members of group B will be given an option to be tested for TB, but are not required to. If any of the

members of group B want to be tested for TB then La Mesa Rehab will cover all the necessary

	expenses at any time during their employment. TB documentation will be kept in the employee personnel file. Review of the Infection Control Committee minutes dated 1/2/24 showed all Infection Control Policies were reviewed without changes. On 1/11/24 at 1300 hours, the Administrator confirmed the policy showed Staff 2 and PT 1 should have been TB tested and the policy needed to be updated.
I0581	SANITARY ENVIRONMENT CFR(s): 485.62(b)(2) The facility must monitor the infection control program to ensure that the staff implement the policies and procedures and that the policies and procedures are consistent with current practices in the field. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the Infection Control Program included procedures and approved cleaners for disinfecting patient equipment. This failure had the potential to affect the health and safety of all patients, staff and visitors. 1. During a tour of the therapy area on 1/11/24 at 0900 hours, an observation was made of unlabeled spray bottles containing clear liquid. The bottles were observed in baskets on the floor at Bed 1, Bed 2, Bed 3 and Bed 4. The Administrator stated the bottles all contained a solution of 70% isopropyl alcohol and 30% water and they were used for cleaning equipment between patients. 2. During a tour of the facility and concurrent interview with Staff 1 on 1/11/24 at 0900 hours, a container of Lysol Wipes was observed on the counter. Staff 1 was asked how and when the product is used. Staff 1 stated the wipes are used at the end of the day to clean the equipment. When asked to describe the cleaning process Staff 1 stated they wipe with a cloth and let air dry. A review of the label on the Lysol Disinfectant Wipes showed a 2 minute wet/dwell time is needed to disinfectant surfaces. Staff 1 stated they were not aware of what a wet time or dwell time meant and they were not following that process. 3. A pulmonary function (PFT) machine (a device that measures airflow used in respiratory medicine) was observed in Private Room 1 during a tour of the facility. The Administrator was interviewed on 1/11/24 at 1030 hours and asked how the equipment was cleaned. The Administrator stated it was cleaned with alcohol. A follow up interview was conducted with the Clinic Manager at 1100 hours. The manager stated the PFT machine should be cleaned with Opticide Max wipes but that they had run out of them. A review of the manufacturer guidelines showed the equipment should not be cleaned with disinfectant solvents and recommended using Oxivir Wipes (EPA Reg No 70627-60). When asked if the facility referred to the manufacturer's guidelines for cleaning the Manager and Administrator stated they do not.

	Review of the Infection Control Policy and Procedure updated 1/3/24, showed the following: Policy Ic-2 (I-581): The clinic will monitor the infection control program to ensure that the staff implements the policies and procedures and that the policies and procedures are consistent with current practices in the field. Procedure: The Administrative Board appoints an Infection Control Committee that will provide the required treatment, monitor and as needed modify infection control policies and procedures. Minutes of the meeting will be maintained in Form Ic-2: Infection Control Committee Minutes, and will be utilized in the yearly Program Evaluation, as in Policy Ut-2: Utilization Review: Program Evaluation. During a review of the Infection Control Committee Minutes dated 1/2/24 showed all policies and procedures were reviewed without change. During an interview with the Administrator and Clinic Manager on 1/2/24 at 1030 hours, they both verified the IC committee did not review or approve cleaning products.