Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	054549	06/23/2022
Name of Provider or Supplier	**Street Address, City, State**	
Valley Corf Inc	18425 Burbank Blvd Suite 520, Tarzana, 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 reflect the findings from a re-certification and re-licensing survey conducted due to a change in location from 6/22/22 to 6/23/22 at a Comprehensive Outpatient Rehabilitation Facility (CORF), Valley CORF Inc. located at 18425 Burbank Blvd., Suite 520, Tarzana, CA 91356. Representing the California Department of Public Health: Surveyor 36943, Occupational Therapy Consultant Surveyor 41379, Occupational Therapy Consultant There were four Standards not in compliance for a Comprehensive Outpatient Rehabilitation Facility.
E0011	CORF/Clinic Development and Fire Safety CFR(s): 485.68(a)(5) 485.68(a)(5) Condition for Participation: [(a) Emergency Plan. The Comprehensive Outpatient Rehabilitation Facility (CORF) 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:] (a)(5) Be developed and maintained with assistance from fire, safety, and other appropriate experts. 485.727(a)(6) Condition for Participation: [(a) Emergency Plan. The Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services ("Organizations") 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:] (a)(6) Be developed and maintained with assistance from fire, safety, and other appropriate experts.

	This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop the facility's Disaster Plan with assistance from experts. This deficient practice had the potential to lack guidance for appropriate procedures to protect the health and safety of patients, staff, and the public in event of an emergency. Findings: A review of the facility's undated policy titled, "Disaster/Emergency Procedures," indicated procedures for severe weather, earthquake, biohazards chemical spills/fumes /vapors, and fire. During an interview and review of the facility's Disaster/Emergency Procedures on 6 /23/22, at 5:49 PM, the facility's Administrator stated the facility's emergency plan was not developed or reviewed with expert personnel.
E0020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 485.68(b)(1) 403.748(b)(3), 416.54(b)(2), 418.113(b)(6)(ii), 441.184(b)(3), 460.84(b)(3), 482.15(b)(3), 483.73(b)(3), 483.475(b)(3), 485.68(b)(1), 485.542(b)(3), 485.625(b)(3), 485.727(b)(1), 485.920(b)(2), 491.12(b)(1), 494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at 403.748(b)(3) and ASCs at 416.54(b)(2) and REHs at 485.542(b)(3):] Safe evacuation from the [RNHCI or ASC or REHs] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at 485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at 485.727(b)(1), and ESRD Facilities at 494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at 491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to include specific staff responsibilities in the facility's policy and procedure for the emergency preparedness plan. This deficient practice had the potential to prevent the staff, including newly hired staff, from being knowledgeable of their responsibilities during an emergency. Findings:

	A review of the facility's undated policy titled, "Disaster/Emergency Procedures," indicated procedures for severe weather, earthquake, biohazards chemical spills/fumes /vapors, and fire. The policy indicated "Personnel have been assigned to evacuate casualties outside the facility" and "Personnel have been assigned to assist the casualties until Paramedics and Fire rescue personnel arrive." The policy did not specifically indicate which facility personnel would perform these tasks in the event of an emergency. During an interview and review of the facility's Disaster/Emergency Procedures on 6 /23/22, at 2:16 PM, the Administrator (ADM) stated the policy did not specify the staff's responsibilities during an emergency. The ADM stated the staff was educated on their assignments during the emergency preparedness in-service, but the ADM stated the policy did not indicate their responsibilities. Thad ADM stated it was important for the policy to reflect the staff's responsibilities to ensure new facility staff were aware of their role and to limit confusion during an emergency.
E0023	Policies/Procedures for Medical Documentation CFR(s): 485.68(b)(3) 403.748(b)(5), 416.54(b)(4), 418.113(b)(3), 441.184(b)(5), 460.84(b)(6), 482.15(b)(5), 483.73(b)(5), 483.475(b)(5), 484.102(b)(4), 485.68(b)(3), 485.542(b)(5), 485.625(b)(5), 485.727(b)(3), 485.920(b)(4), 486.360(b)(2), 491.12(b)(3), 494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at 403.748(b) and REHs at 485.542(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to include, in the emergency preparedness plan policy and procedure, the process of securing the facility's medical records in the event of an emergency. This deficient practice had the potential for unauthorized access to patients' protected health information during an emergency evacuation from the facility. Findings: During an observation on 6/22/22, at 11:10 AM, the facility kept the file folders of patients currently undergoing treatment (active patients) in overhead cabinets at the reception desk. The facility kept discharged patients' file folders in overhead cabinets in the staff lounge.

	During a review of active and discharged patients' clinical records, each file folder included but was not limited to the patient's name, birthdate, address, telephone number, insurance information, physician's information, past medical history, evaluation, and treatment notes. A review of the facility's undated policy titled, "Disaster/Emergency Procedures," indicated "In the event of a fire alarm or in the event that a fire occurs, the Administrator or designee shall immediately initiate an evacuation of the facility." The policy did not include procedures for securing patients' files prior to evacuation. During an interview and review of the facility's Disaster/Emergency Procedures on 6/23/22, at 2:16 PM, the Administrator (ADM) stated the policy did not indicate procedures for securing patient files prior to an evacuation. The ADM stated it was important to secure patient files, which included social security numbers and personal information, to prevent someone from accessing the patients' information while the facility staff was not present.
E0029	Development of Communication Plan CFR(s): 485.68(c) 403.748(c), 416.54(c), 418.113(c), 441.184(c), 460.84(c), 482.15(c), 483.73(c), 483.475(c), 484.102(c), 485.68(c), 485.542(c), 485.625(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c). (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]. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to include a communication plan in their emergency preparedness policy and procedure. This deficient practice had the potential to prevent communication with local sources of assistance, the patients' physicians, and the patients' families in the event of an emergency, including but not limited to evacuation from the facility. Findings: A review of the facility's undated policy titled, "Disaster/Emergency Procedures," indicated procedures for severe weather, earthquake, biohazards chemical spills/fumes/vapors, and fire. The policy did not include a communication plan with local sources of assistance, patients' physicians, and patient's families in the event of an emergency. During an interview and review of the facility's Disaster/Emergency Procedures on 6/23/22, at 2:16 PM, the Administrator (ADM) stated the local emergency numbers were not included in the facility's policy but were posted at the reception desk. The ADM stated the policy did not include a communication plan during an emergency. The ADM stated communication was important to prevent panic and contact appropriate individuals, including patients' families, during an emergency.
I0000	The following reflect the findings from a re-certification and re-licensing survey conducted due to a change in location from 6/22/22 to 6/23/22 at a Comprehensive Outpatient Rehabilitation Facility (CORF), Valley CORF Inc. located at 18425 Burbank Blvd., Suite 520, Tarzana, CA 91356.

	Representing the California Department of Public Health: Surveyor 36943, Occupational Therapy Consultant Surveyor 41379, Occupational Therapy Consultant There were 1 Condition of Participation and 14 Standards found not in compliance for a Comprehensive Outpatient Rehabilitation Facility. The following 1 Condition of Participation was not met for CORF certification: §485.58 - Comprehensive rehabilitation program
I0509	ADMINISTRATOR CFR(s): 485.56(b)(2) The governing body must appoint an administrator who implements and enforces the facility's policies and procedures. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's Administrator (ADM) failed to implement the facility's policies and procedures by failing to ensure: a. The Therapy Aide job description was included in the facility's policy and procedures; b. The Therapy Aide 1 (TA 1) performed duties consistent with the signed job description. This deficient practice resulted in one of 10 sampled patients (Patient 2) receiving direct physical therapy services from an unlicensed staff. c. Two of 14 employee files had evidence of Health Insurance Portability and Accountability Act of 1996 (HIPAA, a federal law that required standards to protect sensitive patient health information from being disclosed) training. d. Seven of 14 employee files had evidence of Hepatitis B (Hep B, a virus that causes severe liver infection) declination form or Hep B immunization records. e. The governing body reviewed the policies and procedures annually in accordance with the facility's policy; and f. Two first aid kits were complete, contained updated products, and were inspected monthly in accordance with the facility's policy. These deficient practices had the potential to affect the facility's internal operations and provision of services. Findings: a. During an observation, on 6/22/22, at 9:55 AM, the Therapy Aide 1 was in the pulmonary rehab gym with patients. A review of the Therapy Aide 1's personnel file included a job description, signed 10

/31 (unknown year), as the Therapy Aide/Coordinator.

During a review of the facility's policy and procedure manual, it included a job description for Physical Therapy Aide. The facility's manual did not include a job description for the Therapy Aide/Coordinator.

During an interview, on 6/23/22, at 3:42 PM, the Administrator (ADM) stated the Physical Therapy Aide job description was inaccurate. The ADM stated the job description for Therapy Aide/Coordinator was not included but should have been updated in the policy and procedure manual.

b. A review of the job description of, "Therapy Aide/Coordinator," signed and dated on 10/31 (unknown year) by TA 1, indicated, "the Therapy Aide will not be able to treat patients in any way."

During a review of Patient 2's Physical Therapy (PT) Evaluation, dated 6/8/22, it indicated Patient 2 had gait abnormality (difficulty walking) and both lower leg weakness. The PT treatment plan included therapeutic exercise and balance training. The PT evaluation included a short-term goal for the patient to tolerate 30 to 40 minutes of exercises with minimal exertion.

During an observation, on 6/22/22, at 11:15 AM, in the gym area next to the parallel bars (apparatus with two bars that is used for therapy training), TA 1 performed leg exercises with Patient 2 who was seated in a wheelchair.

A review of Patient 2's Physical Therapy Daily Note, dated 6/22/22, indicated Patient 2 completed one set of 10 repetitions of leg strengthening exercises.

During an interview, on 6/23/22, at 2:15 PM, TA 1 stated he performed leg exercises with Patient 2 on 6/22/22 to help Patient 2 with increasing his leg strength. TA 1 stated that Physical Therapy Assistant 1 (PTA 1) was his supervisor and TA 1 performed exercises with patients that PTA 1 informed him to complete.

During an interview, on 6/23/22, at 4:45 PM, the ADM stated TA 1 could not perform any exercises with a patient. The ADM stated TA 1's job description indicated a therapy aide could not provide any direct patient care. The ADM also stated TA 1 could not perform any exercises with a patient without direct supervision from a supervising physical therapist based on professional standards and regulations. The ADM stated that a physical therapy assistant could not supervise a therapy aide or instruct a therapy aide to perform direct patient care. The ADM stated the facility did not conduct a Therapy Aide Skills checklist for patient care activities because the Therapy Aide job description indicated a Therapy Aide at the facility did not perform any patient treatment activities.

A review of the facility's undated policy and procedure titled, "Professional Standards of Practices," indicated, "it is the responsibility of the Administrator to ensure that each professional discipline offered by the facility functions in accordance with applicable professional standards and practices."

A review of the California Code of Regulations, Title 16, Division 13.2 for the Physical Therapy Board of California, Article 6 titled Physical Therapy Aides, Section 1399 - Requirement for Use of Aides, indicated "(c)(3)(D) The physical therapist shall provide continuous and immediate supervision of the aide. The physical

therapist shall be in the same facility as the aide and in immediate proximity to the location where the aide is performing patient related tasks ...When patient related tasks are provided to a patient by an aide the physical therapist shall at some point during the treatment day provide direct service to the patient as treatment ..."

A review of the California Code of Regulations, Title 16, Division 13.2 for the Physical Therapy Board of California, Article 4 titled Physical Therapist Assistant, Section 1398.44 - Adequate Supervision Defined, indicated "(d)(7) A physical therapist assistant shall not: supervise a physical therapy aide performing patient-related tasks."

c. During a review of 14 employee files, including the facility's Medical Director (MD) and the Administrator (ADM), there was no evidence of completed HIPAA training.

During an interview and record review of all 14 employee files, on 6/23/22 at 4:00 PM, the ADM confirmed the MD and the ADM employee files did not have documentation of completed HIPAA training. ADM stated HIPAA training was required for all staff due to federal requirements for privacy of patient health records.

A review of the facility's undated policy titled, "Personnel Training," indicated, "Within two weeks after hiring the staff member, the following training will be offered which the employee will need to acknowledge the training ...training: HIPPA training."

d. During a review of 14 employee files, the employee files indicated seven of 14 employee files had no evidence of a signed Hepatitis B (Hep B) vaccine declination form or copies of Hep B immunization records. The following employee files did not have a signed Hep B vaccine declination form and did not have evidence of receipt of the Hep B vaccine immunization records: 1) Operations Manager, 2) Assistant Manager, 3) Medical Director, 4) Physical Therapist 1, 5) Respiratory Therapist 1, 6) Certified Occupational Therapy Assistant 1, and 7) Administrator.

During a concurrent interview and record review of all 14 employee files, on 6/23/22 at 4 PM, the Administrator (ADM) confirmed the following employee files did not have a signed Hep B vaccine declination form and did not have evidence of receipt of the Hepatitis B vaccine immunization records: 1) Operations Manager, 2) Assistant Manager, 3) Medical Director, 4) Physical Therapist 1, 5) Respiratory Therapist 1, 6) Certified Occupational Therapy Assistant 1, and 7) Administrator. The ADM stated it was facility policy to notify staff of the risk of Hepatitis B and to offer the vaccine for all staff who would like to receive the vaccine.

A review of the facility's undated policy and procedure titled, "Pre-Employment Screening and Immunizations," indicated "Hepatitis B vaccine is offered to all employees at risk in compliance with [Occupational Safety and Health Administration] OSHA standards. Those susceptible employees who do not wish to take the Hepatitis B vaccine or who have received it previously must sign a form declining to take the offered vaccine."

e. During an entrance conference interview on 6/22/22, at 10:15 AM, the facility's Administrator (ADM) stated the Administrative Board included the ADM, the Alternate Administrator, and the facility's physician (MD 1). The ADM stated the Administrative/Governing Board met annually to review the policies and procedures.

	A review of the undated policy titled, "Governance," indicated the "Policy and Procedure manual will be updated with names and signatures of the Administrative Board and their signatures documenting a review/acceptance/revision of this manual" annually. A review of the Governing Board Meeting Minutes, dated 1/6/21, indicated the Administrative/Governing Baord reviewed and made modifications to the policy and procedure manuals. There were no Governing Board Meeting Minutes for 2022. During an interview on 6/23/22, at 1:47 PM, the ADM stated the Governing Board met on 1/2/22 to review the policy and procedures. The ADM stated there was no documentation or meeting minutes for the review on 1/2/22. f. During an observation on 6/22/22, at 12:16 PM, in the pulmonary rehab gym, a cabinet above the sink contained a first aid kit. The first aid kit contained nine insect sting relief padding with an expiration date of 2/2008 (14 years ago). The first aid kit also contained five alcohol preparation pads with an expiration date of 10/2008. There were multiple empty containers inside the first aid kit. A review of the facility's undated policy titled, "First Aid Kit," indicated the "first aid kit for this facility is located in the lounge/conference room, and is maintained by inventory of its contents on a monthly basis to ensure that contents are complete and do not become out of date." A review of the facility's "First Aid Kit Inventory" indicated the first aid kit was checked on 1/2022 and 4/2022. The First Aid Kit Inventory, dated 4/2022, indicated the following items were present in the kit: first aid cream packs, alcohol wipes, cold pack, hot pack, 3-inch ace bandage (compression bandage), bandage measuring ¾-inches by 3-inches, bandage measuring 1-inch by 3-inch, plastic patch, knuckle bandage, fingertip bandage, sterile eye pads, gauze dressing, non-stick pads, gauze roll, cloth tape roll, scissors, tweezers, and latex free gloves. During an interview and inspection of the first aid kit, on 6/22/22, at 12:16 PM, the Administrator (ADM) stated that the first aid kit was visually inspected monthly but was officially checked and documented quarterly. The ADM stated the following items were missing from the first aid kit: first aid cream packs, cold pack, hot pack, 3-inch ace bandage, bandage measuring ¾-inches by 3-inches, bandage measure 1-inch by 3-inch, plastic patch, knuckle bandage, fingertip bandage, non-stick pads, gauze roll, cloth tape roll, and tweezers. The ADM also acknowledged that the insect sting relief padding and alcohol swabs expired in 2008. The ADM stated there was a second first aid kit, but the contents were not noted in the First Aid Kit Inventory. The ADM stated that the First Aid Kit Inventory was inaccurate, and the second first aid kit did not have its own First Aid Kit Inventory log. The ADM also stated the facility did not have a good system of keeping track of the First Aid Kit supplies. The ADM stated it was important to have supplies in the first aid kit in the event of an emergency, including if a patient had a cut or open wounds.
I0532	COMPREHENSIVE REHABILITATION PROGRAM CFR(s): 485.58 The facility must provide a coordinated rehabilitation program that includes, at a minimum, physicians' services, physical therapy services and social or psychological

	services. The services must be furnished by personnel that meet the qualifications set forth in 485.70 and must be consistent with the plan of treatment and the results of comprehensive patient assessments. This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 10 of 10 sampled patients received a comprehensive rehabilitation program by failing to ensure the following: 1. The facility's Medical Director (MD) participated in a care conference for one of 10 patients (Patient 9). (Refer to I 533). 2. Conduct monthly patient case review conferences for four of 10 sampled patients (Patient 8, 10, 4 and 5) in accordance with facility policy. (Refer to I 545) 3. A Therapy Aide did not perform direct patient care when a supervising physical therapist was not present for one of 10 sampled patients (Patient 5). (Refer to I 549) 4. The Occupational Therapist (OT 1) had the appropriate advanced practice certification from the California Board of Occupational Therapy (CBOT) prior to providing one of 10 sampled patients (Patient 8) with physician agent modalities (PAMs, the application of light, water, temperature, sound, or electricity to produce a response in muscles or other soft tissue). (Refer to I 552) 5. One of 10 sampled patients (Patient 10) completed a screening and received follow-up education regarding the need for social work services. (Refer to I 553) The cumulative effect of these systemic issues resulted in the facility's failure to provide a comprehensive, coordinated program by qualified staff.
I0533	PHYSICIAN SERVICES CFR(s): 485.58(a)(1) A facility physician must be present in the facility for a sufficient time to-- - Provide, in accordance with accepted principles of medical practice, medical direction, medical care services and consultation; - Establish the plan of treatment in cases where a plan has not been established by the referring physician; - Assist in establishing and implementing the facility's patient care policies; and - Participate in plan of treatment reviews, patient case review conferences, comprehensive patient assessments and reassessments and utilization reviews. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's Medical Director (MD) did not participate in a Patient Care Conference for one of 10 patients (Patient 8). This deficient practice prevented the MD from being knowledgeable of the provision of services for Patient 8. Findings: A review of Patient 8's Patient Care Conference, dated 2/4/22, included signatures of a Respiratory Therapist, the Administrator (ADM), and the Social Worker. The

	signature for the MD was missing. During an interview on 6/23/22, at 3:25 PM, the ADM stated the MD did not attend Patient 8's Patient Care Conference. The ADM stated case conferences were important to discuss the patient's progress, change goals, and discuss how to improve the patient's functional status. A review of the facility's undated policy titled, "Case Review Conferences," indicated the "Participants shall include ALL clinical staff, including the Medical Director."
I0545	COORDINATION OF SERVICES CFR(s): 485.58(c)(4) Mechanisms to assist in the coordination of services must include scheduling patient case review conferences for purposes of determining appropriateness of treatment, when indicated by the results of the initial comprehensive patient assessment, reassessment(s), the recommendation of the facility physician (or other physician who established the plan of treatment), or upon recommendation of one of the professionals providing services. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct monthly case conferences for four of 10 sampled patients (Patient 4, 5, 8, and 10) in accordance with the facility's policy. This deficient practice prevented communication between the professional personnel to ensure the facility provided adequate and comprehensive services. Findings: A review of the facility's undated policy titled, "Case Review Conferences," indicated "The Program Coordinator shall schedule and hold a meeting of the clinical staff at least once a month. These meetings shall be held to discuss the plan of treatment for each patient currently in service at the facility." During an interview on 6/23/22, at 3:00 PM, the Administrator (ADM) stated case review conferences should occur monthly for each patient. a. A review of Patient 4's Respiratory Therapy evaluation, dated 3/21/22, indicated Patient 4 had shortness of breath and deconditioning. A review of Patient 4's Sign In Sheet indicated Patient 4 completed a total of 28 visits from 3/21/22 to 6/22/22. A review of Patient 4's clinical record did not include any case review conferences completed for Patient 4. During an interview on 6/23/22, at 3:25 PM, the ADM stated case conferences were important to discuss the patient's progress, change goals, and discuss how to improve the patient's functional status. During an interview and record review on 6/23/22, at 4:15 PM, the ADM reviewed Patient 4's clinical records and confirmed the clinical records did not include any case

review conferences. The ADM stated there should have been at least three case review conferences completed for Patient 4 because the facility completed one case review conference for each patient at least once a month.

b. A review of Patient 5's Physical Therapy Evaluation, dated 3/23/22, indicated Patient 5 had gait abnormality (difficulty walking) and a balance impairment.

A review of Patient 5's Sign In Sheet indicated Patient 5 completed a total of 14 visits from 3/23/22 to 6/3/22.

A review of Patient 5's clinical record did not include any case review conferences completed for Patient 5.

During an interview on 6/23/22, at 3:25 PM, the ADM stated case conferences were important to discuss the patient's progress, change goals, and discuss how to improve the patient's functional status.

During an interview and record review on 6/23/22, at 4:15 PM, the ADM reviewed Patient 5's clinical records and confirmed the records did not include any case review conferences. The ADM stated Patient 5 should have had at least two case review conferences completed because the facility completed one case review conference for each patient at least once a month.

c. A review of Patient 8's Respiratory Therapy evaluation, dated 2/18/22, indicated Patient 8 had restrictive lung disease and increased shortness of breath with exertion.

A review of Patient 8's Occupational Therapy (OT) Evaluation, dated 2/18/22, indicated Patient 8's treatment diagnosis included was not limited to weakness, abnormal posture, lack of coordination, repeated falls, stiffness of unspecified joint, and pain in unspecified shoulder. A review of Patient 8's OT Discharge Summary indicated Patient 8 was discharged on 5/16/22.

A review of Patient 8's Sign In Sheet indicated Patient 8 completed a total of 21 visits from 2/18/22 to 5/16/22.

A review of Patient 8's Patient Care Conference Form indicated Patient 8's care was discussed on 2/4/22. Patient 8's clinical record did not include additional Patient Care Conference Forms.

During an interview and review of Patient 8's clinical record on 6/23/22, at 3:25 PM, the ADM confirmed Patient 8's only had one care review conference on 2/4/22. The ADM stated that Patient 8 did not but should have had a care conference in 3/2022 and 4/2022. The ADM stated case conferences were important to discuss the patient's progress, change goals, and discuss how to improve the patient's functional status.

d. A review of Patient 10's Respiratory Therapy (RT) evaluation, dated 9/22/21, indicated Patient 10's diagnosis included chronic respiratory failure (airways carrying air to lungs become narrow and damaged) with hypoxia (body does not receive enough oxygen) due to history of Coronavirus-19 (COVID-19, new infectious viral disease that can cause respiratory illness).

A review of Patient 10's Sign in Sheet indicated Patient 10 completed a total of 21 visits from 9/22/21 to 2/18/22.

	A review of Patient 10's clinical record did not include any case review conferences completed for Patient 10. During an interview and review of Patient 10's clinical record on 6/23/22, at 3:00 PM, the ADM confirmed that Patient 10's clinical records did not include any case review conferences. During an interview on 6/23/22, at 3:25 PM, the ADM stated case conferences were important to discuss the patient's progress, change goals, and discuss how to improve the patient's functional status.
I0549	PROVISION OF SERVICES CFR(s): 485.58(d)(4) (d)(4) The services must be furnished by personnel that meet the qualifications of 485.70 and the number of qualified personnel must be adequate for the volume and diversity of services offered. Personnel that do not meet the qualifications specified in 485.70(a) through (m) may be used by the facility in assisting qualified staff. When a qualified individual is assisted by these personnel, the qualified individual must be on the premises, and must instruct these personnel in appropriate patient care service techniques and retain responsibility for their activities. Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], are not required to comply with requirements of 485.58 (d)(4). This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure qualified staff performed physical therapy services by failing to ensure that a therapy aide did not perform direct care physical therapy services for one of 10 sampled patients (Patient 2) when a supervising physical therapist was not present. This deficient practice resulted in Patient 2 receiving direct physical therapy services from an unlicensed staff. Findings: A review of Patient 2's Physical Therapy (PT) Evaluation, dated 6/8/22, indicated Patient 2 had gait abnormality (difficulty walking) and both lower leg weakness. The PT treatment plan included therapeutic exercise and balance training. The PT Evaluation included a short-term goal for Patient 2 to tolerate 30 to 40 minutes of exercises with minimal exertion. During an observation on 6/22/22, at 11:15 AM, in the gym area next to the parallel bars (apparatus with two bars that is used for therapy training), Therapy Aide 1 (TA 1) performed leg exercises with Patient 2, who was seated in a wheelchair. A review of Patient 2's Physical Therapy Daily Note, dated 6/22/22, indicated Patient 2 completed one set of 10 repetitions of leg strengthening exercises. During an interview on 6/23/22, at 2:15 PM, TA 1 stated he performed leg exercises with Patient 2 on 6/22/22 to help Patient 2 with increasing his leg strength. TA 1 stated that Physical Therapy Assistant 1 (PTA 1) was his supervisor and performed exercises with patients that PTA 1 informed him to complete.

	During an interview on 6/23/22, at 4:45 PM, the Administrator (ADM) stated TA 1 could not perform any exercises with a patient without direct supervision from a supervising physical therapist. The ADM stated that a physical therapy assistant could not supervise a therapy aide or instruct a therapy aide to perform direct patient care. A review of the California Code of Regulations, Title 16, Division 13.2 for the Physical Therapy Board of California, Article 6 titled Physical Therapy Aides, Section 1399 - Requirement for Use of Aides, indicated "(c)(3)(D) The physical therapist shall provide continuous and immediate supervision of the aide. The physical therapist shall be in the same facility as the aide and in immediate proximity to the location where the aide is performing patient related tasks ...When patient related tasks are provided to a patient by an aide the physical therapist shall at some point during the treatment day provide direct service to the patient as treatment ..." A review of the California Code of Regulations, Title 16, Division 13.2 for the Physical Therapy Board of California, Article 4 titled Physical Therapist Assistant, Section 1398.44 - Adequate Supervision Defined, indicated "(d)(7) A physical therapist assistant shall not: supervise a physical therapy aide performing patient-related tasks."
I0552	PROVISION OF SERVICES CFR(s): 485.58(d)(7) All services must be provided consistent with accepted professional standards and practice. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's Occupational Therapist (OT 1) provided one of 10 sampled patients (Patient 8) with physical agent modalities (PAMs, the application of light, water, temperature, sound, or electricity to produce a response in muscles or other soft tissue) without obtaining advanced practice certification from the California Board of Occupational Therapy (CBOT) and without appropriate supervision. This deficient practice resulted in OT 1 applying PAMs to Patient 8 without adequate competency and appropriate supervision, which could affect the provision of care. Findings: A review of Patient 8's Occupational Therapy (OT) Evaluation, dated 2/22/22, indicated Occupational Therapist 1 (OT 1) performed the OT evaluation. OT 1 indicated Patient 8's treatment plan included hot/cold packs as needed for stiffness and electrical stimulation (mild electrical pulses through the skin to help stimulate injured muscles or manipulate nerves to reduce pain) as needed for upper and lower back pain. A review of Patient 8's OT Discharge Summary, signed by OT 1 on 5/16/22, indicated Patient 8 was provided with skilled treatment intervention including hot/cold packs as needed for stiffness and electrical stimulation as needed for upper and lower back pain. A review of CBOT's Advanced Practice (https://www.bot.ca.gov/licensees/advanced.shtml) information indicated "Occupational therapists in the process of completing the requisite (required) education and training may provide advanced practice services,

	however, it must be under the supervision of an occupational therapist approved by the Board in the advanced practice area, a physical therapist (for hand therapy and/or physical agent modalities), a speech language pathologist (for swallowing assessment, evaluation and intervention), or a physician and surgeon." CBOT's Advanced Practice information also indicated "the supervisor and occupational therapist must have a written agreement outlining the plan of supervision and training in the advanced practice area. The level of supervision is determined by the supervisor whose responsibility it is to ensure that the amount, degree, and pattern of supervision is consistent with the knowledge, skill and ability of the occupational therapist, and appropriate for the complexity of client needs and number of clients for whom the occupational therapist is providing advanced practice services." A review of OT 1's California Board of Occupational Therapy (CBOT) license, dated 6/23/22, did not include any advanced practice certification in PAMs. A review of OT 1's personnel file included five continuing education certificates in PAMs. OT 1's personnel file did not include a written agreement outlining the plan of supervision and training in PAMs from the physical therapist, physician, or surgeon. During a telephone interview on 6/23/22, at 4:49 PM, OT 1 stated OT 1's application for advanced practice certification in PAMs was submitted to the CBOT but never received any approval. OT 1 stated OT 1 provided Patient 8 with a hot pack and electrical stimulation on the date of the OT evaluation on 2/22/22. OT 1 stated OT 1 could provide PAMs if a Physical Therapist was on the premises. During an interview and record review on 6/23/22, at 4:49 PM, the Administrator (ADM) stated the facility did not have any documentation that indicated a Physical Therapist supervised OT 1 performing PAMs with Patient 8. The ADM reviewed the facility's schedule for 2/2/22 and confirmed the Physical Therapist was not in the facility.
I0553	SCOPE AND SITE OF SERVICES CFR(s): 485.58(e) The facility must provide all the CORF service required in the plan of treatment and, except as provided below, must provide the services on its premises. Exceptions: Physical therapy, occupational therapy and speech language pathology services furnished away from the premises of the CORF may be covered as CORF services if Medicare payment is not otherwise made for these services. In addition, a single home visit is covered if there is need to evaluate the potential impact of the home environment on the rehabilitation goals. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to screen one of 10 sampled patients (Patient 10) for social work services and did not follow-up with Patient 10 regarding social work. This deficient practice had the potential to prevent Patient 10 from receiving comprehensive care. Findings: A review of Patient 10's Respiratory Therapy (RT) evaluation, dated 9/22/21, indicated Patient 10's diagnosis included chronic respiratory failure (airways carrying air to lungs become narrow and damaged) with hypoxia (body does not receive

	enough oxygen) due to history of Coronavirus-19 (COVID-19, new infectious viral disease that can cause respiratory illness). The RT evaluation indicated Patient 10 was hospitalized three times since January 2021 due to COVID-19 and complications of COVID-19. A review of Patient 10's clinical record indicated Patient 10 received RT services from 9/22/21 to 2/18/22 (five months). Further review of Patient 10's clinical record included a blank Psychosocial Services form with the question, "Would you like to be seen by our Licensed Clinical Social Worker (LCSW) for an evaluation?" Patient 10 did not mark a response and did not sign the acknowledgement that the facility offered LCSW services. During an interview on 6/22/22, at 10:15 AM, the Administrator (ADM) stated the LCSW came to the facility at least monthly. During a follow-up interview and review of Patient 10's clinical record on 6/23/22, at 3:00 PM, the ADM stated each patient should complete the Psychosocial Services form to screen the patient for any social work needs. The ADM reviewed Patient 10's clinical record and confirmed Patient 10 did not complete the Psychosocial Services form. The ADM stated the clinical record did not have any documentation a staff member followed up with Patient 10 regarding social work services. The ADM stated Patient 10 was Spanish speaking and possibly did not understand the form. The ADM stated the facility had two Spanish speaking staff members that could have interpreted.
I0561	CONTENT CFR(s): 485.60(a)(1) The clinical record for each patient must contain the initial assessment and subsequent reassessments of the patient's needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the Respiratory Therapy (RT) re-certification assessment was dated and accurate for one of 10 sampled patients (Patient 5). This deficient practice resulted in an incomplete clinical record for Patient 5. Findings: A review of Patient 5's RT evaluation, dated 3/23/22, indicated Patient 5 had shortness of breath and deconditioning. The RT evaluation included a respiratory therapy treatment frequency of two to three times a week for a certification period from 3/23 /22 through 5/22/22. A review of Patient 5's Respiratory Therapy recertification assessment did not indicate the completion date of the recertification. During an interview and record review on 6/23/22, at 4:15 PM, the Administrator (ADM) reviewed Patient 5's clinical records and confirmed that the RT recertification assessment was not dated. ADM stated that all medical records need to be dated because it indicated when the assessment was completed, helped clinicians to keep track of a patient's progress, and determined when documents were completed.

	A review of the facility's undated policy and procedure titled, "Contents of the Clinical File," indicated, "the clinical file for each patient shall contain ...ongoing progress notes, including detailed clinical observations of the clinicians, the times and dates of services ..."
I0563	CONTENT CFR(s): 485.60(a)(3) The clinical record for each patient must contain identification data and consent or authorization forms. This STANDARD is not met as evidenced by: Based on interview and record review, one of 10 sampled patients (Patient 9) did not have the patient's identifying information on the Physical Therapy Discharge Summary. This deficient practice resulted in Patient 9's clinical records to contain incomplete information and had the potential to result in an inadequate evaluation of Patient 9's care. Findings: A review of Patient 9's clinical record indicated the Physical Therapy (PT) Evaluation was completed on 7/12/21. A review of Patient 9's PT Discharge Summary did not include Patient 9's name, primary diagnosis, and date of birth. During an interview and review of Patient 9's clinical record on 6/23/22, at 3:25 PM, the Administrator confirmed Patient 9's PT Discharge Summary did not include Patient 9's name. A review of the facility's undated policy titled, "Clinical Record," indicated that "The clinical file for each patient shall contain, at a minimum, the following documents: ... Identification data."
I0567	CONTENT CFR(s): 485.60(a)(7) The clinical record for each patient must contain, upon discharge, a discharge summary including patient status relative to goal achievement, prognosis, and future treatment considerations. This STANDARD is not met as evidenced by: Based on interview and record review, four of four sampled patients (Patient 7, 8. 9, 10) who were dischaged from the facility did not have a dated discharge summary for Respiratory Therapy (RT). For Patient 9, the Physical Therapy (PT) Discharge Summary was not dated. These deficient practices resulted in incomplete clinical records for Patient 7, 8, 9, and 10. Findings: A review of the facility's undated policy titled, "Clinical Record," indicated that "The clinical file for each patient shall contain, at a minimum, the following documents: ... Ongoing progress notes, including detailed clinical observation of the clinicians, the

	times and dates of services, a description of the services rendered and the original signature of the clinician." a. A review of Patient 7's clinical record indicated the RT evaluation was completed on 3/21/22. A review of Patient 7's RT Discharge record did not indicate a date. During an interview and review of Patient 7's clinical record on 6/23/22, at 3:00 PM, the Administrator did not know when Patient 7 was discharged from RT since the RT Discharge record was not dated. b. A review of Patient 8's clinical record indicated the RT evaluation was completed on 2/18/22. A review of Patient 8's RT Discharge record did not indicate a date. During an interview and review of Patient 8's clinical record on 6/23/22, at 3:25 PM, the Administrator confirmed Patient 8's RT Discharge record was not dated. c. A review of Patient 9's clinical record indicated the RT evaluation was completed on 7/12/21. A review of Patient 9's RT Discharge record did not indicate a date. A review of Patient 9's clinical record indicated the PT Evaluation was completed on 7 /12/21. A review of Patient 9's PT Discharge Summary did not indicate a date. During an interview and review of Patient 9's clinical record on 6/23/22, at 3:25 PM, the Administrator (ADM) confirmed Patient 9's RT Discharge record was not dated. The ADM also confirmed Patient 9's PT Discharge Summary was not dated. d. A review of Patient 10's clinical record indicated the RT evaluation was completed on 9/22/21. A review of Patient 10's RT Discharge record did not indicate a date. During an interview and record review of Patient 10's clinical record on 6/23/22, at 3: 00 PM, the Administrator confirmed Patient 10's RT Discharge record was not dated.
I0568	PROTECTION OF CLINICAL RECORD INFORMATION CFR(s): 485.60(b) The facility must safeguard clinical record information against loss, destruction, or unauthorized use. The facility must have procedures that govern the use and removal of records and the conditions for release of information. The facility must obtain the patient's written consent before releasing information not required to be released by law. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to lock and safeguard patient clinical records as evidenced by discharged patient records placed in cabinets without a lock inside an unsupervised and unlocked room. This deficient practice had the potential for unauthorized access to protected health information. Findings: During an observation and interview on 6/22/22, at 11:50 AM, the Administrator (ADM) stated the door to the Staff Lounge was unlocked. The ADM stated the left and middle overhead cabinets contained discharged patient records. The left and

	middle overhead cabinets were observed without any locks. The ADM stated the cabinets were locked at the end of the day. The ADM also stated the corner overhead cabinet contained a box of discharged patient records with at least 10-15 patient records. The ADM stated that patient records should not be in the corner overhead cabinet because the door to the corner cabinet could not be locked. The ADM stated that all patient clinical records should be always locked to maintain privacy and protect files from unauthorized access. The ADM stated that cleaning staff, oxygen delivery staff, patients, and family could potentially access the patient files if the cabinets were left unlocked. A review of the facility's policies and procedures titled, "The Patient Record," indicated "medical records are stored in the Medical Record File cabinets. This File is to remain locked at all times. When a record is needed for review or therapy documentation the staff member should get the key from the key lock cabinet and relock the Medical Record File cabinet when the file is returned." A review of the facility's policy and procedure titled, "Clinical Records, Information, and Patient's Rights," indicated "clinical record information is recognized as confidential and is to be maintained against loss, destruction, or unauthorized use."
I0579	SANITARY ENVIRONMENT CFR(s): 485.62(b) The facility must maintain a sanitary environment and establish a program to identify, investigate, prevent, and control the cause of patient infections. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 21 bottles of hand sanitizer (liquid or gel, typically containing alcohol, that is used to clean the hands and kill infection-causing microorganisms) were discarded after the expiration date. This deficient practice had the potential to promote an unsanitary environment, including improper hand hygiene before, during, and after patient care. Findings: During an observation and interview on 6/22/22, at 11:40 AM, in the Physician's Office, the Administrator (ADM) opened a upper cabinet of the two-shelf storage cabinet which contained hand sanitizer bottle. The ADM stated the 21 bottles of hand sanitizers had an expiration date of 5/2022. The ADM stated the 21 bottles of hand sanitizers were expired and could not be used. The ADM stated hand sanitizer supplies were provided to patients to perform hand hygiene because the patients use and touch shared exercise equipment in the facility. The ADM stated that the hand sanitizers would not be effective in sanitizing hands if used after the expiration date. A review of the facility's policy and procedure, revised 4/13/20, titled, "Infectious Plan for COVID-19," indicated "the company promotes frequent and thorough hand washing, by providing employees, customers, and worksite visitors with a place to wash their hands. If soap and running water are not immediately available, for any reason, the company will ensure to provide alcohol-based hand rubs containing at least 60% alcohol."
I0580	SANITARY ENVIRONMENT

CFR(s): 485.62(b)(1)

The facility must establish written policies and procedures designed to control and prevent infection in the facility and to investigate and identify possible causes of infection.

This STANDARD is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to maintain a sanitary environment when the facility failed to:

a. Establish and implement written policies and procedures for cleaning patient modality (type of electrical, thermal, or mechanical energy that causes physiological changes) equipment for paraffin wax bath (machine that heats and holds paraffin wax for heat treatment) and cold pack freezer, and

b. Clean and log modality equipment cleaning for paraffin wax bath, hydrocollator (thermostatically controlled water heating device that stores heating pads for heat treatment), and cold pack freezer machines according to manufacturer's recommendations.

These deficient practices had the potential to contribute to the transmission and spread of infection among patients and staff who use the modality equipment.

Findings:

a. During an observation on 6/22/22, at 10:00 AM, in the gym area, a paraffin wax bath machine with melted wax inside had a rack on the bottom with brown-colored residue. A top loading freezer containing cold packs had about a half-inch (1/2-inch) thick layer of ice from the middle to top portion of the freezer.

During an interview and record review of all facility policies and procedures on 6/23 /22, at 4:30 PM, the Administrator (ADM) confirmed there were no facility policies and procedures for cleaning and maintaining modality equipment for the paraffin wax bath machine and the cold pack freezer. The ADM stated there should be a policy and procedure developed so that all staff would know the procedure on how to clean each type of equipment and when to complete the cleaning. The ADM stated that the cold pack freezer and the paraffin wax bath machine should be cleaned at least once a month.

b. During an observation on 6/22/22, at 10:00 AM, in the gym area, a paraffin wax bath machine with melted wax inside had a rack on the bottom with brown-colored residue. A top loading freezer containing cold packs had about a half-inch (1/2-inch) thick layer of ice from the middle to top portion of the freezer. The were two small hydrocollator machines (#1 and #2) located next to the treatment table. Both machines (#1 and #2) had rust along the top edge of the hydrocollator cover. Hydrocollator #1 had four hot packs inside. Three of the four hot packs had brown stains on the top of the hot packs.

During an observation and interview on 6/22/22, at 11:57 AM, the Administrator (ADM) stated the cold pack freezer and paraffin bath wax machine should be cleaned once a month. The ADM confirmed there was rust along the top edge of both Hydrocollator #1 and Hydrocollator #2. The ADM stated the hydrocollators should be

	cleaned once a month. During an interview and record review on 6/23/22, at 1:45 PM, Therapy Aide 1 (TA 1) stated the cold pack freezer should be defrosted every two weeks, the paraffin wax bath should be cleaned every two weeks, and the hydrocollators should be cleaned every two weeks. TA 1 reviewed the Hydrocollator Temperature Logs for the months of June 2022, May 2022, April 2022, March 2022, and January 2022 and stated the only documented evidence of cleaning the hydrocollators was on 4/8/22. TA 1 reviewed the Cold Pack Freezer and Paraffin Wax Bath Temperature Logs for the months of June 2022, May 2022, April 2022, and March 2022 and stated the logs had no documented evidence of any cleaning of the paraffin wax bath or the cold pack freezer. TA 1 stated he did not document when the paraffin wax bath and the cold pack freezer were cleaned. TA 1 stated it was important to document each cleaning to keep track of when the equipment was cleaned and to ensure it was completed every two weeks. During an interview and record review of all facility policies and procedures on 6/23 /22, at 4:30 PM, the ADM confirmed the facility did not have any policies and procedures for cleaning and maintaining modality equipment for the paraffin wax bath machine and the cold pack freezer. The ADM stated there should be a policy and procedure developed so that all staff would know the procedure on how to clean each type of equipment and when to complete the cleaning. A review of the facility's policy and procedure, dated 10/1/18, titled, "Use of hydrocollator," indicated, the "tank needs to be drained, cleaned and inspected at minimum intervals of every two weeks."
I0584	MAINTENANCE CFR(s): 485.62(c) The facility must establish a written preventive maintenance program for equipment, physical location, and grounds. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to establish and implement written policies and procedures for patient safety and maintenance of patient modality (type of electrical, thermal, or mechanical energy that causes physiological changes) equipment, including checking daily temperatures for paraffin wax bath (machine that heats and holds paraffin wax for heat treatment for patients), hydrocollator (thermostatically controlled water heating device that stores heating pads for heat treatment), and cold pack freezer. This deficient practice had the potential to cause burns and injuries to patients and staff using the modality equipment. Findings: During an observation on 6/22/22, at 10:00 AM, in the gym area, four modality machines were observed: a paraffin wax machine, a top loading freezer containing cold packs, and two small hydrocollator machines. During an interview and record review of all facility policies and procedures on 6/23

	/22, at 4:30 PM, the Administrator (ADM) confirmed there were no facility policies and procedures for checking daily temperatures for modality equipment of paraffin wax bath, cold pack freezer, and hydrocollators. The ADM also stated there was no written guidelines on what the safe and acceptable temperature ranges should be for each modality for paraffin wax, ice pack freezer, and hydrocollators. The ADM stated it was important to have a policy and for staff to know what the temperature ranges should be so that all staff knew how to check the temperatures and what the safe temperatures were for the modalities to prevent burns and injuries to patients using the modalities.
I0585	MAINTENANCE CFR(s): 485.62(c)(1) The facility must establish a written preventive maintenance program to ensure that all equipment is properly maintained and equipment needing periodic calibration is calibrated consistent with the manufacturer's recommendations. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure: a. Daily temperatures were taken for paraffin wax (machine that heats and holds paraffin wax for heat treatment for patients), hydrocollator (thermostatically controlled water heating device that stores heating pads for heat treatment), and top loading freezer with cold packs and were within acceptable temperature ranges; and b. The hydrocollator water line was filled to a proper water line level and all hydrocollator packs were fully submerged. These deficient practices had the potential to cause accidents and injuries to all patients and staff who used the machines for therapeutic treatment. Findings: a. During an observation on 6/22/22, at 10:00 AM, in the gym area, four modality (type of electrical, thermal, or mechanical energy that causes physiological changes) machines were observed: a paraffin wax bath machine, a top loading freezer containing cold packs, and two small hydrocollator machines. During an interview on 6/22/22, at 11:57 AM, the Administrator (ADM) stated the temperatures for the paraffin wax, cold pack freezer, and two hydrocollators were taken daily and documented on facility logs. A review of the June 2022 Hydrocollator Temperature Log indicated one log for Hydrocollator #2 and no log for Hydrocollator #1. The June 2022 Temperature Log for Hydrocollator #2 had missing temperatures from 6/8/22 to 6/23/22. A review of the May 2022 Temperature Log for Hydrocollator #1 and #2 had missing temperatures for the following dates: 5/23/22 to 5/27/22, and 5/31/22. The temperatures recorded from 5/2/22 to 5/6/22 and 5/9/22 to 5/13/22 ranged from 140 degrees (did not indicate Fahrenheit or Celsius) to 150 degrees. A review of the April 2022 Hydrocollator Temperature Log did not indicate which

hydrocollator (#1 or #2) the log was for. The log had missing temperatures for the following dates: 4/1/22, 4/18/22 to 4/22/22, 4/25/22 to 4/29/22. The recorded temperatures from 4/12/22 to 4/16/22 ranged from 144 degrees to 145 degrees.

A review of the June 2022 Paraffin Bath Temperature Log indicated missing temperatures for 6/2/22, 6/7/22, 6/10/22, 6/13/22, 6/16/22, 6/22/22, 6/23/22. The recorded temperatures were 130 degrees.

A review of the May 2022 Paraffin Bath Temperature Log indicated missing temperatures for 5/26/22, 5/27/22, 5/31/22. The recorded temperatures ranged from 120 degrees to 132 degrees.

A review of the April 2022 Paraffin Bath Temperature Log indicated missing temperatures for 4/28/22 and 4/29/22. The recorded temperatures ranged from 120 degrees to 140 degrees.

A review of the May 2022 Cold Pack Freezer Temperature Log indicated recorded temperatures ranging from 20 degrees to 41 degrees.

A review of the April 2022 Cold Pack Freezer Temperature Log indicated recorded temperatures ranging from 17 degrees to 41 degrees.

A review of the March 2022 Cold Pack Freezer Temperature Log indicated recorded temperatures ranging from 20 degrees to 50 degrees.

During an interview and record review on 6/23/22, at 1:45 PM, Therapy Aide 1 (TA 1) reviewed all Hydrocollator, Paraffin Bath Wax, and Cold Pack Freezer Temperature Logs and confirmed the logs were missing documented temperatures. TA 1 stated he took the temperatures daily but documented the temperatures twice a week. TA 1 stated the temperature range for the cold pack freezer should be between 15 and 25 degrees Celsius. TA 1 stated the temperature range for the paraffin wax should be between 105 degrees Fahrenheit (F) and 115 degrees F. TA 1 stated the temperature range for the hydrocollator should be between 145 degrees F to 160 degrees F. TA 1 stated that if the temperatures were not within range, then he should notify the therapists and unplug the machine. TA 1 stated if the temperatures were out of range and the therapists used the modalities, then it could burn the patients.

During an interview and record review of the Hydrocollator, Paraffin Wax Bath, and Cold Pack Freezer Temperature Logs, the Administrator (ADM) confirmed the temperatures were not logged daily and that the temperatures for both hydrocollators, paraffin wax bath, and cold pack freezer were out of range. The ADM stated the temperature range for the cold pack freezer should be eight (8) degrees F to 20 degrees F. ADM stated the temperature range for the paraffin wax bath should be between 110 degrees F and 125 degrees F. ADM stated the temperature range for the hydrocollators should be between 160 degrees F to 165 degrees F. The ADM confirmed there were no facility policies and procedures for checking daily temperatures for modality equipment of paraffin wax, ice pack freezer, and hydrocollators. The ADM also stated there was no written guidelines on what the safe and acceptable temperature ranges should be for each modality for paraffin wax bath, cold pack freezer, and hydrocollators. The ADM stated it was important to have a policy and for staff to know what the temperature ranges should be so that all staff knew how to check the temperatures and what the safe temperatures were for the modalities to prevent burns and injuries to patients using the modalities.

	b. During an observation on 6/22/22, at 10:15 AM, there were two small hydrocollator machines (#1 and #2) located next to the treatment table. The water level inside Hydrocollator #1 was about two inches below the top. Four out of the four hot packs inside Hydrocollator #1 were not fully submerged in water. The water level inside Hydrocollator #2 was about two to three inches below the top. Two out of the three hot packs inside Hydrocollator #2 were not fully submerged in water. During an observation and interview on 6/22/22, at 11:57 AM, the Administrator (ADM) and Physical Therapy Assistant 1 (PTA 1) stated the water level for the hydrocollators should cover all the hot packs. The ADM and PTA 1 confirmed the hot packs inside Hydrocollator #1 and Hydrocollator #2 were not fully submerged in water. A review of the facility's policy and procedure, dated 10/1/18, titled, "Use of hydrocollator," indicated, "maintain water level over the top of the hot pack to avoid damage to the heating element, the stainless steel or the [hot pack]."