STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555587	A. BUILDING _____ B. WING _____	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALLY KIDS REHABILITATION HOSPITAL - D/P SNF	1720 MOUNTAIN VIEW LOMA LINDA, CA 92354

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a COVID-19 FOCUSED SURVEY FOR INFECTION CONTROL. A COVID-19 Focused Infection Control Survey was conducted by the California Department of Public Health on behalf of the Centers for Medicare & Medicaid Services (CMS) on February 24, 2021 through March 2, 2021. Total residents: 46 Representing the California Department of Public Health: Surveyor 40583, Health Facility Evaluator Nurse.	F 000		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms	F 886		3/22/21

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

Electronically Signed | 03/15/2021

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.

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F 886	Continued From page 1 consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state	F 886		

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F 886	Continued From page 2. and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and facility record review, the facility failed to ensure facility infection control practices were maintained when seven of 244 facility staff failed to have COVID-19 (a contagious and potentially fatal respiratory virus) testing done and did not sign a facility declination (a formal refusal) form, declining COVID-19 testing as indicated in the facility policy and procedure located in the facility mitigation plan. This failure placed all facility staff and residents at risk of contracting COVID-19. Findings: During an interview on February 24, 2021, at 10:05 AM, with housekeeping (HSK) 1, when asked if they were getting COVID-19 testing stated, "I decline my COVID testing. It's not really mandatory. If I feel sick, I will get a test. Actually, a lot of people decline testing. It's our preference if we get tested." During an interview on February 24, 2021, at 10:12 AM, with respiratory care practitioner (RCP) 1, when asked how if they were getting COVID-19 tested stated, "I'm testing once a week, you can decline..." During an interview on February 24, 2021, at 11 AM, with the Infection Preventionist (IP), the IP indicated that 25 facility staff had neither tested for COVID-19 nor signed a declination, declining COVID-19 testing.	F 886	1. The Employee Health Nurse provided education to six of the seven employees noted in the plan of correction. Employees were educated on Totally Kids Rehabilitation Hospital (TKRH) COVID-19 testing policy, signed declination form, and submitted it to the Employee Health Nurse on March 13, 2021. One employee declination could not be obtained due to separation from Totally Kids Rehabilitation Hospital prior to receipt of Plan of Correction. 2. TKRH COVID-19 testing policy was revised to clarify when declination form must be on file with Human Resources. The policy will be reviewed and approved by policy committee (Regulatory Function Team committee) on March 15, 2021. 3. VP of Human Resources reviewed TKRH D/P-SNF employee records on February 24, 2021 for compliance with hospital policy on COVID-19 testing. 4. Human Resources will schedule rapid antigen testing and/or PCR testing during onboarding of new employees. New hires will receive current COVID-19 testing policy during general orientation. 5. All TKRH D/P-SNF staff will be notified by March 19, 2021 via HR communication portal, huddles, and	

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F 886	Continued From page 3 During an interview on February 24, 2021, at 12:35 PM, with the Vice President of Human Resources (VP HR), the VP HR indicated 26 facility staff did not have a declination on file and had not tested for COVID-19. The VP HR further stated, "Yes, I see the problem, it's a liability issue." During an e-mail exchange on February 24, 2021, at 3:41 PM, with the VP HR, the VP HR clarified that the above number of employees that had neither signed a declination nor had any COVID-19 testing on file was 29, not 26 as previous stated. The VP HR further stated in his e-mail, "These 21 did NOT work in the period 1/31-2/20. Eight remain that DID work during this period and who have not signed a declination form and have not tested for COVID-19." During a review of the facility document titled, "Subject: COVID-19 Mitigation Plan...," indicated, "Testing Staff...[facility name] will document any staff refusing to take a COVID-19 test. [facility name] will develop a process/guideline for the management of staff refusal to test according to regulatory requirements. The process will include education and attestation [facility declination of staff declining COVID-19 testing] to adhere to CDC [Centers for Disease Control and Prevention] guidelines for self-isolation, symptom recognition, exposure, and reporting to work."	F 886	whiteboard on the updated COVID-19 testing policy. 6. Vice President of Human Resources and/or designee will perform audits to verify compliance with employee testing and/or declination documentation on file. This will be monitored monthly and reported to the Quality Assurance Performance Improvement committee quarterly for a minimum of one quarter. 7. The Vice President of Human Resources will monitor for continued compliance. 8. Vice President of Human Resources, Employee Health Nurse, Human Resources Manager, Vice President of Patient Care/CNO, Infection Prevention and Control Nurse, Executive Vice President/Chief Operating Officer, Chief Executive Officer, Vice President of Operations, and Vice President of Regulatory Compliance participate in COVID Incident Command and were involved in the implementation of this corrective action. 9. Governing Body will be informed of 2567 and plan of correction at the next scheduled meeting on May 13, 2021.	