



IDAHO DEPARTMENT OF
HEALTH & WELFARE

G.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK--ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

November 17, 2015

Bobette Steffler, Administrator
McCall Rehabilitation & Care Center
418 Floyde Street
McCall, ID 83638-4508

Provider #: 135082

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER
LETTER**

Dear Ms. Steffler:

On **November 9, 2015**, a Facility Fire Safety and Construction survey was conducted at **McCall Rehabilitation & Care Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 30, 2015**. Failure to submit an acceptable PoC by **November 30, 2015**, may result in the imposition of civil monetary penalties by **December 20, 2015**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **December 14, 2015**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 14, 2015**. A change in the seriousness of the deficiencies on **December 14, 2015**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **December 14, 2015**, includes the following:

Denial of payment for new admissions effective **February 9, 2016**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 9, 2016**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 9, 2015**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **November 30, 2015**. If your request for informal dispute resolution is received after **November 30, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135082	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MC CALL, ID 83638	
(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
K 000	INITIAL COMMENTS The facility is a single story, type V (111) wood frame building that was built in 1965. The original building was flat roof construction which has been built over with a peaked roof system. The facility is fully sprinklered to include the attic space with a fire alarm system with corridor detection. The facility is currently licensed for 65 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on November 9, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Nate Elkins Health Facility Surveyor Facility Fire Safety & Construction NFPA 101 LIFE SAFETY CODE STANDARD	K 000	Plan of Correction does not constitute an admission that the deficiencies alleged did in fact exist. This Plan of Correction is filed as evidence of McCall Rehab & Care Center desire to comply with the requirements of participation and to continue to provide high quality resident care. The facility does ensure that all smoke compartment doors will resist the passage of smoke.	12/31/15
K 027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by:	K 027	<ul style="list-style-type: none"> The facility maintenance director on 11/19/15 lowered west smoke compartment door. By 12/10/15 the facility maintenance director or designee evaluated all smoke compartment doors. The maintenance director inserviced staff by 12/11/15 to notify maintenance director of any smoke compartment doors that are not functioning properly. Starting on 12/11/2015 maintenance director will audit gap distance on all smoke compartment doors monthly. The maintenance director will report findings from the audit quarterly in the CQI meeting. Compliance, continuation or discontinuation of monitoring will be discussed in the quarterly meeting. 	2

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] *[Signature]* *11/27/15*

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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K 027	<p>Continued From page 1</p> <p>Based on observation, operational testing, and interview, the facility failed to maintain smoke barrier doors that would resist the passage of smoke. Failure to maintain smoke barrier doors could allow smoke and dangerous gases to pass freely between smoke compartments. This deficient practice affected 2 of 4 smoke compartments, 12 residents, staff, and visitors on the date of survey. The facility is licensed for 64 SNF/NF beds with a census of 25 on the day of survey.</p> <p>Findings include:</p> <p>During the facility tour on November 9, 2015 at approximately 2:30 PM, observation and operational testing of the cross corridor door in the west corridor when released from the magnetic hold open device and closed revealed a 1 1/4 inch clearance between bottom of door and floor covering that would allow the passage of smoke. When asked, the Maintenance Supervisor and the Administrator stated the facility was unaware of the door clearance. This finding was acknowledged by the Administrator and the Maintenance Supervisor at the exit conference.</p> <p>Actual NFPA Standards:</p> <p>19.3.7.6* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.</p> <p>8.3.4 Doors.</p>	K 027			

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K 027	Continued From page 2 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to protect hazardous areas with self closing doors and smoke resistive partitions. Failure to protect hazardous areas may expose the facility to products of combustion in event of fire. This deficient practice affects all residents, staff, and visitors on the date of survey. The facility is licensed for 65 SNF beds with a census of 25 the day of survey. Findings include: 1.) During the facility tour on November 9, 2015 at approximately 1:30 PM, observation of the pass through service/tray window that measured	K 029 The facility does ensure it protects the hazardous areas with self-closing doors and smoke resistive partitions. <ul style="list-style-type: none"> By 12/11/15 the maintenance director will remove the service window and area will be walled off. On 11/11/15 the maintenance director removed the kick stand on the kitchen door leading into the service hallway. By 12/13/2015 an outside vendor will equip the identified doors in kitchen leading into high hazard areas with magnetic door suspension. By 12/11/15 the maintenance director or designee will evaluate each self-closing door in the facility to ensure they close properly. By 12/11/15 the maintenance director will inservice staff about the requirement of hazardous areas, self-closing doors, and smoke resistive partitions. By 12/11/2015 the maintenance director will visually audit self-closing doors monthly and the administrator and/or designee will present findings from the audit to the quarterly CQI meeting. Compliance, continuation or discontinuation of monitoring will be discussed in the quarterly CQI meeting. 	12/13/15	

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K 029	<p>Continued From page 3</p> <p>2 feet 9 inches by 7 feet 10 inches revealed the manual roll up door was not on a self closure. When asked, the Maintenance Supervisor and the Administrator stated the facility was unaware that the roll up door had to be self closing.</p> <p>2.) During the facility tour on November 9, 2015 at approximately 1:30 PM, observation of the door leading from the kitchen into the corridor and dining facility area was not on a self closure. When asked, the Maintenance Supervisor and the Administrator stated the facility was unaware the door had to be self closing.</p> <p>3.) During the facility tour on November 9, 2015 at approximately 2:15 PM, observation of the door leading from the kitchen into the service corridor was equipped with a kick down door stop that was impeding the door from self-closing. When asked, the Maintenance Supervisor and the Administrator stated the facility was unaware the facility could not impede the door from self-closing.</p> <p>Actual NFPA reference 19.3.2.1 Hazardous Areas.</p> <p>Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p>	K 029		

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K 029	<p>Continued From page 4</p> <p>(1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p>	K 029		