January 11, 2019

Cole Clarke, Administrator
McCall Rehabilitation and Care Center
418 Floyde Street
McCall, ID 83638-4508

Provider #: 135082

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Clarke:

On January 8, 2019, a Facility Fire Safety and Construction survey was conducted at McCall Rehabilitation and 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
Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 24, 2019**. Failure to submit an acceptable PoC by **January 24, 2019**, may result in the imposition of civil monetary penalties by **February 15, 2019**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 12, 2019**, (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 **April 8, 2019**. A change in the seriousness of the deficiencies on **February 22, 2019**, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by **February 12, 2019**, includes the following:

Denial of payment for new admissions effective **April 8, 2019**.

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 **July 8, 2019**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **January 8, 2019**, 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:

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 **January 24, 2019**. If your request for informal dispute resolution is received after **January 24, 2019**, 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, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures
**INITIAL COMMENTS**

The facility is a single story, type V (II) 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. The facility is equipped with an automatic fire alarm system which protects corridors and open spaces and was upgraded in 2015. The Essential Electrical System is supplied by a propane powered, on-site automatic generator. The facility is currently licensed for 65 SNF/NF beds and had a census of 29 on the date of the survey.

The following deficiency was cited during the annual fire/life safety survey conducted on January 8, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70, and 42 CFR 483.80.

The survey was conducted by:

Linda Chaney  
Health Facility Surveyor  
Facility Fire Safety and Construction

**FACILITY STANDARDS**

**RECEIVED**  
JAN 24 2019

**LINDA CHANEY**  
Health Facility Surveyor

**K 100**  
General Requirements - Other CFR(s):  
NFPA 101

General Requirements - Other  
List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:
Based on record review, and interview, the facility failed to develop and implement a comprehensive water management plan. Failure to develop and implement a facility specific water management plan could increase risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. This deficient practice could potentially affect 29 residents, visitors and staff on the date of the survey.

Findings include:

During the review of facility records on January 8, 2019, from approximately 8:00 AM to 10:00 AM, the facility water management plan was lacking required elements, to include a comprehensive facility risk assessment, control measures for the identified risks, and testing protocols. When asked, the Maintenance Director stated the facility was aware of the requirements and was currently working on completing a compliant water management plan.

Actual Standard:

42 CFR § 483.80 Infection control.

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

Additional Reference:

Centers for Medicare/Medicaid Services QSO Letter 17-30.

<table>
<thead>
<tr>
<th>Provider/Supplier/CLIA Identification Number:</th>
<th>135082</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility ID: MDS001590</td>
<td>01/08/2019</td>
</tr>
<tr>
<td>Name of Provider or Supplier</td>
<td>MCCALL REHABILITATION AND CARE CENTER</td>
</tr>
<tr>
<td>Street Address, City, State, Zip Code</td>
<td>418 FLOYDE STREET, MCCALL, ID 83638</td>
</tr>
<tr>
<td>ID Prefix Tag</td>
<td></td>
</tr>
<tr>
<td>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</td>
<td></td>
</tr>
<tr>
<td>ID Prefix Tag</td>
<td></td>
</tr>
<tr>
<td>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</td>
<td></td>
</tr>
<tr>
<td>Completion Date</td>
<td></td>
</tr>
</tbody>
</table>

1. No Residents are known to have been affected by this practice.

2. All Residents had the potential to be affected by this practice, no residents are known to have been affected.

3. The facility water management plan has been revised to include a comprehensive facility risk assessment as well as control measures implemented for each risk identified and appropriate testing protocols.

4. To ensure that this practice does not recur, tests required by this water management plan will be entered into the TELS system. Completion of the required testing and results of the tests will be reported in the monthly QAPI meeting for the next 3 months and any concerns addressed.
January 11, 2019

Cole Clarke, Administrator
McCall Rehabilitation and Care Center
418 Floyde Street
Burgdorf, ID 83638-4508

Provider #: 135082

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Clarke:

On January 8, 2019, an Emergency Preparedness survey was conducted at McCall Rehabilitation and Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

MCCALL REHABILITATION AND CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

418 FLOYDE STREET
MCCALL, ID 83638

ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

E 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. The facility is equipped with an automatic fire alarm system which protects corridors and open spaces and was upgraded in 2015. The Essential Electrical System is supplied by a propane powered, on-site automatic generator. The facility is currently licensed for 65 SNF/NF beds and had a census of 29 on the date of the survey.

The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on January 8, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The survey was conducted by:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety and Construction

RECEIVED
JAN 24 2019

FACILITY STANDARDS