



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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

December 4, 2014

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

Provider #: 135082

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

Dear Ms. Steffler:

On **November 21, 2014**, 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 one that comprises a pattern 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 and a similar State Form 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 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 both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

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Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 15, 2014**. Failure to submit an acceptable PoC by **December 15, 2014**, may result in the imposition of civil monetary penalties by **January 5, 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 26, 2014**, (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 26, 2014**. A change in the seriousness of the deficiencies on **December 26, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 26, 2014**, includes the following:

Denial of payment for new admissions effective **February 21, 2015**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey

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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 21, 2015**, 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 21, 2014**, 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:

<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

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This request must be received by **December 15, 2014**. If your request for informal dispute resolution is received after **December 15, 2014**, 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,

A handwritten signature in black ink, appearing to read 'M P Grimes', with a long horizontal flourish extending to the right.

Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

PRINTED: 01/08/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/21/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MCCALL REHABILITATION &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>418 FLOYDE STREET MC CALL, ID 83638</b>		
(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 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 21, 2014. 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:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000			
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily	K 051			12/25/14

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

TITLE

(X6) DATE

Electronically Signed

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 051	<p>Continued From page 1 available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure all areas requiring smoke detection were covered with smoke detection devices. Failure to provide adequate early notification would result in lack of sufficient time for occupant response during a fire event. This deficient practice affected residents, staff and visitors utilizing the dining hall on the date of the survey. The facility is licensed for 65 SNF/NF beds and had a census of 24 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 21, 2014 from 1:30 PM to 4:00 PM, observation of the dining room ceiling revealed the flat ceiling was divided by multiple beams measuring approximately 18 inches in depth. Further observation found no smoke detection devices in the spatial areas created by these divisions and the only detection for this area was from one (1) corridor detector and one (1) detector in the activity area to the south of the dining hall.</p> <p>Actual NFPA standard:</p>	K 051	<p>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 Rehabilitation &amp; Care Center desire to comply with the requirements of participation and to continue to provide high quality resident care.</p> <p>The facility does ensure the fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building.</p> <ul style="list-style-type: none"> <li>- The facility hired an outside vendor to install smoke detectors in identified areas by 12/20/14.</li> <li>- The facility's Maintenance Director or designee evaluated other areas in facility to be affected on 12/11/14.</li> <li>- The facility's Administrator inserviced the Maintenance Director by 12/16/14 on areas that require smoke detection, are covered with smoke detection devices.</li> </ul>		

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K 051	Continued From page 2  2-3.4.6.1* Flat Ceilings. For ceiling heights of 12 ft (3.66 m) or lower, and beam or solid joist depths of 1 ft (0.3 m) or less, smooth ceiling spacing running in the direction parallel to the run of the beams or solid joists shall be used and one-half the smooth ceiling spacing shall be in the direction perpendicular to the run of the beams or solid joists. For beams over 1 ft (0.3 m) in depth, spot-type detectors shall be permitted to be located either on the ceiling or on the bottom of the beams. For beam depths exceeding 1 ft (0.3 m) or for ceiling heights exceeding 12 ft (3.66 m), spot-type detectors shall be located on the ceiling in every beam pocket. For solid joists, the detectors shall be located on the bottom of the joists.	K 051	- Starting on 12/22/14 the Maintenance Director will visually audit smoke detectors monthly and the Administrator 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.		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain sprinkler pendants unobstructed and keep riser equipment areas free of storage. Failure to keep sprinkler systems maintained properly could result in the system not responding in the manner to which it is designed, damage to integral components, or the inability for proper servicing. This deficient practice affected 6 residents, staff and vendors in	K 062	The facility does ensure automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. - The facility hired an outside vendor to replace sprinkler pendants throughout the building. The vendor had to order parts and is unable to schedule replacement until end of January to mid February. An	2/16/15	

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K 062	<p>Continued From page 3</p> <p>2 of 5 smoke compartments; staff and vendors utilizing the Mechanical/Maintenance area on the date of the survey. The facility is licensed for 65 SNF/NF beds and had a census of 24 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on November 21, 2014 from 1:30 PM to 4:00 PM, observation of the Mechanical/Riser room and the Maintenance office found twelve (12) sprinkler pendants covered with paint. Further investigation found two (2) additional heads in the hall outside the Kitchen abutting the dining room. When asked, the Maintenance Director stated he had been made aware of painted heads being present in the facility during the most recent quarterly sprinkler inspection and that he was aware of this being a problem.</p> <p>2) During the facility tour conducted on November 21, 2014 from 1:30 PM to 4:00 PM, observation of the sprinkler riser located in the Mechanical room found it was filled with storage of wheelchair, bed and a variety of assorted metal appliance parts. When asked, the Maintenance Director stated he was aware that this storage was not allowed.</p> <p>Actual NFPA standard:</p> <p>Finding (1)</p> <p>NFPA 25 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1*</p>	K 062	<p>extension request was sent to Bureau of Facility Standards on 12/11/14 requesting an extension to 2/16/15.</p> <ul style="list-style-type: none"> <li>- The facility Maintenance Director cleared out the sprinkler riser location in the Mechanical room of storage on 11/28/14.</li> <li>- The facility Maintenance Director visually inspected each sprinkler pendant inside facility on 12/8/14 to identify sprinkler pendants needing replacement.</li> <li>- The facility Maintenance Director visually inspected sprinkler riser location in the Mechanical room to ensure it was free of storage on 12/8/14.</li> <li>- The facility Administrator on 12/16/14 educated the Maintenance Director to ensure the sprinkler pendants are unobstructed. By 2/16/15 with the completion of the sprinkler pendant replacement, the facility Maintenance Director will oversee any painting to ensure sprinkler heads are protected.</li> <li>- The facility Administrator inserviced all staff on 12/10/14 of ensuring that the sprinkler riser location in the Mechanical room is free of storage. The Maintenance Director taped off area around sprinkler risers indicating where it must be free of storage.</li> <li>- Starting 2/16/15 visual inspection of the sprinkler pendants will be included in the monthly maintenance inspections to ensure the sprinkler pendants are unobstructed. Starting 12/22/14 areas around the sprinkler risers in the Mechanical room will be added to the weekly inspections to ensure it is free of</li> </ul>		

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K 062	Continued From page 4 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.  Finding (2)  9-2.3* All system valves shall be protected from physical damage and shall be accessible. NFPA 101 LIFE SAFETY CODE STANDARD	K 062	items. Maintenance inspections will be presented in the quarterly CQI Meeting. Compliance, continuation or discontinuation of monitoring will be discussed in quarterly CQI meeting.		
K 064 SS=D	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the "K" style fire extinguisher was at the correct height and placarded. Failure to position and sign extinguishers properly could potentially result in damage to the equipment, or using the wrong extinguisher designed for the hazard. This deficient practice affected staff and	K 064	The facility does ensure that fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10. - The facility's Maintenance Director by 12/16/14 raised the "K" style fire extinguisher to the correct height and	12/25/14	

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K 064	<p>Continued From page 5</p> <p>vendors utilizing the main Kitchen on the date of the survey. The facility is licensed for 65 SNF/NF beds and had a census of 24 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 21, 2014 from 1:30 PM to 4:00 PM, observation of the K-style fire extinguisher in the main kitchen found it placed directly on the floor under a prep sink and unsigned. When asked, the Kitchen staff and the Maintenance Director both indicated they were not aware that this extinguisher required specific placement and signage.</p> <p>Actual NFPA standard:</p> <p>NFPA 10 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.</p> <p>1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).</p>	K 064	<p>added the placard stating "The fire protection system shall be activated prior to using the fire extinguisher."</p> <ul style="list-style-type: none"> <li>- The facility's Maintenance Director inspected all fire extinguishers throughout the building to ensure they were at the correct height by 12/16/14. The facility's Administrator inserviced the Maintenance Director on 12/16/14 on the requirement ensuring the fire extinguishers are placed at the correct height and that the "K" style fire extinguisher has the proper placard.</li> <li>- Starting 12/22/14 the facility's Maintenance Director will include visual inspection of the fire extinguisher height to his monthly maintenance log.</li> <li>- The Maintenance Director will report findings to Administrator or designee who will report findings from monthly inspections to the quarterly CQI Meetings. Compliance, continuation or discontinuation of monitoring will be discussed in quarterly CQI meeting.</li> </ul>	12/25/14	
K 076	NFPA 101 LIFE SAFETY CODE STANDARD	K 076			

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K 076 SS=D	<p>Continued From page 6</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that electrical systems installed in oxygen transfilling locations were installed in accordance with NFPA 99. Failure to provide electrical installations in oxygen storage locations at the designated height could potentially result in damage of these installations. This deficient practice affected staff or vendors engaged in oxygen transfilling or storage in the outside oxygen transfilling room.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 21, 2014 from 1:15 PM to 4:00 PM, observation of the light switch in the oxygen transfill room found it to be installed at approximately 46 inches above the floor.</p> <p>Actual NFPA standard:</p>	K 076	<p>The facility does ensure that medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu. ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu. ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <ul style="list-style-type: none"> <li>- The facility's Maintenance Director installed the electrical system in oxygen transfilling location in accordance with NFPA 99 by 12/10/14.</li> <li>- The facility's Administrtor inserviced the Maintenance Director on the requirement of the electrical system in the oxygen transfilling location by 12/16/14.</li> <li>- The facility's Maintenance Director will visually inspect the electrical system in</li> </ul>	

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K 076	Continued From page 7  NFPA 99 4-3.1.1.2 (a) * Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both)..... 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage.	K 076	the oxygen transfilling location monthly and will add to the monthly maintenance log starting 12/22/14. - The Maintenance Director will report findings to Administrator or designee who will report findings from monthly inspections to the quarterly CQI meetings. Compliance, continuation or discontinuation of monitoring will be discussed in the quarterly CQI meeting.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001590</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/21/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MCCALL REHABILITATION &amp; CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>418 FLOYDE STREET MC CALL, ID 83638</b>
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(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) COMPLETE DATE
C 000	<p><b>16.03.02 INITIAL COMMENTS</b></p> <p>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 with a fire alarm system with corridor detection. The facility is currently licensed for 65 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on November 21, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000		
C 226	<p><b>02.106 Meet Fire and Life Safety Standards</b></p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.</p> <p>This Rule is not met as evidenced by: Please refer to federal "K" tags on CMS form 2567</p> <p>K 051 Smoke detection</p>	C 226	See POC for K051, K062, K064, and K076.	2/16/15

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
Electronically Signed

TITLE

(X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001590</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/21/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MCCALL REHABILITATION &amp; CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>418 FLOYDE STREET MC CALL, ID 83638</b>
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C 226	Continued From page 1 K 062 Sprinkler system maintenance K 064 Fire extinguisher placement and signs K 076 Oxygen room electrical installations	C 226		