



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

March 29, 2016

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

Provider #: 135082

Dear Ms. Steffler:

On **March 18, 2016**, a survey was conducted at McCall Rehabilitation & Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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/or Medicaid program participation requirements.

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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 8, 2016**. Failure to submit an acceptable PoC by **April 8, 2016**, may result in the imposition of civil monetary penalties by **May 1, 2016**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

- **Civil Monetary Penalty**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 18, 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, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina

Bobette Steffler, Administrator  
March 29, 2016  
Page 3 of 4

Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (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.

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](#)

This request must be received by **April 11, 2016**. If your request for informal dispute resolution is received after **April 11, 2016**, 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, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



David Scott, R.N., Supervisor  
Long Term Care

DS/lj

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

PRINTED: 08/17/2016  
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. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility March 14-18, 2016.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Presie Billington, RN Linda Kelly, RN</p> <p>Abbreviations included: Abx- Antibiotic ADL - Activity of Daily Living AEB - As evidence by BID - Twice a day BPSD - Behavioral and Psychological Symptoms of Dementia CAA - Care Area Assessment CCM - Clinical Case Manager CNA - Certified Nurse Assistant CP - Care Plan CT - Computerized Tomography DNS - Director of Nursing Services ER - Emergency Room ICC - Infection Control Committee L -liters LN - Licensed Nurse MD - Medical Doctor mg - Milligram(s) MMSE - Mini Mental State Exam NC - Nasal Cannula O2 - Oxygen OT - Occupational Therapist POA - Power of Attorney PT - Physical Therapy RSC - Resident Services Coordinator Sat - Saturation SS - Social Services</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

04/07/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 000	Continued From page 1 WC - Wheelchair MDS - Minimum Data Set	F 000			
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.  This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to provide privacy	F 164	Preparation and submission of this Plan of Correction does not constitute an	4/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 164	<p>Continued From page 2</p> <p>when discussing financial issues and medical appointments for 1 random resident (#11). The failure had the potential to negatively affect the resident's psychosocial well-being. Findings included:</p> <p>On 3/16/16 at 2:20 pm, Resident #11 said that a few months prior the Administrator confronted him/her in the dining room during lunch and discussed the money he/she owed the facility in front of other residents and staff. The resident said he/she did not like that discussion taking place in that setting in front of others.</p> <p>A Grievance/Complaint Report, dated 9/16/15, documented, "Resident was confronted about needing to pay his patient share amount at lunch time in the dining area by [administrator's name]..."</p> <p>The Grievance/Complaint Report included a statement from CNA #3, dated 9/22/15, which documented, "At 11:30 am on 9/16/15 [administrator's name] was talk [sic] to [resident's name]. About his pay source [sic]. They got very loud about this problem in Resident dinning area." An unsigned and undated note also documented that two male residents witnessed the encounter and the administrator was "there specifically to engage [the] resident."</p> <p>On 3/17/16 at 9:55 am, CNA #3 stated the 9/16/15 encounter between Resident #11 and the administrator and said the discussion involved the resident paying his/her "share" and an appointment. The CNA said it happened in the dining room just before lunch. The CNA said he/she was the only staff present; a male</p>	F 164	<p>admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.</p> <p>The facility does ensure the resident(s) are provided personal privacy and confidentiality when discussing financial issues and medical appointments.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>By 4/26/16, the Administrator will be provided a 1:1 in- service education by the company president regarding F-164 on Personal Privacy/Confidentiality of records with emphasis on providing resident(s) with privacy when discussing financial issues and medical appointments.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 164	Continued From page 3 resident and a female resident were also present.  On 3/17/16 at 11:50 am, the Administrator said the 9/16/15 discussion with Resident #11 in the dining room was about a dental appointment and transportation to the appointment. The Administrator said she "never" talked to the resident about money in the dining room. The Administrator said she and the Assistant Administrator talked to the resident privately about the money issue a few days later in the resident's room. The Administrator said LN #2 and a male resident were present when the 9/16/15 discussion took place in the dining room.	F 164	This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, alert Resident(s) may have the potential to be affected by this deficiency; therefore; - By 4/27/16, Resident(s) appointment schedule(s) and financial information with alert Resident(s) will be discussed in the RSC office or place of preference by the alert Resident(s). - By 4/26/16, a Communication log, was developed by the Director of Nurses that shows discussion with alert residents regarding appointment schedule(s) and/or financial information that took place in RSC office or place of preference by the alert resident(s).  Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:  To ensure that the deficient practice does not recur, By 4/26/16, the facility Department Managers will be provided an in-service education by the Director of Nurses or her designee with regards to F-164 on Personal Privacy/Confidentiality of records with emphasis; - On providing alert resident(s) with privacy when discussing financial issues and/or medical appointments. - Resident(s) appointment schedule(s) and financial information will be discussed with alert Resident(s) in the RSC office or		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 164	Continued From page 4	F 164	<p>place of preference by the Resident(s), starting 4/27/16.</p> <p>- Regarding the Communication log, that will show discussion took place in RSC office or preference by the alert resident(s) regarding appointment schedule(s) and/or financial information.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Director of Nurses or designee will review the Communication log, to ensure that the discussions with alert residents regarding appointment schedule(s) and/or financial information took place in RSC office or location of personal preference of the alert resident(s).</p> <p>Monitoring will start on 4/28/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Director of Nurses or designee will present to the quarterly QA&amp;A Committee meeting any findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>		
F 226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written</p>	F 226		4/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 226	<p>Continued From page 5</p> <p>policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of personnel files and staff interview, it was determined the facility failed to verify the professional credentials for 2 of 5 new employees, including the nursing license for 1 LN (Staff A) and the State Nurse Aide Registry for 1 of 2 CNAs (Staff B) before or upon hire. The failure placed 9 of 9 sample residents (#s 1 through 9) under the LN and CNA's care at increased risk when the facility failed to ensure staff held appropriate credentials and those credentials were in good standing. Findings included:</p> <p>On 3/15/16, review of five new employee personnel files revealed the following: a. Staff A, was hired 11/23/15 but the LN's nursing license was not verified until 1/4/16, 43 days after hire. b. Staff B was hired on 1/20/16 but the CNA's certification was not verified until 3/15/16, 56 days after hire.</p> <p>On 3/15/16 at 3:30 pm, the Administrator said the DNS had viewed Staff A's nursing license on-line but did not print the document. The Administrator also said the DNS had previously printed Staff B's CNA verification and status but could not find the documentation.</p>	F 226	<p>The facility does ensure the verification of professional credentials.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> <li>- Staff A (LN) license verification was printed on 01/04/2016, and in good standing.</li> <li>- Staff B (C.N.A.) certification verification was printed on 03/15/2016, and in good standing.</li> </ul> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>All Residents may have the potential to be affected by this deficiency, hence by 4/26/16, All Nurses License(s) and C.N.A.s certificate(s) will be reverified and reprinted to ensure professional credentials are appropriate and in good standing by the Director of Nurses or LN designee.</p> <p>Measures that will be put into place or systemic changes you will make to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 226	Continued From page 6	F 226	<p>ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur, by 4/26/16 the Director of Nurses will be in-serviced by the facility Administrator or her designee, related to F-226 with emphasis on the importance of verifying and printing of all Nurse license(s) and C.N.A.s certificate(s) before or upon hire to ensure that staff's professional credentials are appropriate and in good standing.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur;</p> <p>Monitoring will be done through:</p> <p>The facility Administrator or designee will do a random sampling of at least (3) new hire nursing staff to ensure that Nurses License(s) or C.N.A.s certificate(s) are verified and printed before or upon hire to ensure that staff's professional credentials are appropriate and in good standing.</p> <p>Monitoring will start on 4/28/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Administrator or designee will submit to the QA&amp;A Committee any findings and/or corrective actions taken during the quarterly QA&amp;A Committee Meeting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 226	Continued From page 7	F 226			
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure residents were treated with dignity and respect during their dining experience. This was true for 1 of 9 sample residents (# 8) and 1 random resident (#12). The failure had the potential to negatively affect the residents' self-esteem. Findings included:</p> <p>1. On 3/15/16 at 7:45 am, LN #2 was observed as he/she administered six oral medications to Resident #8 in the dining room five minutes after the first breakfast meal was served. Twenty-three other residents were in the dining room.</p> <p>Immediately after the observation, LN #2 said the resident had not asked for any of the medications and none of the medications were ordered to be administered with food.</p> <p>2. On 3/15/16 at 9:00 am, LN #2 was observed as he/she interrupted Resident #12's breakfast to administer eye drops and an insulin injection in</p>	F 241	<p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p> <p>The facility does promote care for resident in manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>By 4/26/16, the Director of Nurses or LN designee will provide 1:1 education with LN#2 regarding F-241 on ensuring the resident(s) is treated with dignity and respect during dining experience, with emphasis on not administering medications during meal times or interrupting resident(s) meal, unless such medication is ordered to be given during mealtime.</p> <p>Identification of other residents having the same potential to be affected by the same</p>	4/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 241	<p>Continued From page 8</p> <p>the resident's abdomen. The resident was seated in a recliner next to the bed in his/her room with the meal tray on an over bed table in front of the resident. The LN moved the overbed table with the meal tray on it away from the resident while she administered the medications.</p> <p>Immediately afterward, the LN said he/she interrupted the resident's meal because he/she was getting behind in passing medications.</p>	F 241	<p>practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, all residents may have the potential to be affected by this deficiency, therefore on 4/19/16 a visual observation will be done by the Director of Nurses or LN designee on all three (3) meals to ensure that LN are not administering medications during meal times or interrupting resident(s) meal, unless such medication is ordered to be given during mealtime.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur by 4/26/16 the Director of Nurses or LN designee will provide inservice education to all L.N. regarding F-241 on ensuring that the resident(s) is treated with dignity and respect during dining experience, with emphasis on not administering medications during meal times or interrupting resident(s) meal, unless such medication is ordered to be given during mealtime.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 241	Continued From page 9	F 241	<p>Monitoring will be done through:</p> <p>The Director of Nurses or LN designee will do a random visual observation during meal service to ensure the resident(s) is treated with dignity and respect during their dining experience, with emphasis on not administering medications during meal times or interrupting resident(s) meal, unless such medication is ordered to be given during mealtime.</p> <p>Monitoring will start on 4/28/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Director of Nurses or LN designee will present to the quarterly QA&amp;A Committee meeting any findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>		
F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident</p>	F 250	<p>The facility does provide</p>	4/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 250	<p>Continued From page 10</p> <p>interview and record review, it was determined the facility failed to implement social service interventions to meet a resident's mental health needs. This was true for 1 of 4 (#4) residents sampled for social services and had the potential for psychosocial harm when the resident's anger, anxiety, and depression were not addressed by the facility to provide non-pharmacological aide with these conditions. Findings include:</p> <p>Resident #4 was admitted to the facility on 12/24/15 with multiple diagnoses including dementia without behavioral disturbance cancer, and adult failure to thrive. On 3/7/16, a single episode of major depression, was added to the resident's diagnoses.</p> <p>A Social Service Evaluation, dated 12/24/15, completed by the RSC documented, "Resident can be demanding and difficult to work with. Resident struggles with cognition deficits. He is capable of making decisions but is often confused about facts. He is rigid and wants things to go his way. He lacks patience and flexibility but his stubbornness is manageable."</p> <p>The Admission MDS, dated 12/31/15, coded the resident had difficulty hearing; usually had the ability to understand others and was understood; moderate memory impairment; periodic disorganized thinking; felt down, depressed, or hopeless; felt tired or had little energy; felt bad about himself; and had trouble concentrating.</p> <p>Social Service notes from 1/4/16 to 3/8/16 documented: a. 1/4/16 - Resident's mood assessment indicated the resident suffered from mild</p>	F 250	<p>medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>On 3/7/16 Resident #4 started on an antidepressant medication for depression and care plan was updated for non-drug interventions on 3/8/16. The Social Service Consultant will evaluate Resident #4 for depression by 4/15/16.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, other residents who have diagnosis of depression may be affected by this deficiency, therefore, the Administrator or designee will review all resident□s with diagnosis of depression by 4/20/16 to ensure that non-drug interventions are included in resident(s) depression care plan and a referral is made to Social Service Consultant when necessary.</p> <p>Measures that will be put into place or systemic changes you will make to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 250	<p>Continued From page 11</p> <p>depression. The resident admitted he was depressed and stated it related to weakness and lack of independence.</p> <p>Resident #4's depression was not addressed on the care plan until 3/8/16 and documented the resident had depression as evidenced by yelling at others. Interventions included: Verbally redirect resident to another subject, Social Services to provide 1:1 as needed, offer resident something to eat or drink as needed, and praise resident and thank him for talking with staff.</p> <p>A Physician Note, dated 3/7/16, documented, "Staff has noticed he has been angry. When asked if an antidepressant would help him, he stated maybe."</p> <p>A Physician Order, dated 3/7/16, documented, start Paxil 10 mg tablet by mouth every morning.</p> <p>Nurses Notes documented on 3/9/16 that the resident was tearful, wanted to visit with staff, and had increased signs and symptoms of depression.</p> <p>On 3/14/16 at 4:20 pm, Resident #4 was observed in his wheelchair sitting in front of the sink. When asked how he was doing, the resident stated, "I can't get a hold of my son or my friend and I don't think I will make it through the night. I am so weak." When asked if he knew why he was so weak, he stated he had not had a very good appetite and was not eating well.</p> <p>On 3/15/16 at 10:00 am, Resident #4 was observed sitting in the recliner in his room. When asked how he was feeling, the resident stated he</p>	F 250	<p>ensure that the deficient practice does not recur includes the following:</p> <p>By 4/26/16, the Administrator or designee will provide 1:1 education with the RSC regarding F-250 on ensuring;</p> <ul style="list-style-type: none"> <li>- The importance of non-drug interventions being included in resident(s) depression care plan and that a referral is made to Social Service Consultant when necessary.</li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Administrator or designee will review at least three (3) residents with diagnosis of depression to ensure that non-drug interventions are included in resident(s) depression care plan and a referral is made to Social Service Consultant when necessary.</p> <p>Monitoring will start on 4/28/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or designee will present to the quarterly QA&amp;A Committee meeting any findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>		

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

PRINTED: 08/17/2016  
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. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 250	<p>Continued From page 12</p> <p>was not feeling very well and wanted to go home. When asked about his military career, the resident stated he had been a scout in WWII and it was a dangerous job. He stated he was hit in the head by a piece of shrapnel and could not move; he started to tear up and stated the men in his platoon had to carry him out. When asked if it was difficult to talk about the war he stated, "Yes." He continued to speak about his wife and children, his career in the medical field, and his current business adventure. When the resident spoke about his ranch and home his eyes lit up in the anticipation of returning home.</p> <p>On 3/16/16 at 11:00 am Resident #4 was sitting in the recliner, in his room. When asked how he was doing he stated not very well. He stated he did not want to be at the facility and wanted to go home. He stated he would hire someone to come and care for him if he could just go home and said he did not want to die at the facility. He asked for help contacting his friend, who he wanted to take him home. Resident #4 stated if he could not go home he would stop eating and drinking, and noted, "I won't be a burden for anyone anymore."</p> <p>On 3/16/16 at 1:25 pm, when asked to describe her role the SS consultant stated she reviewed records; discussed social service processes with the RSC, provided input regarding activity programs and non-pharmacological interventions for residents, evaluated residents for counseling services, educated staff on how to intervene during a catastrophic event and how to join the residents in there individualized journeys. When asked how often she consults at the facility she said every six months, but is always available on</p>	F 250			

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

PRINTED: 08/17/2016  
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. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 250	<p>Continued From page 13</p> <p>an as needed basis. When asked if she had been asked to evaluate and provide input for Resident #4, the consultant stated she had not and did not know Resident #4. When asked if she should have been consulted regarding his depression she stated, "Absolutely."</p> <p>On 3/17/16 at 2:25 pm, when asked if the facility was aware of Resident #4's wishes, anxiety, and sadness, the Administrator and DNS stated they were and the resident had been struggling with these things for a while. When asked if the SS consultant had been asked to assess the resident and provide input into non-pharmacological interventions for him, the Administrator stated they had not asked SS to assess the resident, but should have sought input. When asked how often the SS consultant visited the facility, the Administrator stated every six months and that the SS consultant was available by phone if needed.</p> <p>On 3/17/16 at 3:55 pm, when asked if non-pharmacological interventions had been attempted prior to starting the resident on Paxil, the physician told the surveyor to ask the facility. When asked what signs and symptoms the Paxil was intended to address for Resident #4, the physician stated, "I prescribed the Paxil based on a conversation with [Staff #4] and what nursing staff told me." When asked what she was told, the physician stated, "[Resident #4] was experiencing increased anger due to his circumstances." When asked if a SS evaluation and input would have been appropriate prior to initiation of the Paxil, the physician stated, "I don't need to consult with SS or have SS evaluate a patient prior to prescribing an antidepressant. I'm</p>	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 250	Continued From page 14 not sure that would have even made a difference to me."	F 250			
F 329 SS=G	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure a medication prescribed for Alzheimer's disease, had adequate indications for use; was adequately monitored; was not administered at	F 329	The facility does ensure that each resident's drug regimen is free from unnecessary drugs.  Corrective action(s) accomplished for	4/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 329	<p>Continued From page 15</p> <p>an excessive dose; and was reduced or discontinued when the resident experienced adverse consequences to the medication. This was true for 1 of 4 (#4) sampled residents. Resident #4 was harmed when he experienced nausea/vomiting, increased weakness, increased confusion and delusions, and tremors related to Aricept. Findings include:</p> <p>Resident #4 was discharged from the hospital and admitted to the facility on 12/24/15 with multiple diagnoses including squamous cell carcinoma of the face with cellulitis, leukocytosis [abnormal increase in the number of circulating white blood cells], recurrent falls, pressure ulcer of the right hip, dementia without behavioral disturbance, amnesia, and failure to thrive.</p> <p>A Hospital Discharge Summary, dated 12/24/15, documented, "The patient's dementia has not been worked up consider referral to neurology for further work-up as outpatient."</p> <p>A Social Service Evaluation, dated 12/24/15, documented, "Resident can be demanding and difficult to work with. Resident struggles with cognition deficits. He is capable of making decisions but is often confused about facts. He is rigid and wants things to go his way. He lacks patience and flexibility but his stubbornness is manageable."</p> <p>Social Service notes from 1/4/16 to 3/8/16 documented: * 1/4/16 - Upon assessment of the resident's cognition it was determined the resident suffered from moderate impairment. "The resident was assessed three additional times after admission</p>	F 329	<p>those residents found to have been affected by the deficient practice:</p> <p>Resident #4 Aricept 23 mg was ordered by his Primary Physician, subsequently through his Primary Physician's proficient consultation with Resident #4 Neurologist. The Neurologist recommended the medication for brain atrophy/Alzheimer's Disease. Aricept is not an anti-psychotic drug. Resident #4 received the 23 mg Aricept as ordered by his Primary Physician on 03/09/16 to 03/12/16 and 03/14/16, Resident refused on 03/13/16, 03/15/16, and 03/16/16. Aricept 23 mg was given as prescribed by Resident #4 Primary Physician. The resident was being monitored by LN and changes were reported to primary physician and DPOA. A recommendation by the Director of Nurses to discontinue Resident #4 Aricept was declined by his Primary Physician and instead his Primary Physician agreed to change the dose to 5 mg daily on 3/17/16. Aricept 5 mg daily order was discontinued on 4/4/16.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, other Resident(s) on Aricept may have the potential to be affected by this</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 329	<p>Continued From page 16 and his score went up." The resident's clinical record did not include the three additional assessments nor did it document any additional information regarding the resident's cognition.</p> <p>The Admission MDS, dated 12/31/15, coded the resident had difficulty hearing, usually had the ability to understand others and to be understood, moderate memory impairment, periodic disorganized thinking, felt down depressed or hopeless, felt tired or had little energy, felt bad about himself, and had trouble concentrating.</p> <p>The current care plan documented Resident #4 had a recent illness and deconditioning in the home setting which led to a decline in cognition. Interventions included: Encourage communication as a way to improve memory; ask about past experiences to assist with long-term memory; and assist resident with finishing his thoughts as needed. On 3/14/16, the following intervention was added, "If resident rambles to other subjects allow him to talk and then redirect."</p> <p>A neurology consult, dated 2/9/16, documented, the resident was doing "very well up until November and stated he has had mild problems with memory for about the last two months... He reports no family history of dementia and complained of generalized weakness and increased confusion for the last 3 days. He reported flu-like symptoms as have many people at the facility. He is not on medications for dementia and does not report psychotic symptoms. He scored a 9/30 on his MMSE." [According to the Alzheimer's Society the MMSE</p>	F 329	<p>deficiency, hence;</p> <ul style="list-style-type: none"> <li>- By 4/20/16, all current Aricept order(s) will be reviewed by the Pharmacist Consultant to ensure adequate dosage for Aricept order(s).</li> <li>- By 4/20/16, all current refusal of Aricept by the Resident(s) will be reviewed by the Director of Nurses or LN designee to ensure all current refusal of Aricept by the Resident(s) includes reason for refusal on the MAR.</li> <li>- By 4/20/16, all current Aricept order(s) will be reviewed by the Director of Nurses or LN designee to ensure that the adverse side effects to be monitored related to Aricept, are incorporated on the MAR.</li> </ul> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur, By 4/20/16 the Director of Nurses or LN designee will notify all attending physicians via letter regarding the Aricept Manufacturer's specifications for dosage and administration.</p> <p>By 4/20/16, the facility Director of Nurses or LN designee, will provide an in-service education to all License Nurses with regards to F-329 with emphasis on;</p> <ul style="list-style-type: none"> <li>- Ensuring that when receiving a new order to start Aricept, that the physician is notified regarding the Aricept</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 329	<p>Continued From page 17</p> <p>is used to assist in the assessment of dementia and is only one part of the assessment.] "Based on the limited amount of information available, it appears the patient suffers from Alzheimer's disease and is in the moderate to severe stage of this. As the patient reports that he is feeling ill and confused, it is unclear if his score today on the MMSE represents his true baseline. It is recommended that this be repeated by his physician when he is feeling better, and prior to final determination regarding competency. Aricept and Namenda may provide some benefit..."</p> <p>Nurses Notes from 2/9/16 to 3/7/16 documented two occurrences of increased confusion for Resident #4:</p> <p>a. On 3/5/16 at 12:30 pm, the resident was alert with confusion to time and situation and not easily re-oriented.</p> <p>b. On 3/6/16 R 1:00 pm, the resident was alert with less confusion than the day before.</p> <p>Physician Visits for 2/9/16 and 3/7/16 documented:</p> <p>a. 2/9/16 - "Probable dementia of the Alzheimer's type with a score of 9/30 on MMSE. Performance may have been affected by an intercurrent [sic] illness, UA pending."</p> <p>b. 3/7/16 - "Staff has noticed he has been angry. Patient is very talkative today but fixated on recent visit with [Physician's name] and the forms he had to fill out. He denies other particular problems, although he is a very poor historian. His visit with neurology was reviewed and he scored a 9/30 on MMSE and either Aricept or Namenda were recommended." The note did not include whether a repeat MMSE assessment was</p>	F 329	<p>Manufacturer's specifications for dosage and administration.</p> <ul style="list-style-type: none"> <li>- Importance of documenting reason for the refusal of Aricept on the MAR.</li> <li>- The adverse side effects to be monitored in relation to Aricept, are incorporated on the MAR.</li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur;</p> <p>Monitoring will be done through:</p> <p>The Director of Nurses or LN designee will review at least three (3) Residents(s) on Aricept to ensure;</p> <ul style="list-style-type: none"> <li>- That when License Nurse(s) receiving a new order from the physician to start an Aricept, that the physician is notified regarding the Aricept Manufacturer's specifications for dosage and administration.</li> <li>- License Nurse(s) documenting the reason for Resident(s) refusal of Aricept on the MAR.</li> <li>- That the adverse side effects to be monitored in relation to Aricept were incorporated on the MAR.</li> </ul> <p>Monitoring will start on 4/28/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Director of Nurses or LN designee will present to the quarterly QA&amp;A Committee meeting any findings and/or corrective actions taken.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 329	<p>Continued From page 18</p> <p>completed prior to the initiation of the Aricept; whether a risk and benefits had been discussed with the resident; and whether there was input from the resident.</p> <p>A Physician Order, dated 3/7/16, documented a new order for Aricept 23 mg by mouth daily.</p> <p>The FDA and 2015 Manufactures specifications, for dosage and administration of Aricept documented:</p> <p>a. Dosing in mild - moderate Alzheimer's Disease - The recommended starting dosage for Aricept is 5 mg administered once per day in the evening, just prior to bed. The maximum recommended dosage is 10 mg per day. A dose of 10 mg should not be administered until patients have been on a daily dose of 5 mg for 4 to 6 weeks.</p> <p>b. Dosing in moderate - severe Alzheimer's Disease - The recommended starting dosage of Aricept is 5 mg administered once per day in the evening prior to bed. The maximum recommended dosage is 23 mg per day. A dose of 10 mg should not be administered until patients have been on a daily dose of 5 mg for 4 to 6 weeks. A dose of 23 mg per day should not be administered until the patients have been on a daily dose of 10 mg for at least 3 months.</p> <p>c. The most common adverse reactions for patient's receiving Aricept 23 mg daily include vomiting, nausea, dizziness, anorexia, fatigue, somnolence, depression, and has the potential to cause hallucinations.</p> <p>The March 2015 MAR documented the following:</p> <p>a. The resident received the first dose of Aricept on 3/8/16 and from 3/9/16 to 3/12/16 and 3/14/16.</p>	F 329	<p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 329	<p>Continued From page 19</p> <p>b. The resident refused the Aricept on 3/13, 3/15 and 3/16/16. The documented refusals did not include an explanation or reason for the refusals.</p> <p>c. The MAR did not document the adverse side effects nurses should be monitoring and documenting related to the Aricept.</p> <p>Nurses Notes from 3/9/16 to 3/14/16 after the Aricept was initiated documented:</p> <p>a. 3/9/16 at 1:00 am - Resident #4 was tearful, wanted to talk with staff, and told them they were special.</p> <p>b. 3/9/16, day shift - Updated the resident's POA regarding Resident #4's increased signs and symptoms of depression, seeing God, and new order for Aricept.</p> <p>c. 3/10/16, day shift - Resident with large incontinent bowel movement and multiple periods of confusion.</p> <p>d. 3/11/16, day shift - Resident with emesis x 1 today and increased weakness and confusion. Called POA [and] explained decline in resident's condition and concerns regarding him "passing away."</p> <p>e. 3/12/16 at 11:00 am - Resident verbalized nausea/vomiting; experienced increased confusion; started having delusions and accusing staff of poisoning his food; would not follow directions; could not be redirected; and developed tremors in his extremities.</p> <p>f. 3/14/16 at 4:00 pm - Resident experienced increased weakness; decreased level of consciousness; decreased strength; and decreased oral intake.</p> <p>On 3/16/15 at 10:00 am, the resident discussed many areas of his life including his military service during WWII and how he was wounded</p>	F 329			

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

PRINTED: 08/17/2016  
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. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 329	<p>Continued From page 20</p> <p>when a piece of shrapnel hit him in the head; how he met his wife; his children; his life as a physician; his ranch with his log cabin home; and his current business venture.</p> <p>On 3/17/16 at 2:25 pm, when asked if the facility requested the Social Service consultant to evaluate Resident #4's memory impairment, the Administrator and DNS stated they had not asked, but should have. The Administrator stated they were concerned the memory issues were related to the resident's current medical conditions and would improve with time. When asked if the facility questioned the Aricept dose, the DNS stated she thought about it but did not pursue it with the physician and should have. When asked if the nurses were monitoring the medication for adverse side effects, the DNS stated they were not and should be.</p> <p>On 3/17/16 at 3:55 pm, via telephone interview with the resident's physician, when asked if it would have been important to address and resolve the resident's medical concerns prior to initiating the Aricept; how it was determined the benefits of this medication were greater than the risks; and if the resident's baseline cognition had been assessed, the physician stated, "If you want to know that you need to read the neurology evaluation and ask the neurologist. I can't speak to what he was thinking. I prescribed the Aricept based on his recommendation." When asked why the resident was started on 4.5 times (23 mg) the manufactures recommended dosage, the physician stated, "If I started the resident on that dose (23 mg) it was a mistake and it should have been started at the lower dose (5 mg)." The physician then directed the surveyor to change</p>	F 329			

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

PRINTED: 08/17/2016  
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. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 329	<p>Continued From page 21</p> <p>the order to the lowest dose. The surveyor informed the physician the order would have to be given to a nurse at the facility. The DNS, who was present for the interview, informed the physician she would take the order. The physician stated, "I am on vacation and I am driving right now so I can't look up the dose, just put him on the lowest dose and I will address it when I get back." When the DNS asked the physician if she would consider discontinuing the medication or holding the medication related to the resident experiencing adverse effects, the physician indicated she did not want the medication held and the resident should be transported to the hospital if he experienced dehydration related to nausea/vomiting/ diarrhea from the Aricept.</p> <p>On 3/18/16 at 9:05 am, the facility's pharmacist stated he would not question the physician's order regarding the dose of the medication. He stated the pharmacy would check the new medication with the resident's current medications for possible drug interactions. The pharmacist stated the facility's consulting pharmacist would be responsible for reviewing the resident's record and addressing potential concerns regarding the dosage. When asked if Aricept should be started at 23 mg, the pharmacist stated, "No, it should have been started at the lowest dose, 5 mg and then titrated up if necessary." When asked if increased weakness; decreased level of consciousness, decreased strength, decreased oral intake, nausea/vomiting, increased confusion, new onset delusions, and tremors could be associated with such a high dose of Aricept, the pharmacist stated, "Absolutely."</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 353 SS=F	<p><b>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</b></p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident group interview, review of a 3-week nursing schedule, record review, observations, and resident and staff interviews, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of residents. This affected 7 of 9 sample residents (#s 1, 2, 4, 5, 8, 9, and 10), 1 random resident (#14), 4 of 6 residents who attended the group interview, and had the potential to effect all other residents in the facility. This failed practice created the potential for</p>	F 353	<p>The facility does ensure there is adequate staffing to provide for the needs and well-being of each resident.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>On those days mentioned in the Statement of deficiencies-form CMS-2567, the facility was in compliance</p>	4/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 353	<p>Continued From page 23</p> <p>psychosocial and physical harm for all residents in the facility. Findings include:</p> <p>1. On 3/16/16 at 10:00 am, when residents were asked if there were enough staff to take care of everyone, 5 of 6 residents stated there was not. Two residents stated, "Staff will answer your call light, turn it off, and tell you they will be back and they don't come back." Two residents stated, "For the number of residents the aides are spread real thin. They tell you they will be back soon, but it's more like 30 minutes or longer." One resident stated call lights were on all night (10 pm - 6 am) the night before (3/15/16). One resident stated he had to wait longer than one hour for his call light to be answered. One resident stated, "During the day shift, a couple of days ago I had to wait an hour or longer to get off the toilet. I had ring around the butt!" Five residents stated there was not enough staff to help everyone who needed it during meals.</p> <p>2. On 3/16/16 between 7:40 am and 8:30 am, there were twenty-four residents were observed eating breakfast in the dining room. Ten of those residents required various levels of assistance from supervision to total assist. At 7:50 am, Resident #4 was served his breakfast on a lipped plate with the lip turned away from him. The resident's plate was at least 6-8 inches in front of him and the table was at chest level. Resident #4 scooped up a small amount of food on his fork and it fell on the table. He attempted to scoop it off the table and missed. He unsuccessfully attempted to scoop up more food from his plate and placed the empty fork in his mouth. The resident attempted a third bite which fell on his clothing protector. He unsuccessfully attempted</p>	F 353	<p>with the State guidelines on the 2.4 hours per patient day.</p> <p>Staffing schedule was reviewed and completed by the Director of Nursing on 4/1/16 and additional staffing will be added when necessary.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>All residents in the facility may have the potential to be affected by this deficiency; therefore On 4/19/16, the Administrator or designee and Director of Nurses or designee will do a visual observation of meal service to ensure resident(s) receive adequate assistance. On 4/19/16 through 4/20/16 the Administrator or designee and Director of Nurses or designee will do random visual rounds to ensure call lights are answered in a timely manner for each shift.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur, Starting 3/30/16 the facility recruited by word of mouth, continued with listing in Job Service, and placed help wanted advertisement in weekly local paper (by</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 353	<p>Continued From page 24</p> <p>to scoop the food off the clothing protector. CNA #3 was alerted to the observation and left Resident #1 to assist Resident #4. CNA #3 verbalized Resident #4 had new adaptive plate and fork for breakfast and called out in a raised voice to no one in particular, "What side is the lipped part of the plate supposed to be on? CNA #6, who was removing residents from the dining room, stated, "The lipped part is supposed to be towards the resident." CNA #3 repositioned the plate and attempted to cue Resident #4 as she walked back to assist Resident #1.</p> <p>At 8:05 am, CNA #3 was observed assisting Resident #1 and 3 other residents requiring total assistance. When asked if this was a normal occurrence during meals, CNA #3 stated it was "always" like that and there was "never" enough help to assist all those residents requiring help. The LN was observed periodically assisting residents but was unable to assist any one resident for the entire meal due to other residents requiring her assistance outside of the dining room.</p> <p>At 8:10 am, CNA #3 moved to another table to assist Resident #2 with her breakfast, which had been served at 7:50 am. The CNA cut up the resident's pancakes and sausage and fed her a bite. When asked how she was doing, Resident #2 stated, "I am fine when she feeds me." After CNA #3 overheard Resident #1's comment, she returned to assist Resident #1. CNA #3 assisted Resident #1 with 2-3 more bites and then moved to assist Random Resident #14 with her breakfast, which had also been served at 7:50 am.</p>	F 353	<p>4/14/16) for C.N.A.s. Also continue to work with College of Western Idaho for local C.N.A. class.</p> <p>By 4/26/16 the Administrator or designee will inservice Nursing staff on F-353 with emphasis on the importance of providing residents with the necessary assistance during mealtime and answering call lights in timely manner.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Administrator or designee will do a random visual observation of meal service to ensure resident(s) receive adequate assistance. Administrator or designee will do a random visual round to ensure call lights were answered in a timely manner. The Administrator or designee will interview three (3) random residents to ensure the resident(s) is receiving adequate assistance at meals and to ensure call lights are answered in a timely manner.</p> <p>Monitoring will start on 4/28/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or designee will present to the quarterly QA&amp;A Committee meeting any findings and/or corrective actions taken.</p>		

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

PRINTED: 08/17/2016  
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. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 353	<p>Continued From page 25</p> <p>At 8:15 am, CNA #6 sat down to assist Random Resident #15 with her meal in between assisting residents on the hall.</p> <p>At 8:20 am, Resident #4 continued to struggle with his breakfast, Resident #9 was observed eating her cooked cereal with her knife, and Resident #8 was observed having emesis at the breakfast table. When asked if she needed assistance, Resident #8 was unable to respond. The nurse was alerted to Resident #8 having emesis at the table and her inability to respond. The nurse stated that was not unusual for Resident #8 to have emesis during meals related to her risk for aspiration. The nurse stated the resident declined a mechanically altered diet or thickened liquids. Additionally the nurse stated the resident did not cut her food up and "shovels it in her mouth." The nurse instructed CNA #6 to take the resident to her room and she (nurse) would be down "shortly" to listen to the resident's lungs.</p> <p>At 8:25 am, the Administrator and DNS were informed of the observations and asked to watch. The Administrator stated there was not enough staff to assist all of the residents that required help. The Administrator assented that due to the limited number of staff available to assist residents the food was not at a desirable temperature, which decreased palatability. The Administrator stated, "We used to have 3 CNAs on the floor to assist with meals, however there are only 2 CNAs on the floor now until 10:00 am due to staffing challenges." The Administrator then walked over to Resident #4 and asked if he would like his breakfast re-heated. She took the resident's plate to the activity room and re-heated</p>	F 353	Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 353	Continued From page 26 it in the microwave oven.  At 8:30 am, the DNS was observed to assisting Resident #4 with his meal. The Administrator and DNS stated there was "room for improvement."  Failure to provide adequate nursing staff affected residents dining experience and had the potential to affect residents' meal intakes and weight. Additionally, failure to provide adequate nursing staff placed residents at risk for injury related falls, aspiration, unmet toileting needs, and other ADL needs for which the residents required assistance.	F 353			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		4/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 431	Continued From page 27  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure medication labels matched physician orders, medications were labeled, and expired medications and biologicals were not available for resident use. This was true for 1 of 9 sample residents (#6), two random residents (#12 and #13), and other residents who may have required screening for TB, influenza vaccination, insulin, or laboratory blood tests. The failure created the potential for less than optimal benefit and/or adverse reactions if medications were not administered at the frequency ordered, the wrong dose was administered, the wrong medication was administered, and for inaccurate TB screening and laboratory results. Findings included: 1. During medication pass observations, the following were observed: a. On 3/14/16 at 2:45 pm, LN #1 administered Restasis 1 drop in each eye for chronic dry eyes to Resident #12. The LN said the resident requested the medication early. The pharmacy	F 431	The facility does ensure that medication labels matched physician orders, medications were labeled, and expired medications and biological were not available for resident use.  Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:  - By 4/15/16 the Pharmacy sent a new order of Restasis with the accurate Pharmacy label. - By 4/15/16 the Pharmacy sent a new order of Levemir with the accurate Pharmacy label. - On 3/15/16 the Director of Nurses disposed of the expired laboratory test tubes. - On 3/15/16 the Director of Nurses disposed of the expired Lantus insulin bottle. - On 3/15/16 the Director of Nurses		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 431	Continued From page 28 label on the Restasis documented, "1 drop in both eyes every day..." The Restasis order, dated 8/15/16, documented, "Twice daily" administration." On 3/14/16 at 3:00 pm, LN #1 said, "It's BID," when asked about the discrepancy between the Restasis order and the pharmacy label. b. On 3/15/16 at 9:00 am, LN #2 prepared Resident #12's Restasis eye drops and Levemir insulin for injection. The Restasis pharmacy label still documented "every day" rather than twice daily as ordered. The LN drew up Levemir 30 units in the syringe. The Levemir pharmacy label documented, "Inject 20 units subcutaneously every morning ..." As the LN left the medication cart with the medications in hand, she was asked about the dose of Levemir. The LN stated, "The label is wrong. It says 20 [units] but she gets 30 [units]." The LN reviewed the physician's Levemir order with the surveyor before he/she administered the medications. The order, dated 12/7/15, documented Levemir 30 units daily. 2. On 3/15/16 at 9:40 am, during inspection of the medication room with the DNS, two expired gold top laboratory test tubes were found. One of the test tubes expired July 2015 and the other expired October 2015. The DNS disposed of the expired test tubes. 3. On 3/15/16 at 10:00 am, during the medication refrigerator inspection with the DNS, an unopened Lantus insulin bottle, labeled house stock and expired as of May 2015, was found. There were also no "open" date on an opened 10 tests vial of Tuberculin for TB screening and an opened 5 dose vial of Influenza Virus vaccine. The DNS disposed of all of the expired items. 4. On 3/15/16 from 10:15 am to 10:30 am, during inspection of the West Wing medication cart with	F 431	disposed of the undated, open vial of Tuberculin for TB screening and the undated, open vial of Influenza vaccine. - On 3/15/16 the Director of Nurses disposed of the Hydrocodone-APAP and the Oxycodone.  By 4/20/16, The Director of Nurses and LN #1 will be provided 1:1 In-Service education by the Pharmacy Consultant with regards F 431 with emphasis on the importance of making sure that medication(s) are labeled and/or that medications can not be separated from bottle without labels.  By 4/14/16, The Director of Nursing will inform the contracting pharmacy of the expired medications and the incorrect labels.  Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:  All Residents may have the potential to be affected by this deficiency therefore; - By 4/19/16, the Director of Nurses or LN designee inspected both Medication Carts to ensure that medications have the accurate Pharmacy labels per MD order. - By 4/19/16, the Director of Nurses or LN designee inspected the Medication Room to ensure that there is no expired laboratory test tubes. - By 4/19/16, the Director of Nurses or LN designee inspected the Medication		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 431	<p>Continued From page 29</p> <p>LN #2, Resident #6's pack of Hydrocodone-APAP was found with an expiration date of 11/30/15. The LN said she would notify the DNS and the medication would be destroyed. A plastic zip bag with "Oxycodone 5 mg" in handwriting on the bag was also found in a locked drawer in the cart. The bag contained a bottle of Oxycodone 5 mg for Resident #13 and 4 unmarked clear plastic packs with 10 small white tablets in each pack. The unmarked packs were closed with staples. The LN said the tablets in the unmarked packs were also the resident's Oxycodone 5 mg. The LN said she would ask the DNS what to do with the tablets in the unmarked packs.</p> <p>On 3/15/16 at 10:40 am, the DNS said a bottle of 80 Oxycodone 5 mg tablets from home came with Resident #13 when the resident was admitted to the facility. The DNS said she knew the tablets in the unmarked packs were Oxycodone 5 mg because she and LN #1 had divided the Oxycodone into 4 packs of 10 and left the rest in the bottle to make it easier for nurses to count the medication. The DNS said she would call the pharmacy for direction about the unlabeled packs of medication.</p> <p>On 3/15/16 at 11:00 am, the DNS, with the Administrator present, said the tablets in the unmarked packs would be destroyed.</p>	F 431	<p>Refrigerator to ensure that there was no expired house stock of insulin bottles.</p> <ul style="list-style-type: none"> <li>- By 4/19/16, the Director of Nurses or LN designee inspected the Medication Refrigerator to ensure that opened vials of Tuberculin for TB Screening and/or Influenza Virus Vaccine have an open date. <input type="checkbox"/></li> <li>- By 4/19/16, the Director of Nurses or LN designee inspected both Medication Carts to ensure that there was no unlabeled medication(s).</li> </ul> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur an In-service training will be completed by 4/20/16 by the Pharmacy Consultant regarding F- 431 to all License Nurses and HIM (who picks up test tubes) to ensure that;</p> <ul style="list-style-type: none"> <li>- Pharmacy medication labels match MD order, and replacement medications must be ordered from Pharmacy with dosing changes.</li> <li>- Importance of disposing any expired medications and/or laboratory test tube,</li> <li>- Importance on checking at front and back label of medications when delivered by the pharmacy,</li> <li>- Importance of dating Tuberculin or TB Screening and/or Influenza Virus Vaccine vials when opened,</li> <li>- Importance of making sure that medication(s) are labeled and/or that</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 431	Continued From page 30	F 431	<p>medications can not be separated from bottle without labels.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Director of Nurses or LN designee will inspect;</p> <ul style="list-style-type: none"> <li>- Medication carts to ensure that medications have accurate Pharmacy labels,</li> <li>- That there is no expired laboratory test tubes in medication room,</li> <li>- That there is no expired house stock of insulin bottles in the medication refrigerator,</li> <li>- That if there is an opened vial of Tuberculin for TB Screening and/or Influenza Virus vaccines in medication refrigerator that they have a open date,</li> <li>- That there are no unlabeled medications in medication carts.</li> </ul> <p>Monitoring will start on 4/28/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nurses or LN designee will present to the QA&amp;A Committee in her quarterly report findings from observations and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the</p>		

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

PRINTED: 08/17/2016  
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. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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	
F 431	Continued From page 31	F 431	QA&A Committee quarterly 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. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

C 000	16.03.02 INITIAL COMMENTS  The following deficiencies were cited during the state licensure and complaint survey conducted at the facility March 14 -18, 2016.  The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Presie Billington, RN Linda Kelly, RN	C 000		
C 664	02.150,02,a Required Members of Committee  a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) attendance records, it was determined the facility failed to ensure the FSS and a housekeeping/laundry representative participated in ICC meetings at least quarterly. The lack of participation of all ICC members created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings included:  On 3/17/16 at 10:40 am, the facility's Infection Control Program was reviewed with the DNS and CCM. The DNS said she was training the CCM to take over the program. The DNS said the ICC met monthly and that the Medical Director, Pharmacist, Administrator, CCM, all department heads, and herself participated in the ICC.  On 3/17/16 at 11:45 am, the Administrator provided ICC attendance records dated 9/10/15,	C 664	The facility does ensure that all required members of Infection Control Committee (ICC) or their designee are present for the quarterly Infection Control meetings.  Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:  By 4/26/16 the FSS and Housekeeping/Laundry representative will be provided 1:1 inservice education by Administrator or designee on the importance of attending the quarterly Infection Control Committee (ICC) meeting.  Identification of other residents having the same potential to be affected by the same deficient practice and what corrective	4/29/16

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  04/07/16
------------------------------------------------------------------------------------------------------------------------------------	-------	---------------------------

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. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/18/2016</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) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

C 664	Continued From page 1  10/8/15, 11/12/15, 12/10/15, 1/14/16, 2/11/16, and 3/10/16. The Administrator said the FSS did not attend any ICC meetings because she was busy in the kitchen. Review of the ICC attendance records also revealed that a housekeeping/laundry representative did not attend meetings in October, November, or December 2015.	C 664	<p>action(s) taken includes the following:</p> <p>There were no residents affected by this deficiency</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>By 4/26/16 all ICC members will be provided an inservice by Administrator or designee with regards to C664 with emphasis of attending quarterly ICC meetings.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Administrator or designee will review quarterly ICC attendance record sign in sheets to ensure all members of ICC meetings are present on a quarterly basis.</p> <p>Monitoring will start on 4/28/16. This will be done quarterly for 4 quarters.</p> <p>The facility Administrator or designee will present to the QA&amp;A Committee in her quarterly report findings from observations and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>	
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

August 15, 2016

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

Provider #: 135082

Dear Ms. Steffler:

On **March 18, 2016**, an unannounced on-site complaint survey was conducted at McCall Rehabilitation & Care Center. This complaint was investigated during the facility's Federal Recertification, State Licensure, and Complaint survey conducted on-site from March 14, 2016 to March 18, 2016.

Twenty-eight residents and nine sampled residents were observed for quality of life and quality of care throughout the survey. In addition, seven Certified Nursing Assistants, four Licensed Nurses, the Director of Nursing Services, the Administrator, the Activity Director, the Medical Records Director, two therapy staff, two housekeepers, three kitchen staff, and the Maintenance Director were observed for the provision of care and services throughout the survey process.

The clinical records of nine residents were reviewed for quality of life and quality of care issues, the facility's Grievance/Complaint reports and Abuse Allegation investigations for January 1, 2015 through March 2016 were reviewed, and Incident/Accident reports from May 2015 to March 2016 and Resident Council Meeting minutes from January to March 2016 were reviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007015**

Allegation #1:

The floor in an identified resident's room was often wet and/or sticky with urine.

Findings #1:

Based on observations, record reviews, and interviews, there was no evidence that residents' rooms, common areas, or television areas smelled of urine and/or had wet and/or sticky floors. This allegation was not substantiated.

Conclusion:

Unsubstantiated. Lack of sufficient evidence.

Allegation #2:

The identified resident had a seizure and was medicated with a muscle relaxant. When he awoke, the resident had missed the pre-activity preparation for an upcoming activity.

Findings #2:

The identified resident's record was reviewed regarding the activity in question and included documentation the resident had attended the pre-activity preparation and the scheduled activity. The allegation was unsubstantiated.

Conclusion:

Unsubstantiated. Lack of sufficient evidence.

Allegation #3:

The facility would not fix the identified resident's electric wheelchair.

Findings #3:

Based on record review and staff interview, it was determined the resident had an electric wheelchair during his first admission to the facility, however the facility identified the wheelchair was missing pieces and was unsafe to use. The identified resident discharged from the facility and re-admitted a second time without the electric wheelchair. The concerned party notified the facility that the resident needed a new electric wheelchair and felt the facility was responsible to provide it. The facility offered to assist the family with the necessary paperwork to request assistance from insurance to obtain a new wheelchair and the family declined. It was determined the allegation was unsubstantiated.

Conclusion:

Unsubstantiated. Lack of sufficient evidence.

Allegation #4:

Bobette Steffler, Administrator  
August 15, 2016  
Page 3 of 3

The staff are short-tempered and angry.

Findings #4:

Based on observations, interviews, and record review, there was no evidence that staff were short-tempered or acted angry towards the identified resident or any other resident in the facility. The identified resident stated during an interview, "I like it here, the staff treat me very well, and if I can't be at home this is a good place." The allegation was unsubstantiated.

Conclusion:

Unsubstantiated. Lack of sufficient evidence.

Allegation #5:

There are an insufficient number of staff to care for all of the residents.

Findings #5:

Based on resident group interview, review of the three-week nursing schedule, record review, observations, and resident and staff interviews, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of residents. This allegation was substantiated and cited at F353.

Conclusions:

Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



Nina Sanderson, LSW, Supervisor  
Long Term Care

Bobette Steffler, Administrator

August 15, 2016

Page 4 of 3



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

July 25, 2016

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

Provider #: 135082

Dear Ms. Steffler:

On **March 18, 2016**, an unannounced on-site complaint survey was conducted at McCall Rehabilitation & Care Center. The complaint was investigated during the facility's Federal Recertification, Complaint Investigation, and State Licensure survey conducted on-site from March 14, 2016 to March 18, 2016.

Twenty-eight residents in general and nine specific residents were observed for quality of life and quality of care concerns throughout the survey. Seven Certified Nursing Assistants, four Licensed Nurses, the Director of Nursing Services, the Administrator, the Assistant Administrator, the Activities Director, the Medical Records/Transport driver, two therapy staff, two housekeepers, three kitchen staff, and the Maintenance Director were observed for the provision of cares, medication administrations, and services, during the survey.

Interviews regarding quality of life and quality of care concerns, as well as abuse, neglect, and misappropriation of residents' belongings, including medications, were conducted with three individual residents, six residents in a Resident Group meeting, and two resident representatives. In addition, interviews regarding the same topics were conducted with five direct care staff, three charge nurses, the Director of Nursing Services, and the Administrator.

Bobette Steffler, Administrator  
July 25, 2016  
Page 2 of 3

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007050**

**ALLEGATION #1:**

The facility "was missing medications taken by a nurse" but did not investigate or report the missing medications and did not do a drug urine screen on the nurse. In addition, when the missing medication was discovered the "doctor for the center" wrote prescriptions to cover the missing items.

**FINDINGS:**

The clinical records of nine residents were reviewed for quality of life and quality of care concerns and the controlled medication reconciliation records for ten residents was reviewed. In addition, the facility's Grievance/Complaint Reports and Abuse Allegation Investigations, both for January 1, 2015 through March 2016, as well as Incident and Accident reports for May 2015 through March 2016, medication error reports, and Resident Council meeting minutes for January, February, and March 2016 were also reviewed.

Based on the observations, record reviews, and interviews, there was no evidence that medications had been missing or were misappropriated. It was determined the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

Several residents have hit and "abused" other residents without staff intervention or prevention and two nurses hit residents without interventions or preventative measures. One resident hit people with a broom and the facility uses other residents to watch that resident. "Mental abuse" was perpetrated against residents by making them wait for coffee and a nurse "abused" a resident and was not allowed in the resident's room. An unidentified resident was allegedly "held down by the nurses" during an adult brief change and presented with bruising afterwards.

**FINDINGS:**

Based on the observations, interviews, and record reviews, there was no evidence that residents hit one another with a broom, residents had to wait for coffee, any resident had to "watch" other

Bobette Steffler, Administrator  
July 25, 2016  
Page 3 of 3

residents, or that staff hit residents or held them down. There was no evidence that residents were mentally or physically abused. It was determined that the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The "D" is stylized with a vertical line through it, and "Scott" is written in a cursive-like font.

David Scott, RN, Supervisor  
Long Term Care

DS/lj