



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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July 28, 2016

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

Provider #: 135082

Dear Ms. Steffler:

On July 28, 2016, an off-site follow-up of your facility was conducted to verify correction of deficiencies noted during the survey of March 18, 2016. McCall Rehabilitation & Care Center was found to be in substantial compliance with federal health care requirements regulations as of July 5, 2016.

Thank you for your assistance during the off-site follow-up process. 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, RN, 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: 135082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/28/2016
NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION & CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MC CALL, ID 83638		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>On July 28, 2016, an off-site follow-up survey of your facility was conducted to verify correction of deficiencies noted during the survey of June 3, 2016. McCall Rehabilitation and Care Center was found to be in substantial compliance with federal health care regulations as of July 5, 2016.</p> <p>The surveyor conducting the survey was Loretta Todd, R.N.</p>	{F 000}		

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

TITLE

(X6) DATE

Electronically Signed

08/08/2016

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.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001590	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/28/2016
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NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MC CALL, ID 83638
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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{C 000}	<p>16.03.02 INITIAL COMMENTS</p> <p>On July 28, 2016, an off-site follow-up survey of your facility was conducted to verify correction of deficiencies noted during the survey of June 3, 2016. McCall Rehabilitation and Care Center was found to be in substantial compliance with federal health care regulations as of July 5, 2016.</p> <p>The surveyor conducting the survey was Loretta Todd, R.N.</p>	{C 000}		
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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 08/08/16
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