



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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May 5, 2017

Jeff Lines, Administrator
McCall Rehabilitation & Care Center
418 Floyde Street
Mc Call, ID 83638-4508

Provider #: 135082

Dear Mr. Lines:

On **April 21, 2017**, 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. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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) and on or before the "Opportunity to Correct." **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. Waiver renewals may be requested on the Plan of Correction.

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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 **May 15, 2017**. Failure to submit an acceptable PoC by **May 15, 2017**, may result in the imposition of penalties by **June 10, 2017**.

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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 26, 2017 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 20, 2017**. A change in the seriousness of the deficiencies on **June 5, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **July 20, 2017** includes the following:

Denial of payment for new admissions effective **July 20, 2017**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 18, 2017**, 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 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.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 20, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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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 **May 15, 2017**. If your request for informal dispute resolution is received after **May 15, 2017**, 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,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style.

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 05/18/2017
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 04/21/2017
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	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from April 18, 2017 to April 21, 2017. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Patricia Perryman, RN Survey Abbreviations: AD = Activities Director ADL = Activities of Daily Living CDC = Centers for Disease Control CNA = Certified Nursing Assistant DON = Director of Nursing IDT = Interdisciplinary Team LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment NOC = Night PRN = As Needed PVD = Peripheral Vascular Disease RCD = Regional Clinical Director	F 000			
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was	F 241	Preparation and submission of this Plan	5/18/17	

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

TITLE

(X6) DATE

Electronically Signed

05/11/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	<p>Continued From page 1</p> <p>determined the facility failed to ensure residents were treated with dignity and respect during their dining experience when staff did not engage the residents while talking amongst themselves. This was true for 1 of 7 sampled residents (#7) and 2 random residents (#9 & #10) reviewed for resident rights and created the potential to negatively affect residents' sense of self-worth and self-esteem. Findings include:</p> <p>On 4/18/17 at 12:55 pm, CNAs #1, #2 and #3 were observed assisting Residents #7, #9 and #10 with their meals. All three CNAs were discussing the topics of hay bales and horses with each other for several minutes. None of the CNAs engaged or included the residents they were assisting into the conversation.</p> <p>On 4/19/17 at 7:55 am, CNAs #1 and #2 were observed assisting Residents #7 and #9 with their meals. The two CNAs were discussing the topics of how early CNA #1 went to bed the previous night and how her leg hurt, the best way to cook clams and fixing a roof. Neither CNA engaged or included the residents they were assisting into the conversation.</p> <p>On 4/19/17 at 9:05 am, CNA #1 said Residents #7, #9 and #10 no longer talked much. CNA #1 said she and the other CNAs talked about subjects that might interest the residents, but said she could see how it may have appeared that she was not engaging the residents.</p> <p>On 4/19/17 at 9:15 am, CNA #2 said she tries to have small talk and bring the residents into conversations amongst staff as "it's better than dead silence."</p>	F 241	<p>of Correction does not constitute an 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.</p> <p>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>F- 241 SS=D ¿483.10(a)(1) <input type="checkbox"/> Dignity and Respect of Individuality</p> <p>The facility does ensure that Resident(s) are treated with dignity and respect during their dining experience by staff engaging the Resident(s) during their conversation.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>By 05/15/2017, the Administrator or Designee will provide a 1:1 in-service education to C.N.As #1, #2, and #3, regarding F-241 regarding Dignity and Respect to Individuality, on ensuring that Residents are treated with dignity and respect during their dining experience ,with emphasis on the importance of</p>		

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F 241	Continued From page 2 On 4/20/17 at 8:25 am, the Director of Nursing [DON] said she would expect staff to engage the residents during meal times, even if the residents were not able to talk.	F 241	<p>engaging the Resident(s) with their conversation, even if the Resident(s) are not able to talk .</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, all current Resident(s) who attend dinning may have the potential to be affected by this deficiency, therefore; By 05/17/2017, the Administrator or Designee and Director of Nursing or Licensed Nurse Designee will do a one time visual observation on all three (3) meals to ensure that Resident(s) are treated with dignity and respect during their dining experience, i.e. C.N.A.s are engaging the Resident(s) with their conversation, even if the Resident(s) are not able to talk...</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 05/15/2017, the Director of Nursing or License Nurse Designee, will provide an Educational In-service training to all C.N.As regarding F-241, on ensuring that Residents are treated with dignity and</p>		

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F 241	Continued From page 3	F 241	<p>respect during their dining experience ,with emphasis on the importance of engaging the Resident(s) with their conversation, even if the Resident(s) are not able to talk.</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: The Administrator or Designee will do a random visual observation in the Dining area during meal service to ensure that the Resident(s) are treated with dignity and respect during their dining experience i.e. C.N.A.s are engaging the Resident(s) with their conversation, even if the Resident(s) are not able to talk. Monitoring will start on 05/18/2017. 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&A Committee meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>		
F 248 SS=E	<p>483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>(c) Activities.</p> <p>(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing</p>	F 248		5/18/17	

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F 248	<p>Continued From page 4</p> <p>program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and interview with staff and a resident's Interested Party, it was determined the facility failed to provide an ongoing program of activities that included:</p> <ul style="list-style-type: none"> - Conducting planned activities, - Clear communication of upcoming activity changes to staff and residents, and - Following a resident's activity care plan. <p>This was true for 1 of 5 residents who attended the resident group interview, and 1 of 7 sampled residents (#7) reviewed for activities, and had the potential to affect all 20 residents in the facility. This deficient practice created a potential for psychosocial harm should residents not have the opportunity to socialize with their peers, participate in activities as anticipated, and/or participate in those activities specifically care planned for their enjoyment. Findings include:</p> <p>The facility's 2001 Activities policy documented the following: "It is requested that a two (2) hour advance notice of a cancellation or change be provided so that appropriate personnel and residents may be notified of such changes...Sufficient activity personnel will be on duty to meet the needs of the residents...The</p>	F 248	<p>F- 248 SS=E ¿483.24(c)(1) Activities Meet Interests/Needs of Each Res</p> <p>The facility does provide an on-going program of activities that includes: Conducting planned activities, Clear Communication of upcoming activity changes to staff and residents, and Following a resident's activity care plan.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>By 05/15/2017, the Administrator or Designee will provide a 1:1 in-service education to Activity Director and Activity Assistant, regarding F-248, with emphasis on providing an ongoing program of activities that included: Conducting planned activities, Clear Communication of upcoming activity changes to staff and residents, and Following a resident's activity care plan.</p> <p>By 05/17/2017, an Activity Care Plan Binder, will be created by the Activity</p>		

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F 248	<p>Continued From page 5</p> <p>activity care plan contains a listing of activities that the resident enjoys, or may enjoy..."</p> <p>1. The facility's April 2017 Activity Calendar documented the following activities and times:</p> <ul style="list-style-type: none"> * 4/18/17 - 2:30 pm: Bowling * 4/19/17 - 10:00 am and 1:30 pm: 1-to-1 Time * 4/20/17 - 9:15 am: Communion and 1-to-1 Time * 4/20/17 - 12:00 pm: Family Style Lunch * 4/20/17 - 2:30 pm: Painting/Reading * 1-to-1 Time was scheduled for a total of 27 times for the month * Family Style Lunch was scheduled for a total of 4 times. <p>a. On 4/18/17 at 2:35 pm, the facility's large activity calendar in the main hallway documented a bowling activity was to be conducted at that time. Plastic bowling pins and a bowling ball were observed in a crate in the activity room, but from 2:35 pm to 3:20 pm, there was no bowling activity conducted anywhere in the facility. At 3:20 pm, the main hallway activity calendar was observed with the bowling activity crossed out and a hand written note that documented, "Postponed until Thursday 2:30."</p> <p>On 4/19/17 at 4:30 pm, during the Resident Group Interview, one resident who did not want to be identified said the activities were "good," but sometimes "you twiddle your thumbs."</p> <p>On 4/20/17 at 2:30 pm, the main hallway calendar documented "Painting/Reading" scheduled for 2:30 pm was canceled and, in a handwritten note, readers were notified "bowling" would take its place. At 2:35 pm, the AD</p>	F 248	<p>Director or Designee, and will be put in the Nurses Station for the Staff to reference to for Residents activity plan of care.</p> <p>By 05/15/2017, Resident #7 activity care plan was placed in the Activity Care Plan Binder, in the Nurses Station for the Staff to reference to with regards to her activity plan for example but not limited to Staff to tune Resident #7 television to animal channel or one showing cartoons or comedy for auditory and visual stimulation PRN.</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 current Resident(s) may have the potential to be affected by this deficiency, hence by 05/15/2017 the Administrator or Designee and Director of Nursing or License Nurse Designee will do a one-time unannounced visual observation to ensure the following: Activities are conducted as planned, Clear Communication of upcoming activity changes to staff and residents, and Following of a resident's activity care plan.</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>		

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F 248	<p>Continued From page 6</p> <p>(Activities Director) was observed setting up the bowling activity. At 2:40 pm, the AD was observed going room to room on the West hallway asking residents if they wanted to join the activity. No other staff were observed asking residents about the activity and staff was not observed asking residents on the East hallway whether they wanted to participate in the activity. At 2:47 pm, there were two residents at the activity and at 3:01 pm one more resident had joined the activity.</p> <p>c. From 4/19/17 to 4/21/17 the following was observed during "1-to-1 Time:"</p> <p>* On 4/19/17 at 10:20 am, the main hallway calendar documented "1-to-1 Time" was to begin at 10:00 am. At 10:20 am, the AD was observed in a meeting in the business office with other staff. From 10:20 am to 10:45 am, no other staff were observed engaged in a 1-to-1 activity in the facility. At 10:45 am, the AD was observed making a phone call on the phone outside of the business office.</p> <p>*On 4/19/17 at 1:45 pm, the main hallway calendar documented "1-to-1 Time" was to have begun at 1:30 pm. At 1:45 pm, the AD was observed in her office using a cellphone; no other staff were observed engaged in a 1-to-1 activity anywhere in the facility. At 1:55 pm, the AD was observed entering the room of a newly admitted resident where she conducted what appeared to be an activity assessment. At 2:05 pm, the AD was observed leaving the resident's room and returning to her office, where she remained until 2:10 pm.</p>	F 248	<p>To ensure that the deficient practice does not recur, By 05/15/2017, the Administrator or Designee, will provide in-service to all Staff regarding F-248, with regards to the Activity Care Plan Binder, that was created by the Activity Director or Designee and to be put in the Nurse Station for the Staff to reference to, to ensure that the established activity care plan for the Resident(s) is followed.</p> <p>By 05/15/2017, the Administrator or Designee will in-service all Staff regarding F-248, with emphasis on providing an ongoing program of activities that included the importance of: Conducting planned activities, Clear Communication of upcoming activity changes to the residents, and Following a resident's activity care plan.</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: The Administrator or Designee will do a random unannounced visual observation to ensure the following: Activities are conducted as planned, Clear Communication of upcoming activity changes to staff and residents, and Following of a resident's activity care plan.</p> <p>Monitoring will start on 05/18/2017. This</p>		

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F 248	<p>Continued From page 7</p> <p>*On 4/20/17 at 9:15 am, the main hallway calendar documented "Communion/1-to-1 Time" was scheduled to begin at 9:15 am. At 9:15 am, 5 residents were observed in the Day Room with a local clergy member offering communion. At 9:20 am, the AD was observed in a resident's room assisting the resident with audio headphones. From 9:23 am to 9:37 am, the AD was observed in either her office or the MDS office; no other staff were observed engaged in 1-to-1 activity in the facility.</p> <p>d. On 4/20/17 at 12:00 pm, the main hallway calendar documented a "Family Style Lunch" was to have begun at noon, and the dining room hours of service posting documented lunch began at 12:10 pm. From 12:00 pm to 12:15 pm, 13 residents were observed in the dining room while the AD and other staff members assisted residents with drink service. No other activity was observed in the dining room or any other area of the facility.</p> <p>e. On 4/20/17 at 3:20 pm, the main hallway calendar documented an activity of "Daisy Girl Scouts" was to have begun at 3:15 pm. The AD and three residents were observed in the dining room with two visitors, who were playing a dominos game with one of the residents. Just prior to 3:30 pm, another resident self-ambulated into the dining room and at 3:30 pm, several Daisy Girl Scouts with their two leaders arrived in the dining room. There were no observed attempts by staff to gather any other residents at that time in either the East or the West hallways as the AD sat down and listened to the Girl Scouts give a presentation to the four residents. At 3:35 pm, the Regional Clinical Director (RCD)</p>	F 248	<p>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&A Committee meeting the findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>		

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F 248	<p>Continued From page 8</p> <p>and the Director of Nursing (DON) were observed going room to room on the West hallway asking residents if they wanted to join the ongoing activity. No staff were observed asking residents on the East hallway whether they wished to attend the activity. At 3:45 pm, there were a total of eight residents attending the activity where the Girl Scouts were coloring pictures for the residents.</p> <p>f. On 4/20/17 at 4:20 pm, the main hallway calendar was observed with all of the activities for 4/21/17 canceled and in their place the calendar documented, "[AD] and [AD's Assistant] Gone." At 4:30 pm, the Administrator said the AD's Assistant had been absent from work all week due to medical issues and the AD had already left for the day and had a medical appointment that would prevent her from being at work on 4/21/17.</p> <p>On 4/21/17 from 8:10 am to 11:40 am, the main hallway calendar documented, "[AD] and [AD's Assistant] Gone."</p> <p>On 4/21/17 at 8:12 am, a resident who did not want to be identified said he/she was not always informed when an activity was canceled.</p> <p>On 4/21/17 at 9:10 am, a resident who did not want to be identified said he/she did not know if an activity had been canceled since he/she did not participate very often in group activities.</p> <p>On 4/21/17 at 9:30 am, CNA #4 said she checked the main hallway activity calendar or asked activity staff what activities were offered. She said she did not know what activities were</p>	F 248			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 248	<p>Continued From page 9 scheduled for that day.</p> <p>On 4/21/17 at 9:45 am, CNA #5 said she checked the main hallway activity calendar or asked the AD or a nurse to find out what activities were offered. She said she did not know what activities were scheduled for that day.</p> <p>On 4/21/17 at 10:50 am, the Administrator said he was not sure how residents were informed when an activity was canceled or changed and said he could see how a resident might assume there were no planned activities when the main hallway calendar did not document activities planned for the day. The Administrator said the AD probably put on the calendar that she and her assistant were gone for 4/21/17 as a way to communicate to staff and residents that they were both gone. He said he was not sure why the Bowling activity was postponed or why another activity was not substituted in its place. He said he was not sure why the Story Time activity never occurred as scheduled. He said the 1-to-1 Time activity consisted of the AD, the AD's Assistant, or other staff members spending extra time with residents doing 1-on-1 activities like sensory stimulation, games, reading, etc. He said an activity assessment should not be counted as a 1-to-1 Time activity. The Administrator stated the AD's Assistant would often conduct 1-to-1 Time activities when the AD was in meetings such as 4/19/17, but the AD's Assistant was not in the facility that day. When told of the lack of 1-to-1 Time activities, the Administrator said he was not sure why the 1-to-1 Time activities were not conducted during that time as scheduled. The Administrator said the Family Style Lunch activity consisted of the AD sitting with residents during</p>	F 248			

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F 248	<p>Continued From page 10</p> <p>lunch so all residents had an opportunity to spend a little extra time with the AD each month. He said he was not sure how the Family Style Lunch differed from other staff members assisting residents with their meal. The Administrator said the activity staff and CNAs should ask residents to join the activities.</p> <p>2. Resident #7 was admitted to the facility on 2/24/16 with multiple diagnoses, including intellectual disabilities, and cerebral palsy [birth injury resulting impairment or loss of motor function].</p> <p>Resident #7's 1/10/17 quarterly MDS assessment documented she was dependent on staff for all activities of daily living [ADLs].</p> <p>The current activity care plan, dated 1/27/17, documented staff were to tune Resident #7's television to the animal channel or one showing cartoons or comedy "for auditory and visual stimulation PRN," and that the AD was to offer "informal" 1-to 1 activities "PRN."</p> <p>Resident #7's Activity Quarterly progress note, dated 1/10/17, documented, "Res[indent] watches TV daily. She observes group exercises & other group activities."</p> <p>An Activities Detail Report, from 1/1/17 to 4/20/17, documented 1-to-1 activities were conducted with Resident #7 on 1/30/17 and 4/18/17.</p> <p>Resident #7 was observed in her room at the following dates and times:</p>	F 248			

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F 248	<p>Continued From page 11</p> <p>* 4/20/17 - 10:55 am: Resident #7 was in her recliner and partially engaged with the TV turned to a news talk show on a network affiliate.</p> <p>* 4/20/17 - 11:20 am: Resident #7 was in her recliner with the TV turned to a news talk show on the same network affiliate.</p> <p>* 4/20/17 - 1:28 pm: CNA #3 assisted Resident #7 in her wheelchair from the dining room to the resident's room and turned the TV onto a soap opera on the same network affiliate channel, gave Resident #7 her call light, and left the room.</p> <p>* 4/20/17 - 1:30 pm: Resident #7 did not appear to be engaged in the soap opera and did not respond when asked if she wanted to watch the soap opera.</p> <p>* 4/20/17 - 2:05 pm: Resident #7 was in her wheelchair with her roommate in the room and the TV was turned to a daytime entertainment talk show on the same network affiliate</p> <p>* 4/20/17 - 2:42 pm: CNA #2 assisted Resident #7 in her wheelchair from the therapy room to the resident's room, gave Resident #7 the call light, and left the room. Resident #7's TV was turned to a daytime entertainment talk show on the same network affiliate.</p> <p>* 4/20/17 - 2:45 pm: CNA #1 and the MDS Coordinator entered Resident #7's room with her present.</p> <p>* 4/20/17 - 3:00 pm: Resident #7 was in her wheelchair with her roommate in the room and the TV was turned to a judicial reality TV show on</p>	F 248			

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F 248	<p>Continued From page 12 the same network affiliate.</p> <p>* 4/20/17 - 3:50 pm: Resident #7 was in her wheelchair with her roommate in the room and the TV was turned to a judicial reality TV show on the same network affiliate. Resident #7 did not appear to be engaged in the show.</p> <p>* 4/20/17 - 4:15 pm: Resident #7 was asleep in her wheelchair and the TV was turned to the same network affiliate news broadcast.</p> <p>* 4/21/17 - 9:00 am: Resident #7 was in her wheelchair with the TV turned to a news talk show on the same network affiliate.</p> <p>* 4/21/17 - 10:10 am: Resident #7 was in her recliner with the TV turned to a romance channel.</p> <p>On 4/20/17 at 2:57 pm, CNA #2 said Resident #7 enjoyed watching TV and when the Activities Department provided 1-to-1 Time.</p> <p>On 4/20/17 at 4:00 pm, Resident #7's Interested Party said Resident #7 enjoyed animal and comedy TV shows.</p> <p>On 4/21/17 at 9:30 am, CNA #4 said Resident #7 very much enjoyed the animal TV channel and liked comedy shows and jokes. CNA #4 said staff also tuned Resident #7's TV to a romance story channel.</p> <p>On 4/21/17 at 9:45 am, CNA #5 said Resident #7 watched a romance type TV channel and "loved" to watch cartoons.</p> <p>On 4/21/17 at 11:45 am, the Administrator said</p>	F 248			

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F 248	Continued From page 13 staff should have followed Resident #7's activities care plan regarding the types of TV shows she enjoyed. He said it appeared Resident #7 participated in two 1-to-1 activities from January 2017 through 4/21/17.	F 248			
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that	F 309		5/18/17	

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F 309	<p>Continued From page 14</p> <p>residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and clinical record review, it was determined the facility failed to ensure physician orders were implemented for 1 of 8 residents (#4) reviewed for assistive devices. This deficient practice had the potential to cause more than minimal harm to Resident #4, who was not provided with a protective foot device or skin care as ordered by the physician to prevent further damage to an ulcerated heel. Findings include:</p> <p>Resident #4 was admitted to the facility on 10/28/16, with diagnoses that included Type II diabetes mellitus, peripheral vascular disease (PVD) with severe bilateral lower extremity ischemia [inadequate blood supply to an organ or part of the body], a non-healing ulcer on the left heel, and spinal stenosis [a narrowing of the open spaces within the spine].</p> <p>An Interdisciplinary Team (IDT) Progress Note, dated 3/8/17, documented Resident #4 was sent to a wound clinic on 2/7/17, where he was assessed with severe bilateral lower extremity [both legs] peripheral artery occlusive disease [obstruction of a major artery resulting in inadequate blood supply to parts of the body beyond the obstruction - in this case, the legs].</p> <p>Resident #4's clinical record documented he was discharged from the facility to a hospital for an</p>	F 309	<p>F- 309 SS=D ¿483.24, 483.25(k)(l) <input type="checkbox"/> Provide Care/Services for Highest Well Being</p> <p>The facility does ensure that physician orders for protective foot devices for skin care i.e. foam stocking and Darco boot were implemented as ordered by the physician ,and that if refused the Licensed Nurse(s) document Resident <input type="checkbox"/> refusal.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>By 05/15/2017, the Licensed Nurses identified during the survey, who did not apply Resident #4 foam stocking and Darco boot nor documented Resident <input type="checkbox"/> refusal to wear the foam stocking and Darco boot, will be provided with 1:1 in-service education by the Director of Nurses or Licensed Nurse Designee regarding F-309, with emphasis on the importance of implementing physician orders in regards to protective foot devices for skin care i.e. the foam stocking and Darco boot, and the importance of documenting when the Resident refuses protective foot devices</p>		

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F 309	<p>Continued From page 15</p> <p>arterial angiograph [x-ray technique used to visualize the inside of the body] on the left leg to repair circulation (no date given) and was readmitted to the facility on 2/13/17.</p> <p>A 3/8/17 Skin Team review documented Resident #4, "was provided with preventative measures and rehabilitation services since admission...is able to reposition independently in bed and offload [reduce pressure] in wheelchair (or chair)."</p> <p>The most recent MDS (Minimum Data Set) assessment, dated 3/11/17, documented Resident #4 had mild cognitive impairments, experienced delusions, was verbally inappropriate with others, and presented with 2 diabetic foot ulcers and a surgical wound.</p> <p>A Physician Progress Note for Resident #4, dated 3/21/17, documented, "Wound 1: On the posterior left heel, the large necrotic [dead tissue] ulceration is increasing in size and depth, and is dark brown to gray in color with very strong odor and moderate amount of purulent [consisting of, containing, or discharging pus] drainage found to be trapped under the necrotic tissue. This was the expected course as we were suspicious that the pressure (sic) injury was quite deep under the large necrotic cap..."</p> <p>A 3/21/17 physician's order directed staff to equip Resident #4 with a "Darco and foam stocking ... during the day, offloading [of] the [left] heel, [and a] Prevalon boot [pressure relieving boot]...at [night]."</p> <p>A Physician Progress Note for Resident #4 from</p>	F 309	<p>for skin care i.e. the foam stocking and Darco boot.</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, all current Resident(s) who have current physician order for protective foot devices for skin care i.e. foam stocking and Darco boot may have the potential to be affected by this deficiency, therefore by 05/15/2017, The Director of Nursing or Licensed Nurse Designee will do a one-time visual observation on all Resident(s) with current physician order for protective foot devices for skin care i.e. foam stocking and Darco boot, to ensure that such order is implemented and to ensure that the Licensed Nurse(s) documented Resident's refusal for protective foot devices for skin care i.e. foam stocking and Darco boot.</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 05/15/2017, the Director of Nursing or Licensed Nurse Designee, will provide an</p>		

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F 309	<p>Continued From page 16</p> <p>a Wound Clinic appointment on 3/24/17, documented his heel wound was to be treated twice daily, and Resident #4 was to receive several courses of antibiotics, as well as "offloading, Darco shoe [pressure relieving shoes] and foam stocking during the day."</p> <p>An IDT progress note, dated 3/24/17, documented, "[Resident #4] went to the wound clinic this morning and is now wearing a new, protective boot. He was very pleased with the care he was given ..."</p> <p>The Wound Center Summary of Resident #4's visit on 4/7/17 documented the left heel wound was a Stage IV ulcer.</p> <p>Resident #4's care plan was updated on 4/7/17 to direct staff to "[provide] treatment as prescribed [and apply] foam stocking and Darco boot to L [left] foot ..."</p> <p>Nurse's Notes from 2/13/17 to 4/18/17 documented Resident #4 exhibited confusion, delusional thinking, and refusal of cares. A 4/6/17 Nurse's Note, however, was the only documentation in the clinical record of Resident #4 not wearing the Darco boot.</p> <p>On 4/18/17 at 8:20 am, Resident #4 was observed in a wheelchair in his room with loosely fitting stockings, slippers on both feet, and a bandage on the heel of his left foot. Both feet were flat on the floor and Resident #4 was observed at various times throughout survey using both feet without the protective boot on to propel himself in the wheelchair through the facility.</p>	F 309	<p>Educational in-service training to all Licensed Nurses regarding F-309, with emphasis on the importance of implementing physician orders in regard to protective foot devices for skin care i.e. the foam stocking and Darco boot, and the importance of documenting when the Resident refuses protective foot devices for skin care i.e. the foam stocking and Darco boot.</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: The Director of Nurses or Licensed Nurse Designee will do a random unannounced visual observation of at least three (3) Resident(s) with current physician order for protective foot devices for skin care i.e. foam stocking and Darco boot, to ensure that such order is implemented and to ensure that the Licensed Nurse(s) documented Resident's refusal for protective foot devices for skin care i.e. foam stocking and Darco boot.</p> <p>Monitoring will start on 05/17/2017. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Director of Nurses or Licensed Nurse Designee will present to the quarterly QA&A Committee meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the</p>		

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F 309	Continued From page 17 On 4/19/17 at 9:05 am, LN #1 was observed removing the bandage to Resident #4's left heel to expose a round, scabbed area covering the entire back of Resident's #4's left heel and Achilles tendon area. LN #1 cleaned the wound with Betadine, applied a clean abdominal pad dressing to the area, reapplied stockings and a protective Darco boot to Resident #4's left foot, and then placed his left foot on the elevated wheelchair footrest it was on prior to the dressing change. On 4/19/17 at 8:10 am, the DON stated Resident #4 was to have a Darco boot on his left foot during daytime hours to protect the venous stasis ulcer on the heel, but that he "sometimes refuses things."	F 309	QA&A Committee quarterly meeting.		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures	F 441		5/18/17	

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F 441	<p>Continued From page 18 for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p>	F 441			

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 04/21/2017
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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F 441	<p>Continued From page 19</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, it was determined the facility failed to ensure staff followed its infection prevention and control program to maintain a sanitary environment and help prevent the development and transmission of communicable diseases and infections. This was true for 1 of 8 residents (#1) reviewed for infection control and created the potential for more than minimal harm should residents become infected due to poor hygienic practices by facility staff. Findings include:</p> <p>Resident #1 was admitted to the facility 4/9/15 with diagnoses that included Type II diabetes mellitus, mild cognitive impairment, multiple sclerosis, visual loss to both eyes, and hypertension.</p> <p>On 4/18/17 at 3:45 pm, LN #1 was observed providing skin care to Resident #1's excoriated buttocks. LN #1 washed her hands, collected and set-up supplies on a bedside table, mixed a topical ointment, and placed these items on a barrier covering the bedside table. LN #1 then changed her gloves without washing/sanitizing her hands, removed a pillow from between Resident #1's legs, repositioned the resident, and pulled down the resident's unsoiled brief to</p>	F 441	<p>F- 441 SS=D ¿483.80(a)(1)(2)(4)(e)(f) <input type="checkbox"/> Infection Control, Prevent Spread, Linens</p> <p>The facility does ensure that Nursing Staff washed/sanitized hands between glove changes when performing wound care.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>By 05/15/2017, Licensed #1 will be provided 1:1 in-service education by the Director of Nurses or Licensed Nurse Designee with regards to F-441, with emphasis on the importance of washing/sanitizing hands between glove changes when performing wound care.</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>		

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F 441	<p>Continued From page 20</p> <p>expose the resident's buttocks area. The nurse then changed gloves without washing/sanitizing her hands and wiped cream from the resident's buttocks with wet wipes. The areas were noted to have several reddened excoriations and Resident #1 reacted when these areas were touched by saying, "Ouch." LN #1 then removed her gloves, washed her hands and re-gloved. She applied the cream mixture with her gloved fingers to the excoriated areas, changed gloves again without washing/sanitizing her hands, and re-applied the unsoiled brief before collecting and disposing of the used supplies. LN #1 then repositioned the resident for comfort, removed her gloves, and washed her hands.</p> <p>On 4/18/17 following the wound care, LN #1 stated standards of professional practice dictate that hand sanitizer is to be used between glove changes if there was no contamination, and if the gloves were contaminated then the nurse is to wash his/her hands between glove changes. LN #1 stated she did not have sanitizer with her and failed to follow accepted practice.</p> <p>On 4/20/17 at 2:03 pm, the Infection Control Nurse stated LN #1 should have washed or sanitized her hands between glove changes when performing wound care for Resident #1.</p> <p>The facility's Handwashing/Hand Hygiene Policy documented, revised September 2005, documented: "All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial</p>	F 441	<p>However, all current Resident(s) may have the potential to be affected by this deficiency, therefore by 05/15/2017, the Director of Nursing or Licensed Nurse Designee will do a one-time visual observation on three (3) shifts to ensure that the Licensed Nurse(s) washed/sanitized hands between glove changes when performing wound care.</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 05/15/2017, the Director of Nursing or Licensed Nurse Designee, will provide an educational in-service training to all Licensed Nurses regarding F-441, with emphasis on the importance of washing/sanitizing hands between glove changes when performing wound care.</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: The Director of Nurses or Licensed Nurse Designee will do a random unannounced visual observation to ensure that the Licensed Nurse(s) washed/sanitized hands between glove changes when performing wound care.</p> <p>Monitoring will start on 05/17/2017. This</p>		

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F 441	<p>Continued From page 21</p> <p>soap and water under the following conditions: ...after handling items potentially contaminated with blood, body fluids or secretions...If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol...before preparing or handling medications, before handling clean or soiled dressing, gauze pads, etc., after contact with a resident's intact skin...after handling used dressings, contaminated equipment, etc ...After removing gloves. The use of gloves does not replace handwashing/hand hygiene."</p> <p>The Centers for Disease Control [CDC] website at www.CDC.gov, last updated 3/15/17, states, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications...Immediately after glove removal.</p> <p>Nursing staff failed to follow the facility's policy and nationally recognized standards of practice established by the CDC.</p>	F 441	<p>will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Director of Nurses or Licensed Nurse Designee will present to the quarterly QA&A Committee meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>		