



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

February 7, 2018

Jeff Lines, Administrator
McCall Rehabilitation and Care Center
418 Floyde Street
McCall, ID 83638-4508

Provider #: 135082

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Lines:

On **January 26, 2018**, a Facility Fire Safety and Construction survey was conducted at **McCall Rehabilitation And Care Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 20, 2018**. Failure to submit an acceptable PoC by **February 20, 2018**, may result in the imposition of civil monetary penalties by **March 11, 2018**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 2, 2018**, (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 **March 2, 2018**. A change in the seriousness of the deficiencies on **March 2, 2018**, 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 **March 2, 2018**, includes the following:

Denial of payment for new admissions effective **April 26, 2018**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 26, 2018**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 26, 2018**, 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:

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<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 **February 20, 2018**. If your request for informal dispute resolution is received after **February 20, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 02/06/2018
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 01/26/2018
NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION AND 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)
E 000	Initial Comments Unless otherwise indicated, the general use of the terms "facility" or "facilities" refers to all provider and suppliers affected by this regulation. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. The facility is a single story, type V (111) wood frame building that was built in 1965. The original building was flat roof construction which has been built over with a peaked roof system. The facility is fully sprinklered to include the attic space. The facility is equipped with an automatic fire alarm system which protects corridors and open spaces and was upgraded in 2015. The facility is currently licensed for 65 SNF/NF beds and had a census of 26 on the dates of the survey. The following deficiencies were cited during the Emergency Preparedness Survey conducted on January 25 and 26, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction	E 000	
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness	E 001	Plan of correction does not constitute an admission the the deficiencies alleged did in fact exist. This plan of correction is filed as evidence of McCall Rehab and Care Center desire to comply with requirements of participation and to continue to provide quality resident care.

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

TITLE

(X6) DATE

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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E 001	Continued From page 1 program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to establish and maintain a current, comprehensive Emergency Preparedness program which includes policies and procedures in accordance with 42 CFR 483.73. Failure to meet this standard has the potential to hinder facility response during an emergency which requires coordination and cooperation with local resources available. This deficient practice affected 26 residents, staff and visitors on the date of the survey. Findings include: On January 25, 2018, from 12:00 PM to 5:30 PM, review of the provided emergency plan, policies and procedures, revealed the facility had not developed a current policy or emergency plan	E 001			

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E 001	Continued From page 2 that complied with all applicable Federal, State and Local Emergency Preparedness requirements. When asked, the Administrator and Maintenance Supervisor revealed the facility was currently working on the missing requirements and would be completing the policies and procedures soon. a. Refer to E 0024 as it relates to the facility use of volunteers CFR reference: 42 CFR 483.73	E 001		
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an	E 024	The facility does ensure that all aspects of the emergency preparedness plan are in place and in accordance with Federal, State, and local laws. -On 01/30/2018 the emergency preparedness manual was updated to include E 024 Policies/Procedures -Volunteers and Staffing -On 02/23/2018 an all staff inservice was conducted informing employees of the added policy and procedures pertaining to E 024 Volunteers and Staffing.	03/09/18

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E 024	<p>Continued From page 3 emergency. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop, document and maintain current emergency policies, procedures and operational plans for the use of volunteers to address surge needs during an emergency. Lack of current plans and policies for the use of volunteers has the potential to hinder the facility's ability to care for residents and provide continuation of care during a disaster. This deficient practice could potentially affect 26 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On January 25 from 12:00 PM to 5:30 PM, review of provided policies, procedures and emergency preparedness records failed to demonstrate a current plan, which addressed the use of volunteers, or integration of State and Federally designated health care professionals to address surge needs during an emergency.</p> <p>Interview of the Administrator and Maintenance Supervisor revealed the facility was currently working with county officials and other health care facilities to create an updated list of available medical professionals in the local area that would be available in the event the facility had surge needs. Their plan is to update the policies and procedures when this information on volunteers becomes available.</p> <p>Reference: 42 CFR 483.73 (b) (6)</p>	E 024		
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K 000	INITIAL COMMENTS The facility is a single story, type V (111) wood frame building that was built in 1965. The original building was flat roof construction which has been built over with a peaked roof system. The facility is fully sprinklered to include the attic space. The facility is equipped with an automatic fire alarm system which protects corridors and open spaces and was upgraded in 2015. The facility is currently licensed for 65 SNF/NF beds and had a census of 26 on the dates of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on January 25 through January 26, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 42 CFR 483.80 and 42 CFR 483.65. The survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction K 911 SS=F Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567, Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 000		
		K 911		

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

TITLE

(X6) DATE

[Signature] ED- 2-20-18

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K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 911		

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K 911	<p>Continued From page 1</p> <p>Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop switch. Failure to provide a remote stop switch prohibits the shutdown of the generator when the room is filled with fire or smoke.</p> <p>This deficient practice affected 26 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on January 26, 2017 from approximately 8:00 AM to 9:00 AM, observation revealed the facility did not provide a remote manual stop switch for the EES generator located outside the room housing the prime mover. When asked, both the Maintenance Assistant and the Administrator stated the facility was not equipped with a remote stop switch, nor were they aware of the requirement.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building.</p> <p>5.6.5.6.1 The remote manual stop station shall be labeled.</p> <p>NFPA 99</p> <p>6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE)</p>	K 911	<p>The facility does ensure that the emergency generator is functioning properly, and that the EES generator is properly equiped.</p> <p>-On 02/12/2018 Facility maintenance director called Neil Thompson licenced electrician to schedule maintenance on EES generator.</p> <p>-Scheduled maintenance is planned for 03/05/2018.</p> <p>-Electrician will install an annunciator and emergency stop swith outside the generator room and it will be labled.</p>	

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K 916 SS=F	<p>Electrical Systems - Essential Electric System CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the EES (Essential Electrical System) was installed in accordance with NFPA 99. Failure to provide an alarm annunciator for the EES could hinder early notification of equipment failures, leaving the facility without emergency power during an outage. This deficient practice affected 26 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on January 26, 2018, from approximately 8:00 AM to 9:00 AM, observation of the work stations throughout the facility, did not reveal an alarm annunciator for the EES. When asked, the Maintenance Supervisor stated that he was not aware of an alarm panel, or other device which would indicate the facility was under auxiliary power (generator) during a power outage.</p> <p>Actual NFPA standard:</p>	K 916		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2018
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 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2018
NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MC CALL, ID 83638		
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K 916	Continued From page 3 NFPA 99 Chapter 6 Electrical Systems 6-4 Essential Electrical System Requirements - Type 1. 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load (b) When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine generator alarm condition shall indicate the following: (a) Low lubricating oil pressure (b) Low water temperature (below that required in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed	K 916			
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second	K 918	The facility does ensure that the EES generator is tested in accordance with NFPA 101 Guidelines. -On 02/19/2018 Facility maintenance director was inservices on how to correctly document testing of the EES generator.		

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K 918	<p>Continued From page 4</p> <p>criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This deficient practice affected 26 residents, staff and visitors on the date of the survey.</p>	K 918	<p>-On 02/19/2018 Facility Maintenance director was inserviced on proper load testing times for the EES generator.</p> <p>-On 02/12/2018 Facility maintenance director scheduled a EES generator load test to be done on 03/07/2018 by Rocky Mountain Cummins.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

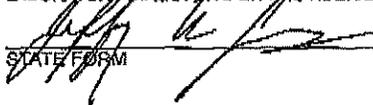
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K 918	<p>Continued From page 5</p> <p>Findings include:</p> <p>1.) During review of the facility generator inspection and testing records on January 25, 2018, from approximately 10:00 AM to 12:00 PM, the facility failed to provide the following weekly generator inspection logs:</p> <p>a.) Between 1/8/17 - 1/14/17 b.) Between 5/28/17 - 6/3/17 c.) Between 8/20/17 - 8/26/17</p> <p>2.) During review of the facility generator inspection and testing records on January 25, 2018, from approximately 10:00 AM to 12:00 PM, the facility failed to provide a three year, four hour load test.</p> <p>When asked, the Maintenance Supervisor stated that the facility was unaware of the missing inspections and load test requirement.</p> <p>Actual NFPA standard:</p> <p>NFPA 110 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.9* Level 1 EPSS shall be tested at least once within every 36 months.</p>	K 918		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001590	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE BUILDING B. WING: _____	(X3) DATE SURVEY COMPLETED 01/26/2018
NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MC CALL, ID 83638		
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C 000	INITIAL COMMENTS The facility is a single story, type V (111) wood frame building that was built in 1965. The original building was flat roof construction which has been built over with a peaked roof system. The facility is fully sprinklered to include the attic space. The facility is equipped with an automatic fire alarm system which protects corridors and open spaces and was upgraded in 2015. The facility is currently licensed for 65 SNF/NF beds and had a census of 26 on the dates of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on January 25 - 26, 2018. The facility was surveyed under the LIFE SAFETY CODE 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction	C 000		
C 260	02.106.07,h Weekly Cleaning of Range Hoods/Filters h. All range hoods and filters shall be cleaned at least weekly. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain the kitchen hood and filter systems. Failure to maintain kitchen hood and filter systems could result in build up of grease and other combustible materials that can create a fire event. This deficient practice affected the kitchen staff on the date of the survey.	C 260	Plan of correction does not constitute an admission the the deficieneies alleged did in fact exist. This plan of correction is filed as evidence of McCall Rehab and Care Center desire to comply with requirements of participation and to continue to provide quality resident care. The facility will ensure that hood and filters are cleaned and/or maintained on a weekly basis. -On 02/20/2018 Kitchen manager was inserviced on hood maintenance and cleaning -On 02/20/2018 Kitchen manager was given paperwork for documenting hood cleaning and maintenance.	03/09/18

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



TITLE

ED

(X6) DATE

2-20-18

Bureau of Facility Standards

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C 260	Continued From page 1 Findings include: During the facility tour on January 26, 2018, from approximately 8:00 AM to 9:00 AM, observation of the hood and filters in the kitchen revealed they were dirty and appeared to have a greasy build up. When asked, kitchen staff stated the hood and filters were only cleaned semi-annually by the outside contractor and stated they do not clean the filters.	C 260		