



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

November 9, 2018

Cole Clarke, Administrator
McCall Rehabilitation And Care Center
418 Floyde Street
Mc Call, ID 83638-4508

Provider #: 135082

Dear Mr. Clarke:

On **October 23, 2018**, a survey was conducted at McCall Rehabilitation And 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 an isolated deficiency that constitutes actual 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.) **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.

Cole Clarke, Administrator
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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 **November 19, 2018**. Failure to submit an acceptable PoC by **November 19, 2018**, may result in the imposition of civil monetary penalties by **December 12, 2018**.

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**

Denial of payment for new admissions effective January 23, 2019

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We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 23, 2019**, 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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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)

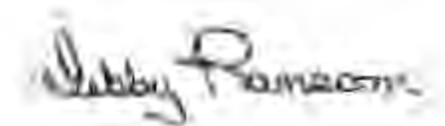
[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **November 19, 2018**. If your request for informal dispute resolution is received after **November 19, 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, comments or concerns, please contact Belinda Day, RN or Laura Thompson, RN at (208)

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334-6626, option 5.
Sincerely,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive, slightly slanted style.

Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

dr/lj
Enclosures

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 C 10/23/2018
NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET BURGDORF, 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 complaint survey of the facility. The survey team entered the facility on October 22, 2018 and exited the facility on October 23, 2018. The surveyors were: Jenny Walker, RN, Team Leader Susette Mace, RN Abbreviations: cm = centimeter CNA = Certified Nursing Assistant DNS = Director of Nursing MASD = Moisture Associated Skin Damage MDS = Minimum Data Set RN = Registered Nurse TAR = Treatment Administration Record	F 000			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		11/19/18	

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

TITLE

(X6) DATE

Electronically Signed

11/16/2018

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 580	<p>Continued From page 1</p> <p>treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, observation, and record review, it was determined the facility failed to ensure a resident's physician was notified when moisture associated skin damage (MASD) to her</p>	F 580	<p>1. Physician was notified on 10/23/18 of the skin breakdown on resident #6 and new treatment orders received and initiated.</p>		

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F 580	<p>Continued From page 2</p> <p>sacrum (low back) worsened and developed into 2 pressure ulcers. This was true for 1 of 6 (#6) residents reviewed for physician notification. This failure placed Resident #6 at risk of harm due to lack of physician oversight and care in the treatment of her wounds. Findings include:</p> <p>1. Resident #6 was admitted to the facility on 4/22/14, with multiple diagnoses including dementia.</p> <p>Resident #6's annual MDS assessment, dated 9/11/18, documented she was severely cognitively impaired and required two person assistance with bed mobility and transfers. The MDS assessment documented Resident #6 was at risk for pressure ulcers and had no unhealed pressure ulcers.</p> <p>Resident #6's October 2018 Physician's Order Summary Report documented staff was to apply Calmoseptine cream (barrier cream with zinc) every shift to her left buttock for prevention of skin break down, initiated 7/1/18.</p> <p>A Nurse's Progress Note, dated 8/11/18 at 9:39 PM, documented Resident #6 had an open pressure ulcer on the left buttock and staff were to continue to apply barrier cream until the physician was notified for new orders.</p> <p>A weekly Skin Evaluation report, dated 8/12/18 at 6:00 AM, documented Resident #6 had "MASD to left buttocks with measurements of 0.5 x 0.5 x 0 cm and MASD to her sacrum with measurements of 1 x 0.8 x 0 cm. A dressing was applied and will continue to monitor."</p>	F 580	<p>2. All resident records were reviewed and no other residents were identified as being affected from lack of notification to a physician.</p> <p>3. All licensed nurses were in-serviced on 10/30/18 & 11/2/18 on the requirement to notify residents' physician when there is a change of condition.</p> <p>4. To monitor performance and ensure corrective action was effective and compliance sustained, DNS or designee will audit the 24 hour report daily for 2 weeks to identify any change of condition and that the MD was notified. Any areas of concern will be addressed at the time of findings. If no compliance issues are noted after two weeks, 24 hour report will be reviewed 5 days a week in stand-up meeting for the next 4 weeks to assure MD has been notified as needed. On-going, the 24 hour report will be reviewed during daily stand up to ensure MD has been notified. Results will be reviewed at the monthly QAPI meeting for the next 3 months.</p>		

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

PRINTED: 01/11/2019
FORM APPROVED
OMB NO. 0938-0391

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F 580	<p>Continued From page 3</p> <p>Resident #6's clinical record did not include documentation the physician was notified of the need for a dressing to her left buttock and sacrum or an order for the dressing was received from the physician.</p> <p>A Nurse's Progress Note, dated 8/18/18, documented Resident #6 had two pressure ulcers on her buttocks and educated staff to turn Resident #6 side to side to keep her off of her buttocks. Resident #6's clinical record did not include documentation the physician was notified of the two pressure ulcers to her buttocks.</p> <p>A weekly Skin Evaluation report, dated 8/19/18, documented Resident #6 had an open area to her coccyx (tailbone) and staff continued to apply Calmoseptine barrier cream for treatment.</p> <p>A weekly Skin Evaluation report, dated 8/26/18, documented Resident #6 had a pressure ulcer to her sacrum.</p> <p>A Nurse's Progress Note, dated 9/4/18 at 3:31 PM, documented Resident #6 had an open area to her sacrum.</p> <p>A weekly Skin Evaluation report, dated 9/24/18 at 11:03 AM, documented Resident #6 had a stage II pressure area to her coccyx with measurements of 1.5 cm x 1.5 cm x 0.2 cm.</p> <p>A weekly Skin Evaluation report, dated 10/1/18 at 11:03 AM, documented Resident #6 had a pressure ulcer to her sacrum and staff continued to apply Calmoseptine barrier cream.</p> <p>There was no documentation the physician was</p>	F 580			

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F 580	Continued From page 4 notified when Resident #6 MASD to her sacrum worsened to a pressure ulcer. There were no new physician orders to treat Resident #6's pressure ulcer to her sacrum from 8/11/18 to 10/23/18. On 10/23/18 at 9:45 AM, the DNS was observed measuring Resident #6's sacrum wound and stated it was a stage III pressure ulcer. On 10/23/18 at 11:00 AM, the DNS stated the physician should have been notified on 8/11/18 for new wound care orders when Resident #6 developed a pressure ulcer to her left buttock.	F 580			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		11/19/18	

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F 657	<p>Continued From page 5</p> <p>disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure residents' care plans were regularly reviewed and revised as warranted. This was true for 2 of 6 residents (#2 and #6) reviewed for care plan revisions. These failures placed Resident #2 and Resident #6 at risk of harm when their care plans were not revised to include interventions to prevent pressure ulcers. Findings include:</p> <p>1. Resident #6 was admitted to the facility on 4/22/14 with multiple diagnoses, including dementia.</p> <p>Resident #6's annual MDS assessment, dated 9/11/18, documented she was severely cognitively impaired and required two person assistance with bed mobility and transfers. The MDS assessment documented Resident #6 was at risk for pressure ulcers and had no unhealed pressure ulcers.</p> <p>A weekly Skin Ulcer Non-Pressure record, dated 7/11/18 at 4:44 PM, documented Resident #6 developed moisture associated skin damage (MASD) to her buttock on 7/1/18. Staff were directed to apply barrier cream to Resident #6's buttocks and an air mattress was applied to prevent further skin breakdown. A new intervention was to direct staff to offload</p>	F 657	<p>1. Resident #2 is no longer in the facility. The care plan for resident #6 was reviewed and revised on 10/23/18.</p> <p>2. All residents had the potential to be affected by this issue. The care plans of all residents have been reviewed and revised as necessary.</p> <p>3. All staff that revise care plans have been in-serviced on reviewing and revising care plans when there is a change of condition.</p> <p>4. The DNS or designee will audit the 24 hour report daily for the first two weeks to ensure care plans have been updated when there is a change of condition. Any areas of concern will be addressed at the time of findings. If compliance is achieved after the first two weeks, over the next four weeks the DNS or designee will review the 24 hour report five days a week during stand-up meeting for care plan revisions on change of condition. On-going, the DNS or designee will continue to monitor the 24 hour report for required care plan up dates in stand-up meetings. Results of these audits will be reviewed in the monthly QAPI meeting for</p>		

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F 657	<p>Continued From page 6 (eliminate or reduce pressure on) Resident #6's buttocks. The new intervention was not documented on Resident #6's care plan.</p> <p>Resident #6's care plan, initiated on 7/19/18, documented an air bed/pressure relieving mattress and wheelchair cushion; barrier cream applied after toileting; document location of wound; dressing changes per physician orders; and evaluate wound and notify the physician if indicated.</p> <p>A Nurse's Progress Note, dated 8/18/18, documented Resident #6 had two pressure ulcers on her buttocks and staff were educated on turning Resident #6 side to side to keep her off of her buttocks. The care plan was not revised to direct staff to turn Resident #6 side to side to keep her off of her buttocks.</p> <p>A weekly Skin Evaluation report, dated 9/24/18 at 11:03 AM, documented Resident #6 had a stage II pressure area to her coccyx. The evaluation documented staff were to lay Resident #6 down after every meal. The care plan was not revised to direct staff to lay Resident #6 down after every meal.</p> <p>On 10/23/18 at 11:00 AM, the DNS stated Resident #6's care plan should have been revised on 8/18/18 and 9/24/18 in regards to offloading, turning, and laying Resident #6 down after every meal.</p> <p>2. Resident #2 was admitted to the facility on 2/21/18 with multiple diagnoses, including coronary artery disease and congestive heart failure.</p>	F 657	the next 3 months.		

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F 657	Continued From page 7 Resident #2's admission MDS assessment, dated 2/27/18, documented she was moderately cognitively impaired and required one person limited assistance with bed mobility and transfers. The MDS assessment documented Resident #2 was at risk for pressure ulcers and had no unhealed pressure ulcers. Resident #2's care plan, initiated on 3/14/18, documented Resident #2 had MASD to her abdominal folds. The care plan interventions included to keep skin clean and dry and provide treatments as ordered by the physician. A Nurse's Progress Note, dated 3/19/18, documented Resident #2 developed two pressure ulcers to the left buttock. The care plan was not revised to promote healing of the pressure ulcers or to prevent additional pressure ulcers from developing. On 10/23/18 at 11:15 AM, the DNS stated the care plan was not revised when Resident #2 developed the two pressure ulcers to her left buttock on 3/19/18.	F 657			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined the facility failed to ensure residents were provided with bathing	F 677	1. Residents #4,5,6 are receiving baths per the care plan.	11/19/18	

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F 677	<p>Continued From page 8</p> <p>consistent with their needs. This was true for 3 of 5 (#4, #5, and #6) residents reviewed for bathing. This failure created the potential for harm if residents experienced embarrassment, isolation, decreased sense of self-worth, skin impairment, or other form of compromised physical and/or psychosocial well-being, related to lack of cleanliness. Findings include:</p> <p>Residents did not receive showers/baths consistent with their shower/bath schedules. Examples include:</p> <p>a. Resident #4 was admitted to the facility on 1/26/18 with multiple diagnoses, including diabetes mellitus.</p> <p>A quarterly MDS assessment, dated 10/17/18, documented Resident #4 was cognitively intact and required physical help with bathing.</p> <p>The facility's shower schedule, dated 8/27/18, documented Resident #4's shower schedule was on Mondays and Fridays by the evening shift.</p> <p>Resident #4's bathing records from 9/23/18 to 10/22/18 were reviewed. Resident #4 did not receive a shower or bath for 7 days from 9/23/18 to 10/2/18; 5 days from 10/2/18 to 10/8/18; 6 days from 10/9/18 to 10/15/18; and 7 days from 10/16/18 to 10/22/18.</p> <p>On 10/23/18 at 9:30 AM, Resident #4 stated she did not receive her shower last night because the staff told her they were too busy. Resident #4 stated she will get one tonight. Resident #4 stated she was scheduled to receive a shower on Mondays and Thursdays, but does not always</p>	F 677	<p>2. All residents of the facility have the potential to be affected by this practice. All residents' bath schedules have been reviewed and baths are being provided as care planned.</p> <p>3. The shower schedule has been reviewed and updated to meet the needs of the residents. C.N.A.'s were in-serviced on 11/1/18, 11/2/18, & 11/5/18 on providing baths per the schedule and properly documenting. The licensed staff were in-serviced 10/30/18 & 11/2/18 on supervision of the bath schedule and ensuring that it is being followed by the C.N.A.'s.</p> <p>4. The DNS or designee will review documentation of compliance to the bath schedule five times a week for the first two weeks. Any areas of concern will be addressed at the time of the findings. If compliance is achieved, the DNS or designee will continue auditing two times per week for four weeks. On-going, the DNS or designee will continue to monitor compliance with the bath schedule in stand-up meetings. Results will be reported monthly in the QAPI meeting for 3 months.</p>		

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F 677	<p>Continued From page 9 get a shower on her scheduled days.</p> <p>b. Resident #6 was admitted to the facility on 4/22/14, with multiple diagnoses including dementia.</p> <p>Resident #6's annual MDS assessment, dated 9/11/18, documented she was severely cognitively impaired and required total assistance from one person for bathing.</p> <p>The facility's shower schedule, dated 8/27/18, documented Resident #6's bathing schedule was on Sundays and Thursdays by the evening shift.</p> <p>Resident #6's bathing records from 9/23/18 to 10/22/18 were reviewed. Resident #6 did not receive a shower or bath for 10 days from 9/23/18 to 10/4/18; 7 days from 10/4/18 to 10/11/18; 7 days from 10/11/18 to 10/18/18; and 4 days from 10/18/18 to 10/22/18.</p> <p>c. Resident #5 was admitted to the facility on 5/30/14, with multiple diagnoses including a stroke.</p> <p>A quarterly MDS assessment, dated 8/21/18, documented Resident #5 was cognitively intact and required physical help with bathing.</p> <p>The facility's shower schedule, dated 8/27/18, documented Resident #5's shower schedule was on Mondays and Tuesdays by the day shift and Fridays by the evening shift.</p> <p>Resident #5's bathing records from 9/1/18 to 10/22/18 were reviewed. Resident #5 did not receive a shower or bath for 7 days from 9/11/18</p>	F 677			

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F 677	Continued From page 10 to 9/18/18; 5 days from 9/18/18 to 9/23/18; 5 days from 9/18/18 to 9/23/18; 5 days from 9/25/18 to 9/30/18; 5 days from 10/2/18 to 10/7/18; 7 days from 10/7/18 to 10/14/18; and 5 days from 10/16/18 to 10/21/18.	F 677			
F 686 SS=G	On 10/23/18 at 3:00 PM, the DNS stated the CNA's needed education on how to chart in the clinical record for residents receiving a shower. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and record review, it was determined the facility failed to prevent the development of avoidable pressure ulcers. This was true for 2 of 5 (#2 and #6) residents reviewed for pressure ulcers. Resident #2 was harmed when she developed stage III pressure ulcers to her buttocks and heels. Resident #6 was harmed when she developed moisture associated skin damage (MASD) that worsened to a stage III	F 686	1. Resident #2 was discharged on 4/20/18. Resident #6 has been assessed and the pressure ulcer is being managed per current physician orders. 2. All other residents are potentially at risk of this practice. All resident charts have been reviewed for risks of developing pressure ulcers on 11/13/18. Findings did not reveal any unknown skin	11/19/18	

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F 686	<p>Continued From page 11 pressure ulcer to her sacrum. Findings include:</p> <p>The facility's Wound Management policy and procedure, dated May 2007, documented nursing staff were to complete weekly skin assessments, a wound flow sheet was to be started when a wound was identified, wounds would be measured weekly, and treatments ordered by the physician would be re-evaluated every two weeks if there was no improvement to the wound.</p> <p>1. Resident #6 was admitted to the facility on 4/22/14, with multiple diagnoses including dementia.</p> <p>Resident #6's annual MDS assessment, dated 9/11/18, documented she was severely cognitively impaired and required two person assistance with bed mobility and transfers. The MDS assessment documented Resident #6 was at risk for pressure ulcers and had no unhealed pressure ulcers.</p> <p>Resident #6's October 2018 Physician's Order Summary Report documented staff were to apply Calmoseptine cream (barrier cream with zinc) every shift to her left buttock for prevention of skin breakdown, initiated 7/1/18.</p> <p>A weekly Skin Evaluation report, dated 7/3/18 at 8:13 AM, documented Resident #6 had MASD to her left gluteal fold (a prominent fold that marks the upper limit of the thigh from the lower limit of the buttock) that measured 0.5 x 0.5 x 0 cm with no depth or tunneling. The staff were to continue to apply Calmoseptine cream to the gluteal fold every shift and as needed.</p>	F 686	<p>issues.</p> <p>3. The ADON and another of our licensed nurses attended the PUPC conference in Boise on 11/9/18 on pressure ulcer management. All licensed staff and nurse aides were in-serviced on assessment, prevention, and management of pressure ulcers. six in-services were completed on 11/10/18.</p> <p>4. Weekly skin at risk checks will be reviewed daily by the DNs or designee for completion and concerns with regards to risks of developing pressure ulcers for four weeks. Any areas of concern will be addressed at the time of the findings. In addition, all residents followed in weekly wound rounds will have documentation reviewed for completion and possible concerns. If compliance is achieved, the DNS or designee will continue auditing two times per week for the next four weeks. Findings will be reported monthly in QAPI meeting.</p>		

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F 686	Continued From page 12 A weekly Skin Ulcer Non-Pressure record, dated 7/11/18 at 4:44 PM, documented Resident #6 developed MASD to right buttock on 7/1/18 that measured 2.0 x 1.5 x 0 cm. The wound was intact and discolored with pink color in the wound bed. The document directed staff to continue to apply barrier cream and apply an air mattress to Resident #6's bed to facilitate healing. A weekly Skin Evaluation report, dated 7/18/18 at 3:12 PM, documented Resident #6 had MASD to the left gluteal fold which measured 0.3 x 0.3 x 0 cm. Resident #6's care plan for potential skin breakdown and MASD to sacrum (low back), revised 7/19/18, documented staff were to apply an air bed/pressure relieving mattress and wheelchair cushion; apply barrier cream after each incontinence episode, document the location of the wound and the progress in wound healing on an ongoing basis, and notify the physician as indicated. A Nurse's Progress Note, dated 8/11/18 at 9:39 PM, documented Resident #6 had an open pressure ulcer on her left buttock and staff were to continued to apply barrier cream until the physician was contacted for new treatment orders. A weekly Skin Evaluation report, dated 8/12/18 at 6:00 AM, documented Resident #6 had "MASD to left buttocks with measurements of 0.5 x 0.5 x 0 cm and MASD to her sacrum with measurements of 1 x 0.8 x 0 cm. A dressing was applied and will continue to monitor."	F 686			

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F 686	Continued From page 13 Resident #6's clinical record did not include documentation the physician was notified of the development of the pressure ulcer on 8/11/18 and there was not an order for a dressing to be applied to her sacrum. A Nurse's Progress Note, dated 8/18/18, documented Resident #6 had two pressure ulcers on her buttocks and educated staff to turn Resident #6 side to side to keep her off of her buttocks. Resident #6's clinical record did not include documentation the physician was notified of the two pressure ulcers to her buttocks. A weekly Skin Evaluation report, dated 8/19/18, documented Resident #6 had an open area to her coccyx (tailbone) and staff continued to apply Calmoseptine barrier cream for treatment. A weekly Skin Evaluation report, dated 8/26/18, documented Resident #6 had a pressure ulcer to her left buttock with measurements of 0.3 x 0.2 x 0 cm and a stage II pressure ulcer to her sacrum with measurements of 0.5 x 0.2 x 0.1 cm. There was no documentation from 8/11/18 to 8/26/18 the facility notified the physician that Resident #6 had developed a pressure ulcer to her left buttock and a stage II pressure ulcer to her sacrum. The care plan was not revised to direct staff to turn Resident #6 side to side to keep her off of her buttocks. A Nurse's Progress Note, dated 9/4/18 at 3:31 PM, documented Resident #6 had an open area to her sacrum.	F 686			

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F 686	<p>Continued From page 14</p> <p>A Skin Ulcer Non-Pressure Weekly report signed by the wound nurse, dated 9/14/18 at 1:01 PM, documented Resident #6 had MASD to her sacrum with measurements of 1.5 x 0.5 x 0 cm. The report documented Resident #6 was being offloaded (elimination or reduction of pressure) during the day and Calmoseptine was applied every shift and as needed. The care plan was not revised to direct staff to offload Resident #6 during the day.</p> <p>A weekly Skin Evaluation report, dated 9/17/18 at 11:03 AM, documented Resident #6 had MASD to her sacrum with measurements of 1.0 x 0.5 x 0.1 cm.</p> <p>A weekly Skin Evaluation report, dated 9/24/18 at 11:03 AM, documented Resident #6 had a stage II pressure area to her coccyx with measurements of 1.5 x 1.5 x 0.2 cm. The report directed staff to lay Resident #6 down after every meal and continue with the barrier cream. The physician was not notified of the pressure ulcer and the care plan was not revised to have Resident #6 lay down between meals.</p> <p>A Skin Ulcer Non-Pressure Weekly report signed by the wound nurse, dated 9/26/18 at 8:43 PM, documented Resident #6 had MASD to the sacrum with measurements of 1.2 x 0.5 x 0.1 with scant amount of sanguineous drainage (thin, watery, and pale red to pink in color). The wound bed was pink with undefined wound edges.</p> <p>A weekly Skin Evaluation report, dated 10/1/18 at 11:03 AM, documented Resident #6 had a pressure ulcer to her sacrum with measurements of 1.5 x 1.5 cm and staff continued to apply</p>	F 686			

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F 686	<p>Continued From page 15 barrier cream to the pressure ulcer.</p> <p>A Skin Ulcer Non-Pressure Weekly report signed by the wound nurse, dated 10/3/18 at 10:38 PM, documented Resident #6 had MASD to her sacrum with measurements of 2.0 x 0.7 x 0.1 cm. The wound nurse documented, "partial, 90% slough (dead tissue, usually cream or yellow in color) noted to area. No redness surrounding tissue." The Skin Ulcer Non-Pressure Weekly report documented site 2 with an onset date of 10/3/18 to Resident #6's left buttock had MASD with measurements of 0.4 x 0.4 cm with "100% red granulation noted to the wound bed and the wound edges were undefined.</p> <p>The weekly Skin Evaluation report, dated 10/8/18 at 11:03 AM, documented Resident #6 had MASD to her sacrum with measurements of 1.5 x 1.5 x 0.1 cm.</p> <p>A Skin Ulcer Non-Pressure Weekly report signed by the wound nurse, dated 10/10/18 at 11:21 AM, documented Resident #6 had MASD to her sacrum with measurements of 1.5 x 0.5 x 0 cm with partial thickness to the wound.</p> <p>The weekly Skin Evaluation report, dated 10/15/18 at 7:00 AM, documented Resident #6 had an open area on her sacrum. There were no measurements documented.</p> <p>A Skin Ulcer Non-Pressure Weekly report signed by the wound nurse, dated 10/16/18 at 10:10 AM, documented Resident #6 had MASD to her sacrum with measurements of 1.4 x 0.4 x 0 cm. The wound bed was pink with partial thickness and the wound edges were undefined.</p>	F 686			

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F 686	Continued From page 16 On 10/23/18 at 10:35 AM, the DNS stated the wound nurse was on vacation and she would complete the weekly Non-Pressure report this week for Resident #6. The DNS was observed assessing Resident #6's sacrum. The DNS stated Resident #6 had a stage III pressure ulcer to her sacrum. The DNS stated the measurements were 1.5 x 0.6 x 0.2 cm. The wound bed had 75% slough with granulation tissue, wound edges were defined with a scant amount of sanguineous drainage. The DNS stated she was going to notify the physician for new treatment orders. The DNS stated the current order for Calmoseptine was not effective and the physician should have been notified on 8/11/18 when Resident #6 developed the pressure ulcer to her left buttock. The DNS stated the wound nurse and the nurses were not certified in wound treatment and needed to be educated on evaluating wounds, location of the wound, and staging wounds. 2. Resident #2 was admitted to the facility on 2/21/18, with multiple diagnoses including coronary artery disease and congestive heart failure. Resident #2's admission MDS assessment, dated 2/27/18, documented she was moderately cognitively impaired and required one person limited assistance with bed mobility and transfers. The MDS assessment documented Resident #2 was at risk for pressure ulcers and had no unhealed pressure ulcers. Resident #2's care plan, initiated on 3/14/18, documented Resident #2 had MASD to her	F 686			

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F 686	<p>Continued From page 17</p> <p>abdominal folds. The care plan interventions included to keep her skin clean and dry and to provide treatments as ordered by the physician.</p> <p>A Nurse's Progress Note, dated 3/19/18 at 1:12 AM, documented Resident #2 had two open area to her left buttock.</p> <p>A physician's order, dated 3/19/18, documented staff were to apply Calmoseptine barrier cream to Resident #2's left buttock every shift for treatment of the open area.</p> <p>Resident #2's March 2018 TAR documented her skin was assessed each Tuesday. The TAR documented Resident #2 skin was intact on 3/6/18, 3/13/18, and 3/20/18. On 3/27/18 the TAR documented Resident #2 had skin breakdown. The TAR instructed staff to complete an assessment of the skin breakdown, if it was present. Resident #2's clinical record did not include an assessment of the skin breakdown noted on 3/27/18.</p> <p>Resident #2's March 2018 TAR documented Calmoseptine barrier cream was to be applied three times a day to the open area on her left buttock. The TAR did not include documentation the barrier cream was applied during 4 of 39 opportunities.</p> <p>Resident #2's April 2018 TAR documented weekly skin assessments were completed. On 4/3/18 and 4/10/18 the TAR documented breakdown of Resident #2's skin. Resident #2's clinical record did not include assessments describing Resident #2's skin breakdown on 4/3/18 and 4/10/18. On 4/17/18 the TAR</p>	F 686			

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F 686	<p>Continued From page 18 documented Resident #2's skin was intact.</p> <p>Resident #2's April 2018 TAR documented Calmoseptine barrier cream was to be applied three times a day to the open area on her left buttock. The TAR did not include documentation the barrier cream was applied during 4 of 58 opportunities.</p> <p>A Nurse's Progress Note, dated 4/2/18, documented the physician assessed Resident #2. The progress note did not include documentation the open area on Resident #2's left buttock was assessed by the physician or orders for the treatment of the open area.</p> <p>A physician's order, dated 4/18/18, documented a referral to the wound clinic for the treatment of Resident #2's open area on her left buttock.</p> <p>The wound clinic progress note, dated 4/20/18, documented Resident #2 had stage III pressure ulcers on the buttocks and posterior thighs. The wound clinic progress note documented "There are 4 ulcerations present on the right buttock with the largest being 2 cm x 1 cm, and 2 small ulcers on the left upper buttock. On the right posterior thigh, there is a large ulcer covered in adherent fibrin (fibrous protein involved in the clotting of blood) measuring 3.6 cm x 1.2 cm with an unmeasurable depth due to fibrin." The wound clinic progress note documented Resident #2 had stage III pressure ulcers to bilateral posterior heels with at least two on each side. The wound clinic progress note documented "The largest is on the left posterior heel and measures 1.8 cm x 1.3 cm with a depth of 0.2 cm, covered in adherent fibrin and eschar (dry, dark dead</p>	F 686			

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F 686	Continued From page 19 tissue)." Resident #2 was sent to the emergency room from the wound clinic on 4/20/18 and did not return to the facility. On 10/23/18 at 12:00 PM, the DNS stated Resident #2's clinical record lacked documentation of wound measurements or descriptions of the wounds that developed to stage III pressure ulcers. The DNS stated the facility did not complete the required skin assessments when Resident #2 developed pressure ulcers.	F 686			
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an RN was on duty 8 hours a day 7 days a week to provide care and treatment to the residents. This	F 727	1. An RN is scheduled for at least 8 hours per day, 7 days per week. 2. All residents were potentially affected	11/19/18	

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 C 10/23/2018
NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET BURGDORF, 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 727	Continued From page 20 was true for 3 of the 21 days reviewed. This affected 5 of 5 (#1, #3, #4, #5, and #6) sample residents residing in the facility and had the potential to affect the other 24 residents residing in the facility. This created the potential for harm if residents' nursing needs went unmet. Findings include: The facility's Three-Week Nursing Schedule between 9/30/18 and 10/20/18 documented there was less than 8 hours of RN coverage on 10/7/18, 10/14/18, and 10/20/18. The facility's daily time sheet record documented that on 10/7/18 an RN was in the facility for 7.55 hours, on 10/14/18 an RN was in the facility for 6.13 hours, and on 10/20/18 an RN was in the facility for 6.4 hours. This created the potential for the routine and emergency nursing needs of Residents #1, #3, #4, #5, and #6, as well as, the other 24 residents residing in the facility, to go unmet. On 10/23/18 at 2:30 PM, the DNS stated the RN was unaware she was the only RN for those days and did not stay in the facility for the 8 hours.	F 727	by this practice. No residents are know to have been affected. 3. At least one RN is scheduled for 8 hours every day. The schedule has been revised to identify days when only one RN is scheduled so he/she knows to complete 8 hours before clocking out. RN staff were in-serviced on 11/14/18. 4. DNS will review and approve the monthly schedule as well as any schedule changes to ensure that an RN is scheduled each day for at least 8 hours. The DNS or designee will review RN worked hours weekly for 4 weeks to assure compliance. Findings will be reported monthly in QAPI meeting for 3 months.		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself	F 842		11/19/18	

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 C 10/23/2018
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F 842	<p>Continued From page 21 is permitted to do so.</p> <p>§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <ul style="list-style-type: none"> (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <ul style="list-style-type: none"> (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained</p>	F 842			

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F 842	<p>Continued From page 22</p> <p>for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to document weekly skin assessments in the resident's clinical record. This was true for 1 of 6 (#2) residents whose records were reviewed. This deficient practice created the potential for harm when clinical information was not accurate and complete. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 2/21/18 with multiple diagnoses, including coronary artery disease and congestive heart failure.</p> <p>A Nurse's Progress Note, dated 3/19/18 at 1:12 AM, documented Resident #2 had two open areas on her left buttock.</p>	F 842	<p>1. Resident #2 discharged from the facility on 4/20/18.</p> <p>2. All other residents were potentially at risk. All residents' charts have been reviewed for skin assessment to identify risks of developing pressure ulcers on 11/13/18. Findings did not reveal any unknown skin issues.</p> <p>3. The ADON and another of our licensed nursing staff attended the PUPC conference in Boise on 11/9/18 on pressure ulcer management. All licensed staff and nurse aides were in-serviced on assessment, prevention, and management of pressure ulcers. Six</p>		

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 C 10/23/2018
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F 842	<p>Continued From page 23</p> <p>A physician's order, dated 3/19/18, documented staff were to apply Calmoseptine barrier cream to Resident #2's left buttock every shift for treatment of an open area.</p> <p>Resident #2's March 2018 TAR documented her skin was assessed each Tuesday. The TAR documented Resident #2 skin was intact on 3/6/18, 3/13/18, and 3/20/18. On 3/27/18 the TAR documented Resident #2 had skin breakdown. The TAR instructed staff to complete an assessment of the skin breakdown, if it was present. Resident #2's clinical record did not include an assessment of the skin breakdown noted on 3/27/18.</p> <p>Resident #2's April 2018 TAR documented weekly skin assessments were completed. On 4/3/18 and 4/10/18 the TAR documented breakdown of Resident #2's skin. Resident #2's clinical record did not include assessments describing Resident #2's skin breakdown on 4/3/18 and 4/10/18. On 4/17/18 the TAR documented Resident #2's skin was intact.</p> <p>The wound clinic progress note, dated 4/20/18, documented Resident #2 had stage III pressure ulcers on the buttocks and posterior thighs. The wound clinic progress note documented "There are 4 ulcerations present on the right buttock with the largest being 2 cm x 1 cm, and 2 small ulcers on the left upper buttock. On the right posterior thigh, there is a large ulcer covered in adherent fibrin (fibrous protein involved in the clotting of blood) measuring 3.6 cm x 1.2 cm with an unmeasurable depth due to fibrin." The wound clinic progress note documented Resident #2</p>	F 842	<p>in-services were completed on 11/10/13.</p> <p>4. Weekly skin at risk checks will be reviewed daily by the DNS or designee for completion and concerns with regards to risk of developing pressures ulcers for four weeks. Any areas of concern will be addressed at the time of the findings. In addition, all residents followed in weekly wound rounds will have documentation reviewed for completion and possible concerns. If compliance is achieved, the DNS or designee will continue auditing two times/week for the next four weeks. Findings will be reported monthly in QAPI meeting for 3 months.</p>		

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F 842	<p>Continued From page 24</p> <p>had stage III pressure ulcers to bilateral posterior heels with at least two on each side. The wound clinic progress note documented "The largest is on the left posterior heel and measures 1.8 cm x 1.3 cm with a depth of 0.2 cm, covered in adherent fibrin and eschar (dry, dark dead tissue)."</p> <p>Resident #2 was sent to the emergency room from the wound clinic on 4/20/18 and did not return to the facility.</p> <p>On 10/23/18 at 12:00 PM, the DNS stated Resident #2's clinical record lacked documentation of wound measurements or descriptions of the wounds that developed to stage III pressure ulcers. The DNS stated the facility did not complete the required skin assessments when Resident #2 developed pressure ulcers.</p>	F 842			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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April 8, 2019

Cole Clarke, Administrator
McCall Rehabilitation and Care Center
418 Floyde Street
McCall, ID 83638-4508

Provider #: 135082

Dear Mr. Clarke:

On **October 22, 2018** through **October 23, 2018**, an unannounced on-site complaint survey was conducted at McCall Rehabilitation And Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007771

ALLEGATION #1:

The facility did not provide sufficient staff for the residents.

FINDINGS #1:

During the investigation the three week nursing staff scheduled were reviewed, and the DNS was interviewed.

The facility's Three-Week Nursing Schedule was reviewed for 9/30/18 to 10/20/18 and the schedules documented there was less than 8 hours of RN coverage on 10/7/18, 10/14/18, and 10/20/18.

Cole Clarke, Administrator
April 8, 2019
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The facility's daily time sheet record documented that on 10/7/18 an RN was in the facility for 7.55 hours, on 10/14/18 an RN was in the facility for 6.13 hours, and on 10/20/18 an RN was in the facility for 6.4 hours.

The DNS was interviewed on 10/23/18 at 2:30 PM. The DNS was unaware she was the only RN for those days and did not stay in the facility for the 8 hours.

The allegation was substantiated and deficiencies were cited at F727 related to not having an RN in the facility for 8 hours a day 7 days a week.

CONCLUSIONS:

Substantiated. Federal 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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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April 10, 2019

Cole Clarke, Administrator
McCall Rehabilitation and Care Center
418 Floyde Street
McCall, ID 83638-4508

Provider #: 135082

Dear Mr. Clarke:

On **October 22, 2018** through **October 23, 2018**, an unannounced on-site complaint survey was conducted at McCall Rehabilitation and Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007836

ALLEGATION #1:

A resident developed pressure ulcers after admission to the facility.

FINDINGS #1:

During the survey 6 resident records were reviewed, observations were conducted, residents were interviewed, staff were interviewed, and facility policies and procedures for wound care were reviewed.

The facility's policy titled, "Policy and Procedure-Nursing Administration, Section: Care and Treatment, Subject: Wound Management dated 5/2007" provided by the Director of Nursing stated, "It is the policy of this facility to have a central consistent flow sheet to enable medical staff to evaluate status of wounds. A wound is identified as an Arterial Ulcer, Diabetic Neuropathic Ulcer, Pressure Ulcer, Venous Insufficiency Ulcer, Surgical Wound and Lacerations.

One resident was admitted to the facility in 2/2018, with diagnoses that included local infection of skin and subcutaneous tissue. The resident did not have pressure ulcers present on admission and was assessed as a high risk for developing a pressure sore.

A progress note, dated 3/2018, stated the resident had two open areas to the left buttock region. There was a physician order the same day to apply ointment every shift to the open areas of the left buttock. Review of the March 2018 and April 2018 treatment administration record included documentation the ointment was not applied as ordered on all shifts. Less than a month later the resident 's record stated they had developed two new pressure ulcers to the thighs, and toes.

The resident was referred to and seen at a wound clinic. The wound clinic's documentation described the pressure areas, included the following: " ...Stage 3 Pressure ulcers of buttocks and posterior thighs. There are 4 ulcerations present on the right buttocks with the largest being 2 cm (###) x 1 cm, and 2 small ulcers on the left upper buttock. On the right posterior thigh, there is a large ulcer covered in adherent fibrin measuring 3.6 cm x 1.2 cm with an unmeasurable depth due to fibrin. 4. Stage 3 pressure ulcers of bilateral posterior heels at least 2 on each side. The largest is on the left posterior heel and measures 1.8 cm x 1.3 cm with a depth of 0.2 cm. Covered in adherent fibrin and eschar."

The care plan for the resident did not include interventions were added since the initial entry on admission. There were no interventions to encourage resident to lay down for a period during the day. There was no additional intervention added to the resident 's care plan to prevent the development of additional pressure areas or aid in the healing of the pressure area first identified on the buttock.

During an interview the Director of Nursing Services, (DNS) verified the resident 's record lacked documentation of wound measurements or descriptions of the wounds completed with the weekly assessments. The DNS confirmed she was unable to find any documentation about the pressure ulcer to the buttocks, posterior thigh or heels as identified in the wound clinic report.

The allegation was substantiated and deficiencies were cited at F686 related to the prevention and treatment of pressure ulcers and at F657 for failure to update and revise the care plan as needed.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Cole Clarke, Administrator
April 10, 2019
Page 3 of 3

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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson", is written over a faint, circular watermark or stamp.

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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April 10, 2019

Cole Clarke, Administrator
McCall Rehabilitation And Care Center
418 Floyde Street,
McCall, ID 83638-4508

Provider #: 135082

Dear Mr. Clarke:

On **October 22, 2018** through **October 23, 2018**, an unannounced on-site complaint survey was conducted at McCall Rehabilitation And Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007796

ALLEGATION #1:

The facility's shower room does not have a heater and smells like mold. The facility does not have a designated smoking area. The facility's ceilings have been leaking.

FINDINGS #1:

During the investigation 5 residents were observed and their records were reviewed for Quality of Care and Resident Rights. The facility's policies were reviewed, residents and staff were interviewed and observations of bathing were conducted.

The shower room was observed for mold and use of the heater during and after a shower was completed by residents. No concerns were identified. The shower room did have a heater in the ceiling and was activated by a wall mount timer control. Four residents were interviewed and no concerns were identified for smells of mold or the heater not working in the shower room.

The facility's smoking policy was reviewed and documented the facility was a smoke free campus. The policy documented for staff who smoked they must smoke in their cars. No concerns were identified. One resident was interviewed and no concerns were identified for the facility's smoking policy.

The dining hall ceiling did have a leak and the facility identified the leak location and the facility repaired and fixed the leak. The ceilings in the kitchen and in a resident's room were observed and no concerns were identified. Four residents were interviewed and they did not complain of leaks in the ceilings.

CNAs, nurses, and managers were interviewed and no concerns were identified for smells of mold in the showers or the heaters in the shower room not working. The Administrator stated the facility did have a leak in the dining room ceiling in April and the facility identified the leak and fixed the leak. CNAs, nurses, and managers stated the facility was a smoke free facility and if they personally smoked they knew they had to smoke in their cars.

Based on investigative findings the allegation was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility did not bathe residents.

FINDINGS #2:

The facility's shower schedule was reviewed and residents were not receiving their showers consistent with their shower schedule.

During the review of resident records one resident was admitted to the facility January 2018 and was scheduled to have showers on Mondays and Fridays. The bathing records from 9/23/18 to 10/22/18 were reviewed. The resident did not receive a shower or bath for 7 days from 9/23/18 to 10/2/18; 5 days from 10/2/18 to 10/8/18; 6 days from 10/9/18 to 10/15/18; and 7 days from 10/16/18 to 10/22/18.

The resident was interviewed on 10/23/18 at 9:30 AM and stated she does not always get a shower on her scheduled days.

A second resident, admitted April 2014 and was scheduled to have showers on Sundays and Thursdays. The bathing records from 9/23/18 to 10/22/18 were reviewed. The resident did not receive a shower or bath for 10 days from 9/23/18 to 10/4/18; 7 days from 10/4/18 to 10/11/18; 7 days from 10/11/18 to 10/18/18; and 4 days from 10/18/18 to 10/22/18.

A third resident, admitted May 2014 was scheduled to have showers Mondays, Tuesdays, and Fridays.

The bathing records from 9/1/18 to 10/22/18 were reviewed. The resident did not receive a shower or bath for 7 days from 9/11/18 to 9/18/18; 5 days from 9/18/18 to 9/23/18; 5 days from 9/18/18 to 9/23/18; 5 days from 9/25/18 to 9/30/18; 5 days from 10/2/18 to 10/7/18; 7 days from 10/7/18 to 10/14/18; and 5 days from 10/16/18 to 10/21/18.

The DNS was interviewed on 10/23/18 at 3:00 PM. The DNS stated the CNAs needed education on how to chart in the clinical record for residents receiving shower.

The allegation was substantiated and a deficiency was cited at F677 related to the failure of the facility to ensure residents were provided bathing consistent with their needs.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

Non-nursing staff were completing electronic medical records.

FINDINGS #3:

The medical records supervisor was interviewed about dates being changed and non-nursing staff completing documentation in the residents clinical record. No concerns were identified.

The Administrator and the DNS were interviewed regarding non-nursing staff changing dates or completing documentation in residents clinical records and they stated non-nursing staff were unable to access the residents records because the facility had an electronic medical record which required a username and password to access the program.

The allegation was not substantiated due to lack of evidence the facility's non-nursing staff were changing or completing electronic medical records.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

CNAs documented the residents received restorative care when they provided routine cares.

FINDINGS #4:

Four residents' clinical records were reviewed for restorative care services. Their clinical records documented passive and active range of motion exercises for 15 minutes, six times a week were provided by the restorative aide. The residents were interviewed and stated they did receive range of motion exercises by the assigned restorative aide.

The restorative aide was interviewed and stated the facility has three restorative aides and one of them were scheduled everyday for the residents to receive their restorative exercise program. The restorative aide stated they were trained by the therapist to assure they were providing accurate passive and active range of motion to the residents on the restorative program.

The DNS was interviewed and stated the facility had three restorative aides that were trained by the therapist. The CNAs were not trained to provide passive and active range of motion to the residents for the restorative program.

The allegation was unsubstantiated due to lack of evidence and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility did not provide translation services for Spanish speaking residents.

FINDINGS #5:

CNAs and nurses were interviewed regarding translation services for Spanish speaking residents and they stated the hospital has an interpreter to provide communication assistance to the residents who needed them.

The DNS stated the hospital has an interpreter to provide communication assistance with Spanish speaking residents. The DNS stated the speech therapist provides a communication board for the resident and staff, and there was an app on smartphones to provide translation to communicate with the resident. The DNS stated none of their current residents required a translator for communication.

The allegation could not be substantiated due to lack of evidence the facility did not provide translation services for Spanish speaking residents.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Cole Clarke, Administrator
April 10, 2019
Page 5 of 5

The facility does not provide portable phones.

FINDINGS #6:

The facility was observed to have access to phones for residents to use in the activity room, nurses station, the quiet lounge area, and manager's offices throughout the facility.

Four residents were interviewed regarding using the facility's phone in private. They stated they had their own cell phone to use or they could use one of the phones in the areas of the facility. The residents stated they have used the phone in a manager's office in private and no concerns were identified.

The DNS stated when residents wanted a private conversation on the phone, the nursing staff had access to all the offices to unlock the door for the resident to use the phone in private.

The allegation could not be substantiated due to lack of evidence the facility did not provide phones for resident to use in private.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj