



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF 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
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FAX: (208) 364-1888
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January 31, 2019

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

Provider #: 135082

Dear Mr. Clarke:

On **January 8, 2019**, we conducted an on-site revisit and a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **November 19, 2018**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

F0000 -- S/S: -- -- Initial Comments

F0657 -- S/S: D -- 483.21(b)(2)(i)-(iii) -- Care Plan Timing And Revision

F0584 -- S/S: D -- 483.10(i)(1)-(7) -- Safe/clean/comfortable/homelike Environment

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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 10, 2019**.

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.
- 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*.

As noted in the Bureau of Facility Standards' letter of **November 9, 2018**, following the survey of **October 23, 2018**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS):

- Civil money penalty,
- Denial of Payment for New Admissions effective and termination of the provider agreement on **April 23, 2019**, if substantial compliance is not achieved by that time.
- Termination of the provider agreement 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, it will provide you with a separate formal notification of that determination.

Cole Clarke, Administrator

January 31, 2019

Page 3 of 3

If you believe the 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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)

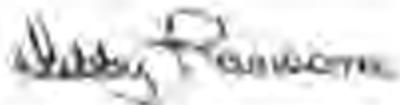
[2001-10 Long Term Care Informal Dispute Resolution Process](#)

[2001-10 IDR Request Form](#)

This request must be received by **February 11, 2019**. If your request for informal dispute resolution is received after **February 11, 2019**, 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 please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



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

DR/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 01/08/2019
NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MCCALL, 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 an on-site revisit and complaint survey conducted from January 7, 2019 through January 8, 2019. The surveyors conducting the survey were: Edith Cecil, RN, Team Leader Cecilia Stockdill, RN CNA = Certified Nursing Assistant DON = Director of Nursing MDS = Minimum Data Set F 584 Safe/Clean/Comfortable/Homelike Environment SS=D CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary,	{F 000}			
		F 584		1/22/19	

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

TITLE

(X6) DATE

Electronically Signed

02/04/2019

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 584	<p>Continued From page 1 orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, it was determined the facility failed to ensure residents were provided with clean bed linens. This was true for 1 of 6 residents (Resident #9) whose bed linens were observed. This failure created the potential for psychosocial harm should residents experience discomfort, embarrassment, and decreased sense of well-being due to lying in a bed with soiled linens. Findings include:</p> <p>The facility's policy and procedure for Bed Making, revised 5/2007, documented the facility was to provide a clean change of linen and a comfortable bed for the resident.</p> <p>Resident #9 was admitted to the facility on 3/9/18</p>	F 584	<ol style="list-style-type: none"> 1. The soiled bed linens for resident #9 were replaced with clean linens. 2. All residents had the potential to be affected by this issue. Room rounds were completed for all residents to check for soiled linens and replaced as needed. 3. In order to ensure this practice doesn't re-occur, housekeeping and nursing staff have been in-serviced to check for soiled bedding during their daily rounds and replace linens as needed. In addition, all resident rooms have been assigned to a department head to be inspected on all days they work and documentation of room inspections will be turned in weekly to the DON. Concerns will be addressed 		

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F 584	<p>Continued From page 2</p> <p>with multiple diagnoses including breast cancer, dementia with behavioral disturbance, and fibromyalgia.</p> <p>Resident #9's quarterly MDS (Minimum Data Set) assessment, dated 12/3/18, documented she was cognitively intact.</p> <p>On 1/7/19 at 1:40 PM, Resident #9's bed was observed to have soiled blankets and linens in place. The draw sheet had a small amount of visible brown-colored crumbs scattered on the surface. The top sheet had three dried brown/yellow areas. A white blanket on the bed had one dried yellow/brown area and three small stained areas which were red in color. A green comforter was on the bed with multiple small stained areas which were red/brown in color and several tiny crumbs red/brown in color.</p> <p>Resident #9 said she did not remember when her bed linens were last changed, but they were supposed to be changed each time she got a shower. She said she received a shower three times a week, and there were times her sheets were not changed after her shower. Resident #9 said she was incontinent of urine and had times where she soiled the bed with urine and it would be wet, and staff would "throw something over it."</p> <p>On 1/7/19 at 3:55 PM, Resident #9's blankets and bed linens appeared in the same condition as previously described. CNA #1 said the bed sheets were soiled and needed to come off. CNA #1 said Resident #9 spilled a lot of coffee and other materials on her bed linens and they were changed often. CNA #1 said she did not know when Resident #9's bed linens were last</p>	F 584	<p>as they are identified during the rounds and daily stand-up.</p> <p>4. To monitor performance and ensure corrective action was effective and compliance sustained, results of these inspections will be reported monthly in QAPI meetings for the next 3 months and any negative trends addressed. The Guardian Rounds will continue to be a part of the facility management routine.</p>		

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F 584	Continued From page 3 changed but they were probably changed that morning and she changed them every time she worked. On 1/7/19 at 4:00 PM, LPN #1 said bed linens should be changed at least once a week, and she had noticed some residents had dirty bed linens. LPN #1 said she removed the dirty bed linens when she saw they were dirty. On 1/8/19 at 8:54 AM, the DON said bed linens should be changed whenever they were soiled, and a complete bed linen change should be done on a resident's shower days. The DON said Resident #9's bed linens should have been changed.	F 584			
{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	{F 657}		1/22/19	

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{F 657}	<p>Continued From page 4 resident's care plan.</p> <p>(F) Other appropriate staff or professionals in 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 record review, facility policy review, and resident and staff interviews, it was determined the facility failed to ensure residents' care plans were updated to include a resident's incontinence. This was true for 1 of 6 residents (Resident #9) whose care plans were reviewed. This failure created the potential for harm should inappropriate care be provided due to lack of information on the care plan. Findings include:</p> <p>The facility's policy and procedure for Care Planning, revised 5/2007, documented the interdisciplinary team (IDT) will develop a comprehensive care plan for each resident.</p> <p>Resident #9 was admitted to the facility on 3/9/18 with multiple diagnoses including breast cancer, dementia with behavioral disturbance, and fibromyalgia.</p> <p>Resident #9's quarterly MDS assessment, dated 12/3/18, documented she was cognitively intact and was frequently incontinent.</p> <p>An MDS quarterly Progress Note, dated 12/6/18 at 10:50 AM, documented Resident #9 was frequently incontinent of bowel and bladder.</p>	{F 657}	<ol style="list-style-type: none"> 1. Resident #9's care plan has been updated to reflect her current bowel and bladder status. 2. All residents had the potential to be affected by this issue. The care plans of all residents have been audited to ensure care plans reflect all areas of care needs based on the most recent comprehensive MDS. 3. In order to ensure this practice doesn't re-occur, the MDS co-ordinator has been in-serviced on ensuring all care plans are comprehensive and complete. 4. To ensure that this corrective action is effective, audits of comprehensive care plans by the DON or designee will be conducted twice per week for four weeks, then every month for three months. Reports of the audits will be reported monthly in QAPI meeting. If any concerns are noted, audits will continue for another month until compliance is achieved. 		

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

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{F 657}	<p>Continued From page 5</p> <p>A Bowel and Bladder Evaluation, dated 12/10/18 at 10:40 AM, documented Resident #9 had bladder incontinence.</p> <p>A Follow Up Question Report documented Resident #9 had episodes of urinary incontinence from 11/20/18 through 1/7/19.</p> <p>Resident #9's current care plan documented she required the assistance of one or two persons with toileting. On 1/8/19 at 8:00 AM, the care plan did not document Resident #9's incontinence.</p> <p>On 1/8/19 at 8:56 AM, the DON said she did not find anything which specifically addressed incontinence on Resident #9's care plan.</p> <p>On 1/8/19 at 9:09 AM, the MDS nurse said when she did the MDS assessment she printed off the list of triggered care areas and made sure they were addressed on the care plan. The MDS nurse said Resident #9's care plan did not address her urinary incontinence, and it should have been on the care plan.</p>	{F 657}			

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F 000	INITIAL COMMENTS An on-site revisit and complaint survey was conducted from January 7, 2019 through January 8, 2019. Refer to survey PTHG12 for details of this citation. The surveyors conducting the survey were: Edith Cecil, RN, Team Leader Cecilia Stockdill, RN	F 000			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		1/22/19	

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

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Electronically Signed

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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 584	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: A federal deficiency was cited at F584. Refer to survey PTHG12 for details of this citation.	F 584	1. The soiled bed linens for resident #9 were replaced with clean linens. 2. All residents had the potential to be affected by this issue. Room rounds were completed for all residents to check for soiled linens and replaced as needed. 3. In order to ensure this practice doesn't re-occur, housekeeping and nursing staff have been in-serviced to check for soiled bedding during their daily rounds and replace linens as needed. In addition, all resident rooms have been assigned to a department head to be inspected on all days they work and documentation of room inspections will be turned in weekly to the DON. Concerns will be addressed as they are identified during the rounds and in daily stand up. 4. To monitor performance and ensure		

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F 584	Continued From page 2	F 584	corrective action was effective and compliance sustained, results of of these inspections will be reported monthly in QAPI meetings for the next 3 months and any negative trends addressed. The Guardian Rounds will continue to be part of the managers routine.		



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June 20, 2019

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

Provider #: 135082

Dear Mr. Clarke:

On **January 7, 2019** through **January 8, 2019**, an unannounced on-site complaint survey was conducted at McCall Rehabilitation and Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007996

ALLEGATION #1:

The facility failed to provide clean bed linens for residents.

FINDINGS #1:

The bed linens of six residents were observed for cleanliness. Grievances were reviewed from 11/2018 to 1/2019. One resident and a resident's family member were interviewed. Three staff members were interviewed.

On 1/7/19, one resident's bed was observed to have soiled blankets and linens in place. The draw sheet had a small amount of visible brown-colored crumbs scattered on its surface. The top sheet had three dried stained areas of small to medium size that were brown/yellow in color. A white blanket on the bed had one dried stained area that was yellow/brown in color and three small dried stained areas that were red in color. A green-colored comforter was on the bed that had multiple small dried stained areas that were red/brown in color and several tiny crumbs that were red/brown in color.

The resident said she did not remember when her bed linens were last changed, but they were supposed to be changed each time she got a shower. She said she received a shower three times a week, and there were times her sheets were not changed after her shower. The Resident said she was incontinent of urine and had times where she soiled the bed with urine and it would be wet, and staff would "throw something over it. "

Later the same day, the previously mentioned resident's blankets and bed linens appeared in the same condition as previously described. A Certified Nursing Assistant (CNA) said the bed sheets were soiled and needed to come off. The CNA said the resident got a lot of coffee and other materials on her bed linens and they were changed often. The CNA said she did not know when the resident's bed linens were last changed, but they were probably changed that morning and she changed them every time she worked.

A nurse said bed linens should be changed at least once a week, and she had noticed some residents having dirty bed linens and she removed the bed linens when she saw they were dirty.

The Director of Nursing (DON) said bed linens should be changed whenever they were soiled, and a complete bed linen change should be done on a resident's shower days. The DON said the previously mentioned resident 's bed linens should have been changed.

Based on the investigative findings, the allegation was substantiated and the facility was cited at 584 related to the facility's failure to ensure residents were provided with clean linens.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility failed to provide pain medication as ordered.

FINDINGS #2:

The records of three residents were reviewed. One resident was interviewed. One family member was interviewed. One staff member was interviewed. Residents were observed for signs and symptoms of pain. Grievances were reviewed from 11/2018 through 1/2019.

The records of two residents documented pain medications were administered as ordered and the residents' pain levels were monitored. One resident's record documented a physician order for pain medication, but it was not administered because her pain level was "0," on a scale of 1-10 with 1 being minimal pain and 10 being the worst pain, when it was assessed by staff.

Another resident's record documented she received pain and anti-anxiety medications, as ordered and needed, as follows:

- Fentanyl patch on 11/1/18 and changed on 11/4/18
- Tramadol twice on 10/31/18, 11/1/18, 11/2/18, and 11/4/18
- Lorazepam twice on 11/2/18, and five times on 11/3/18
- Morphine twice on 11/2/18, three times on 11/5/18, four times on 11/3/18, and five times on 11/4/18

The same resident's record documented hospice was notified when the pain medication was not effective. The resident was more comfortable on 11/4/18, after receiving additional pain medication, and appeared comfortable according to subsequent documentation.

One resident said the facility was providing her with pain medication and she had not gone without it.

There were no observations of residents exhibiting signs and symptoms of pain during the survey.

There were no grievances regarding residents not receiving pain medication or pain issues not being managed.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility did not notify the physician regarding a resident's decline in condition.

FINDINGS #3:

The records of three residents were reviewed. Facility grievances and Incident and Accident reports were reviewed from 11/2018 to 1/2019.

Resident records included documentation their physician was notified when they had a change in condition. The record of one resident documented hospice was notified of her change in condition related to ineffective pain medication, and the physician was notified of her death.

The record of another resident documented the physician was notified of her change in condition related to development of a pressure ulcer. A Progress Note for another resident documented the physician was notified of a resident being transferred to the hospital.

Review of Incidents and Accidents documented the physician was appropriately notified of falls and skin issues. Review of grievances did not document any concerns related to the physician being notified of changes in residents' condition.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to ensure residents were not oversedated from medication.

FINDINGS #4:

The clinical record of three residents were reviewed. Residents were observed for signs and symptoms of oversedation during the survey.

The records of three residents documented appropriate administration of pain medications and monitoring of side effects. There were no observed signs or symptoms of residents being oversedated during the survey.

The record of one resident documented she fell in the facility and fractured both of her hips. After the resident returned to the facility from the hospital, she was placed on hospice services. The resident required pain medications to control her pain as she exhibited signs and symptoms of severe pain at times that was difficult to control. The resident's record documented she received fentanyl, tramadol, lorazepam, and morphine as ordered to help manage her pain.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Cole Clarke, Administrator
June 20, 2019
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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".

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj