



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

November 4, 2019

Kurt Holm, Administrator
McCall Rehabilitation and Care Center
418 Floyde Street
McCall, ID 83638-4508

Provider #: 135082

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Holm:

On **October 22, 2019**, a Facility Fire Safety and Construction survey was conducted at **McCall Rehabilitation and Care Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 18, 2019**. Failure to submit an acceptable PoC by **November 18, 2019**, may result in the imposition of civil monetary penalties by **December 9, 2019**.

Your PoC must contain the following:

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

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 26, 2019**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 20, 2020**. A change in the seriousness of the deficiencies on **December 6, 2019**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **November 26, 2019**, includes the following:

Denial of payment for new admissions effective **January 22, 2020**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 22, 2020**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **October 22, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

Go to the middle of the page to Information Letters section and click on State and select the following:

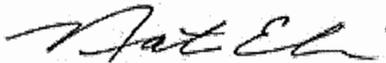
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **November 18, 2019**. If your request for informal dispute resolution is received after **November 18, 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, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

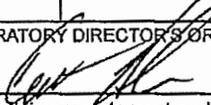
PRINTED: 11/01/2019
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135082 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____ | (X3) DATE SURVEY COMPLETED 10/22/2019 |
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| | |
|--|--|
| 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 |
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| K 000 | INITIAL COMMENTS The facility is a single story, type V (111) wood frame building that was built in 1965. The facility is fully sprinklered to include the attic space. The facility is equipped with an automatic fire alarm system which protects corridors and open spaces. The Essential Electrical System is supplied by a propane powered, on-site automatic generator. The facility is currently licensed for 65 SNF/NF beds and had a census of 31 on the date of the survey. The following deficiency was cited during the annual fire/life safety survey conducted on October 22, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70, and 42 CFR 483.80. The survey was conducted by: Nate Elkins, Supervisor Fire Life Safety Program | K 000 | "The plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, McCall Rehabilitation and Care Center does not admit that the deficiency listed on this form exists, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. | |
| K 291 SS=F | Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to maintain the emergency lighting systems installed throughout the facility to include the battery powered lighting for the generator room. Failure to maintain the emergency lighting could inhibit egress of residents during an emergency | K 291 | | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE <i>Administrator</i> | (X8) DATE <i>11-29-19</i> |
|--|-------------------------------|------------------------------|

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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| K 291 | <p>Continued From page 1 and prevent back-up power to operate the generator. This deficient practice affected 31 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During record review on October 22, 2019, at approximately 10:15 am, no documentation could be produced to indicate a ninety (90) minute annual test of the emergency lighting had been conducted. When asked, the Maintenance Supervisor stated the facility was aware the tests were not completed and provided documentation the battery backup lighting for the generator room had failed and he has not had the opportunity to fix the lighting.</p> <p>Actual NFPA Standard: NFPA 101 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) *The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.</p> | K 291 | <p>K 291</p> <p><u>Corrective Action:</u> The battery powered light in the generator room was repaired and is now in working condition.</p> <p><u>Identification of others affected:</u> On October 23, 2019 facility maintenance director audited all emergency lighting systems throughout the facility. No additional issues were identified.</p> <p><u>Systemic Changes to ensure Deficient Practice Doesn't Repeat</u> Maintenance Director will conduct functional testing monthly for at least 30 seconds. Functional testing will be performed annually for a minimum 1 ½ hours. All adverse findings will be reported to Administrator immediately.</p> <p><u>Monitor of corrective action</u> Testing will be reviewed monthly in facility QAPI meeting to ensure completion of testing and review of any adverse findings.</p> <p><u>Corrective Action Completed:</u> 10/23/2019</p> | | |

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| K 291 | Continued From page 2 (3) Functional testing shall be conducted annually for a minimum of 1-1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator. (4) A visual inspection shall be performed at intervals not exceeding 30 days. (5) Functional testing shall be conducted annually for a minimum of 1-1/2 hours. (6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1-1/2-hour test. (7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. | K 291 | | | |

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| K 291 | Continued From page 3 (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1-1/2 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times. | K 291 | | |
| K 293 SS=F | Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based upon observation and interview the facility failed to ensure Exit or No Exit signs were visible. Failure to provide exit signage can result in impeded or delay evacuation in an emergency. This deficient practice affected 31 residents and staff on the day of the survey. Findings include: During the facility tour on October 22, 2019 at | K 293 | | |

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| K 293 | <p>Continued From page 4</p> <p>approximately 3:00 pm, observation leading to and coming from the East and West Wings revealed no exit signs were placed on either side of the smoke barrier walls. Upon further observation at approximately 3:15 pm, revealed the door leading from the Activities area to the outside was locked without signage that stated, "NO EXIT" When asked, why the door was locked, the maintenance supervisor stated it is not an exit. These findings were acknowledged by the Administrator and the Maintenance Supervisor at the exit conference.</p> <p>Actual NFPA Standard: 7.10.1.5 Exit Access. 7.10.1.5.1 Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants.</p> <p>7.10.8.3* No Exit. 7.10.8.3.1 Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows:</p> <p style="text-align: center;">NO EXIT</p> <p>7.10.8.3.2 The NO EXIT sign shall have the word NO in letters 2 in. (51 mm) high, with a stroke width of 3/8 in. (9.5 mm), and the word EXIT in letters 1 in. (25 mm) high, with the word EXIT below the word NO, unless such sign is an approved</p> | K 293 | <p>K-293</p> <p><u>Corrective Action:</u> On October 23, 2019 facility maintenance director installed approved visible exit signs on both sides of the smoke barrier walls in the West and East Wings. In addition a no exit sign was installed above the east doors in the activity room.</p> <p><u>Identification of others affected:</u> On October 23, 2019 facility maintenance director audited all exit signage throughout the facility. No additional issues were identified.</p> <p><u>Systemic Changes to ensure Deficient Practice Doesn't Repeat</u> Maintenance director will audit all exit signage monthly and will report any adverse findings to the Administrator immediately.</p> <p><u>Monitor of corrective action</u> Safety issues, including appropriate emergency exit signage, will be reviewed in QAPI meeting monthly.</p> <p><u>Corrective Action Completed:</u> 10/23/2019</p> | |

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| K 293 | Continued From page 5 existing sign. | K 293 | K 351 | | |
| K 351 SS=F | <p>Sprinkler System - Installation CFR(s): NFPA 101</p> <p>Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a means to keeping continuous obstructions away from sprinkler heads. Failure to provide clear space for the sprinkler system to effectively operate could hinder protection from fires to fully develop. This deficient practice affects 31 residents and staff on the day of survey.</p> <p>Findings Include:</p> <p>During the facility tour on October 22, 2019, at approximately 9:04 am, observation above the</p> | K 351 | <p><u>Corrective Action:</u> On November 18, 2019 Viking Group Inc. will install four new sprinkler heads, two on each side of the accordion door which divides the activity room from the dining room.</p> <p><u>Identification of others affected:</u> Unobstructed clearance in these rooms will provide improved safety to residents, staff and visitors.</p> <p><u>Measures to ensure Deficient Practice Doesn't Repeat</u> Installed fire sprinkler heads will meet the requirements of NFPA 13</p> <p><u>Monitor of corrective action</u> Viking Group Inc. inspects the fire sprinkler system quarterly. Plant supervisor will monitor new sprinkler heads between these visits and will report any adverse findings to the Administrator</p> <p><u>Corrective Action Completed:</u> Scheduled for 11/18/2019</p> | | |

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| K 351 | Continued From page 6 accordion door separating the Activities areas revealed two (2) Standard Pendent sprinkler heads that were installed within 18 inches of the lintel. Interview with the Administrator, Director of Nursing, and the Maintenance Supervisor during the exit conference at approximately 4:30 pm stated the facility was not aware of the obstruction but did state no change has occurred in this area in some time. Actual NFPA Standard: Continuous or non-continuous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 8.6.5.2. See Table 8.6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge | K 351 | | | |
| K 926 SS=C | Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were trained on the risks | K 926 | | | |

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| K 926 | <p>Continued From page 7</p> <p>associated with the storage, handling and use of medical gases and their cylinders. Failure to ensure all direct-care staff involved with the application, maintenance and handling of medical gases are trained on safety and the risks associated with the use of oxygen, has the potential to expose residents to those hazards. This deficient practice could potentially affect oxygen dependent residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During record review on October 22, 2019, from 9:00 am - 11:30 AM, no documentation was provided to demonstrate all direct-care staff received on-going education for oxygen safety and the risks associated with medical gases. Interview with the Director of Nursing at approximately 3:30 pm determined the facility had not implemented this training to the staff members.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall</p> | K 926 | <p>K-926</p> <p><u>Corrective Action:</u> On October 30, 2019 Justin Kingsbury, RRT from Specialized Medical Services, conducted training for necessary staff and management regarding the maintenance and safe handling of facility oxygen equipment.</p> <p><u>Identification of others affected:</u> Training on the safe handling of oxygen equipment, will provide improved safety to staff, residents and visitors of the facility.</p> <p><u>Systemic Changes to ensure Deficient Practice Doesn't Repeat</u> Management will ensure that regular training in the safe handling of oxygen equipment conducted.</p> <p><u>Monitor of corrective action</u> Necessary training of appropriate staff will be reviewed monthly in facility QAPI meeting.</p> <p><u>Corrective Action Completed:</u> To be completed 11/15/2019</p> | |

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

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

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|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135082 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/22/2019 |
| NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION AND CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MCCALL, ID 83638 | | |
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| K 926 | Continued From page 8 include periodic review of safety guidelines and usage requirements for medical gases and their cylinders. | K 926 | | | |



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

November 4, 2019

Kurt Holm, Administrator
McCall Rehabilitation and Care Center
418 Floyde Street
McCall, ID 83638-4508

Provider #: 135082

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Holm:

On **October 22, 2019**, an Emergency Preparedness survey was conducted at McCall Rehabilitation and Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

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

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosure

TIME RECEIVED
November 20, 2019 at 7:44:16 AM MST
11-20-19;07:45AM;

REMOTE CSID
12086343605

DURATION
48

PAGES
1

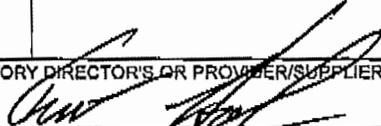
STATUS
Received

;12086343605

1/ 1

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

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

| | | | | |
|---|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135082 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 10/22/2019 |
| NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION AND CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MCCALL, ID 83638 | |
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| E 000 | <p>Initial Comments</p> <p>The facility is a single story, type V (111) wood frame building that was built in 1965. The facility is fully sprinklered to include the attic space. The facility is equipped with an automatic fire alarm system which protects corridors and open spaces. The Essential Electrical System is supplied by a propane powered, on-site automatic generator. The facility is currently licensed for 65 SNF/NF beds and had a census of 31 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on October 22, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Nate Elkins, Supervisor Fire Life Safety Program</p> | E 000 | | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | | TITLE | (X6) DATE |
|  | | | Administrator | 11/19/19 |

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.