IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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

July 15, 2015

Teresa Bruun, Administrator
Promontory Point Rehabilitation
3909 South 25th East,
Ammon, ID 83406

Provider #: 135137

Dear Ms. Bruun:

On **July 1, 2015**, we conducted an on-site revisit 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 **April 16, 2015**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

F157 -- S/S: D -- 42 CFR §483.10(b)(11) -- Notify of Changes (Injury/Decline/Room, etc)
F279 -- S/S: D -- 42 CFR §483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
F280 -- S/S: D -- 42 CFR §483.20(d)(3), 483.10(k)(2) -- Right to Participate Planning Care-Revise Care Plan
F323 -- S/S: D -- 42 CFR §483.25(h) -- Free of Accident Hazards/Supervision/Devices
F329 -- S/S: D -- 42 CFR §483.25(l) -- Drug Regimen is Free From Unnecessary Drugs

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.

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 copy of the Form CMS-2567B, Post-Certification Revisit Report listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 28, 2015**.

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 **March 25, 2015**, following the survey of **March 13, 2015**, we have already made the recommendation to the Centers for Medicare and

Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **September 13, 2015**, if substantial compliance is not achieved by that time. The findings of non-compliance on **July 1, 2015**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **April 1, 2015**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **April 16, 2015**

- A "per instance" civil money penalty of **$2,000.00** for the instance on **March 13, 2015,** described at deficiency **F309 (S/S: G)**

- A "per instance" civil money penalty of **$2,000.00** for the instance on **March 13, 2015,** described at deficiency **F314 (S/S: G)**

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 the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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 **July 28, 2015**. If your request for informal dispute resolution is received after **July 28, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

DAVID SCOTT, R.N., Supervisor
Long Term Care

DJS/dmj
Enclosures

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

PRINTED: 12/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 on-site follow-up survey to the facility's annual federal recertification survey of 3/9/15 through 3/13/15. The surveyors conducting the on-site follow-up survey were: Amy Barkley, RN, Team Coordinator, Linda Hukill-Neil, RN, and Kendra Deines, RN The survey team entered the facility on 6/30/15 and exited on 7/1/15. This report reflects changes resulting from the Informal Dispute Resolution (IDR) process conducted on November 30, 2015. Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status BP = Blood Pressure CM = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing HR = Heart Rate LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PO - By mouth PRN = As Needed RD = Registered Dietician RR = Respiratory Rate VS = Vital Signs WC = Wheelchair WNL = Within Normal Limits	{F 000}	**"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Promontory Point Rehabilitation does not admit that the deficiencies listed on HCFA 2567 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies".** RECEIVED JAN - 4 2016 FACILITY STANDARDS F 157 1. Patient #14 & 16 have discharged from the facility.	
{F 157}	483.10(b)(11) NOTIFY OF CHANGES	{F 157}		7/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 07/28/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 157} SS=D	Continued From page 1 (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure the	{F 157}	2. All patients have the potential to be affected. A root cause analysis revealed that appropriate assessment, nursing diagnosis, planning and notification for evaluation and initiation of appropriate treatment by a physician were not being consistently conducted in regards to changes of condition including high/low blood pressures and low oxygen saturation levels. 3. The DON conducted education on 7/16/15 in regards to the appropriate assessment, nursing diagnosis, planning and notification for evaluation and initiation of appropriate treatment by a physician were not being conducted in regards to changes of condition including high/low blood pressures and low oxygen saturation levels. The Change of Condition Policy and Procedure has been reviewed to make sure it outlines the nurse responsibilities upon admission	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 157}	Continued From page 2 physician was immediately notified when 1 of 4 sampled residents (#14) experienced changes in blood pressures and oxygen saturation levels. This failure had the potential for harm if the resident experienced a change in condition that required a change in treatment such as a decrease in cognition, increase in falls, and/or an increase in agitation. Findings included: The facility's Acute Condition Changes - Clinical Protocol documented that staff, before contacting a physician about residents with acute changes of condition, would make pertinent observations and collect appropriate information using the "Interact Care Paths." The Interact Care Path for Vital Signs documented the facility was to report the following conditions immediately: Systolic Blood Pressure of less than 90 mmHg (millimeters of mercury) and oxygen saturation of less than 90 percent, unless these values were stable and known by the primary care physician. Resident #14 was admitted to the facility on 6/13/15 with multiple diagnoses, including recent cerebrovascular disease with late effects, atrial flutter, delirium, hypertension, and history of sleep apnea. The Nursing Facility Admission Orders, dated 6/12/15, documented, "Oxygen liter flow 1-2 L[liters] adjust to maintain sat[urations] at greater than 90 percent as needed." The current oxygen care plan documented the resident received oxygen related to ineffective gas exchange. Interventions included oxygen saturation checks and liter flow rate monitoring	{F 157}	and throughout the residents stay. Education on the revised policy was done by the DON on 7/16/15. 4. DON or designee will conduct a random weekly audit on 4 patients per week for 6 weeks for appropriate assessment, nursing diagnosis, planning and notification for evaluation and initiation of appropriate treatment by a physician in regards to changes of condition including high/low blood pressures and low oxygen saturation levels. Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN. A nurse consultant will assist with reviews as requested. 5. Date of Completion 7/16/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 157}	Continued From page 3 every shift; monitoring for signs and symptoms of respiratory distress - including respirations, pulse oximetry, restlessness, lethargy, and confusion; and reporting to the physician as needed. The Neurologic Assessment flow sheet and the Medication Administration Record (MAR) for the month of June 2015 documented the following oxygen saturations with and without the liter flow rate: * 6/15/15 at 7:30 PM - oxygen saturation of 84% and at 8:30 PM oxygen saturation of 85%. * 6/16/15 at 5:00 PM oxygen of 71%, at 6:45 PM, and at 7:45 PM oxygen of 88%. * 6/17/15 at 8:00 AM - oxygen saturation of 85% on 2 liters. * 6/18/15 at 5:15 AM - oxygen saturation of 88% on 2 liters. * 6/19/15 at 5:15 AM - oxygen saturation of 85% and at 5:15 PM oxygen saturation of 76%. * Undocumented date at 5:30 AM - oxygen saturation of 86% and at 8:30 PM oxygen saturation of 88%. * 6/24/15 at 2:30 PM - oxygen saturation of 88%. Nurses Progress Notes from 6/15/15 to 6/27/15 did not include documentation related to the low oxygen saturations, nor did the notes document whether the physician was notified per the facility's Interact Care Path protocol. The current care plan documented the resident had hypertension and included the following interventions: Anti-hypertensives as ordered; monitor for side effects, such as orthostatic hypotension; and monitor/document/report to the physician, as needed, any signs of confusion, disorientation, lethargy, and/or irritability.	{F 157}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 157}	Continued From page 4 The Neurologic Assessment flow sheet and the Medication Administration Record (MAR), for June 2015, documented the following blood pressures: * 6/17/15 9:45 AM - 86/50 1:45 PM - 85/46 3:38 PM - 86/50 * 6/18/15 9:15 AM - 88/55 12:54 PM - 88/55 * 6/19/15 1:45 PM - 85/59 5:15 PM - 83/58 * Unknown date 4:00 AM - 85/62 4:30 AM - 87/57 * 6/23/15 2:42 PM - 80/50 Nurses Progress Notes from 6/15/15 to 6/27/15 did not include documentation related to the low blood pressures, nor did the notes document whether the physician was notified per the facility's Interact Care Path protocol. On 7/1/15 at 1:20 PM, the DON reviewed the resident's electronic medical record and stated she could not find documentation in the resident's record that the physician had been notified about the low oxygen saturations and/or the low blood pressures. She stated the facility had recently updated the policy and procedure for physician notification and nurses were using that and the Interact Protocol. She confirmed, per the "Vital Signs" protocol, that staff should have "immediately" notified the physician of the low oxygen saturation levels and hypotensive assessments.	{F 157}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 157}	Continued From page 5 On 7/1/15 at 4:00 PM, the Administrator, Chief Nurse of Operations (CNO), and the DON were notified of the identified concern. On 7/7/15, the State Agency received additional information from the facility which did not resolve the concern.	{F 157}		
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and medical record review, it was determined the facility failed to develop an interim care plan which reflected	{F 279}	**F 279** 1. Patient #15 care plan was updated to reflect current needs and interventions as triggered by CAA's and discussed by Interdisciplinary team. 2. All residents have the potential to be affected. Root cause analysis revealed sufficient education regarding specifics of appropriate care planning and updating of care plans to include interventions was lacking. We believe that staffing education is the best prevention. All nursing staff will receive mandatory education on the assessment process and when and how to update the Care Plan. Through our continued monitoring these processes will be evaluated and any additional processes will be implemented to maintain our	7/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 279}	Continued From page 6 the current status for 1 of 4 sampled residents (#15). The facility failed to address Resident #15's bowel care in which bowel medications and digital stimulation were needed for a paraplegic patient with hemorrhoids, constipation, and neurogenic bowels. This failure created the potential for harm if the resident's assessed needs were not met due to a non-comprehensive care plan. Findings included: Resident #15 was admitted to the facility on 4/24/15 with diagnoses including rehabilitation, muscle weakness, and paraplegia. The resident's 5/1/15 admission MDS assessment documented the following: * Cognitively intact * Required 2-person extensive assistance for transfers * Required 1-person extensive assistance for toileting * Continent of bowel * Involved in the bowel toileting program * No constipation. The resident's June 2015 recapitulated physician's orders documented: 4/24/15 - "Colace Capsule 100 MG (Docusate Sodium) Give 1 capsule by mouth two times a day for constipation/neurogenic bowel." 4/24/15 - "Senna Tablet 8.6 MG (Sennosides) Give 1 tablet by mouth two times a day for constipation/neurogenic bladder." 4/24/15 - "Proctocort Cream 1%...Insert 1 application rectally as needed for Homorrhoids [sic. hemorrhoids] BID [twice a day]." Resident #15's current Care Plan documented: * "Patient has an ADL self care performance	{F 279}	systemic changes. From initial plan of care we have implemented a monitor of systemic changes including shift to shift change report specific to patient condition and care plan update documentation. All nursing Staff are required to perform a complete assessment of their patients. If staff are aware of what they are looking for then this will expedite the management of the patients assessed needs Nursing staff were educated on completing comprehensive care plans. Education provided on 7/16/15. 3. We will maintain this by a. Nursing staff education to review patient medications and orders upon admission and with any new orders for changes in the residents needs to be updated in the care plan. b. DON will review all new admission assessments, orders, and care plans to ensure proper interventions are in place. c. Through our continued monitoring these processes will be evaluated and any additional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 279}	Continued From page 7 deficit r/t [related to] paraplegia." Initiated 4/28/15. * "Transfer: The patient requires (2) staff participation with transfers." Initiated 4/28/15. * "Toilet Use: The patient requires (2) staff participation to use the toilet." Initiated 4/28/15. The resident's Nursing Progress Notes documented: 4/24/15 - "He is a paraplegic following an accident in October 2014 ... requires two plus max[imum] assist for ADL cares ... uses a commode for toilet use ... also presents with bleeding hemorrhoids..." 4/27/15 - "... in an accident in Oct[ober] that resulted in loss of sensation and ability to use BLE [bilateral lower extremities] from chest down ..." 5/2/15 - "... Patient is incontinent of bowel and bladder ..." 5/4/15 - "... incontinent of bowel and bladder. Foley catheter was d/c'd [discontinued] ..." 5/12/15 - "... Bowel sounds active ... requires 1 person assist with transfers/adl [activities of daily living] cares ..." 5/28/15 - "... Bowel sounds active ... denies any abd [abdominal] pain ... Patient is incontinent of bowel and bladder ..." 5/29/15 - "... Patient is incontinent of bowel and bladder ..." 6/4/15 - "... requires 1 person assist with transfers/adl cares. Uses wheelchair for mobility and slide board for transfers ..." 6/7/15 - "... incontinent of urine at times, but continent of bowels. He generally produces a bowel movement each evening using digital stimulation ..." 6/16/15 - "... has a nightly bowel movement with self digital stimulation ..." 6/29/15 - "... Patient is incontinent of bowel and	{F 279}	processes will be implemented to maintain our systemic changes. 4. MDS coordinator will fill out and give to the DNS the CAA communication tool weekly. The DNS will use this form to verify that care plans have been completed for those CAA's triggered and needing to be care planned. DON or designee will conduct a random weekly audit on 4 patient care plans per week for 6 weeks, to ensure that comprehensive care plans have been updated. Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN. Nursing meetings throughout year will address ongoing care planning education. A nurse consultant will assist with reviews as requested. 5. Date of Completion 7/16/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER: PROMONTORY POINT REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE: 3909 SOUTH 25TH EAST, AMMON, ID 83406

(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 279}	Continued From page 8 bladder ..." On 6/30/15 at 9:30 AM, Resident #15 was observed in his room seated in a wheelchair with both feet resting on the foot rests. Resident #15 had a seat belt secured snugly around his waistline and another belt around his chestline and the wheelchair. The resident stated he used a slider board, but was unable to transfer by himself from his wheelchair to his bed. The resident said he had no feeling from his midchest down and needed help for almost every activity. On 7/1/15 at 9:25 AM, the DON was interviewed regarding Resident #15's bowel care. The DON acknowledged the resident did not have a Care Plan that addressed his bowel regime and said, "yes, absolutely" the Care Plan should provide bowel care directives to staff. On 7/1/15 at 4:00 PM, the Administrator, DON, CNO, and additional management team staff were informed of the concerns. The facility provided additional information on 7/7/15 to reflect the resident self-managed his bowel care, but the information did not alleviate the Care Plan issues.	{F 279}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	{F 280}	**F 280** 1. Patient #14 has discharged from the facility. Patient #15's care plan was revised for current needs,	7/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 280}	Continued From page 9 comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to accurately update the care plan for 1 of 4 sampled residents (#15). The failure created the potential for the resident to receive inappropriate care due to lack of direction in the care plan. Resident #15 was admitted to the facility on 4/24/15 with diagnoses including rehabilitation, urinary tract infection, muscle weakness, abnormal posture, and paraplegia. The resident's 5/1/15 admission MDS assessment documented the resident was cognitively intact, required 2-person extensive assist for transfers and dressing, and required 1-person extensive assist for bed mobility, locomotion on the unit, and toilet use. The resident's June 2015 recapitulated physician's orders documented: 4/24/15 - "Admit to skilled nursing facility under the care of [physician's name ..."	{F 280}	assistive/restrictive devices, education provided for self-performing or family performing cares, and for safety. Care plan was updated to reflect changes. Nurse spoke with patient needs and education. 2. All patients have the potential to be affected. Root cause analysis revealed sufficient education regarding specifics of appropriate care planning and updating of care plans to include interventions was lacking. We believe that staffing education is the best prevention. All nursing staff are required to update the patient care plans to include new interventions and care plan any interventions related to restrictive devices, self/family/caregiver providing cares, and UTI's. We will identify these patients by nurse to nurse report, DON review of new admission orders and care plans. DON or designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 280}	Continued From page 10 4/24/15 - "PT/OT [physical therapy/occupational therapy] eval [evaluate] and tx [treat]." 5/11/15 - "Septra DS Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim) Give 1 tablet by mouth two times a day for UTI for 7 days." End date: 5/18/15 6/26/15 - "Seat belt to wheelchair for positioning ..." Patient #15's current Care Plan documented: * "Paraplegia r/t [related to] Spinal injury," initiated 4/28/15. * "PT, OT, evaluate and treat as ordered," initiated 4/28/15. * "... has limited physical mobility r/t spinal injury, paraplegia," initiated 4/28/15. * "Seat belt to wheelchair for positioning/patient's request. Patient is able to demonstrate how to release seat belt," initiated 6/26/15. * "Antibiotic Therapy r/t infection UTI," initiated 5/12/15. * "Administer medications as ordered ... Any antibiotic may cause diarrhea, nausea, vomiting, anorexia ... Observe for possible side effects every shift ..." initiated 5/12/15. The resident's care plan did not include any interventions in regards to the frequency of releasing the restrictive devices, assessment of the skin under the restrictive devices, or offloading for a paraplegic patient with impairment from the chestline down. Additionally, the resident still had an active UTI Care Plan, although he was neither diagnosed with- nor being treated for a UTI. The facility also documented the resident was resistive to cares and education related to catherization, incontinence, and showers. Family provided assistance with the showers, however the Care Plan did not reflect how the facility	{F 280}	review accident and incidents for the prior day. 3. This will be maintained by: a. Nursing staff education to review assessments upon admission and with new assistive/restrictive devices and diet orders. All patients that are identified as having restrictive devices are to be care planned for appropriate interventions. b. Care plan library changes to now include non-pharmacological interventions to be personalized as needed. c. Through our continued monitoring these processes will be evaluated and any additional processes will be implemented to maintain our systemic changes. DON educated nursing staff on properly updating resident care plans to include interventions to frequency or releasing and assessment of skin/offloading for restrictive devices. Also for resolving out UTI care plans when appropriate and education provided to patient and/or family when they provide assistance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 280}	Continued From page 11 addressed these areas of care or the associated resident and family education. The resident's Nursing Progress Notes documented: 4/24/15 - "He is a paraplegic following an accident in October 2014 ... requires two plus max[imum] assist for ADL cares ..." 4/27/15 - "... in an accident in Oct[ober] that resulted in loss of sensation and ability to use BLE [bilateral lower extremities] from chest down ..." 5/11/15 - "... Urine culture results received with orders for Septra DS ...7 days ..." 5/20/15 - "Pt [patient] finished Septra for UTI." 6/4/15 - "... requires 1 person assist with transfers/adl cares. Uses wheelchair for mobility and slide board for transfers ..." On 6/30/15 at 9:30 AM, Resident #15 was observed in his room, seated in a wheelchair with both feet resting on the foot rests. Resident #15 had a seat belt secured snugly around his waistline and another belt around his chestline and the wheelchair. The resident stated he used a slider board, but was unable to transfer by himself from his wheelchair to his bed. The resident said he had no feeling from his midchest down and needed help for nearly every activity. The resident demonstrated his ability to unfasten his seatbelt and then his chest restraint. On 7/1/15 at 9:25 AM, the DON was interviewed regarding Resident #15's Care Plan. The DON acknowledged the resident did not have a current UTI and the Care Plan should have been updated. The DON said the resident's Care Plan should have also contained a directive of care for the seat and chest belts.	{F 280}	d. Policy and procedure reviewed and updated to reflect any needed changes Education provided on 7/16/15. 4. DON or designee will conduct weekly audits on 4 admitted patients' care plans per week for 6 weeks, to ensure that comprehensive care plans have been updated to include assistive/restrictive devices and diet orders. All patients that are identified as having restrictive devices, UTI's, and diet order changes are to be care planned for appropriate interventions. Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN. Nursing meetings throughout year will address ongoing care planning education. A nurse consultant will assist with reviews as requested. 5. Date of Completion 7/16/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 280}	Continued From page 12	{F 280}		
	On 7/1/15 at 3:30 PM, PT #3 was interviewed about Resident #15's seat- and chest belts. PT #3 stated the seat- and chest belts were used by the resident prior to his arrival to the facility, and said, "[I] don't see that either the seat belt or the chest belt is mentioned" in the PT evaluation or the PT notes, "but the need for them in relation to the level of his injury is. He has lack of core strength." The PT stated he/she was not familar with the Restrictive Device Assessment form that had been completed for the resident's seat belt. On 7/1/15 at 4:00 PM, the Administrator, DON, CNO, and additional management team staff were informed of the concerns. The facility provided additional information, but the information did not alleviate the Care Plan issues.		**F 323** 1. Patient #15 was assessed for safety, benefits, and risks of the use of a seat belt and chest restraint including any needed interventions. Family member was assessed and found capable of independently providing safe and proper care for transfers, undressing and dressing, and bath hygiene care 2. All patients using restrictive devices and having family provide care have the potential to be affected. A root cause analysis revealed appropriate planning, implementation, and communication were not conducted for interventions for patients with family providing care and for restrictive devices.	
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, it was determined the facility failed to ensure 1 of 4 sampled residents (#15) was assessed for safety and interventions implemented for his/her care and services as follows:	{F 323}		7/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 323}	Continued From page 13 a) Resident #15 was not assessed for the safety, benefits, and risks of the use of a seat belt and chest restraint, nor were on-going assessments and care planned interventions implemented for the continuation of these assistive devices. b) Resident #15's family member was not assessed nor determined capable of independently providing safe and proper care without staff intervention/assistance for the resident's transfers, undressing and dressing, and bath/hygiene care. Findings include: Resident #15 was admitted to the facility on 4/24/15 with multiple diagnoses including rehabilitation, muscle weakness, abnormal posture, and paraplegia. The resident's 5/1/15 admission MDS assessment documented: * BIMS with a score of 15 for cognitively intact; * No behaviors indicating a rejection of care; * 2-person extensive assist for transfers and dressing; * 1-person extensive assist for bed mobility, locomotion on the unit, and toilet use; * No physical restraints in use; and, * Bath/shower did not occur. Note: On 1/1/15 at 12:10 PM, LN #5 stated the bath/shower was coded as not occurring "since our staff/CNAs were not providing any of the bathing function." The resident's recapitulated Physician's Orders documented: * 4/24/15 - "Admit to skilled nursing facility under the care of [physician's name] ..." * 4/24/15 - "PT/OT eval [evaluate] and tx [treat]."	{F 323}	We believe that staffing education is the best prevention. All nursing staff are required to initiate/update the patient care plans to include interventions for patients with family providing care and for restrictive devices. We will identify these patients by nurse to nurse report, DON review of restrictive device assessments, and DON review of all new admission care plans. Nursing staff were educated on proper interventions, communication, and documentation for restrictive devices, UTI's, and education/assessment of family providing care. Also on care plan updates for those interventions. Education provided at staff meeting on 7/16/15. 3. This will be maintained by a. Staff education as to proper interventions, communication, and documentation for restrictive devices and education/assessment of family providing care. Also on care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 323}	Continued From page 14 * 6/2/15 - "Nystatin Powder 100000 Unit/Gm Apply to Peri area topically as needed for yeast infection." * 6/26/15 - "Seat belt to wheelchair for positioning. (Patient able to demonstrate how to release seat belt)." Patient #15's current Care Plan documented: *Focus: "Patient has an ADL Self Care Performance Deficit r/t paraplegia." Initiated 4/28/15. * Interventions: "Bathing: The patient requires (2) staff participation with bathing ... Dressing: The patient requires (2) staff participation to dress ... Transfer: The patient requires (2) staff participation with transfers..." Initiated 4/28/15. *Focus: "Paraplegia r/t [related to] Spinal injury." Initiated 4/28/15. * Interventions: "PT, OT, evaluate and treat as ordered." Initiated 4/28/15. *Focus: "... has limited physical mobility r/t spinal injury, paraplegia." Initiated 4/28/15. * Interventions: "Seat belt to wheelchair for positioning/patient's request. Patient is able to demonstrate how to release seat belt." Initiated 6/26/15. (Refer to F280 citation related to the seat belt and chest restraint care directives for Resident #15. The resident's 4/24/15 PT Evaluation & Plan of Treatment History documented: "... about 2 months ago where pt has been living in a motel room with his ex-wife assisting him. Pt had been attempting home health physical therapy and nursing care in the motel room but struggled d/t [due to] the confined space. While at the motel, pt developed a UTI with sepsis and was hospitalized on 4/18 ..."	{F 323}	plan updates for those interventions. b. Director of Nursing will review care plans for proper interventions, communication, and documentation for restrictive devices and education/assessment of family providing care. Also on care plan updates for those interventions. 4. DON or designee will conduct a weekly audit on all newly admitted patients for proper interventions, communication, and documentation for restrictive devices and education/assessment of family providing care. Also on care plan updates for those interventions each week for 6 weeks. Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN. A nurse consultant will assist with reviews as requested. 5. Date of Completion 7/16/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 323}	Continued From page 15 The resident's Interventions and Tasks report documented Resident #15 was scheduled for bathing on Wednesdays and Saturdays, but had refused baths/showers from facility staff from 4/29/15 through 6/27/15. NOTE: Bathing was provided by a family member. Please refer to F 280. Resident #15's Restrictive Device Assessment documented, dated 6/26/15, documented the resident had a diagnosis of paraplegia and "[was] alert and oriented times 3 [person, place, time]. He is able to demonstrate how to release seat belt. [Resident] has requested the use of seat belt to wheelchair for comfort/positioning." On 7/7/15 the Bureau of Facility Standards received an addendum from the facility in regards to the seat belt and chest belt. The 7/3/15 statement, written by a physical therapist, documented, "... When pt [patient] came to our facility on 4/24/15, pt came with a manual w/c equipped with a seat belt and chest restraint that was fitted to him ... to assist with safety and balance ... Pt's cognition has always been intact since his arrival here, and he has been very aware of safety concerns associated with his decreased trunk stability ..." Note: The seat belt assessment, plan of care, and physician's order was not completed until 6/26/15, although the resident had been using a seat belt since admission to the facility on 4/24/15. Also, a chest belt was not ordered by a physician, a restrictive device assessment was not completed, and the chest belt was not part of the resident's care plan. The resident's Nursing Progress Notes	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 323}	Continued From page 16 documented: * 4/24/15 - "He is a paraplegic following an accident in October 2014 ... requires two plus max[imum] assist for ADL cares ..." * 4/27/15 - "... in an accident in Oct[ober] that resulted in loss of sensation and ability to use BLE [bilateral lower extremities] from chest down ..." * 5/2/15 - "... Requires 1 person assist with transfers/adls [activities of daily living]. Uses wheelchair for mobility with staff assistance to propel ..." * 5/7/15 - "... is a 1-2 assist slide board transfer ... loss of sensation and ability to use BLE [bilateral lower extremities] from chest down ..." * 5/12/15 - "... 1 person assist with transfers/adl/ambulation ..." * 5/25/15 - "... Requires 1 person assist with transfers/adls ..." * 5/31/15 - "... is a 1-2 assist slide board transfer ..." * 6/4/15 - "... requires 1 person assist with transfers/adl cares. Uses wheelchair for mobility and slide board for transfers ..." * 6/7/15 - "... produces a bowel movement each evening using digital stimulation, followed by a nightly shower which he completes with the assistance of a family member under staff supervision ..." * 6/15/15 - "... is a 1 assist slide board transfer. Pt is dependent on dressing and assisted with other ADLs ..." * 6/23/15 - "... Pt is a 1 assist slide board transfer ... Pt is dependent on dressing ..." * 6/27/15 - "... requires one person assist with ADL cares. He is non ambulatory and self propels wheelchair for locomotion ..." Note: The Nursing Progress Notes contained no documentation in regards to the seat belt or chest	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 323}	Continued From page 17 restraint, nor whether the resident was assessed for safety with those devices. The Nursing Progress Notes contained no documentation of resident refusals of staff assistance with baths/showers. The Nursing Progress Notes on 6/7, 6/8, and 6/21/15 documented the resident was assisted by a family member with a shower under staff supervision. On 6/30/15 at 9:30 AM, Resident #15 was observed seated in a wheelchair in his room with both feet resting on the foot rests. Resident #15 had a seat belt secured snuggly around his waistline and another belt around his chestline and the wheelchair. The patient stated he used a slider board, but was unable to transfer by himself from his wheelchair to his bed. The patient said he had no feeling from his midchest down and needed help with most activity. The resident demonstrated his ability to unfasten his seatbelt and chest belt. On 7/1/15 at 12:45 PM, the OTR/L [Occupational Therapy Registered License] was interviewed regarding the bath/shower assessment for Resident #15. The OTR/L stated he was involved in the initial observation/assessment on 4/24/15 and for bathing/hygiene the resident was assessed to be "max assist with bathing" and "required more than 50% assistance at least with one [staff]." The OTR/L said the bathing assessment encompassed the entire task from the beginning to the end, including the transfer, undressing, dressing, and etc. The OTR/L said a family member was present during the initial assessment, but was not physically helping the patient during the assessment process. When the OTR/L was asked how the resident's safety while under the care of the facility was ensured with a	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 323}	Continued From page 18 family member being responsible for transfers, undressing, showers, and dressing, he stated "I was not assessing her abilities on the first day, and assumed since she was his full time caregiver prior to his coming here that she would know how to provide his care." On 7/1/15 at 1:08 PM, CNA #4 was interviewed regarding Resident' #15's baths/showers. The CNA stated the resident was a "younger man and very private" and had, since his admission to the facility, refused to allow the staff to provide showers. The CNA said a family member "did everything" for the resident and staff only provided towels upon request. On 7/1/15 at 3:30 PM, PT #3 stated Resident #15's seat and chest belts were used by the resident prior to coming to the facility. PT #3 said, "Don't see that either the seat belt or the chest belt is mentioned" in the PT evaluation or the PT notes, "but the need for them in relation to the level of his injury is. He has lack of core strength." On 7/1/15 at 4:00 PM, the Administrator, DON, CNO, and additional management team staff were informed of the concerns. The facility provided additional information that did not alleviate the concerns.	{F 323}		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329	**F 329** 1. Patient #14 discharged from the facility. 2. All residents on antipsychotic therapy have the potential to be affected.	7/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 19 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to determine the cause of a resident's escalated behaviors and initiate nonpharmacological interventions to address those behaviors prior to the initiation of antipsychotic therapy and use of duplicate antipsychotic medications. Additionally, the facility failed to develop specific care plan interventions to address the resident's challenging behaviors. This was true for 1 of 1 (#14) sampled residents. Resident #14 was exposed to the potential for more than minimal when he experienced increased sedation and agitation that affected his ability to participate in physical- and speech therapies, and eventual hospitalization for further evaluation of the increased behaviors.	F 329	A root cause analysis revealed that there was a lack of communication between the medical director and family physician that the family/resident went to see and medications changes made at that appointment. We believe that staffing education is the best prevention. All nursing staff are required to initiate non-pharmacological interventions for behaviors prior to administration of antipsychotic therapy and for use of duplicate antipsychotic medications. We will identify these patients by nurse to nurse report, DON review of new orders for antipsychotic medications, duplicate antipsychotic medications, and non-pharmacological interventions. 3. DON educated nursing on initiating non-pharmacological interventions, monitoring to avoid duplicate antipsychotic medications on 7/16/15. 4. This will be maintained by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 20 NOTE: Resident #14 was admitted to a local hospital immediately prior to his admission to the facility. That hospital documented the following: * History and Physical, dated 6/9/15: "The patient was brought in by family members apparently somewhat confused ... He is unsure why he is here other than stating that his mind has not been working. He does have some word salad on initial evaluation; however, begins to answer questions appropriately, but then rambles on with other nonsensical sentences or words." * Occupational Therapy Initial Evaluation, dated 6/10/15: "P[atient] is very confused, it appears that the [patient] was seeing things in his room like machinery that he was fixing, or a young girl, and something else he would just point at." * Speech Therapy Initial Evaluation, dated 6/11/15: "He has shown limited ability to understand verbal instructions and questions and is very verbose w/little content in his speech. Cannot appropriately answer yes/no questions or answer questions about daily item's function ... Memory and Attention were not assessed due to patient's confused status. He has no known history of previous cognitive/communication deficits." Resident #14 was admitted to the facility on 6/13/15 with multiple diagnoses, including history and recent Cerebrovascular Accident (CVA), hemiparesis, falls, delerium, Type II diabetes, and urinary tract infection. The resident's admission medication orders did not include anti-psychotic medications. The Admission MDS, dated 6/19/15, documented:	F 329	a. Nursing staff education to initiating non-pharmacological interventions, monitoring to avoid duplicate antipsychotic. b. Through our continued monitoring these processes will be evaluated and any additional processes will be implemented to maintain our systemic changes. DON or designee will conduct audits on all new admissions with prescribed antipsychotic medications for 6 weeks, for initiating non-pharmacological interventions and monitoring to avoid duplicate antipsychotic. Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN. A nurse consultant will assist with reviews as requested. 5. Date of Completion 7/16/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 21 * Short-term and long-term memory impairment; * Moderately impaired decision making skills; * Continuous inattention and disorganized thinking; * Fluctuation in altered level of consciousness and psychomotor retardation; * Hallucinations and delusions present; * No physical/behavioral symptoms or rejection of cares present; and * Wandering occurred daily. The Psychotropic Medications care plan, dated 6/17/15, documented, the resident used psychotropic medications (resperidone) related to delerium due to CVA. Interventions included: Monitor/record occurrence of target behavior symptoms and specify wandering; inappropriate response to verbal communication; violence/aggression towards staff/others; document per facility protocol; report to MD as needed - side effects and adverse reactions of psychoactive medications, including unsteady gait, tardive dyskinesia, fatigue, and insomnia; and behavioral symptoms not usual to the resident. NOTE: The 2016 Nursing Drug Handbook documented the following adverse reactions associated with the use of Risperdal, "akathisia, dystonia, agitation, anxiety, hallucinations, mania, impaired concentration, and fatigue; and use cautiously in in patients with cerebrovascular disease." The Black Box Warning documented, "Elderly patients with dementia-related psychosis treated with antipsychotics are at increased risk for death; drug is not approved to treat elderly patients with dementia-related psychosis." The Impaired Cognitive care plan, dated 6/24/15,	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 22	F 329		

documented the resident had impaired cogintion/dememtia/impaired thought process related to CVA. Interventions included: Identify self at each interaction; face resident when speaking; make eye contact; reduce any distractions; use consistent, simple, directive sentences; provide necessary cues; stop and return if agitated; monitor, document, and record any changes in decision making ability, memory, recall and general awareness; difficulty expressing self; difficulty understanding others; level of consciousness; and mental status.

On 6/30/15, the facility was asked and could not provide a behavior and/or impaired cognition care plan in place prior to the current care plan, therefore, it could not be determined how the resident's "delerium secondary to a CVA," was being monitored and addressed adequately.

Resident #14's Physician Orders (P.O.), Nurses Progress Notes (NPN), Medication Administration Record (MAR), Office Visit Notes (OVN), Psychotropic Drug Use Assessment (PDUA), Agitation Assessment (AA) Physical Therapy Notes (PTN), Interdisciplinary (IDT) Minutes, and Speech Therapy Notes (STN) were reviewed and included the following information:

The Nursing Admission Assessment, dated 6/13/15, documented Resident #14 was oriented to person only; he innapropriately answered questions, was unable to understand; "wanders mentally;" was unable to make needs known, and required assistance with decision making due to his [impaired] cognitive status.

* PTN - 6/13/15: "Pt [Patient] was very confused today and demonstrated severe expressive and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 23 receptive aphasia that was diffucult to manage." * NPN - 6/14/15, at 5:24 AM: "Pt appears to be adjusting well to facility. Pt appears to be sleeping." * NPN - 6/14/15 at 11:38 PM: "Patient was alert for the first few hours of this shift. He is oriented to self only, often calling staff members by family members (sic) names. Patient was attempting to self transfer out of bed several times, when approached by staff he denied needs and was assisted back to bed. Patient did fall asleep and was quite lethargic when approached for HS [night] medications. He took several minutes of cueing and reminding to take his medications ..." * PTN - 6/15/15: "Pt demonstrates moderate to severe ataxia and continues to be limited by confusion and hallucinations." Note: This was the first documentation of the presence of hallucinations in the facility and did not include any documentation as to the specific characteristics of the hallucinations, how they were harmful to the resident or others, what non-pharmacological interventions were attempted, nor the effectiveness of those interventions, or whether all nursing staff were alerted to the resident's new symptom of hallucinations. * NPN - 6/15/15 at 5:00 PM: "Pt was agitated and was using 02 [oxygen] hose like a rope/lasso. Pt redirected with coffee and food." * PTN - 6/16/15: "Pt showing confusion and does not know why he is here, pt told and then he forgets later needing reminded again." * NPN - 6/16/15 at 6:22 PM: "Patient is alert and confused, per patient norm following recent CVA. He is occasionally able to be reoriented to current situation, but easily forgets. Patient describes	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 24 visual and audible hallucinations this shift, which is not a new occurrence for the patient. Patient has been very restless and anxious this evening and his family has asked for [the] physician to be consulted regarding possible treatment options for the agitation and hallucinations." Note: It could not be determined from the nursing documentation, what the visual and audible hallucinations were, how persistent they were, or how they were harmful to the resident or others. There was no documentation of any non-pharmacological interventions attempted, nor the outcome of those interventions, if attempted. * PTN - 6/17/15: "Pt showing confusion needing repeated [voice commands] to stay on task during Nustep activity." * IDT Minutes - 6/17/15 at 12:00 PM: "Family is concerned about behaviors ... Will consult with the Internal Medicine/Cardiology Physician for additional opinion regarding patient and psychotropic medication cessation effects (was on risperdone at the hospital, was discontinued on day of discharge) and the benefit vs risks of starting this medication again..." * PDUA - 6/17/15: - The resident did not have a diagnosed psychiatric disorder; - The resident was receiving the anti-psychotic medication Risperdal; - The area on the assessment to list specific symptoms to monitor left blank; - Indicated reason for the medication: "Delerium [related to] CVA." - Risperdal started on 6/17/15 and was "unknown at the time" if the medication use was temporary. - Medical Factors, Side Effects Factors, and Cognitive/Behavior/Mood Factors for	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 25 consideration on the form left blank. - The resident had problems with balance, gait, and/or positioning ability. - The form documented the psychotropic drug use side effects and the Cognitive/Behavior/Mood factors did not impact the resident's ability to function. It was unclear how this was determined as the identified areas of the assessment were left blank. NOTE: The resident's entire medical record was requested on 6/30/15 and 7/1/15. The facility provided the record, which did not include an Agitation Assessment, which the facility provided to the Bureau of Facility Standards on 7/7/15. *AA - 6/17/15: Grabbing "onto" people, performing repititious mannerisms, cursing or verbal aggression, "weird laughter or crying" (occurred 1 to 2 times "that" day), physical and verbal sexual advances, general restlessness, and repetitious sentences or questions (occurred a few times an hour "that" day, however, there was no documentation in the resident's record to support the identified behaviors). * P.O. (verbal) 6/17/15, at 4:23 PM: "Risperdal 0.5 mg one po twice daily." NOTE: The only documentation in the resident's record related to the use of Risperdal was located in the IDT Minutes for 6/17/15 and documented, "The resident was on risperdone at the hospital [and it] was discontinued on the day of discharge." * STN - 6/17/15, at 6:43 PM: "He [Resident #14] perseverated continually on topics of police officers, wittnesses, and needing SLP's [Speech Therapist's] papers and clipboard."	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 26 * MAR - 6/17/15, at 8:00 PM: Risperdal, 0.5 mg. * MAR - 6/18/15, at 8:00 AM: Risperdal, 0.5 mg. * P.O. - 6/18/15, at 5:28 PM: "Risperdal 0.25 mg give one by mouth two times a day for delerium related to CVA." * NPN - 6/18/15, at 5:34 PM: "Patient is alert and confused, per patient's norm[al] related to recent CVA. Patient has been very sleepy this shift. Not easily aroused related to new order of Risperdal 0.5 mg BID [twice a day]. Family consulted and is in agreement to reduce dose of Risoperdal to 0.25 mg twice daily per telephone order recieved by the Physician." * STN - 6/18/15, at 6:24 PM: "Pt was still in bed when SLP arrived. Pt's continued to be sleepy and was unable to attend to tx [treatment] tasks. With constant redirection and sternal rubbing, pt would wake up and briefly answer questions as well as follow a few one step commands, but it was intermittent as he would continue to fall back asleep. SLP discussed pt with nsg. [nursing]. SLP was informed that pt had been given a new medicine that may be having an impact." * PTN - 6/19/15: "Pt is still suffering from side effects from medication changes and was not responsive." * P.O. - 6/19/15, at 12:50 PM: "Risperdal 0.25 mg tablet, give one tablet by mouth at bedtime for delerium r/t CVA." * NPN - 6/19/15, at 1:30 PM: Care plan meeting held with family who verbalized concerns related to the resident's medications, which were addressed by the DON. The note did not include specific details of those concerns voiced by family or how the concerns had been addressed by the DON. * STN - 6/19/15, at 3:08 PM: "Pt was still struggling to recover from a medication issue. Pt was extremely tired and had difficulty opening his	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 27 eyes to partipate [sic]. He would open briefly and attempt [sic] to answer a question or two and then would close his eyes again and not respond. SLP noticed that pt had pocketed some food and meds. SLP attempted to have pt drink to wash down, but pt was unable to follow through on this task..." * NPN - 6/19/15, at 5:15 PM: "Patient remains sleepy this shift difficult to arouse related to new order of Risperdal." * MAR - 6/19/15, at 8:00 PM: Risperdal, 0.25 mg. * NPN - 6/20/15, at 6:14 PM: "Patient is lethargic and confused this shift." * MAR - 6/20/15, at 8:00 PM: Risperdal, 0.25 mg. * PTN - 6/21/15: "Pt was more fatigued today than yesterday ... Pt continues to demonstrate inappropriate behaviors and reaquires freq[uent] redirection." The note did not document the nature of the "inappropriate behaviors," or whether nursing staff had been notified. * MAR - 6/21/15, at 8:00 PM: Risperdal, 0.25 mg. * PTN -6/22/15: "Pt alert but not oriented, he thought he needed to get ready for a weddign [sic] reception then later for a funeral." * NPN - 6/22/15, at 4:09 PM: "Pt requires continuous reminding of time and situation.... Pt continues to be restless and trying to self transfer." * MAR - 6/22/15, at 8:00 PM: Risperdal, 0.25 mg. * PTN - 6/23/15: "Pt struggled with seated bench press more than he has previously as he is much more fatigued than usual . Pt struggled with seated peg board activity today d/t increased fatigue and decreased attention to task. Pt did seem overly fatigued today compared to normal. Pt showing poor safety awareness not following instructions well in safety with standing ... Pt continues to be fair [sic] confused, difficuloty [sic] staying on task."	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 28 * STN - 6/23/15: "At the end of [the] tx [treatment] session, pt was taken to the nurses station and placed in his wheelchair with his tray in front of him and his deck of cards to keep him occupied, as he becomes very bored alone in his room." * SWN - 6/23/15, at 4:30 PM: "This worker informed family of different interventions with meds ..." *NPN - 6/23/15, at 4:40 PM: "Pt fell in hallway, hit his head into nurses cart at 3:40 PM ... MD was notified .. MD ordered to increased [sic] risperidone [Risperdal] to .50mg [sic] PO [by mouth], and to F/U [follow-up] with primary care provider." NOTE: It was unclear why the physician who was the resident's care provider while residing in the facility would have the resident follow-up with his out-patient physician, or why the physician ordered an increase in the resident's anti-psychotic medication in response to the resident's fall. * P.O. - 6/23/15, at 5:30 PM: "Risperdal tablets 0.25 mg tablets, give two tablets by mouth at bedtime for delerium r/t CVA." * MAR - 6/23/15, at 8:00 PM: Two 0.25 mg tablets of Risperdal. * NPN - 6/24/15, at 6:22 PM: "Patient is alert and confused per norm [sic]. He has moments of clarity, but for the majority of this shift he does not recognize family members, place, situation, or time of day. He is pleasant and talkative today." * MAR - 6/24/15, at 8:00 PM: , Two 0.25 mg tablets of Risperdal. * NPN - 6/24/15, at 9:52: "Pt refusing to wear o2 [sic] ... pt. verbally and physically abusive to staff combative alert very confused and restless ..." *AA - 6/24/15, at 11:05 AM:	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 29 - Handling things inappropriately, performing repititious mannerisms, "weird laughter or crying," and negativism occurred 1 to 2 times "that" day. - Hitting, grabbing people, pushing, trying to get to a different place, and cursing or verbal aggression occurred a few times "that" day. - Physical sexual advances, general restlessness, verbal sexual advances, and repetitive sentences or questions, occurred a few times an hour for "that" day; no documentation in the resident's record to illustrate the identified behaviors. * Physician's Office Consult (community physician) - 6/25/15, at 2:38 PM: "[Resident #14] had a recent stroke ... He has had a lot of new behavioural [sic] issues as well as hallucinations and overall it sounds like delerium. He was receiving risperdal in the hospital at 0.5 mg. It is unclear whether or not this was effective in the hospital, but he was not prescribed it on discharge to the SNF (Skilled Nursing Facility). After getting to the SNF his behaviour [sic] issues were too much for staff and he was prescribed risperdal again, however this time it was at twice the dose in the hospital and [Resident #14] slept for a long time according to family ... He has appeared to have terrible anxiety as well according to his [family member]." During the exam, "[Resident #14] did get the year right of 2015 ... and then slipped directly into taking about his guns and his boss. He repeatedly talked about talking to his brother who is deceased ... He asked who all the people behind me were and what their names were, but there was no one behind me and the door was closed ..." The consult did not document the visual hallucinations were harmful and/or distressing to the resident. The physician documented, "I agree that the facility he is in is likely not equipped for he [sic] level of redirection and care. The family reports	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 30 lorazepam was discussed, however I do think that while he does have somen anxiety, I think most of this is from delerium ... I think we could go with an atypical anti-psychotic, however usual first treatment is haldol, and while this is an older med, it does offer us the ability to make smaller adjustments and one of the families [sic] biggest concerns with the risperdal is that they [sic] [he] went from an ineffective dose to an excessively sedating dose with not much room in between to find the right range. For these reasons I will try Haldol first and make small adjustments as necessary." NOTE: The 2016 Nursing Drug Handbook documented the following adverse reactions associated with the use of Haldol:"Severe extrapyramidal reactions, sedation, drowsiness, lethargy, confusion, and vertigo; use cautiously in elderly and debilitated patients. The Black Box Warning documented,"'Elderly patients with dementia-related psychosis treated with atypical or conventional antipsychotics are at increased risk for death. Antipsychotics aren't approved for the treatment of dementia-related psychosis." * P.O. - 6/25/15: "Haloperidol 2 MG ORAL TABS 1 tab po [by mouth] q [every] 4 hours prn [as needed] for agitation and hallucinations." NOTE: This order was from the resident's community physician, while the risperdal was ordered by the facility physician. The order for the Risperdal was not discontinued or otherwise changed with the addtion of a second anti-psychotic medication. * MAR and eMAR - 6/25/15, at 6:52 PM: Haldol 2 mg tablet given for agitation and hallucinations for	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 31 "noted agitation, patient attempting to swing fist in air and yelling. Staff attempted to re-assure patient with no positive results." At 9:53 PM, the note documented, "PRN Administration was: Effective." * MAR and eMAR - 6/25/15, at 11:00 PM: Haldol 2 mg tablet given for "agitated and combative." At 12:00 AM, the note documented, "PRN Administration was: Effective." * MAR and eMAR - 6/26/15, at 2:59 AM: Haldol 2 mg tablet given related to, "Patient's family member requested that medication be given every 4 hours to keep patient's agitation minimal." At 4:03 AM, the note documented, "PRN Adminstration was: Effective." * On 6/26/15 the facility received and additional faxed order from the physician's office, which documented, "Haldol 2 mg Q [every] 4 hrs [hours], hold if pt [patient] sedated & Haldol 2 mg QHS [every day at hour of sleep] PRN [as needed] for agitation." Note: None of the resident's previous anti-psychotic orders had been discontinued. At this time, the resident's MAR documented the resident was to receive Risperdal 0.5 mg at bedtime, Haldol 2 mg every 4 hours routinely and every 4 hours as needed, and another 2 mg of Haldol as needed at bedtime. * MAR and eMAR - 6/26/15, at 11:01 AM: Haldol 2 mg tablet given for "patient talking to people that are not there." At 1:01 PM, the note documented, "PRN was: Effective, patient did appear to be less agitated and was not talking to unseen people at this time." * MAR - 6/26/15, at 4:00 PM: "Scheduled dose" of Haldol 2 mg tablet was given. * NPN - 6/26/15, at 7:00 PM: "Patient is alert and	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 32 confused per norm[al] ... continues with aggressive and violent behavior that progressively worsens throughout the day ... [He] received pm haldol for agitation and hallucinations, with no noted benefit. New orders received to change haldol 2 mg to q4h and add an additional pm tablet at HS. Patient medicated per new schedule and remains agitated. He has required one on one constant care to provide safety this shift. His family has not been present to aid in this supervision this shift. Patient escalated into violent behavior without any foreseeable [sic] event and repeatedly punched a CNA in the stomach and attempted to hit her in the face. Family was immediately contacted to come assist with calming this patient. Patient was sent to the Emergency Room at a local hospital via non emergent ambulance and admitted for futher evaluation of his change in behaviors." * On 6/27/15, at 2:47 PM, the clinical note from the hospital physician documented the resident had a "right periventricular acute focal infarct." On 7/1/15, at 3:00 PM, the DON was asked how the facility determined the resident's behavioral changes were not related to an underlying medical condition secondary to the resident's CVA. The DON stated, "We cannot go against the physician's orders." The DON could not answer whether the pharmacist had reviewed Resident #14's medication orders for compliance with federal regulatory requirements at F329, and was unable to provide the clinical rationale supporting the use of two antipsychotic medications, or the associated risk of using the two medications concurrently, given the resident's history of CVA. On 7/1/15, at 3:30 PM, the LSW could not identify specific target behaviors for the use of two	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 33 anti-psychotic medications for Resident #14. Additionally, the LSW was unable to describe the resident's behavioral history, other than the resident was receiving Risperdal in the hospital prior to his admission to the facility, and that the family had requested the resident resume that medication. The LSW stated there was no documentation in the resident's record of her conversations with the resident's family regarding his behavioral history. On 7/1/15, at 4:00 PM, the Administrator, DON, CNO, and other management staff were notified of the concern. Additional information received from the facility at the Bureau of Facility Standards (BFS) on 7/7/15 did not resolve the concern. On 7/8/15, at 3:45 PM, the BFS contacted the chief nurse at the physician's office to clarify additional information provided by the facility on behalf of the physician. The nurse stated the facility called the physician's office on 7/7/15 and requested the physician write a letter explaining why the resident was ordered to receive concurrent doses of Risperdal and Haldol. The chief nursed stated the physician did not have the patient on both medications and that Resident #14 should not have received Risperdal "at all." The chief nurse stated she would fax the BFS a copy of a letter she faxed earlier to the facility. On 7/9/15, at 8:40 AM, the State Agency received a letter from the physician that prescribed the Haldol. That letter documented, "[Resident #14] on 6/25/15 for his acute agitation after entering the skilled nursing facility. At that time I was told that the house physician would like to change him from his risperdal to Ativan for his acute agitation	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135137		R-C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMONTORY POINT REHABILITATION	3909 SOUTH 25TH EAST AMMON, ID 83406

(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 329	Continued From page 34 ... I felt that Patient #14 was having acute delerium, and benzodiazepines can worsen delerium; I felt haldoperidol would be a better choice. I discussed in my note that the risperdal did not have the dosing flexibility and that is probably why he had trouble with ineffectiveness on one side and oversdation on the other ... My understanding was that the staff at the skilled nursing was desparate [sic] for help and [Resident #14's] behavior was more than they could handle so the usual treatment for delirium, that of redirection, etc, was not sufficient. My understanding was that a change from risperdal was already being planned from the house physician to ativan. I did not order risperdal at any time and understood that it was stopped because of oversedation. I only ordered haldol."	F 329		