



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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

January 22, 2016

Jason Jensen, Administrator  
Promontory Point Rehabilitation  
3909 South 25th East  
Ammon, ID 83406

Provider #: 135137

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER  
LETTER**

Dear Mr. Jensen:

On **January 13, 2016**, a Facility Fire Safety and Construction survey was conducted at **Promontory Point Rehabilitation** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 4, 2016**. Failure to submit an acceptable PoC by **February 4, 2016**, may result in the imposition of civil monetary penalties by **February 24, 2016**.

Your PoC must contain the following:

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 17, 2016**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **February 17, 2016**. A change in the seriousness of the deficiencies on **February 17, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **February 17, 2016**, includes the following:

Denial of payment for new admissions effective **April 13, 2016**.  
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 13, 2016**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 13, 2016**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

BFS Letters (06/30/11)

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

This request must be received by **February 4, 2016**. If your request for informal dispute resolution is received after **February 4, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

Printed: 01/20/2016  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135137</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - PROMONTORY POINT REHABILITATION<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>01/13/2016</b> |
|--|---|---|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><b>PROMONTORY POINT REHABILITATION</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3909 SOUTH 25TH EAST<br/>AMMON, ID 83406</b> |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

|               |  |       |   |  |
|---------------|--|-------|---|--|
| K 000         | <p><b>INITIAL COMMENTS</b></p> <p>Promontory Point Rehabilitation is a licensed skilled nursing facility. The building is single story with a small mechanical basément and dumbwaiter between floors. The facility is approximately 23,000 square foot of type V (111) construction subdivided into three smoke compartments built in 2010. The building is fully sprinklered with complete smoke detection and manual fire alarm system. Emergency power is provided by an on site generator system.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on January 13, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, New Health Care Occupancy, in accordance with 42 CFR, 483.70.</p> <p>The Survey was conducted by:</p> <p>Nate Elkins<br/>Health Facility Surveyor<br/>Facility Fire Safety &amp; Construction</p> | K 000 | <p><b>"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".</b></p> |  |
| K 062<br>SS=F | <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the fire suppression system was tested and maintained in accordance with NFPA 25. Failure to provide proper testing and inspection of the sprinkler system could result in the system not performing as designed during a fire event. This deficient practice affected all smoke compartments, all residents, staff and visitors on the date of the survey. The facility is</p>   | K 062 | <p><b>K 062</b></p> <p>This has the potential to affect all residents, staff and visitors in the facility. . The needed testing will be scheduled with an inspection company as soon as possible.</p>   |  |

|  |                               |                             |
|--|-------------------------------|-----------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br> | TITLE<br><b>Administrator</b> | (X6) DATE<br><b>1/29/16</b> |
|--|-------------------------------|-----------------------------|

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.

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

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| K 062  | Continued From page 1<br>licensed for 30 SNF/NF beds with a census of 29 on the day of the survey.<br><br>Findings include:<br><br>During record review on January 13, 2016 from 9:00 AM to 10:00 AM, the facility failed to provide a current 5-year internal piping inspection report for the fire suppression system and was not tagged on the sprinkler system. According to the fire suppression inspection reports, the last internal piping inspection was completed in 2009. When asked, the Maintenance Supervisor stated the facility was unaware of the 5-year inspection requirement.<br><br>Actual NFPA standard:<br><br>NFPA 25<br>10-2.2* Obstruction Prevention.<br>Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections. | K 062  | All patients have the potential to be affected.<br><br>The 5 year internal piping inspection was completed on 1/28/16 in accordance with NFPA 25.<br><br>The maintenance manager or designee will add this to the internal audit list to be completed every 5 years. The company who does the annual inspections of the suppression system will also add it to their list of inspections to be completed every 5 years, in accordance with NFPA 25.<br><br>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.<br><br>Date of completion: 1/28/16 |  |
| K 067<br>SS=F  | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2   | K 067  | <u>K 067</u><br><br>This has the potential to affect all residents, staff, and visitors in the facility. The needed  |  |

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| K 067  | <p>Continued From page 2</p> <p>This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to complete 4-year interval testing on its dampers as required under NFPA 90A. Failure to ensure dampers will operate to manufacturer's specifications would allow smoke and dangerous gases to pass freely throughout the facility during a fire event. This deficient practice affected all smoke compartments, all residents, staff and visitors on the date of the survey. The facility is licensed for 30 SNF/NF beds with a census of 29 on the day of the survey.</p> <p>Findings include:</p> <p>During record review on January 13, 2016 from 9:00 AM to 10:00 AM, the facility failed to provide a 4-year interval testing report of its dampers. Upon further observation it was determined dampers were installed in the Heating Ventilation and Air Conditioning (HVAC) system. When asked, the Maintenance Supervisor stated he was unaware dampers were installed and was unaware of the requirement for testing.</p> <p>Actual NFPA standard:</p> <p>NFPA 90A<br/>3-4.7 Maintenance.<br/>At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.</p> | K 067   | <p>testing will be scheduled with an inspection company as soon as possible.</p> <p>All patients have the potential to be affected.</p> <p>The 4 year interval testing on the dampers was completed on 1/26/16 in accordance with NFPA 90A.</p> <p>The maintenance manager or designee will add this to the internal audit list to be completed every <del>5</del><sup>4</sup> years. The company who does the annual inspections of the suppression system will also add it to their list of inspections to be completed every <del>5</del><sup>4</sup> years in accordance with NFPA 90A.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p> <p>Date of completion: 1/26/16</p> |   |