



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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September 1, 2016

Tyler Fackrell, Administrator
Promontory Point Rehabilitation
3909 South 25th East
Ammon, ID 83406

Provider #: 135137

Dear Mr. Fackrell:

On **August 25, 2016**, a survey was conducted at Promontory Point Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **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

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CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 12, 2016**. Failure to submit an acceptable PoC by **September 12, 2016**, may result in the imposition of penalties by **October 6, 2016**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

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 **September 29, 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 **November 23, 2016**. A change in the seriousness of the deficiencies on **October 9, 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 **November 23, 2016** includes the following:

Denial of payment for new admissions effective **November 23, 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 non-compliance, 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 **February 21, 2017**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact 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, 83720-0009; 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. 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 **November 23, 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:

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

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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 **September 12, 2016**. If your request for informal dispute resolution is received after **September 12, 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, 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,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style.

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 09/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/25/2016
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 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification conducted at the facility from August 22, 2016 to August 25, 2016. The surveyors conducting the survey were: Presie C. Billington, RN, Team Coordinator Brad Perry, LSW Definitions include: BP = Blood Pressure CNA = Certified Nursing Assistant LN = Licensed Nurse mg = milligram MAR = Medication Administration Record PTA = Physical Therapy Assistant SBP = Systolic Blood Pressure	F 000			
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when	F 156		9/15/16	

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

TITLE

(X6) DATE

Electronically Signed

09/11/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	<p>Continued From page 1</p> <p>the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone</p>	F 156			

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F 156	<p>Continued From page 2</p> <p>numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure information on how to contact Medicare regarding benefits was posted. This failure to provide Medicare information affected 9 of 9 (#1 - #9) sampled residents and all other residents in the facility who were Medicare beneficiaries. Findings include: On 8/23/16 at 8:30 am, Medicare information,</p>	F 156	<p>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 the CMS 2567 exists, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies.</p>		

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F 156	Continued From page 3 including how to contact Medicare regarding benefits, was not found posted in the facility. On 8/23/16 at 8:35 am, the Administrator said he could not find where Medicare information was posted and said he would make sure it was posted.	F 156	I. The phone number on how to apply for Medicare was posted in a prominent location immediately when its absence was pointed out on 8/23/2016. II. All residents and potential residents wishing to contact the Medicare office have the potential to be affected. The Medicare phone number will remain in a prominent location as noted in the regulation. III. The administrator/designee will check the prominent location monthly X 2 months to ensure compliance, and replace the number as needed. IV. The administrator/designee will report the findings to the monthly QA meeting for 4 months, or until there is 100% compliance, & PRN.		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the results of the most recent annual recertification survey	F 167	I. The most recent standard survey was put in the survey binder located in the library immediately when its absence was	9/15/16	

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F 167	Continued From page 4 was readily accessible to residents. This deficient practice affected any resident or their representative or visitors who may want to review the survey results, including 9 of 9 sample residents (#1 - #9). Findings include: On 8/22/16 at 2:35 pm, a survey results binder was observed in the facility library. The binder did not contain the results of the last annual recertification survey of 3/13/15. On 8/22/16 at 2:35 pm, the Administrator said he could not find the survey results and said he would put the survey in the binder.	F 167	pointed out on 8/23/2016. II. All residents and potential residents wishing to view the most recent survey have the potential to be affected. The most recent standard survey will remain in the survey binder until it is replaced with a more current standard survey, as noted in the regulation. III. The administrator/designee will check the binder monthly X 4 to ensure compliance, and replace as needed any missing required information. IV. The administrator/designee will report the findings to the monthly QA meeting for 4 months, or until there is 100% compliance, & PRN.		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents who wished to self-administer medications were safe to do so. This was true for 1 of 9 sampled residents (#8) and created the potential for medication errors if the resident was not competent to self-administer medications. Findings include: On 8/22/16 at 2:00 pm, a tube of Nystatin Cream 100,000 units/gram was found by the sink in	F 176	I. We completed a medication self-administration evaluation on Resident #8 and found her capable of administering Nystatin cream. She was accordingly care planned to reflect findings. MD was notified and no adverse side effects occurred. No new orders in relation to #8. II. All residents and potential residents have the potential to be affected. III. A Root Cause Analysis through our QA	9/15/16	

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F 176	Continued From page 5 Resident #8's room. On 8/24/16 at 11:37 am, Resident #8 said she applied the Nystatin Cream under her breast a couple of times. There was no documentation found on Resident #8's clinical record that she was assessed to self administer her medication safely. On 8/25/16 at 10:40 am, the DON confirmed Resident #8 was not assessed to self-administer medications safely.	F 176	team revealed that there was an order for the cream and the patient desired to self-administer. The nurse was unaware of the requirement of self-administrating assessment completion. Nursing staff will be educated to ensure all residents wishing to self-administer medication will be assessed to self-administer medication prior to the patient self-administering medication. The care plan will be updated to reflect assessment. If residents are found not capable of self-administering medication, the medication will be kept on the cart and administered by the nurse as ordered. IV. An audit will be conducted by the administrator/designee for medication in the resident rooms and bathrooms weekly X 2 months and monthly X 2 months to ensure compliance. V. The administration/designee will report the findings to the monthly QA meeting for 4 months, or until there is 100% compliance, & PRN.		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure residents' weights were protected from public disclosure.	F 241	I. Resident #11 discharged from the facility on 8/26/2016. Resident #7 was evaluated for her psychosocial well-being	9/15/16	

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F 241	Continued From page 6 This was true for 1 of 9 sampled residents (#7) and 1 random resident (#11). This failed practice had the potential to negatively affect residents' psychosocial well-being when their weights were visible for others to see. Findings include: On 8/23/16 at 11:25 am, a portable scale was observed in the South Hallway between rooms 120 and 121. CNA #1 was observed assisting Resident #11 walk onto the scale. The digital readout of Resident #11's weight was displayed on the scale and was visible to anyone walking by. On 8/23/16 at 11:27 am, PTA #1 was observed pushing Resident #7's wheelchair with the resident in it onto the scale. The digital readout of Resident #7's weight was displayed on the scale and was visible to anyone walking by. On 8/23/16 at 11:30 am, PTA #1 explained the process of weighing residents, which did not include covering the digital readout. On 8/23/16 at 11:35 am, CNA #1 said he normally concealed the digital readout with his hand, but said he may not have done that when he was observed.	F 241	and found that no harm occurred. MD was notified and no new orders. A temporary cover was put in place immediately when the deficient practice was discovered on 8/23/2016. II. All residents and potential residents have the potential to be affected. A more permanent cover for the display has been installed covering the digital display. This cover requires someone to physically lift it in order to view the display. All staff have been educated on the importance of privacy and resident dignity. III. A root cause analysis from our QA team revealed that the scale location has recently changed and the prior location did not allow the reading to be visible to the public. The administration/designee will check the display to ensure compliance weekly X 2 months and monthly X 2 months and replace as needed. IV. The administration/designee will report the findings to the monthly QA meeting for 4 months, or until there is 100% compliance, & PRN.		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		9/15/16	

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F 246	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure a resident with nausea had a receptacle to vomit into. This was true for 1 of 9 sampled residents (#3). The deficient practice had the potential to cause psychosocial harm if the resident vomited on herself when not given an emesis bag or basin. Findings include:</p> <p>Resident #3 was admitted to the facility on 8/15/16 with multiple diagnoses, including peptic ulcer and nausea.</p> <p>Resident #3's Physician's orders, dated 8/15/16, documented PRN Ondansetron for nausea or vomiting.</p> <p>Resident #3's August 2016 MAR documented Resident #3 received 8 doses of Ondansetron from 8/16/16 to 8/22/16.</p> <p>On 8/22/16 at 4:35 pm, Resident #3 was observed in her room sitting in a recliner chair with an emesis bag in her lap. Resident #3 said she had nausea and had vomited several times since she was admitted to the facility.</p> <p>On 8/23/16 at 8:40 am, Resident #3 was observed in her room laying in bed without an emesis bag or basin in her room. Resident #3 said she vomited the previous evening into an emesis bag and was not provided a new bag or basin. She said she had asked a staff member from the night before for a replacement bag, but</p>	F 246	<p>I. Resident #3 was given a receptacle to vomit into on 8/23/16 immediately after it was brought to the facility's attention of said need.</p> <p>II. All residents and potential residents have the potential to be affected.</p> <p>III. Root cause analysis revealed that this was an isolated event. Nursing staff educated on the importance of supplying services and reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>IV. An audit of reasonable accommodations will be conducted by randomly questioning 5 residents weekly for 2 months and then 5 residents monthly for 2 months.</p> <p>VI. The administration/designee will report the findings to the monthly QA meeting for 4 months, or until there is 100% compliance, & PRN.</p>		

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F 246	Continued From page 8 the staff member said she could not find one and she was not offered anything else to use. Resident #3 did not want to vomit on herself and asked the surveyor for a replacement bag. On 8/23/16 at 9:05 am, CNA #2 said she was aware Resident #3 had vomited the night before because that information was shared with her during shift report. On 8/23/16 at 9:13 am, LN #2 said Resident #3 should have something to vomit into due to her nausea. She then went into the resident's room and Resident #3 told LN #2 that no one had offered her an emesis bag since the staff member took it away the night before, saying the facility did not have any more bags. LN #2 confirmed Resident #3 did not have a bag or basin and went to the supply closet to find a new emesis bag for her.	F 246			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure 2 of 2 facility hallway microwaves and 1 of 2 hallway refrigerators were kept clean and maintained under sanitary conditions. This failed practice had the potential to contaminate food. Findings include:	F 253	I. North Side Microwave Cleaned. South side microwave cleaned. South side mini fridge defrosted and cleaned. II. All residents have the potential to be affected by these practices. Fridges and microwaves were placed on a regular cleaning schedule and will be deep cleaned as necessary.	9/15/16	

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F 253	Continued From page 9 1. On 8/22/16 at 2:25 pm, the South Hallway microwave in the chart room was observed with multiple flecks of food debris on all surfaces inside the microwave. On 8/22/16 at 2:25 pm, LN #2 said the microwave was used to reheat residents' food and appeared to have "an explosion" of food which had not been cleaned up. 2. On 8/22/16 at 2:25 pm, the South Hallway mini-fridge in the chart room was observed with a large yellow food spill on the top shelf and several inches of ice build-up in the freezer compartment. Various food items were in the fridge, including applesauce and pudding. On 8/22/16 at 2:25 pm, LN #2 said the mini-fridge was used for residents' food and snacks and the spill appeared to be "applesauce, possibly" and needed to be cleaned up. She said the freezer section needed defrosting. 3. On 8/22/16 at 3:55 pm, the North Hallway microwave in the chart room was observed with multiple flecks of food debris on all surfaces inside the microwave. On 8/22/16 at 3:55 pm, LN #1 said the microwave was used to reheat residents' food and the microwave needed to be cleaned.	F 253	III. A Root cause analysis by our QA team revealed that the fridge and microwave were not on a regular cleaning schedule. The dietary staff will log daily if the microwaves and fridges are clean. Administration/designee will check the logs weekly for 2 months and monthly for 2 months for compliance. IV. The administration/designee will report the findings to the monthly QA meeting for 4 months, or until there is 100% compliance, & PRN.		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431		9/15/16	

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F 431	<p>Continued From page 10</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined the facility failed to ensure expired medications were removed from medication cart and supply cabinet, and medications were properly stored. This was true for 1 of 2 medication carts and 1 of 1 supply cabinet</p>	F 431	<p>I. The medicines identified were properly stored and/or returned to the pharmacy immediately when identified.</p> <p>II. All residents have the potential to be affected. The nurses will be educated on proper storage of medicine and the 6</p>		

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F 431	<p>Continued From page 11</p> <p>checked for expired medications and 2 of 14 rooms (Room 104 and 105) checked during the initial tour. This failed practice created the potential for residents to received expired medications or improperly stored medications with decreased efficacy. Findings include:</p> <p>1. On 8/22/16 between 1:35 pm and 2:25 pm, the following medications were found by the sink in the following room:</p> <p>*Room 104, a bottle of Nystatin [antifungal] Topical Powder 100,000 USP units *Room 115, Nystatin Cream 100, 000 units/gram</p> <p>On 8/24/16 at 9:45 am, LN #2 removed the medication, and said it did not come from the facility's pharmacy. On 8/24/16 at 10:45 am, LN #3 went to room 115, removed the medication, and put it inside the medication cart.</p> <p>2. On 8/23/16 at 9:49 am, a bottle of 10 mg Loratadine [antihistamine], which had expired on August 2013, was found in the North Side medication cart.</p> <p>LN #1 said the medication did not come from the facility's pharmacy and would be discarded.</p> <p>3. On 8/23/16 at 4:00 pm, during inspection of the supply cabinet (RX One) with the DON present, the following medications were found:</p> <p>* 2 bottles of 2.5 ml Travatan Ophthalmic Solution [medication to treat high pressure in the eye], which had expired November 2015.</p> <p>* 9 tablets of 25 mg Chlorthalidone [used to treat</p>	F 431	<p>rights of medication administration to ensure proper efficacy.</p> <p>III. A root cause analysis by our QA team revealed that the dates were not entered into the RX One and the other expired medication in the cart was an isolated event. The team further identified that patients requested the family to bring the medicine from the home.</p> <p>VII. Those with access to RX One will be educated on entering the date of expiration in RX One until a software update occurs requiring an expiration date prior to entering the medicine. The DON or designee will check the RX One and med cart for expired medicine weekly X 2 months and monthly until software is installed. The carts will be audited weekly X 2 months and monthly X2 months by the DON/Designee. An audit will also be conducted by the administrator/designee for medication in the resident rooms and bathrooms weekly X 2 months and monthly X 2 months to ensure compliance.</p> <p>IV. The administration/designee will report the findings to the monthly QA meeting for 4 months, or until there is 100% compliance, & PRN.</p>		

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F 431	Continued From page 12 high blood pressure], which had expired 3/21/16	F 431			
F 514 SS=D	<p>The DON said the expired medications would be returned to the pharmacy.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure blood pressure was monitored as ordered before administration of blood pressure medication. This was true for 1 of 3 (#5) sampled residents and created the potential for harm if medications were given when Resident #5's blood pressure was too low. Findings include:</p> <p>Resident #5 was admitted to the facility on 8/17/16 with multiple diagnoses, including hypertension.</p> <p>Resident #5's physician's orders and MAR for</p>	F 514	<p>I. Resident #5 was assessed and no apparent injury occurred. MD notified and no new orders were given.</p> <p>II. All residents with the diagnosis of Hypertension could be affected. The EMAR has been changed to require the nurse to enter the blood pressure into the EMAR before administration of hypertension medication.</p> <p>III. The Root Cause Analysis by the QA team revealed that this was an isolated event due to her admission order not being entered accurately. Education was given to all of the nurses in regard to</p>	9/15/16	

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F 514	<p>Continued From page 13</p> <p>August 2016 documented an order dated 8/17/16 for Lisinopril 40 mg, 1.5 tablet in the morning for hypertension [60 mg dose] hold if SBP below 120.</p> <p>The August 2016 MAR, documented Lisinopril was administered daily to Resident #5 from 8/18/16 through 8/21/16. There was no documentation Resident #5's BP was checked prior to administration of the medication.</p> <p>On 8/24/16 at 10:30 am, LN #2 said CNAs usually checked the resident's vital signs, but said she did not find documentation that Resident #5's BP was checked on the above dates.</p>	F 514	<p>Hypertension with parameters and the proper way of entering the order into the EMAR, which will require the parameter prior to administering the medication. The corporate compliance officer will audit all new admits admitted with supplemental documentation required daily for 2 weeks then 3 per week weekly x 6 weeks.</p> <p>VI. The administration/designee will report the findings to the monthly QA meeting for 4 months, or until there is 100% compliance, & PRN.</p>		