



IDAHO DEPARTMENT OF
HEALTH & WELFARE

G.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

March 26, 2014

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

Provider #: 135137

Dear Ms. Bruun:

On March 20, 2014, an on-site follow-up revisit of your facility was conducted to verify correction of deficiencies noted during the Recertification and State Licensure survey of December 20, 2013. Promontory Point Rehabilitation was found to be in substantial compliance with health care requirements as of **February 18, 2014**. In addition, a Complaint Investigation survey was conducted in conjunction with the on-site follow-up.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing the deficiencies that have been corrected is enclosed. The findings to the Complaint Investigation is being processed and will be sent to your facility under separate cover.

Thank you for the courtesies extended to us during our follow-up revisit. If you have any questions, concerns or if we can further assist you, please call this office at (208) 334-6626.

Sincerely,

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj
Enclosures



IDAHO DEPARTMENT OF
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May 7, 2014

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

Provider #: 135137

Dear Ms. Bruun:

On **March 20, 2014**, a Complaint Investigation survey was conducted at Promontory Point Rehabilitation. Amy Barkley, R.N, and Nina Sanderson, L.S.W., conducted the complaint investigation.

This complaint was investigated in conjunction with an on-site follow-up to a Recertification and State Licensure survey. The medical records of six residents including that of the identified resident were reviewed as part of the investigation.

The facility's admission agreement was reviewed and interviews were conducted with staff and other residents. The identified resident was no longer at the facility.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006385

ALLEGATION #1:

The complainant stated that an identified resident was told upon admission to the facility there would be a minimum stay of one week, because the facility would not do the paperwork for a lesser stay.

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FINDINGS:

The facility's admission agreement specified no minimum stay requirement. Staff who completed the admission agreement with residents stated there was no minimal admission period. Other residents admitted to the facility stated they had not been informed either verbally or in writing of a minimal stay requirement. The identified resident requested to be discharged less than 48 hours after admission. The physician was notified of the identified resident's wishes and provided a discharge order; the resident discharged home the same day.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated an identified resident was not medicated for pain for an extended period after admission to the facility, despite complaints of pain. The complainant also stated the identified resident did not receive blood pressure medications as ordered. The complainant stated a pain medication ordered by the physician's assistant was not administered. The complainant stated the identified resident requested bowel medications but was not given them.

FINDINGS:

The identified resident's physician orders, pain assessments, nurses' progress notes and Medication Administration Record were reviewed. Since the identified resident had discharged, other residents were interviewed regarding their medications. The facility's policy for medication administration was reviewed.

The facility assessed the identified resident as having pain upon admission but did not have information as to when the resident had last received pain medication prior to admission. Given the type and dose of pain medication ordered for the resident, the facility was concerned that administration of a second dose of the medication could cause an overdose if it was given too soon after the previous dose. Once the concern for an accidental overdose had passed, the resident received pain medication as ordered.

The facility had an order for blood pressure medications for the identified resident, but those medications were held on one occasion due to low blood pressure values. This was documented in the resident's clinical record, in a manner consistent with facility's policy.

The resident received an order for additional pain medication prior to discharge. The medication

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was administered as ordered, upon receipt from the pharmacy.

The facility was able to determine the identified resident had received bowel medications and those medications were effective, within hours before the resident was admitted to the facility.

Based on these results, the facility had no additional bowel medication available for the resident, nor was it clear such medication would have been warranted. The resident discharged from the facility before further bowel medications would have been administered, per the resident's physician orders.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated an identified resident requested water, but none was given.

FINDINGS:

A tour of the facility was conducted on March 20, 2014. Water mugs were available within reach of all residents. Residents' interviews indicated water was always available and refreshed throughout the day.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated an identified resident requested assistance to use the bathroom but such assistance was not provided.

FINDINGS:

The identified resident's record documented assistance to the toilet was provided at least every one to three hours throughout the entire stay in the facility.

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CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated an identified resident's toilet ran all night. A request was placed to fix it, but no repair work was done.

FINDINGS:

The facility's grievance file was reviewed.

There was no documentation either in the resident's record or in the facility's grievances to indicate the allegation had occurred.

The survey team toured the facility on March 20, 2014, and heard no toilets running.

Staff interviews indicated if such a problem occurred and could not be corrected immediately by the staff on hand; a maintenance request could be initiated to have the needed repairs done the next day.

Residents' interviews indicated the facility was in good repair and clean. No resident interviewed could recall ever having difficulty with a running toilet.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated an identified resident requested to see the facility's social worker but did not see one for two days. The complainant stated the identified resident filed a grievance when the social worker arrived.

FINDINGS:

The facility administrator stated it would be reasonable for the social worker to meet with a newly admitted resident within forty-eight to seventy-two hours after admission.

The identified resident's record documented the social worker met with the resident in well under

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the forty-eight hour time requirement. The documentation in the identified resident's record stated the resident did not feel placement in the facility was appropriate and requested to be discharged home. The facility contacted the physician with the resident's request, and the resident discharged home with home health services later that same day.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

As only one of the complaint's allegations was substantiated, but not cited, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Supervisor
Long Term Care

LK/jj