



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

**CERTIFIED MAIL: 7012 1010 0002 0836 4285**

November 13, 2013

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

Provider #: 135137

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

Dear Ms. Bruun:

On **November 5, 2013**, 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 and a similar State Form 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 you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date

Teresa Bruun, Administrator

November 13, 2013

Page 2 of 4

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 both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 26, 2013**. Failure to submit an acceptable PoC by **November 26, 2013**, may result in the imposition of civil monetary penalties by **December 16, 2013**.

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 **December 10, 2013**, (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 **December 10, 2013**. A change in the seriousness of the deficiencies on **December 10, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 10, 2013**, includes the following:

Teresa Bruun, Administrator  
November 13, 2013  
Page 3 of 4

Denial of payment for new admissions effective **February 5, 2014**.  
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 **May 5, 2014**, 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 **November 5, 2013**, 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>

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

Teresa Bruun, Administrator  
November 13, 2013  
Page 4 of 4

following:

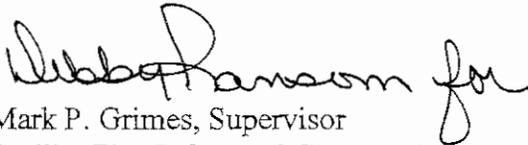
BFS Letters (06/30/11)

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

This request must be received by **November 26, 2013**. If your request for informal dispute resolution is received after **November 26, 2013**, 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,

A handwritten signature in black ink, appearing to read "Mark P. Grimes for". The signature is written in a cursive style with a large initial "M".

Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

Printed: 11/13/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135137</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/05/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>PROMONTORY POINT REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3909 SOUTH 25TH EAST AMMON, ID 83406</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<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 basement 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 deficiency was cited during the annual fire/life safety survey conducted on November 5, 2013. 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 surveyor conducting the survey was:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>NOV 25 2013</b></p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p> <p><b>K 046 POC</b></p> <p><b>Identified Resident Action:</b></p> <p>No Residents have been affected by the deficient practice, but all have the potential to be affected.</p> <p><b>Other Resident Identifiers:</b></p> <p>No Residents identified or directly affected by the practice.</p>	
K 046 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1</p> <p>This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility did not ensure that emergency light testing for 90 minutes once a year was being completed and documented. Failure to test the emergency lights can result in a nonoperational unit not being discovered until needed during an emergency or electrical outage. The facility had a census of twenty eight residents</p>	K 046	<p><b>Measures:</b></p> <p>The Administrator and Housekeeping and/ or Maintenance Director have reviewed current emergency lighting procedure and cross referenced with state guidelines. The facility Administrator will ensure that testing is done at least 30 seconds monthly and an annual test will be conducted for 90 minutes yearly.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Executive Director</b>	(X6) DATE <b>11/22/2013</b>
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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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER <b>PROMONTORY POINT REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3909 SOUTH 25TH EAST 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 046	<p>Continued From page 1 on the day of survey. This deficiency affected all residents, staff and visitors.</p> <p>Findings include:</p> <p>During record review on November 5, 2013 at 9:55 AM, the facility was unable to provide documented testing records for the emergency lights for ninety minutes once annually for the previous 12 month period. When the Administrator was questioned about the lack of emergency light testing records she stated that she unable to provide any further documentation.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101@ Life Safety Code@2000 Edition 18.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p>	K 046	<p><b>Monitoring:</b></p> <p>Starting on 11/26/2013 during the monthly maintenance inspection the Housekeeping and or Maintenance department will perform 30 second emergency lighting test one per month, and then once per year will perform a 90 minute test. Emergency Lighting Test completion will be audited by Administrator monthly for a 90 day audit period. Areas of concern will be immediately addressed and facility will review process in monthly CQI meeting as needed.</p> <p><b>Compliance date 11-26-2013.</b></p>	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER <b>PROMONTORY POINT REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3909 SOUTH 25TH EAST AMMON, ID 83406</b>		
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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>Promontory Point Rehabilitation is a licensed skilled nursing facility. The building is single story with a small mechanical basement 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 deficiency was cited during the annual fire/life safety survey conducted on November 5, 2013. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The surveyor conducting the survey was:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p><b>RECEIVED</b></p> <p><b>NOV 25 2013</b></p> <p><b>FACILITY STANDARDS</b></p> <p><b>C 226 POC</b></p> <p>See Form CMS-2567 POC for K046</p>	
C 226	<p><b>02.106 FIRE AND LIFE SAFETY</b></p> <p><b>106. FIRE AND LIFE SAFETY.</b> Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.</p>	C 226		

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

*[Signature]*

TITLE

*Executive Director*

(X6) DATE

*11/22/2013*

Bureau of Facility Standards

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C 226	Continued From Page 1  This Rule is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567:  1. K046 Ninety minute annual emergency light test.	C 226		