IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

December 28, 2017

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

Provider #: 135137

Dear Mr. Fackrell:

On **December 15, 2017**, 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 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. **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 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 **January 8, 2018**. Failure to submit an acceptable PoC by **January 8, 2018**, may result in the imposition of penalties by **February 1, 2018**.

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 <u>in column (X5)</u>.

  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 **January 19, 2018 (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 **March 15, 2018**. A change in the seriousness of the deficiencies on **January 29, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 15, 2018** includes the following:

Denial of payment for new admissions effective **March 15, 2018**. [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 **June 13, 2018**, 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 **March 15, 2018** 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 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 **January 8, 2018**. If your request for informal dispute resolution is received after **January 8, 2018**, 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,

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj

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		**12/15/2017**

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	F 000		
	The following deficiencies were cited during the federal recertification survey conducted December 12, 2017 to December 15, 2017. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Cecilia Stockdill, RN ABBREVIATIONS: CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DON = Director of Nursing ED = Executive Director LN = Licensed Nurse LPN = Licensed Practical Nurse MAR = Medication Administration Record mg = milligram PRN = as needed RN = Registered Nurse			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		1/17/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 01/04/2018

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		12/15/2017

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 550	Continued From page 1 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined the facility failed to ensure the resident was treated with respect and dignity. This was true for 1 of 1 sampled residents (# 22) and presented the potential for embarssment when a resident's urinary catheter bag was not covered or placed into a privacy bag. Findings include: The facility's policy regarding Quality of	F 550	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.	

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		**12/15/2017**

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 550	Continued From page 2 Life-Dignity, revised 8/09, documented "Staff shall promote dignity and assist residents as needed by: Helping the resident to keep urinary catheter bags covered." 1. Resident #22 was admitted on 12/11/17 with diagnoses including benign prostatic hypertrophy (enlarged prostate), difficulty walking, and muscle weakness. Resident #22's Order Summary Report documented Foley catheter (an indwelling urinary catheter) care every shift was ordered on 12/11/17. On 12/14/17 at 07:08 AM, Resident # 22 was lying in bed and his urinary drainage bag was lying on the floor without a privacy bag. The urinary drainage bag could be easily seen by anyone who entered the room. RN (Registered Nurse) #1 said the urinary bag needed a privacy cover. RN #1 said she would get a privacy bag to cover the urinary drainage bag. On 12/15/17 at 8:44 am, the DON (Director of Nursing) said the facility had not provided staff in-service training specifically dedicated to care of Foley catheters and urinary drainage bags. The DON said it would be the CNA's responsibility to ask for assistance if they were unsure of how to manage a Foley catheter and urinary drainage bag. The DON said it was not acceptable for the urinary drain bag to be without a privacy bag.	F 550	F550 Resident Rights/Exercise of Rights I. Resident #22 was evaluated for his psychosocial well-being and found that no harm occurred. MD was notified and no new orders. The urinary drainage bag was put into a privacy bag immediately when the deficient practice was discovered on 12/15/2017. II. All residents and potential residents with a catheter have the potential to be affected. An audit of every catheter in the facility was performed to find no other drainage bags without a cover. All staff have been educated on the importance of the urinary bag privacy bag and resident dignity. III. A root cause analysis from our QA team revealed that the privacy bag was in place, but the drainage bag was not set in the privacy bag because the staff failed to understand the importance of the privacy bag. The policy has been reviewed and found that no changes are necessary. The administration/designee will check every drainage bag in the facility weekly X 1 month and monthly X 1 month and fix as needed. IV. The administration/designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance, & PRN.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality.	F 583		1/17/18

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		**12/15/2017**

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 583	Continued From page 3 The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined the facility failed to ensure a resident's privacy in their room. This was true for 2 of 24 sampled residents (# 25 and	F 583	I. Resident #25 and #124 were evaluated for their psychosocial well-being and found that no harm occurred. MD was notified and no new	

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		12/15/2017

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 583	Continued From page 4 #124) when a resident's room had private health information hanging on the wall in view of any person who entered the room, and a resident's skin on her low back and buttock was exposed during cares while the window blinds were open. Findings include: 1. Resident #25 was admitted on 11/19/17 with diagnoses including rehabilitation and care after right knee surgery, dementia, and personal history of a mastectomy. The facility's policy regarding Quality of Life-Dignity, revised 8/09, documented, "Signs indicating the resident's clinical status or care needs shall not be openly posted in the resident's room unless specifically requested by the resident or family member. Discreet posting of important clinical information for safety reasons is permissible." On 12/12/17 at 3:01 PM, an eight and one-half by 11-inch sign was posted on the wall above resident #25's bed that read "No lab or blood pressure on right arm [due to] radical mastectomy." Resident #25 said the sign was there because she's not supposed to have her blood pressure checked on her right arm. On 12/15/17 at 8:55 am, the DON (Director of Nursing) said the sign was placed on the wall in Resident #25's room at the request of the resident's daughter, and the resident's daughter insisted on the sign being there. 2. Resident #124 was admitted on 11/23/17 with diagnoses including status post joint replacement of the left knee.	F 583	orders. The sign with the resident privacy information was removed with the permission of the resident/representative on 12/13/2017. The nurse was educated on resident privacy on 12/14/2017. II. All residents and potential residents have the potential to be affected. A 100% audit of signs within the facility has been performed to ensure 100% compliance. The policies have been reviewed and are in compliance with the regulations. All staff have been educated on the importance of privacy and resident dignity as well as following the policy regarding Quality of Life-Dignity. III. A root cause analysis from our QA team revealed that the family placed the sign on the wall because the resident had a problem with getting blood pressure checked in her Right Arm at the hospital. When discussed from a resident privacy standpoint, the representative understood and was willing to have the “radical mastectomy” part of the sign removed. The policy has been reviewed and found that no changes need to be made. A root cause analysis, in regard to the blind being open when performing a skin check, revealed that since the nurse did not anticipate needing to do a skin check when walking in to the room, she did not close the blind initially and was caught off guard from the request to check her upper buttocks. An audit of the resident rooms will be made to ensure signs are in compliance with our policy and federal guidelines on resident privacy weekly for 1 month then monthly for 1 month. An	

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		12/15/2017

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 583	Continued From page 5 The facility's policy regarding Quality of Life-Dignity, revised 8/09, documented "Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." On 12/14/17 at 10:04 am, Resident #124 was sitting in her room and stated that something felt sore in her low back/buttock area. LPN #1 asked Resident #124 to lean forward and pulled the resident's pants down far enough to expose her right upper buttock. The window blinds were in the full open position in Resident #124's room as her upper buttock was exposed, and it was possible for any passerby to see Resident #124 though the open window blinds. There was an open grassy area immediately outside Resident #124's window and a street parallel to the window from which it was possible to see into Resident #124's room. LPN #1 said she did not protect Resident #124's privacy when she examined the resident while the window blinds were open.	F 583	audit of private practices will be conducted by randomly questioning 4 residents weekly for 1 month and then 4 residents monthly for 1 month. IV. The administration/designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance, & PRN.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure the administration of medications and	F 658	I. The medications documented as being given were given to the resident. The physician has been notified.	1/17/18

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		12/15/2017

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 658	Continued From page 6 treatments was consistent with accepted standards of practice. This was true for 1 of 2 licensed nurses (Licensed Practical Nurse #1) and affected 1 of 7 residents (#124) observed during medication pass when the licensed nurse documented a medication was given prior to administering the medication. This failure created the potential for harm if medications were not administered as ordered. Findings include: The facility's Administering Medications policy, revised December 2009, documented, "The individual administering the medication must initial the resident's MAR (medication Administration Record) on the appropriate line after giving each medication..." Resident #124 was admitted on 11/23/17 with diagnoses including status post joint replacement of the left knee, migraine, and multiple fractures of ribs. Resident #124's Order Summary Report documented Tramadol 50 mg (milligrams) 2 tablets by mouth every 4 hours as needed for pain. On 12/14/17 at 10:04 am, LPN #1 prepared to administer 2 Tramadol tablets for Resident #124 at the medication cart. After LPN #1 placed the Tramadol tablets in a medication cup, she electronically signed the Tramadol as given prior to going to the resident's room. When asked when a medication should be documented as given, LPN #1 said she should not sign a medication as being given prior to the medication being administered.	F 658	II. All residents have the potential to be affected. The nurse was educated on proper medication passing technique and professional standards on 12/14/17. All nurses have taken a CE on medication pass as well. III. The policy has been updated/made current. All LPN/RN staff have read current policy and understand requirements. A root cause analysis by our QA team revealed that since the resident requested the medication, the nurse was under the impression that the resident would accept the medication so she erroneously signed the medication out prior to administering the medication. IV. The DON or designee will monitor every floor nurse, 2 per week until all floor LPNs and RNs are monitored for compliance. V. The DON will report the findings to the Administrator/ designee who will report at the monthly QA meeting until there is 100% compliance, & PRN.	
F 661	Discharge Summary	F 661		1/17/18

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		**12/15/2017**

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 661 SS=D	Continued From page 7 CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure appropriate information was documented in the resident's record and provided to the receiving health care provider upon discharge. This was true for 1 of 3 residents (#19) reviewed for	F 661	I. Resident #19 discharged from the facility on 11/29/2017. II. All residents discharging have a potential to be affected. A checklist has been created of required information for every discharge. This checklist is required	

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		**12/15/2017**

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 661	Continued From page 8 discharge from the facility. This failure created the potential for harm and inappropriate care due to incomplete documentation related to the resident's discharge. Findings include: Resident #19 was admitted to the facility on 11/6/17 with diagnoses including compression fractures of the lumbar spine, history of falling, deep vein thrombosis (blood clot), diabetes mellitus type 2, hypertension (high blood pressure), and gout. Resident #19 discharged home on 11/29/17. When asked to provide a discharge summary for Resident #19, the facility provided a packet that included the following documentation: * Resident #19's Physician Order for Patient Discharge documented the physician was notified on 11/28/17 that the resident would be discharged home on 11/29/17 with Home Health services. The physician signed the Physician Order for Patient Discharge on 11/28/17. * A letter of notification was signed by Resident #19 on 11/20/117, acknowledging he would be discharged home on 11/29/17 with Home Health services due to his health improving to a level that he no longer needed the facility's services. * On 11/11/17, Resident #19 signed a document that indicated he selected a Home Health agency and gave permission for the facility to share his medical information with the agency. There was no documentation regarding his course of treatment in the facility regarding Resident #19's compression fracture.	F 661	for every discharge. The Discharge Planner or designee will ensure checklist is complete per regulation. All discharging staff have been educated on said checklist and discharge requirements. III. A root cause analysis by the QA team indicated that since the Requirements of Participation were 14 days old as of the entrance, we were still solidifying changes to our practices. The completed checklist will be scanned into the chart to ensure all of the pieces are present for every discharge meeting the requirement in the regulation. The administrator will verify the requirements are met by auditing 3 discharges every week for 1 month then 1 discharge every month for 1 month. IV. The administration/designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance, & PRN.	

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		**12/15/2017**

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 661	Continued From page 9 There was no discharge summary documentation in Resident #19's medical record. There was no documentation of a recapitulation of the resident's stay, final summary of the resident status, reconciliation of medications prior to discharge, post-discharge plan of care, or documentation the facility provided a discharge summary and other pertinent information to the home health agency. On 12/15/17 at 10:58 am, the ED (Executive Director) said there was no additional documentation regarding a discharge summary for Resident #19.	F 661		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, it was determined the facility failed to ensure residents received adequate respiratory care for a resident receiving oxygen by nasal cannula. This was true for 1 of 3 residents (#23) sampled for respiratory care. The deficient practice had the potential for harm if residents experienced discomfort from non-humidified oxygen. Findings include:	F 695	I. Resident #23 discharged from the facility on 1/4/2017 II. All residents on oxygen have the potential to be affected. Water was obtained and the tubing was corrected when it was brought to our attention. III. A Root Cause Analysis by our QA team revealed that the task did trigger but the CNA responsible didn't complete the	1/17/18

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		12/15/2017

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 695	Continued From page 10 The facility's Oxygen Administration Policy, revised March 2004, directed staff to ensure there is water in the humidifier and that there was enough water to result in water bubbling during the flow of oxygen. The policy also directed staff to "periodically re-check [the] water level." Resident #23 was admitted on 12/1/17 with diagnoses including weakness, pneumonia, and COPD (Chronic Obstructive Pulmonary Disease). Resident #23's Order Summary Report documented oxygen at 1 liter per nasal cannula PRN (as needed). Resident #23's Task Schedule for December 2017 documented, "Oxygen per nasal cannula PRN. Change and date tubing, humidifier, and infection control bag weekly." The task was electronically signed as completed by the CNA (Certified Nursing Assistant) on 12/1 and 12/8/17. On 12/12/17 04:21 PM Resident #23 was sitting on the chair in his room and had a nasal cannula in place for oxygen. The humidifier (container of water attached to the oxygen concentrator) was empty and was dated 12/1. When asked how often the oxygen humidifier is checked and when Resident #23's humidifier was last checked, RN #1 said the CNA changes it weekly and she (RN #1) does not check it, but perhaps she should look at it. On 12/15/17 at 8:44 am, the DON (Director of Nursing) said the nurse on duty should monitor the task of changing the oxygen humidifier by checking the portal in the computer. The DON	F 695	task because they did not understand the importance of it. She did not sign off that it was complete in the computer. Practice has been changed to having oxygen changed weekly on a certain day of the week throughout the building. All nursing staff were in-serviced on following the policy and LPN/RN staff educated to check when they are turning on and off the concentrator. IV. The administration team will check every concentrator weekly for 1 month then monthly for 1 month to ensure oxygen tubing is not older than a week and that there is water in the bubbler. V. The administration/designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and PRN.	

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		**12/15/2017**

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 695	Continued From page 11 said the task should trigger in the computer for the CNA to complete the task every 7 days, and the task did not trigger at the appropriate time for Resident #23. The DON said the nurse should have also visibly checked the humidifier for Resident #23.	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen. This had the potential to affect 24 of 24 residents residing in the facility who consumed food prepared by the facility. This failure created	F 812	I. The staff was immediately in-serviced on proper techniques from dirty to clean dishes in the kitchen. II. All residents are affected by the practices in the kitchen. All dietary staff have been in-serviced by our dietician on proper techniques from dirty to clean	1/17/18

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		12/15/2017

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 812	Continued From page 12 the potential for contamination if residents contracted food-borne illnesses. Findings include: On 12/14/17 at 9:00 am, Dietary Aide #1 was observed loading the dirty dishes on a rack then sprayed the dirty dishes with water and loaded the rack into the dishwasher. After the load was clean, he opened the dishwasher door, brought out the clean rack of dishes with his left hand touching the rack and with his right hand loaded another rack with dirty dishes into the dishwasher. Dietary Aide #1 was not wearing gloves and did not wash hands between loading the dishwasher with dirty dishes and touching the rack of clean dishes he removed from the dishwasher to be put away. Dietary Aide #1 then washed his hands and put away the clean dishes. Dietary Aide #1 did not change his apron from loading the dirty dishes to bringing out the rack of clean dishes, or after washing his hands to put away the clean dishes. On 12/14/17 at 9:15 am, Dietary Aide #1 was asked if he changed his apron during the process between dirty and clean dishes and he stated, "Obviously not." Dietary Aide #1 said he did not wear gloves during the dishwashing process because he could get the job done quicker without wearing gloves. Dietary Aide #1 said he received his training by reading pamphlets that the facility provided on his hire date of 12/16/13. On 12/14/17 10:59 am, the Administrator provided a dietary in-service, dated 9/4/15, documented the dietary staff was to wash their hands after handling garbage, dirty dishes or soiled equipment. The Dietary Manager and the	F 812	dishes in the kitchen according to the "Food Safety and Sanitation Standards for Food Establishment (The Idaho Food Code). All dietary staff will be in serviced according to the code upon hire and annually going forward. The food handlers permit will continue to be kept current for all kitchen staff III. A root cause analysis by our QA team has determined that proper in-services were not performed adequately. The administrator/designee will observe dishwashing 2 times per week for 1 month and then monthly for 1 months and in-service as necessary. IV. The administration/designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance, & PRN.	

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		**12/15/2017**

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 812	Continued From page 13 Administrator was informed Dietary Aide #1 was not wearing gloves and did not change his apron from dirty dishes to clean dishes.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		1/17/18

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		**12/15/2017**

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 880	Continued From page 14 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure staff performed appropriate hand	F 880	I. Resident #22 discharged home on 1/2/2018 and #124 is still present at the facility. The nurse and CNA were	

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		12/15/2017

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 880	Continued From page 15 hygiene measures and managed urinary catheter bags appropriately to reduce the risk of infection. This was true for one LPN (Licensed Practical Nurse #1) and two CNAs (#1 and #2) and affected 2 of 24 residents (#22 and #124). This failure created the potential for residents to develop infections from cross-contamination. Findings include: The facility's Handwashing/Hand Hygiene Policy, revised December 2009, directed staff to wash their hands for at least 15 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions, including: * Prior to and following direct resident contact. * Prior to and following assisting a resident with personal care. * At the beginning of and following contact with a resident's intact skin. * Prior to and following assisting a resident with toileting. * Following handling soiled or used linens, dressings, bedpans, catheters and urinals. The facility did not provide a policy regarding care of a urinary drainage bag. 1. Resident #22 was admitted on 12/11/17 with diagnoses including benign prostatic hypertrophy (enlarged prostate), difficulty walking, and muscle weakness. Resident #22's Order Summary Report	F 880	educated on proper hand hygiene and catheter care respectively. II. All residents have the potential to be affected by proper hand hygiene and residents with catheter care have the potential to be affected by the deficient practice in regard to the catheter care. III. The policies have been reviewed and no change is necessary. All nursing staff have been in-serviced on when to wash hands and have been instructed on proper catheter care through both a Relias course with testing and in-service. IV. A root cause analysis indicated that the CNA usually does catheter care on the bed where the procedure is able to be kept sanitary. The CNA was under the impression that the catheter care had to be performed when requested rather than the normal routine. DON/designee will monitor catheter care 2 x weekly for 4 weeks then weekly x 4 weeks while a resident resides in the facility with a catheter. The DON/designee will randomly observe hand hygiene practices of nurses and CNAs of 4 weekly for 4 weeks and then 1 weekly for 4 weeks. LNs, CNAs and other staff will be reminded to report any hand hygiene violations to the DON so correction can occur as necessary V. The administration/designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance, & PRN.	

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		**12/15/2017**

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 880	Continued From page 16 documented Foley catheter (an indwelling urinary catheter) care every shift was ordered on 12/11/17. On 12/14/17 at 07:08 am, Resident # 22 was lying in bed and his urinary drainage bag was lying directly on the floor without a privacy bag. RN (Registered Nurse) #1 said the urinary bag should be off the floor. RN #1 said she did not know who left the urinary draining bag like that. RN #1 picked up the catheter bag from the floor and hung it from the bed. On 12/12/17 02:37 pm, CNA (Certified Nursing Assistant) #1 assisted Resident # 22 to the toilet in his room. CNA #1 placed Resident # 22's urinary drainage bag on the bathroom floor at two separate times while assisting him on the toilet. CNA #1 did not wash her hands after assisting Resident # 22 on the toilet. CNA #1 then directed Resident #22 to place his dentures in a small basin as she held the basin with her bare hands and touched the inside of the basin with her bare hands. When asked about appropriate hand hygiene, CNA #1 said she should have washed her hands after assisting the resident on the toilet and after handling the Foley bag. On 12/13/17 at 10:54 pm, CNA #2 was assisting Resident # 22 in the bathroom as the resident sat on the toilet. CNA #2 was preparing to perform catheter care for Resident #22 and placed the urinary draining bag and a package of disposable wipes on the bathroom floor. When asked about appropriate infection control practices related to placing the urinary drainage bag and package of wipes on the floor, CNA #2 said "I don't know where else to put it" and hung	F 880		

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		12/15/2017

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 880	Continued From page 17 the urinary drainage bag from his (CNA # 2's) pants pocket. CNA #2 then removed a number of wipes from the package on the floor, placed the package of wipes on the back of the toilet, and performed catheter care for Resident #22 using the wipes. CNA #2 said he last received training regarding catheter care in CNA class 3 years ago. On 12/15/17 at 8:44 am, the DON (Director of Nursing) said the facility had not provided staff in-service training specifically dedicated to care of Foley catheters and urinary drainage bags. The DON said it would be the CNA's responsibility to ask for assistance if they were unsure of how to manage a Foley catheter and urinary drainage bag. The DON said it was not acceptable for the urinary draining bag to be on the floor or without a privacy bag. 2. Resident #124 was admitted on 11/23/17 with diagnoses including status post joint replacement of the left knee. Resident #124's Order Summary Report documented Tramadol 50 mg (milligrams) 2 tablets by mouth every 4 hours as needed for pain. On 12/14/17 at 10:04 am, LPN #1 prepared to administer 2 Tramadol tablets for Resident #124. LPN #1 went to Resident # 124's room, administered the medication to the resident, and exited the room without performing hand hygiene. LPN #1 did not perform hand hygiene before or after entering Resident #124's room and administering the medication. When asked about performing hand hygiene, LPN #1 said she	F 880		

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		**12/15/2017**

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 880	Continued From page 18 should perform hand hygiene before and after administering medication to a resident.	F 880		