



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

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

April 16, 2018

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

Provider #: 135137

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Fackrell:

On **April 4, 2018**, a Facility Fire Safety and Construction survey was conducted at **Promontory Point Rehabilitation** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

Tyler Fackrell, Administrator
April 16, 2018
Page 2 of 4

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 30, 2018**. Failure to submit an acceptable PoC by **April 30, 2018**, may result in the imposition of civil monetary penalties by **May 19, 2018**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 9, 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 **May 9, 2018**. A change in the seriousness of the deficiencies on **May 9, 2018**, may result in a change in the remedy.

Tyler Fackrell, Administrator
April 16, 2018
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **May 9, 2018**, includes the following:

Denial of payment for new admissions effective **July 4, 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 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 **October 4, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **April 4, 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:

Tyler Fackrell, Administrator
April 16, 2018
Page 4 of 4

<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:

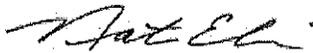
BFS Letters (06/30/11)

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

This request must be received by **April 30, 2018**. If your request for informal dispute resolution is received after **April 30, 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, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 04/13/2018
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 01 - PROMONTORY POINT REHABILITATION B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2018
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	
K 291	<p>Continued From page 1</p> <p>lighting could hinder egress of residents during an emergency. This deficient practice affected 23 residents, staff and visitors on the day of survey.</p> <p>Findings include:</p> <p>During review of the facility emergency lighting test logs on April 4, 2018, from approximately 9:30 AM to 12:30 PM, no documentation could be produced for a 90-minute test of the emergency lighting in the past 12 months. When asked, the Maintenance Director stated the facility was unaware the annual test was overdue.</p> <p>Actual NFPA reference:</p> <p>NFPA 101 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1-1/2 hours if the emergency</p>	K 291	<p>V.Audit reports will be brought to the QA meeting.</p> <p>VI.Completion date: May 3, 2018</p>		

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K 291	Continued From page 2 lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.	K 291		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire alarm systems were maintained in accordance with NFPA 72. Failure to maintain fire alarm systems could result in a lack of system performance during a fire event. This deficient practice affected 23 residents, staff and visitors on the date of the survey. Findings include: During review of the facility inspection records on April 4, 2018, from approximately 9:30 AM to	K 345	K 345 NFPA 101 Fire Alarm System I. Resident Specific: Omni Systems tested the fire alarm system by May 3, 2018. II. Other Residents: All residents have the potential to be affected. III. Facility Systems: Education was performed with the Maintenance Director on the importance of the fire alarm testing in regards to K345. IV. Monitors: Compliance will be monitored by the Director of Maintenance or designee performing audits of the documentation that the annual inspection is completed quarterly x4. V. Audit reports will be brought to the QA meeting. VI. Completion date: May 3, 2018	

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K 345	<p>Continued From page 3</p> <p>12:30 PM, no documentation for a current annual inspection of the fire alarm system was available. The most recent inspection was dated February 2, 2017. When asked, the Maintenance Director stated the facility was not aware the annual inspection was due.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.3.4 Detection, Alarm, and Communications Systems. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use.</p> <p>NFPA 72 14.3 Inspection. 14.3.1* Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. (See Table 14.3.1) 14.4 Testing. 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. (See Table 14.4.5)</p>	K 345		

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K 712 K 712 SS=E	Continued From page 4 Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of required fire drills, one per shift per quarter. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected 23 residents, staff and visitors on the date of the survey. Findings include: During record review on April 4, 2018, from approximately 9:30 AM to 12:30 PM, fire drill documentation revealed the facility failed to perform the following drills: - First shift, second quarter 2017 - Second shift, third quarter 2017 - Second shift, fourth quarter 2017 When asked, the Maintenance Director stated the facility was unaware of the missing fire drills. Actual NFPA standard:	K 712 K 712	K 712 NFPA 101 Fire Drills I. Resident Specific: No Specific Residents were identified. II. Other Residents: All residents have the ability to be affected. We will have documented fire drills on all shifts quarterly to ensure all the staff have adequate practice and training on what to do in case of a fire. III. Facility Systems: Administrator educated Maintenance Director in regard to the requirement of fire drills being held at expected and unexpected times under varying conditions, at least quarterly on each shift. IV. Monitors: Administrator will monitor monthly fire drills conducted and make sure documentation is securely stored electronically and physically indicating fire drills are performed each shift each quarter over the course of the next 12 months. V. The results will be reported monthly at our QA meeting for 12 months. VI. Completion date: May 3, 2018	

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K 712	Continued From page 5	K 712		
K 927 SS=D	<p>19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.</p> <p>Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101</p> <p>Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility blueprints, the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Failure to transfill liquid oxygen with mechanical ventilation could result in creating an oxygen rich environment, increasing the potential for combustion. This deficient practice affected 13 residents, staff and visitors on the date of the survey.</p> <p>Findings include: During the facility tour conducted on April 4, 2018,</p>	K 927	<p>C 927 Gas Equipment</p> <p>I. Resident Specific: No specific residents were identified.</p> <p>II. Other Residents: All Residents have the potential to be affected. The fan has been replaced on 4/13/2018 with the original equipment.</p> <p>III. Facility Systems: This is the only room in the building that transfills oxygen. All residents have the ability to be affected.</p> <p>IV. Monitors: Weekly observation and test of the fan will be completed by the Maintenance Director for 4 weeks. The Maintenance Director has been educated on the requirements of K 927.</p> <p>V. The administration/designee will report the findings to the monthly QA meeting for 2 months.</p> <p>VI. Completion date: May 3, 2018.</p>	

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K 927	<p>Continued From page 6</p> <p>from approximately 3:00 PM to 4:30 PM, observation of the oxygen transfilling room revealed no mechanical ventilation had been installed as required. Further review of the facility blueprints on April 12, 2018, revealed an exhaust fan was not planned for installation in the room when originally built. The original blueprints revealed the room was classified as a wheelchair storage room, which later became an oxygen storage room. No other communication was found to show this room was used for transfilling. When asked, the Maintenance Director attempted to find a vent, or switch, or anything that could potentially provide mechanical ventilation, but none could be located. He then stated, the facility did not have one.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable.</p> <p>11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following:</p> <p>(1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction.</p> <p>(2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring.</p> <p>(3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted.</p> <p>(4) The individual transfilling the container(s) has been properly trained in the transfilling</p>	K 927		

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K 927	Continued From page 7 procedures. 9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft3 of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).	K 927			

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E 000	<p>Initial Comments</p> <p>Promontory Point Rehabilitation is a single-story Type V (111), approximately 23,000 square foot skilled nursing facility built in 2010. The facility is subdivided into three smoke compartments with a small mechanical basement and dumbwaiter used for dietary and supply services. The building is fully sprinklered with complete smoke detection and manual fire alarm system. Emergency power is provided by an on-site generator system. The facility is licensed for 30 SNF/NF beds, and had a census of 23 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the initial Emergency Preparedness Survey conducted on April 4, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	E 000		
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RECEIVED
APR 25 2018
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 4/20/18
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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.