



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – 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 17, 2019

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 9, 2019**, 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 17, 2019
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, 2019**. Failure to submit an acceptable PoC by **April 30, 2019**, may result in the imposition of civil monetary penalties by **May 22, 2019**.

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 14, 2019**, (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 **July 8, 2019**. A change in the seriousness of the deficiencies on **May 24, 2019**, may result in a change in the remedy.

Tyler Fackrell, Administrator
April 17, 2019
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **May 14, 2019**, includes the following:

Denial of payment for new admissions effective **July 9, 2019**.
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 9, 2019**, 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 9, 2019**, 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 17, 2019
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:

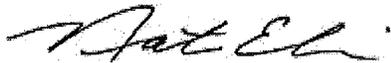
BFS Letters (06/30/11)

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

This request must be received by **April 30, 2019**. If your request for informal dispute resolution is received after **April 30, 2019**, 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,



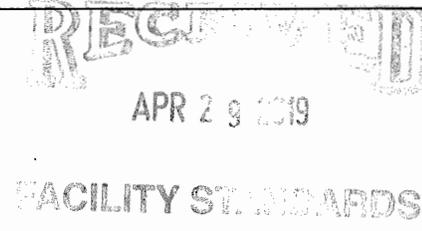
Nate Elkins, Supervisor
Facility Fire Safety and Construction

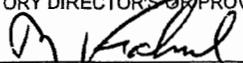
NE/lj
Enclosures

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 04/09/2019
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NAME OF PROVIDER OR SUPPLIER PROMONTORY POINT REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3909 SOUTH 25TH EAST AMMON, ID 83406
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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	INITIAL COMMENTS The facility 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 28 on the date of the survey. The following deficiencies were cited at the above facility during the annual fire/life safety code survey conducted on April 9, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	 <p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Promontory Point Rehabilitation does not admit that the deficiencies listed on the CMS 2567 exists, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies.</p> <p>K 345 NFPA 101 Fire Alarm System- Testing and Maintenance</p> <p>I. Resident Specific: The sensitivity testing of the smoke detectors was conducted on April 23, 2019.</p> <p>II. Other Residents: All residents have the potential to be affected by this deficiency.</p> <p>III. Facility Systems: Education has been provided to the Maintenance Director in regards to the importance of K 345.</p> <p>IV. Monitors: Compliance will be monitored by the Director of Maintenance or designee performing audits of the documentation that the inspection is completed as necessary.</p> <p>V. Audit reports will be brought to the QA meeting.</p> <p>VI. Completion date: May 14, 2019</p>	
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	K 345		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4/29/19
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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.

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

Printed: 04/16/2019
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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 04/09/2019
NAME OF PROVIDER OR SUPPLIER PROMONTORY POINT REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3909 SOUTH 25TH EAST AMMON, ID 83406		
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K 345	<p>Continued From page 1</p> <p>failed to ensure fire alarm systems were maintained in accordance with NFPA 72. Failure to conduct sensitivity testing on fire alarm systems has the potential to hinder system response during a fire event. This deficient practice affected 28 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During review of facility fire alarm inspection records conducted on October 11, 2018, from approximately 1:30 PM to 4:00 PM, no documentation could be produced to indicate sensitivity testing of the smoke detectors was conducted within the last five years. Interview of the Maintenance Supervisor revealed the facility was not aware any sensitivity test have been conducted in the last five years.</p> <p>Actual NFPA standard:</p> <p>NFPA 72 Chapter 14 Inspection, Testing, and Maintenance 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years.</p>	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		

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K 353	<p>Continued From page 2</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect suppression system components has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected 28 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided facility inspection and testing records conducted on 4/9/19 from 8:30 - 11:00 AM, the following records were not available for review:</p>	K 353	<p>K 353 NFPA 101 Sprinkler System</p> <p>I. Resident Specific: Omni Systems came out and tested the sprinkler system on April 23, 2019 for the quarterly waterflow alarm tests. The weekly dry system gauge inspections were started 4/25/2019. The monthly wet system control valve and gauge inspections were started 4/25/2019.</p> <p>II. Other Residents: All residents have the potential to be affected.</p> <p>III. Facility Systems: Education was performed with the Maintenance Director on the importance of the Sprinkler system testing in regards to K353.</p> <p>IV. Monitors: Compliance will be monitored by the Director of Maintenance or designee performing audits of the documentation that the weekly, monthly, and quarterly inspections are complete.</p> <p>V. Audit reports will be brought to the QA meeting.</p> <p>VI. Completion date: May 14, 2019</p>	

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K 353	<p>Continued From page 3</p> <ul style="list-style-type: none"> - No documentation indicating weekly dry system gauge inspections had been completed. - No documentation of monthly wet system control valve and gauge inspections. - No documentation demonstrating completion of quarterly waterflow alarm tests for 3 of the past 4 quarters. <p>Interview of the Maintenance Supervisor revealed he was not aware of the missing documentation prior to the date of the survey.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.</p> <p>5.2.4 Gauges. 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained.</p> <p>Chapter 13 Valves, Valve Components, and Trim</p> <p>13.3.2 Inspection. 13.3.2.1 All valves shall be inspected weekly. 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.</p>	K 353		
K 532 SS=D	<p>Escalators, Dumbwaiters, and Moving Walks CFR(s): NFPA 101</p> <p>Escalators, Dumbwaiters, and Moving Walks 2012 EXISTING</p>	K 532		

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K 532	<p>Continued From page 4</p> <p>Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that dumbwaiter doors were not prohibited from self-closing as designed. Eliminating the ability for doors to dumbwaiters to self-close allows fires, smoke and dangerous gases to pass between floors during a fire. This deficient practice affected staff and visitors in the main dining area on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 9, 2019 from approximately 11:00 AM to 2:30 PM, observation of the dumbwaiter on the main floor revealed the spring for the door to the dumbwaiter hoistway had been disconnected, preventing the dumbwaiter door from self-closing as designed. Further observation revealed the corridor door from the space was not equipped to self-close.</p> <p>Actual NFPA standard:</p> <p>19.5.3 Elevators, Escalators and Conveyors. Elevators, Escalators and Conveyors shall comply with the provisions of Section 9.4.</p>	K 532	<p>K 532 NFPA 101 Escalators, Dumbwaiters, and Moving Walks</p> <ol style="list-style-type: none"> I. Resident Specific: The spring was installed on April 9, 2019. II. Other Residents: All residents have the potential to be affected. III. Facility Systems: All of the staff who use the elevator has been in-serviced on leaving the spring in place in regard to K 532. IV. Monitors: An audit will be conducted by the Maintenance Director/designee of the elevator doors both upstairs and downstairs to ensure compliance weekly for 1 month then monthly for 1 month. V. Audit reports will be brought to the QA meeting. VI. Completion date: May 14, 2019 	
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K 532	Continued From page 5 9.4.2.2 Except as modified herein, existing elevators, escalators, dumbwaiters, and moving walks shall be in accordance with the requirements of ASME A17.3, Safety Code for Existing Elevators and Escalators. ASME A17.3 Section 2 2.6.2 Closing of Hoistway Doors (a) Horizontally sliding doors of automatic-operation elevators shall be provided with door closers arranged to close an open door automatically if the car for any reason leaves the landing zone. (b) Horizontal swinging single or center-opening doors of automatic-operation elevators shall be self-closing. (c) Door closers are not required for the swinging portion of combination horizontally sliding and swinging doors	K 532		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or	K 914	K 914 NFPA 101 Electrical Systems VII. Resident Specific: The electrical outlets were inspected on 4/26/2019. VIII. Other Residents: All residents have the potential to be affected. IX. Facility Systems: Administrator educated Maintenance Director in regards to testing the receptacles. X. Monitors: Compliance will be monitored by the Director of Maintenance or designee performing audits of the documentation annually that electrical outlet inspections are complete. XI. Audit reports will be brought to the QA meeting. XII. Completion date: May 14, 2019	

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K 914	<p>Continued From page 6</p> <p>equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.</p> <p>6.3.4 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview, the facility failed to ensure outlets in resident care areas were maintained and tested. Failure to perform maintenance and testing on electrical systems has the potential of electrical outlet failure, exposing residents to the risks of arc fires. This deficient practice affected 28 residents staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of facility maintenance and inspection records provided on 4/9/19 from approximately 8:45 - 11:00 AM, no records were provided indicating outlets in resident rooms were inspected and tested.</p> <p>2) Interview of the Maintenance Supervisor substantiated a program for annual testing for facility outlets had not been conducted.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 6.3.4.1 Maintenance and Testing of Electrical Systems</p> <p>6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general</p>	K 914		

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K 914	Continued From page 7 anesthesia is administered, shall be tested at intervals not exceeding 12 months.	K 914		



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DAVE JEPPESEN – Director

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

Provider #: 135137

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Fackrell:

On **April 9, 2019**, an Emergency Preparedness 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 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. 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 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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 30, 2019**. Failure to submit an acceptable PoC by **April 30, 2019**, may result in the imposition of civil monetary penalties by **May 22, 2019**.

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 14, 2019**, (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 . A change in the seriousness of the deficiencies on **June 1, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 14, 2019**, includes the following:

Denial of payment for new admissions effective **July 9, 2019**.
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.

Tyler Fackrell, Administrator

April 17, 2019

Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 9, 2019**, 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 9, 2019**, 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

Tyler Fackrell, Administrator

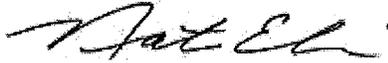
April 17, 2019

Page 4 of 4

This request must be received by **April 30, 2019**. If your request for informal dispute resolution is received after **April 30, 2019**, 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,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj

Enclosures

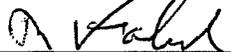
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2019
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NAME OF PROVIDER OR SUPPLIER PROMONTORY POINT REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3909 SOUTH 25TH EAST AMMON, ID 83406
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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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E 000	Initial Comments The facility is a single-story Type V (111) structure and is located within a municipal fire district, with both county and state EMS services available. Originally constructed in 2010, the building houses a small mechanical basement which uses a dumbwaiter hoistway for dietary and supply services delivery. The building is fully sprinklered with complete smoke detection and manual fire alarm system. The facility backup emergency power is provided by an on-site diesel-fired generator. The facility is licensed for 30 SNF/NF beds, and had a census of 28 on the date of the survey. The following deficiency was cited during the annual Emergency Preparedness Survey conducted on April 9, 2019. The facility was surveyed under the Emergency Preparedness Rule as established by CMS, in accordance with 42 CFR 483.73. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	E 000		
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:	E 015	E 015 I. Resident Specific: No specific residents were identified. II. Other Residents: All Residents have the potential to be affected. III. Facility Systems: A list of procedures was approved by the IDT. IV. Monitors: The IDT will continue to evaluate the emergency program which includes sewage and waste disposal during a disaster. V. The administration/designee will report the findings to the QA team. VI. Completion date: May 14, 2019	

RECEIVED
APR 29 2019
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4/29/19
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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.

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

Printed: 04/15/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2019
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NAME OF PROVIDER OR SUPPLIER PROMONTORY POINT REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3909 SOUTH 25TH EAST AMMON, ID 83406
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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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E 015	<p>Continued From page 1</p> <p>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:</p> <ul style="list-style-type: none"> (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: <ul style="list-style-type: none"> (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <ul style="list-style-type: none"> (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: <ul style="list-style-type: none"> (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: <ul style="list-style-type: none"> (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. <p>This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the</p>	E 015		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER PROMONTORY POINT REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3909 SOUTH 25TH EAST AMMON, ID 83406
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E 015	<p>Continued From page 2</p> <p>facility failed to develop procedures in the Emergency Operations Plan (EOP), that were aligned with the policies for providing subsistence in the event of a sewage and waste loss during a disaster. Lack of procedures to provide for sewage and waste disposal during a disaster, has the potential to limit the ability to provide sanitary disposal of waste for residents housed in the facility during an emergency. This deficient practice affected 28 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 4/9/19 from 9:00 - 11:00 AM, review of provided policies and procedures did not reveal the procedure for utilities the facility would follow in the event of a loss of sewage and waste disposal during a disaster.</p> <p>Reference: 42 CFR 483.73 (b) (1)</p>	E 015		
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