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

August 7, 2020

Monte Jones, Administrator
Promontory Point Rehabilitation
3909 South 25th East
Ammon, ID 83406

Provider #: 135137

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

Dear Mr. Jones:

On **July 29, 2020**, 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 siguificant 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.

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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 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 **August 20, 2020**. Failure to submit an acceptable PoC by **August 20, 2020**, may result in the imposition of civil monetary penalties by **September 11, 2020**.

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 **September 2, 2020**, (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 **October 27, 2020**. A change in the seriousness of the deficiencies on **September 12, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 2, 2020**, includes the following:

Denial of payment for new admissions effective **October 29, 2020**.
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 **January 29, 2021**, 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 **July 29, 2020**, 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 **August 20, 2020**. If your request for informal dispute resolution is received after **August 20, 2020**, 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: 08/06/2020
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - PROMONTORY POINT REHABILITATION<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135137 | | 07/29/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PROMONTORY POINT REHABILITATION | 3909 SOUTH 25TH EAST<br>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 000 | INITIAL COMMENTS<br><br>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. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. The facility is licensed for 30 SNF/NF beds, and had a census of 21 on the dates of the survey.<br><br>The following deficiencies were cited during the annual fire/life safety code survey conducted on July 28 - 29, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70.<br><br>The survey was conducted by:<br><br>Linda Chaney<br>Health Facility Surveyor<br>Facility Fire Safety & Construction | K 000 | 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.<br><br>RECEIVED<br>AUG 10 2020<br>FACILITY STANDARDS | |
| K 321<br>SS=F | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. | K 321 | K 321<br><br>1. The storage/furnace room next to resident room #123 and the storage/furnace rom adjacent to the main living room will have self-closing mechanisms installed.<br>2. The facility will be audited for any other hazardous | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8-18-2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | 135137 | | 07/29/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| K 321 | Continued From page 1<br>Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, operational testing and interview, the facility failed to ensure hazardous areas were protected with self-closing doors. Failure to provide self-closing doors for hazardous areas could allow smoke and dangerous gases to pass freely into corridors and hinder egress of occupants during a fire event. This deficient practice affected residents and staff on the dates of the survey.<br><br>Findings include:<br><br>During the facility tour on July 29, 2020, from approximately 9:40 AM to 11:10 AM, observation and operational testing of the following storage areas revealed the doors were not self-closing:<br>1.) Storage/Furnace room next to resident | K 321 | storage areas that do not meet the requirement for a self-closing door.<br>3. The maintenance staff will be educated/trained on the requirement for hazardous storage areas to have a self-closing door.<br>4. The facility will perform monthly audits of the facility for 3 consecutive months looking for hazardous storage areas that do not meet the requirement for a self-closing door. Results will be reported to the QAPI committee.<br>5. Date of compliance is August 18th, 2020. | |

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| K 321 | Continued From page 2<br>room #123<br>2.) Storage/Furnace room adjacent to the main living room<br>Each of the storage rooms were measured to be over 50 square feet and contained fuel fired furnaces, supplies and equipment. When asked, the Maintenance Supervisor stated the facility was not aware the doors needed to be self-closing.<br><br>Actual NFPA standard:<br><br>NFPA 101<br>19.3.2.1 Hazardous Areas.<br>Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1.<br>19.3.2.1.3 The doors shall be self-closing or automatic-closing.<br>19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following:<br>(1) Boiler and fuel-fired heater rooms<br>(2) Central/bulk laundries larger than 100 ft2 (9.3 m2)<br>(3) Paint shops<br>(4) Repair shops<br>(5) Rooms with soiled linen in volume exceeding 64 gal (242 L)<br>(6) Rooms with collected trash in volume exceeding 64 gal (242 L)<br>(7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction<br>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard | K 321 | | |

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| K 353<br>SS=F | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>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.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.6, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect system components as required, 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 21 residents and staff on the dates of the survey.<br><br>Findings include:<br><br>During review of provided facility inspection and testing records conducted on July 28, 2020, from approximately 2:30 PM - 4:30 PM, no documentation for the following required sprinkler | K 353 | K 353<br><br>1. The annual sprinkler inspection, including testing of the antifreeze solution will be performed. The quarterly sprinkler inspections, waterflow alarm flow test will be scheduled for the last two quarters of 2020.<br>2. The annual sprinkler inspection, including testing of the antifreeze solution will be performed. The quarterly sprinkler inspections, waterflow alarm flow test will be scheduled for the last two quarters of 2020.<br>3. The maintenance staff will be educated/trained on the requirement for annual and quarterly sprinkler inspections. The sprinkler inspection vendor has updated contact information for the Maintenance Director and Administrator.<br>4. The facility will create a schedule for the following | |

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| K 353 | Continued From page 4<br>inspections could be produced:<br><br>1.) Annual sprinkler inspection, including testing of the antifreeze solution. Last known annual inspection was April 2019.<br>2.) Quarterly sprinkler inspections, waterflow alarm flow test for 1st and 2nd quarter 2020 and 3rd and 4th quarter 2019.<br><br>When asked, the Maintenance Supervisor stated the facility was aware of the missing inspections and had already scheduled the sprinkler company to come out and complete an annual inspection.<br><br>Actual NFPA standard:<br><br>NFPA 101<br>9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.<br><br>NFPA 25<br>5.2* Inspection.<br>5.2.1 Sprinklers.<br>5.2.1.1* Sprinklers shall be inspected from the floor level annually.<br>5.2.1.4 The supply of spare sprinklers shall be inspected annually for the following:<br>(1) The correct number and type of sprinklers as required by 5.4.1.4 and 5.4.1.5<br>(2) A sprinkler wrench for each type of sprinkler as required by 5.4.1.6<br>5.2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level.<br>5.2.3* Hangers and Seismic Braces. Sprinkler | K 353 | 12 months to perform quarterly audits of the sprinkler inspections for the rest of 2020. A quarterly review of the schedule will be performed for the next 2 quarters to ensure that the sprinkler inspections are on track. Results will be reported to the QAPI committee.<br>5. Date of compliance is August 18th, 2020. | |

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| PROMONTORY POINT REHABILITATION | 3609 SOUTH 28TH EAST<br>AMMON, ID 83406 |

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| K 353 | Continued From page 6<br>pipe hangers and seismic braces shall be inspected annually from the floor level.<br>5.2.8* Information Sign. The information sign shall be inspected annually to verify that it is securely attached and is legible.<br>5.3.3 Waterflow Alarm Devices.<br>5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.<br>5.3.4* Antifreeze Systems. The freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary. | K 353 | | |
| K 363<br>SS=D | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or | K 363 | K 363<br>1. The door for resident room #116 latching mechanism was replaced.<br>2. The facility will perform an audit for all resident room doors to ensure that they latch.<br>3. The maintenance staff will be educated/trained on the requirement for resident room doors to latch correctly.<br>4. The facility will perform monthly audits for 3 consecutive months for resident room doors ensuring that they latch | |

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| K 363 | Continued From page 6<br>pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, operational testing, and interview the facility failed to maintain doors protecting corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely between smoke compartments, preventing defend in place. This deficient practice has the potential to affect 1 resident and staff on the dates of the survey.<br><br>Findings include:<br><br>During the facility tour on July 29, 2020, from approximately 9:40 AM to 11:10 AM, observation and operational testing of the corridor door to resident room #116 revealed the door would not latch. When asked, the Maintenance Supervisor stated the facility was unaware the door was not latching properly.<br><br>Actual NFPA Standards: | K 363 | correctly. Results will be reported to the QAPI committee.<br>5. Date of compliance is August 18th, 2020. | |

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| PROMONTORY POINT REHABILITATION | 3909 SOUTH 25TH EAST<br>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 363 | Continued From page 7<br>19.3.6.3* Corridor Doors.<br>19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply:<br>(1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door.<br>(2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7. | K 363 | | |

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

August 7, 2020

Monte Jones, Administrator
Promontory Point Rehabilitation
3909 South 25th East
Ammon, ID 83406

Provider #: 135137

RE: **EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Jones:

On **July 29, 2020**, an Emergency Preparedness survey was conducted at Promontory Point Rehabilitation by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj

Enclosure

| 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 | | 07/29/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PROMONTORY POINT REHABILITATION | 3909 SOUTH 25TH EAST<br>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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>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. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. The facility is licensed for 30 SNF/NF beds, and had a census of 21 on the dates of the survey.<br><br>The facility was found to be in substantial compliance during the initial Emergency Preparedness Survey conducted on July 28 - 29, 2020. The facility was surveyed under the Emergency Preparedness Rule, in accordance with 42 CFR 483.73.<br><br>The survey was conducted by:<br><br>Linda Chaney<br>Health Facility Surveyor<br>Facility Fire Safety & Construction | E 000 | | |

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

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.