STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135137	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Promontory Point Rehabilitation	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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interview, it was determined the facility failed to ensure a resident and their representative received assistance to exercise their right to formulate an Advance Directive. This was true for 9 of 12 residents (Resident #2, # 3, #17, #29, #37, #52, #60, #61 and #66) whose records were reviewed for advance directives. This deficient practice created the potential for harm or adverse outcomes if residents' wishes were not followed or documented regarding their advance care planning. Findings include: The facility's Patient's Rights Regarding Treatment and Advance Directive policy, revision date 12/1/22, documented on admission, Promontory Point Rehabilitation will determine if the patient has executed an advance directive, and if not, determine whether the patient would like to formulate and advance directive. Upon admission, should the patient have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the patient wishes to change or continue these instructions. The following resident's records did not include an advance directive or documentation information about an advance directive was provided to the resident or the resident's representative. Resident #2 was admitted to the facility 3/3/26, with multiple diagnoses including nondisplaced fracture of left femur (thigh bone) and chronic respiratory failure. A Social Services note, dated 3/4/26, documented when Resident #2 was asked if he had a POA/Living Will he stated he did. When asked if the facility could get a copy to have on file, Resident #2 stated the facility could. Social Service documented that he would follow up in a couple of weeks for upload or with Resident #2. On 5/27/26 at 11:34 AM, a record review of Resident #2's medical record did not document an advance directive or follow up with Resident #2 or resident representative. Resident #37 was initially admitted to the facility 7/26/23, and readmitted on [DATE], with multiple diagnoses including displaced intertrochanteric fracture (thigh bone) and delirium (disorientation to time and place, usually with hallucinations). A Social Services note, dated 5/12/26, documented when Resident #37 was asked if she had a POA/Living Will she stated she did not. When asked if she would like assistance to make one she stated she would like assistance in making one. Social Service documented that he would assist her and upload a copy when done. On 5/26/26 at 10:55 AM, Resident #37's medical record had documented Resident #37 had been (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transferred to a local emergency department due to low blood pressure and low oxygen saturation on 5/13/26. Resident #37's transfer document checklist dated 5/13/26, marked Advance Directive had been sent with Resident #37 to the emergency department. On 5/27/26 at 11:39 AM, a record review of Resident #37's medical record did not document an advance directive or follow up with Resident #37. On 5/28/26 at 10:53 AM, the Administrator stated he had assisted Resident #37 on the afternoon of 5/27/26, to complete her Advance Directive. Resident #60 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including diabetes and anxiety. A Social Services note dated 5/20/26, documented when Resident #60 was asked if he had a POA/Living Will he stated he did. When asked if the facility could get a copy to have on file, Resident #60 stated he would let his family know. Social Service documented that he would follow up in a couple of weeks for upload or with Resident #60. On 5/28/26 at 10:04 AM, a record review of Resident #60's medical record did not document an advance directive or follow up with Resident #60 or resident representative. On 5/28/26 at 10:54 AM, the LSW stated they had not received a copy of Resident #60's advance directive from his family. Resident #61 was originally admitted on [DATE], and readmitted on [DATE], with multiple diagnoses including multiple fractures of ribs and atrial fibrillation (irregular, rapid heartbeat). On 5/26/26 at 11:24 AM, a record review of Resident #61's medical record did not document an advance directive. On 5/27/26 at 12:15 PM, Resident # 61's medical record had not documented a Social Services note that Resident #61 had been asked about her advance directive or if she wanted assistance in making an advance directive. On 5/28/26 at 10:57 AM, the LSW stated they had not followed up with Resident #61 about her advance directive and she did not have an advance directive in her medical record. Resident #66 was initially admitted on [DATE], and readmitted on [DATE], with multiple diagnoses including acute embolism and thrombosis (blood clots) and anemia. On 5/26/26 at 9:42 AM, a record review of Resident #66's medical record did not document an advance directive. A Social Services note, dated 5/18/26, documented when Resident #66 was asked if he had a POA/Living Will he stated he did. When asked if the facility could get a copy to have on file, Resident #66 stated he would let his wife know. Social Service documented that he would follow up in a couple of weeks for upload or with Resident #66. On 5/28/26 at 11:04 AM, the LSW stated they had not received a copy of Resident #66's advance (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	directive from his wife or documented a follow up. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including urinary tract infection and discitis (a painful inflammation and infection of the intervertebral disc space in the spine). A Social Services note, dated 3/17/26, documented when Resident #3 was asked if she had a POA/Living Will she stated she did. When asked if the facility could get a copy to have on file, Resident #3 stated she would let her family know. Social Service documented that he would follow up in a couple of weeks for upload or with Resident #3. On 5/27/26 at 2:48 PM, a record review of Resident #3's medical record did not document an advance directive or follow up with Resident #3 or resident representative. On 5/28/26 at 10:47 AM, the Administrator stated Resident #3 did not have an advance directive in her medical record and they did not follow up. Resident #17 was admitted to the facility on [DATE], with multiple diagnoses including sepsis (a life-threatening emergency that happens when your body's response to an infection damages vital organs and, often, causes death) and hypertension. Resident #17's Social Services note, dated 3/24/25, documented, When the patient was asked if she has a POA/Living Will. She says she does. Asked if we could have a copy to have on file at the facility. She says she does not. Resident #17's Initial Care Planning Conference form dated 3/24/26, documented POA/Living Will: Yes (No). Resident #17's Baseline care plan dated 3/24/26, did not address her advance directive status. On 5/28/26 at 10:49 AM, the LSW stated they had not received a copy of Resident #17's advance directive from her family. Resident #29 was admitted to the facility on [DATE], with multiple diagnoses including fractured pubis (pelvis bone) and chronic kidney disease. Record review of Resident #29's medical record did not include an advance directive or documentation information about an advance directive was provided and discussed with her or resident representative. On 5/28/26 at 10:50 AM, the Administrator stated Resident #29 had no advance directive and Social Services should have offered to assist Resident #29 formulate one. Resident #52 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including fractured hip and hypertension. Resident #52's Social Services notes dated 2/26/26, documented she has one (advance directive) and will follow up. No follow up note documented in Resident #52's medical record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #52 was discharged [DATE], and readmitted [DATE], and review of her medical record did not have documentation of her advance directive. On 5/28/26 at 10:24 AM, the LSW stated Resident #52 did not have an advance directive in her medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, manufacture's manual review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment for 2 of 2 residents (#57 and #66) observed for respiratory equipment use and clean/sanitary laundry rooms. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include:The facility's Nebulizer Therapy policy revision date [DATE], directed staff to clean the nebulizer after each use. Once completely dry, store the nebulizer cup and the mouthpiece in a ziplock bag.The facility's Laundry policy dated [DATE], documented the laundry equipment will be used and maintained according to manufacturer's instructions.The Top Load Washer Owner's manual provided by the Administrator documented cleaning of the top-loading washer should be performed at a minimum once per month or every 30 wash cycles, whichever occurs sooner.The Electric Dryer Owner's Manual provided by the Administrator documented the lint screen to be cleaned before or after each load.The following was observed for proper laundry handling:-On [DATE] at 1:39 PM, the housekeeper was observed carrying clean bed linens down the hallway, uncovered.On [DATE] at 1:40 PM, the housekeeper stated she was taking the clean bed linens to hall 300 and the linens should have been bagged.On [DATE] at 3:36 PM, the IP stated clean linen should be bagged when going down the hall. The following was observed for nebulizer use:-On [DATE] at 9:56 AM, observed Resident #66's nebulizer mouthpiece and tubing on his bedside table not covered.-On [DATE] at 10:21 AM, observed on Resident #57's bedside table his nebulizer mouthpiece and tubing not covered.The following was observed on the treatment cart:-On [DATE] at 7:19 AM, observed on the hall 100 treatment cart a bottle of hand sanitizer with an expiration date of [DATE].On [DATE] at 7:23 AM, RN #1 stated the sanitizer should not have been on the cart.On [DATE] at 11:21 AM, the DON stated the hand sanitizer should have been discarded by nursing when it had expired.-Observed in the laundry rooms:On [DATE] at 3:48 PM, with CNA #1 present observed in the laundry room used for linens a blue apron and goggles with a light gray fuzzy film.CNA #1 was asked if there were aprons and goggles that were used when placing dirty laundry in the washing machine and she stated there was no apron or goggles that the staff only wear gloves to the load dirty laundry into the washing machine. CNA #1 also stated that the CNAs do the laundry, there were no designated laundry staff.On [DATE] at 3:50 PM, observed above the dryer in the linen laundry room, on the vent and ceiling around vent a gray fuzzy substance.On [DATE] at 3:52 PM, observed the ceiling above the washing machine a splattering of a dry yellow substance.On [DATE] at 3:58 PM, in the laundry room for personal linens observed the small Amana washing machine with a gray fuzzy substance on the back panel of the machine. The soap dispensing compartment of the washing machine was filled with a dry, grainy substance. The machine agitator had a dry, gray substance on the top and down the middle. The inside of the lid, on the bottom lip of the machine, had a dry, gray substance. On [DATE] at 3:59 PM, observed the base of the hole in the wall where the hot and cold-water pipes come out of the wall for the washing machine had a thick layer of a gray fuzzy substance. The pipes from the ceiling above the dryers had a gray fuzzy substance on them.On [DATE] at 4:00 PM, observed the Amana dryer lint filter compartment with a layer of black, fuzzy substance.On [DATE] at 4:04 PM, the floor behind the dryers in the personal linen laundry room were observed to have a layer of gray, fuzzy substance.On [DATE] at 4:06 PM, observed the three vents in the personal linen laundry room with a gray, fuzzy substance on the vents and on the ceiling around the vents.On [DATE] at 7:11 AM, the Maintenance Director stated the floor staff wash the laundry and there were goggles and an apron for the staff to use but they do not always use them when washing laundry, and they should.When the Maintenance Director was asked who was responsible for cleaning the laundry rooms, he stated it was his and the housekeeper's responsibility to keep the laundry rooms clean and they cleaned them weekly.Review of the Weekly Laundry Cleaning/Audit (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented:-Leaks in chemical hoses-Washer machine no leaking-Washer Drain free of obstruction-Dryer lint vacuum-Dryer running properly-Laundry room floor clean and room organizedReview of the weekly cleaning schedule did not document cleaning of the laundry machines or other areas of the laundry rooms.On [DATE] at 1:58 PM, the Administrator stated there was no cleaning schedule for the personal size washing machines or dryers.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure informed consent was obtained prior to initiation of psychotropic medications for 1 of 1 resident (Resident #60) reviewed for unnecessary medications. This deficient practice placed residents at risk of receiving medications without knowledge of the reason why medications were prescribed, the expected benefits, and the risks associated with the medications. Findings include:Resident #60 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including anemia (a condition in which there is a reduced number of circulating red blood cells) and diabetes. A physician order dated 5/19/26, documented Resident #60 was to start Bupropion HCl oral tablet 100 mg two times a day. On 5/27/26 at 10:06 AM, review of the May 2026 medication administration record had documented Resident #60 received Bupropion HCl 100 mg on 5/19/26, at bedtime. On 5/27/26 at 10:24 AM, Resident #60's signed Psychotropic Medication Administration Disclosure dated 5/20/26, listed Bupropion for a diagnosis of major depressive disorder. On 5/28/26 at 11:26 AM, the DON stated, Resident #60 should have signed the psychotropic medication administration disclosure prior to administration of Bupropion HCl but had not.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review, and policy review it was determined the facility failed to assess whether residents had the ability to self-administer their medications for 1 of 1 resident (Residents #66) reviewed for self-administration of medications. This failure created the potential for adverse effects if medications were self-administered inappropriately by the resident. Findings include: The facility's Self-Administration of Medication policy revised 10/22/22, documented residents may self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely . 3. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment, which is placed in the patient's medical record . 10. The care plan must reflect patient self-administration and storage arrangements for such medications. Resident #66 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including acute embolism and thrombosis (blood clots) and anemia. On 5/26/26 at 9:12 AM, observed in Resident #66's room one Albuterol inhaler lying on the bed linen next to the resident. On 5/26/26 at 9:39 AM, review of Resident #66's medical record included physician orders dated 5/15/26, for Albuterol Sulfate HFA Inhalation Aerosol Solution. On 5/27/26 at 2:10 PM, Resident #66's medical record had not documented an interdisciplinary team assessment, care plan update for self-administration of medication for Albuterol inhaler to be self-administered. On 5/28/26 at 2:28 PM, the DON stated Resident #66 had not been assessed by the interdisciplinary team for self-administration of medications and should not have had the albuterol inhaler at his bedside.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, record review, and staff interview, it was determined the facility failed to ensure a resident's call light was within reach for 1 of 37 residents (Resident #9) reviewed for residents' rights. This deficient practice had the potential to cause harm if the resident could not call for assistance when needed or experienced an adverse medical event that required attention. Findings include: The facility's Call Lights Accessibility and Timely Response policy, no version date, documented. 5. Staff will ensure the call light is within reach of resident and secured, as needed. Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including displaced trimalleolar fracture (ankle fracture), major depressive disorder, and diabetes. On 5/26/26 at 11:17 AM, observed Resident #9 sitting in her recliner with her legs propped up. The recliner was positioned with the back against the bed and the call light plugged into the wall and the cord hanging down the wall and under the foot of her bed and not within her reach. Resident #9 unable to independently reach call light. On 5/28/26 at 2:32 PM, the DON stated resident's call light should be within reach and had not been.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interviews it was determined the facility failed to ensure transferring information and documentation, notice of bed-hold policy, and notice to the State Long-Term Care Ombudsman for 2 of 12 residents (#37 and #47) and the facility reviewed for transfers. This deficient practice had the potential to result in adverse outcomes if the residents were not treated in a timely manner, allowed to return to the facility, or protected from inappropriate transfers and discharges. Findings include: The facility's Bed Hold Notice Before/Upon Transfers revision date 12/1/22, documented, 1. When a patient is transferred to the hospital or goes on therapeutic leave, facility will provide to the patient and/or representative written or verbal information that specifies: a. The duration of the state bed-hold policy, if any, during which the patient is permitted to return and resume residence in the nursing facility. 2. In the event of an emergency transfer of a patient, the facility will provide within 24 hours written or verbal notice of the facility's bed-hold policies.5. Facility will keep a signed and dated copy of bed-hold notice information given to the patient and/or representative in the patient's file.1. Resident #37 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including displaced intertrochanteric fracture (thigh bone) and delirium (disorientation to time and place, usually with hallucinations).On 5/26/26 at 1:53 PM, review of Resident #37's medical record had documented on 5/13/26 at 2237, resident had been transferred to the local emergency department due to low blood pressure and low oxygen saturation. On 5/26/26 at 1:56 PM, Resident #37's medical record had not documented a bed-hold policy had been reviewed with the resident or her representative. On 5/28/26 at 11:09 AM, the Administrator stated Resident #37 had not been presented with a bed-hold policy and should have been.2. Resident #47 was admitted to the facility on [DATE], with multiple diagnoses including weakness and recent sepsis (a serious condition in which the body's response to an infection causes injury to its own tissues). On 5/27/26 at 10:24 AM, review of Resident #47's medical record documented Resident #47 had been transferred to the local emergency department on 4/7/26 at 17:57, for increased cough, shortness of breath, and low oxygen saturations. On 5/27/26 at 11:32 AM, Resident #47's medical record had not documented required pertinent medical information including care plan goals, medication list, and advance directive was provided to the receiving hospital. On 5/27/26 at 11:34 AM, Resident #47's medical record had not documented a bed-hold policy had been presented to the resident or resident's representative.On 5/28/26 at 1:11 PM, the Administrator stated Resident #47's medical record had not documented the required transfer information and should have. 3. On 5/28/26 at 12:07 PM, the surveyor requested six months of the facility's Ombudsman notifications of transfers and discharges.On 5/28/26 at 12:33 PM, the Administrator stated the facility did not have documentation of notifications to the Ombudsman as requested.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, staff interviews, and the State Operations Manual, Appendix PP it was determined the facility failed to ensure nurse staffing information was accurate and included scheduled and actual hours. This failed practice had the potential to affect the 37 residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include:State Operations Manual, Appendix PP -.the facility posts the following information on a daily basis: facility name, current date, total number and actual hours worked by licensed and unlicensed nursing staff, and resident census. On 5/27/26 at 11:14 AM, the daily posted staffing sheets were reviewed for the months of December 2025 - May 2026, the following was observed:No actual licensed and unlicensed staff hours documented on the sheets for the 6 months reviewedOn 5/27/26 at 1:41 PM, the Administrator stated the facility had not documented the actual licensed and unlicensed staff hours on the daily posted staffing sheets and the facility daily staff schedules are not kept as time adjustments are only made on the staff time sheets.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and the FDA Food Code, the facility failed to ensure food was appropriately stored, distributed, and labeled. This deficient practice had the potential to affect all residents and staff who received meals prepared in the facility's kitchen. This placed residents and staff at risk for potential contamination of food and adverse health outcomes including food-borne illnesses. Findings include:The FDA Food Code Section 3-305.11 Food Storage documented, food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination.The FDA Food Code Section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding documented bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature Danger Zone of 5 degree C to 57 degree C (41 degree F to 135 degree F) too long. On 5/26/26 at 5:52 AM, observed in the kitchen with the Administrator present three uncovered plates of food on the serving counter (tray line area): - one plate filled with cooked peas and carrots - one plate filled with cooked mashed sweet potato-looking orange substance - one plate filled with meat and gravy-like off white thick substanceOn 5/28/26 at 2:28 PM, the Dietary Manager stated the three plates of food had been left out from the prior dinner meal for the night shift staff and should have been discarded but had not been.On 5/27/26 at 3:43 PM, the following was observed in the 100 Hall resident unit refrigerator with RN #2 present:Multiple Ensure bottles - not dated or labeled with resident nameMultiple soda bottles - labeled with resident room number and residents' initials onlyThree cans of drinks - labeled with staff initials On 5/27/26 at 3:45 PM, RN #2 stated the refrigerator contents should be labeled with the resident name and the date and staff drinks should not have been in the refrigerator.On 5/27/26 at 4:13 PM, the following was observed in the 200 & 300 Hall resident unit refrigerator with staff present:One large bottle of Gatorade - not dated or labeled with resident name On 5/28/26 at 11:22 AM, the DON stated the unit refrigerators are for resident items only and items should have been dated with the resident's room number, first name and last name initial and had not been.