



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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

FILE COPY

February 11, 2015

Stephen Farnsworth, Administrator
Gateway Transitional Care Center
527 Memorial Drive
Alameda, ID 83201-4063

Provider #: 135011

Dear Mr. Farnsworth:

On **January 27, 2015**, a Complaint Investigation survey was conducted at Gateway Transitional Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated 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 and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). **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. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and

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return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 24, 2015**. Failure to submit an acceptable PoC by **February 24, 2015**, may result in the imposition of civil monetary penalties by **March 16, 2015**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 3, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised as appropriate) on **March 3, 2015**. A change in the seriousness of the deficiencies on **March 3, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 3, 2015** includes the following:

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Denial of payment for new admissions effective **April 27, 2015**. [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 **July 27, 2015**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option #2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy if appropriate.

If upon the subsequent revisit, your facility has not achieved substantial compliance we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 27, 2015**, 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)

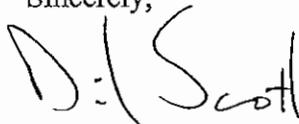
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2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **February 24, 2015**. If your request for informal dispute resolution is received after **February 24, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink that reads "D. J. Scott". The signature is written in a cursive style with a large initial "D" and "S".

DAVID J. SCOTT, R.N., Supervisor
Long Term Care

DJS/dmj
Enclosures

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

PRINTED: 02/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/27/2015
NAME OF PROVIDER OR SUPPLIER GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 627 MEMORIAL DRIVE ALAMEDA, ID 83201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your facility. The survey team entered the facility on January 26, 2015 and exited the facility on January 27, 2015. The surveyors conducting the complaint investigation were: Lorraine Hutton RN Arnold Rosling RN, QIDP Survey Definitions: BIMS = Brief Interview of Mental Status CNA = Certified Nursing Assistant DNS/DON = Director of Nursing IDT = Interdisciplinary Team MAR = Medication Administration Record MDS = Minimum Data Set LN = Licensed Nurse LPN = Licensed Practical Nurse mg = milligrams RN = Registered Nurse SSD = Social Services Director	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to provide social worker services to 1 of 1 (#1) sampled residents	F 250	1. Resident #1 no longer resides in the facility. Therefore no immediate corrections could be made for this resident. 2. Other residents may be affected by a similar alleged deficient practice. 3. Facility IDT will review on business days any identified related social service needs as outlined in the interpretive guidelines found in F-250 and for all new admissions. Social Worker to report back to IDT and any other involved parties any identified social service needs. Facility staff was educated regarding social worker responsibilities and when those services are appropriate on 2/10/15. Facility Social Worker was educated on Federal Regulation 250 regarding Social Worker responsibilities on 1/30/15. 4. DNS/LN Designee to audit Social Worker responding to any social services needs through the facility daily IDT meeting to ensure accurate follow up is taking place and documented appropriately. 5 days/week for 2 weeks 3 days a week for 3 weeks Weekly for 1 month IDT will continue to review 5 days a week ongoing. Report findings to QA. Audits will begin on 2/17/15. 5. Date of Compliance 3/3/15.		

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.

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F 250	<p>Continued From page 1</p> <p>who needed the service. There was a potential for harm when social services did not assist residents and families in working through conflicts and indecisions about care. Findings include:</p> <p>Resident #1 was admitted to the facility 12/14/12, and readmitted on 11/22/14, with diagnoses of rehabilitation and after care for a healing traumatic fracture of the the upper arm, and pulmonary embolism and Infarction.</p> <p>The resident's family member signed the resident's "Do Not Resuscitate (DNR) advanced directives. In addition, the family decided the resident was not to receive a feeding tube, IV fluids, antibiotics or blood products.</p> <p>On 11/19/14 at 6:40 p.m., a nurse documented, "Aid [sic] was assisting patient with repositioning in the wheelchair at approximately 11:15 [a.m.] when aid [sic] noted that pt appeared to be SOB [short of breath]... Nurse assessed patient and noted that O2 [oxygen] sat[uration levels] were 74% on RA [room air]... Family and MD was notified of change...Family agreed to have chest x-ray done but did not want patient transported to ER. Patient was DNR post on file. Family came to facility to visit. Staff left patient and family in the room to get x ray scheduled in house. Nurse went back into the room approx[imately] 5 - 10 min later and noted that patient was pale and head was lending [sic] forward in the chair. Vitals taken O2 sats 42% on 4 liters via nasal cannula... Family stated they wanted EMS to be called and airway to be maintained..." The resident was transported to the hospital at 11:50 a.m. The ADON talked with the family as they were being walked out to their car. The resident was admitted to the hospital.</p>	F 250		
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F 250	<p>Continued From page 2</p> <p>The resident was readmitted to the facility on 11/22/14.</p> <p>On 11/23/14 at 12:27 p.m., an RN documented the resident was "complaining of cough and shortness of breath." The physician was notified and a sputum culture and chest x-ray was ordered.</p> <p>On 11/23/14 at 7:48 p.m., the chest x-ray was completed and the technician indicated possible pneumonia in the left lung region. The RN documented, "...family informed of patient information, family requests no antibiotics at this time, family wishes to speak to physician regarding hospice care... Family requests comfort and foley cath..."</p> <p>On 11/23/14, the physician ordered, " Hospice to evaluate and treat with/Access diagnosis: Pneumonia."</p> <p>On 11/24/14, the physician ordered the resident to receive the antibiotic Levaquin tablet 750 mg one tablet by mouth one time a day for upper respiratory infection.</p> <p>On 12/3/14 at 2:12 p.m., the social worker made a note about the resident returning from the hospital and that the resident's family was "very involved" in the resident's care.</p> <p>On 12/3/14 there was documentation the resident had MRSA (methicillin resistant staphylococcus aureus) and was "still in isolation." The medical record documentation was not clear when the resident was placed in isolation or the type of isolation precautions taken, nor was there</p>	F 250		
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F 250	Continued From page 3 documentation about how the resident and family were working through the resident being isolated. The resident's clinical condition stabilized with oxygen to maintain his saturation level above 90%. The resident's cognitive condition started to decline and by 12/18/14, the nurse documented, "Alert oriented X 4 resident is Forgetful / Confused. Patient... he has episodes of forgetfulness / confusion, which require frequent reminding." On 12/27/14 at 6:33 p.m. the family was contacted about the residents's deteriorating condition. Their wishes were to "proceed with DNR and comfort care. Patient family wish to not have hospice treatment at this time." The resident expired the morning of 12/28/14. The facility social worker was interviewed on 1/27/15 at 4:45 p.m. When questioned about the lack of information showing whether the social worker was assisting the resident and family in working through the many issues with the resident's vacillating condition, the social worker stated that she did have conversations with the resident and family but did not document what was discussed. The administrator and DON were present during the interview. No further information was provided.	F 250	F-309 1. Resident #3 no longer resides in the facility; no immediate corrections could be made for resident #3. Facility IDT immediately reviewed resident #6 care plan and provided interventions to ensure all care planned interventions were in place. 2. Other residents with diagnosis of dysphagia or insurance residents may be affected by a similar alleged deficient practice. 3. a. Receptionist will print out daily census sheet identifying insurance residents prior to scheduling ancillary services. Receptionist will review payer source at time of ordered resident appointments and communicate to business office manager to obtain prior auth. b. IDT to identify all residents with diagnosis of dysphagia and review with speech therapist all dysphagia care plans to ensure appropriate interventions are in place. Staff has been educated to follow resident care plans at all times. Education provided on 2/10/15. There will be a list of residents with the diagnosis of dysphagia along with their dietary care plans/ interventions placed in a binder in the dining room drawer. Dining room monitor to ensure staff are referring to care plans to ensure dietary care plan implementation.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309			

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F 309	<p>Continued From page 4 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, it was determined the facility failed to assure nursing staff followed residents' physician orders and resident care plans. This was true for 2 of 6 residents reviewed (#s 3 & 6), and had the potential for more than minimal harm if residents did not receive physician-ordered and care planned care, treatments and/or medications.</p> <p>1. Staff failed to obtain a physician ordered CAT Scan for Resident #3 when proper authorization from the resident's insurance carrier was not obtained. The failure to obtain the CAT scan put the resident at risk for serious unresolved health issues requiring further medical treatment.</p> <p>2. Resident #6 was put at risk for harm (aspiration pneumonia) when staff failed to follow the resident's dysphagia care plan.</p> <p>Findings included:</p> <p>1. On 12/22/14, Resident #3 was admitted to the facility from a local hospital with diagnoses including resolving pneumonia, pulmonary abscess and pulmonary emboli.</p> <p>An Order Summary Report, dated 12/30/14, documented the resident's physician ordered, "CT of Chest with Contrast to check for resolution of lung abscess."</p>	F 309	<p>4. a. Business office manager to audit receptionist adherence to appropriate prior authorization of ancillary services protocol: 3 times per week for 2 weeks Weekly for 2 months Report results to QA. Audits will begin on 2/17/15.</p> <p>b. ADON/LN designee to audit appropriate care planned dysphagia interventions are in place during all meal times: daily for 2 weeks 3 times per week for 2 weeks Weekly for 1 month Report results to QA.</p> <p>5. Date of Compliance 3/3/15</p>	

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F 309	<p>Continued From page 5</p> <p>No report of the results of the CT scan was found in the resident's medical record. In addition, a 1/7/15 procedure report from the hospital documented the CT scan was not completed due to lack of prior authorization.</p> <p>On 1/27/15 at 2:35 pm, the DON was interviewed regarding the CT scan. The DON stated that the CT scan was not done on 1/7/15 when the resident was taken to outpatient services. The DON stated when facility staff took the resident to the outpatient department the clerk told them a prior authorization (PA) from the resident's insurance company was needed before the scan could be completed. The DON stated he/facility staff did not know a PA was needed and, therefore, did not attempt to obtain one until 1/8/15. The DON stated when they attempted to get the PA between 1/8/15 and 1/10/15, the insurance company either did not return their calls, routed them to insurance staff not able to help obtain the PA or were kept on hold for "three hours." On 1/10/15, the facility received a physician's order to take the resident to the emergency room to have the CT Scan completed.</p> <p>Note: The 1/10/15 report documented the abscess and pulmonary emboli treated during the resident's hospital stay were resolving, but the resident had two new infiltrates in his lungs indicating a new pneumonia. The resident was admitted to the hospital for the treatment of pneumonia and sepsis.</p> <p>2. Resident #6 was admitted to the facility on 10/22/14, and readmitted on 11/21/14, with</p>	F 309			

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F 309	<p>Continued From page 6</p> <p>diagnoses of acute respiratory failure, pneumonia unspecified, bipolar, schizophrenia, and diabetes mellitus type unspecified.</p> <p>The most recent admission MDS assessment, dated 10/29/14, documented the resident:</p> <ul style="list-style-type: none"> - was cognitively intact with a BIMS of 14, - had problems with inattention and disorganized thinking, - required supervision and set up for eating, - no swallowing problems. <p>The resident's care plan, dated 10/22/14, documented:</p> <ul style="list-style-type: none"> - "[Residents' name] has swallowing problems as well as familiar tremors." The interventions were: - "All staff to be informed on [resident's] special dietary and safety needs. Diet is 1800 cal ADA [American Dietetic Association] puree." Initiated 10/22/14. - "Diet to (be)followed as prescribed." Initiated 10/22/14. - "Instruct resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly." Initiated 10/22/14. - "[Resident name] has been educated about diet textures and risks of not following the diet order. [Resident] may eat foods not on this current diet texture order if [resident] is supervised by staff." Initiated 11/07/14. - "Keep head of bed elevated 45 degrees during meal and thirty minutes afterwards." Initiated 10/22/14. - "Monitor for shortness of breath, choking, labored respirations, lung congestion." Initiated 10/22/14. - "Provide weighted utensils as needed for meals." Initiated 10/22/14. - "Refer to Speech therapist for Swallowing 	F 309		

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F 309	<p>Continued From page 7 Evaluation." Initiated 10/22/14.</p> <p>The resident was seen by two different speech therapists, who documented:</p> <ul style="list-style-type: none"> * Resident will swallow successive amounts of any/all solids/liquids * Diet to consist of mechanical soft solids and thin liquids * Swallow technique precautions * Minimal pocketing. <p>A physician's order for 11/26/14 documented: "Speech therapy to eval[uate] and treat for dysphagia secondary to recent hospitalizations for acute respiratory failure.</p> <p>The 12/19/14 discharge recommendations included: Diet / Liquids: Solids - Puree Consistencies Liquids - Nectar Thick Liquids Strategies: Upright and in dining room for all meals Supervision: Occasional supervision (DR for all meals)</p> <p>The physician's order for 1/15/2015 documented: SLP clarification order for eval and treat for dysphagia 3 times weekly for 2 weeks. Patient will understand risk for aspiration pneumonia consuming unprescribed consistencies 9/10 trials. The speech therapist evaluation documented goals of:</p> <p>Short Term Goals #1.0 Patient will understand risk of aspiration and pneumonia 7/10 trials. Long Term Goals #1.0 Patient will understand risk of aspiration pneumonia when consuming unprescribed</p>	F 309		

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NAME OF PROVIDER OR SUPPLIER GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 627 MEMORIAL DRIVE ALAMEDA, ID 83201		
(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)	(X6) COMPLETION DATE	
F 309	<p>Continued From page 8 consistencies 9/10 trials. The evaluation further documented under OBJECTIVE TESTS/MEASURES & ADDITIONAL ANALYSIS: Behaviors Impacting Safety: Pt sneaks food and liquid other than those prescribed.</p> <p>The 1/23/15 discharge recommendations were: Diet/Liquids: Solids = pureed consistencies Liquids = Nectar thick liquids Strategies: Patient will consume prescribed diet consistencies while in the facility. Supervision: Occasional supervision (Patient will remain at risk for aspiration, therefore, he should eat in a location in which others are present.)</p> <p>The resident's 1/27/15 Physician Orders documented: * "Patient to use weighted plates and utensils and large portions due to tremor." Ordered 11/21/14. * "Fortified diet pureed texture, nectar thick consistency, large portions. If refuses thickened liquids, OK to give glucerna out of can." Ordered 1/27/15. * "Speech therapy to eval and treat." Ordered 11/21/14. * "SLP (Speech Language Pathologist) clarification order for eval and treat for dysphagia 3 times weekly for 2 weeks. Pt will understand risk for aspiration pneumonia consuming unprescribed consistencies 9/10 trials, one time a day until 1/30/15 23:59." Ordered 1/15/15.</p> <p>The progress notes were reviewed from 11/21/14 through 1/27/15. The progress notes failed to contain information about supervision of the resident or eating unprescribed consistencies of food. The resident fell two times in a 5 minute</p>	F 309			

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

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F 309	<p>Continued From page 9</p> <p>time span on 1/11/15 and was sent to an emergency room and returned the same day. A 2:42 p.m. progress note documented: "Resident arrived back to facility at approx 1300 [1:00 p.m.] Resident diagnoses made by ER physician was aspiration pneumonia. Resident also educated about importance of following physician diet plans to avoid aspiration. Resident states acknowledgement but education is ineffective by resident continuing to consume thin liquids against medical advice. Nurse will continue to educate and monitor for compliance."</p> <p>On 1/27/15 at 8:35 a.m., the resident was observed in the dining room eating breakfast. The resident had thickened liquids and pureed cereal and eggs, as well as a weighted spoon to assist with tremors. The resident was observed scooping his food to his mouth every 2 to 3 seconds. The resident did not chew but swallowed, and ate the bowl of cereal in less the 2 minutes. No staff were in the area to encourage the resident to slow down and take smaller bites.</p> <p>On 1/27/15 at 12:15 p.m., the resident was observed with three glasses containing about 8-ounces of thickened fluids - water, juice, and milk - from which he was observed gulping the fluids with his neck hyperextended get all the fluid in the glasses. No staff encouraged the resident to slow down. Staff brought the resident a bowl of thickened soup and a non-weighted spoon at 12:30 p.m. The resident was observed to eat the bowl of soup and spill about an eighth of its contents. He consumed the soup in less then 2 minutes. At 12:45 p.m., the resident received a plate of pureed potatoes, meat, vegetables and yogurt. Using the un-weighted spoon, the resident</p>	F 309			

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F 309	Continued From page 10 proceeded to eat the lunch. He scooped the food swallowed without chewing until his lunch was finished in less then 5 minutes. There was no staff available to encourage the resident to slow down and chew each bite. On 1/27/15 at 2:30 p.m., the speech therapist, DON and ADON were interviewed about the observation of the resident at the breakfast and lunch meals. The speech therapist stated a Resident Physician made changes to the consistency of the resident's diet on 1/22/15. When the resident's regular physician was contacted on 1/27/15, the diet was changed back to pureed. The speech therapist said she educated staff on food consistency, and noted, "Distant supervision is alright, he aspirates silently, you don't see it when it happens." When asked about the speed at which the resident ate his meals she stated, "He should (slow down) to decrease his risk of aspiration." The facility failed to: - follow the residents care plan "to eat slowly and chew each bite thoroughly", putting the resident at risk for aspiration pneumonia, - document supervision and noncompliance with the diet. - use the weighted utensils so he gets larger bolus of food which helps him swallow.	F 309			
F 369 SS=D	No Further information was provided. 483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them.	F 369	F-369 1. Resident #6 affected, facility ensured that weighted utensils were provided per residents dietary care plan for the following meals. 2. Other residents that require assistive devices for meals have the potential to be affected. 3. The facility will provide appropriate assistive devices to all resident that are care planned for such devices during all meals. Dietary manger to educate dietary staff on providing assistive devices per care plan and as stated on the dietary tray card for all meals. Dietary aides to ensure the appropriate devices are on the resident's tray prior to serve out. Facility staff was educated on reviewing resident tray cards prior to serving the resident the meal on 2/10/15. 4. Dietary manager to audit the meal tray line staff to ensure appropriate assistive devices are placed on the corresponding meal trays prior to serve out as stated on meal tickets. 5 days per week for 2 weeks 3 days per week for 2 weeks Weekly for 1 month Report finding to QA. Audits will begin on 2/17/15. 5. Date of Compliance 3/3/15.		

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F 369	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and care plan review, it was determined the facility failed to ensure 1 of 1 (#6) sampled resident who required assistive devices at meals received the device. This created the potential for harm if the resident had difficulty eating that could lead to weight loss or other health related issues. Findings include:</p> <p>Resident #6 was admitted to the facility 10/22/14 with diagnoses of acute respiratory failure, history of aspiration pneumonia, schizophrenia, bipolar disorder, history of seizures and diabetes mellitus unspecified.</p> <p>The most recent admission MDS, dated 10/29/14, documented the resident: - was cognitively intact with a BIMS of 14, - had problems with inattention and disorganized thinking, - required supervision and set-up help for eating.</p> <p>The resident's physician orders documented on 11/21/14 an order for the resident to "use weighted plates and utensils and large portions due to tremor."</p> <p>The resident's comprehensive care plan for "swallowing problems as well and familiar tremors," dated 10/22/14, documented an intervention of, "Provide weighted utensils as needed for meals."</p> <p>The diet slip from the kitchen and delivered with the resident's meals documented, "Built up handles & divided dish for every meal."</p>	F 369			

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F 369	Continued From page 12 On 1/27/15 at 12:30 p.m., the resident was served thickened chicken noodle soup with an un-weighted spoon rather than the weighted spoon as care planned. At 12:45 p.m., the resident received a plate of pureed food, which he ate with the unweighted soup spoon. The resident's hand was observed to have tremors as he tried to feed himself. The resident spilled approximately a quarter of his meal back onto the plate and clothing protector, and was able to consume only about 75% of the meal.	F 369			
F 514 SS=D	The administrator and DON were informed of the failure to follow the care plan on 1/27/15 at 3:00 p.m. No further information was provided. 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to assure residents' medical records were accurate and	F 514	F-514 1. Resident #3 no longer resides in the facility so immediate measures could not be implemented. 2. Other residents may be affected by a similar alleged deficient practice. 3. Facility will accurately document a resident's condition in the resident's medical record as outlined in interpretive guidelines of F-514. IDT will review all progress notes from the last 24 hours, any change of condition; to ensure that the documentation provides an accurate record of managing the resident's progress in maintaining or improving functional abilities and mental status. Facility staff has been educated on appropriate documentation in all staff meeting held on 2/10/15. IDT initiated reviewing of progress notes to ensure documentation, as outlined in F-514 interpretive guidelines, to show a picture of the resident's progress including response to treatment, change in condition, and changes in treatment during every morning meeting. 4. DNS/DNS designee to audit that IDT review of clinical documentation outlined above is being completed and that appropriate documentation is maintained in resident's clinical record. 5 days per week for 2 weeks 3 days per week for 2 weeks Weekly for 1 month Report results to QA. Audits will be on 2/17/15. 5. Date of compliance 3/3/15.		

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F 514	<p>Continued From page 13 complete. This was true for 1 of 6 residents reviewed (#3) for medical record accuracy and completeness. The lack of complete and accurate information had the potential to interfere with resident care by not documenting services the residents did or did not receive and their response to those services.</p> <p>Findings included:</p> <p>On 12/22/14, Resident #3 was admitted to the facility with diagnoses of resolving pneumonia, pulmonary abscess and pulmonary emboli.</p> <p>An incident report, dated 1/9/15, documented Resident #3 fell that day at 8:00 pm. LN #1 documented the resident's vital signs from 1/9/15 at 8:00 pm to 1/10/15 at 6:00 am on a Neurological Assessment sheet used by the facility to monitor residents after falls.</p> <p>Progress notes for 1/9/15 at 3:54 pm documented Resident #3 stated he was short of breath, had a productive cough, pulmonary rales, rhonci, wheezing and dyspnea. The physician was notified and new orders were received. LN #1 came on shift at 7:00 pm. and documented the resident's oxygen levels four times during the night shift (8:00 pm to 6:00 am), in addition to those vital signs taken for the Neurological Assessment. There were no progress notes in the resident's record, however, documenting lung assessments or respiratory status from 8:00 p.m. on 1/9/15 to 6:00 a.m. 1/10/15. The 1/10/15 day shift did not address the resident's respiratory condition in the progress notes until 12:29 pm.</p> <p>A Late Entry by LN #2, dated 1/10/25 at 5:00 p.m. and 5:45 p.m. documented, "Sent to ER for CT</p>	F 514			

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F 514	Continued From page 14 and to have lab lab drawn ... sent resident to ER for CT with contrast and lab draw r/t [related to] resident SOB - resident left facility with transportation, notified daughter." This entry did not document the date and time for which the entry was late-entered. The entry also failed to indicate whether the resident was transported via ambulance, private vehicle, or facility vehicle. On 1/27/15 at 2:35 pm, the DON was interviewed regarding nursing documentation of monitoring and assessment of the resident's changes in conditon as well as the failure of late entries to clearly indicate the time and date the late entry covered. The DON stated the facility nurses had been reminded to add the date and time of the event when writing a late entry. The DON acknowledge LN #1 did not write narratives regarding the resident's respiratory status on night shlft of 1/9/15, but provided documentation that the resident's oxygen level and vital signs were monitored throughout the night.	F 514			

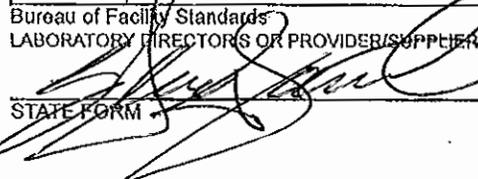
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2015
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NAME OF PROVIDER OR SUPPLIER GATEWAY TRANSITIONAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE ALAMEDA, ID 83201
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your facility. The survey team entered the facility on January 26, 2015 and exited the facility on January 27, 2015. The surveyors conducting the complaint investigation were: Lorraine Hutton RN Arnold Rosling RN, QIDP	C 000		
C 696	02.152 Social Services Program 152. SOCIAL SERVICES. The facility shall provide for the identification of the social and emotional needs of the patients/residents either directly or through arrangements with an outside resource and shall provide means to meet the needs identified. The program shall be accomplished by: This Rule is not met as evidenced by: Please refer to F250 as it relates to the provision of social services.	C 696	Refer to F-250 POC	
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F 309 as it relates to following physician's orders and care plans.	C 784	Refer to F-309 POC	

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FEB 11 2015
STATE OF IDAHO

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 2/13/15
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Bureau of Facility Standards

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C 787	02.200,03,b,iii Fluid/Nutritional Intake iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please refer to F369 as it relates to assistive eating devices.	C 787	Refer to F-369 POC	
C 881	02.203,02 Individual Medical Record 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please refer to F 514 as it relates to complete and accurate medical records.	C 881	Refer to F-514 POC	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RICHARD M. ARMSTRONG -- Director

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

March 20, 2015

Stephen Farnsworth, Administrator
Gateway Transitional Care Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Farnsworth:

On **January 27, 2015**, an unannounced on-site complaint survey was conducted at Gateway Transitional Care Center.

During the survey, observations were conducted on January 26, 2015 and January 27, 2015, for a cumulative of thirteen and three quarters of an hour.

Residents' Rights information, Grievance Reports, Resident Council minutes, Incident and Accident Reports, residents' medical records and telephone installation work orders were reviewed for December 1, 2014 through January 27, 2015. In addition, interviews were conducted with the Administrator, Director of Nursing (DoN), two licensed nursing staff, the Maintenance Director and the Social Worker with the following results:

The complaint allegations, findings and conclusions are as follows:

Complaint #6821

ALLEGATION #1:

Residents' rights are not upheld.

FINDINGS #1:

During the survey, three residents were interviewed between January 26, 2015 and January 27, 2015. All three residents stated they felt their rights were respected by the facility. This included the right to

Stephen Farnsworth, Administrator

March 20, 2015

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receive and make phone calls, the right for the resident and/or their authorized family member to review their medical records and the right to be notified of significant medical changes.

The three residents were asked if staff were available to help them receive telephone calls, make telephone calls and assure they could do so in privacy. Each of the three residents stated they had no personal concerns with telephone use and two of them stated they had observed staff assist other residents receive telephone calls.

Grievance Reports, Incident and Accident Investigations, Resident Council Meeting Minutes and residents' medical records did not include evidence of residents' rights violations.

For example, two of six records documented the residents were responsible for themselves with no assigned health care power of attorney (POA). One of the two records documented the resident had signed a release that authorized her family could be notified of health care changes and healthcare information. This resident's nurses notes documented the family was notified of a fall on December 22, 2014, and loose dentures in January 2015.

The second resident's record did not contain documentation permitting release of health care information to his family. The resident experienced a fall on January 9, 2015. The January 9, 2015, incident report documented no observed injuries or complaints of pain following the fall. Per the facility's fall protocol, the resident was placed on seventy-two hour monitoring of his vital signs and neurological status. The incident report documented the physician was notified of the fall on January 9, 2015, but the resident's family was not. On January 10, 2015, the same resident was taken to the hospital for a CAT scan of his lungs and was admitted for pneumonia. Nurses Notes dated January 10, 2015, documented the resident's family was notified of his hospital admission.

During an interview on January 27, 2015, the Director of Nursing agreed the second resident's family was not notified of the January 9, 2015, fall due to privacy regulations. They were notified of the resident's admission to the hospital because it was an acute/possibly emergency situation.

HIPPA (Health Care Information Privacy Protection Act) prohibits facilities from releasing information to the families of residents who are alert, oriented and determined to be responsible for themselves, without express consent from the resident.

Review of one resident's medical record documented the resident was admitted to the newly remodeled rehabilitation unit of the facility in December 2014. At the time of his admission, the resident's record documented his family requested a working telephone in his room. A work order was submitted but after 19 days, the family expressed concerns that the resident still did not have a telephone in his room that was working.

During an interview with the Administrator and Social Worker in January 27, 2015, the Administrator stated between December 2014 and January 2015 residents living on the new rehabilitation hall

Stephen Farnsworth, Administrator

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experienced difficulties with the phone lines in their room. The residents were able to call out but could not receive calls into their room. A work order was placed with the telephone provider who was not able to resolve the issues until mid-January 2015. Between December 2014 and January 2015, both the social worker and the administrator stated residents received calls at the nurses' station and/or social workers office, if privacy was desired. The administrator stated he received no complaints in December or January that residents had difficulty receiving or making telephone calls. The social worker stated she received a call from a family member on January 9, 2015, who was concerned that a telephone was still not available in a resident's room. Neither federal nor state regulations require that a telephone be available in each resident's room. The regulations do require the facility to provide reasonable access to a telephone to make/receive calls in privacy.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents are not provided with appropriate medical care and services.

FINDINGS #2:

During the investigation, residents were observed and medical records were reviewed; including physician's orders, nurses' notes, progress notes, therapy notes, weight records, Incident and Accident investigations, grievance records and hospital admission and discharge records. In addition, nursing staff, social service staff, administrative staff and a speech therapist were interviewed.

Two of six residents reviewed did not receive appropriate medical care. The facility received a Federal citation at F309 and a State citation at C784. Please refer to the Federal CMS-2567 report.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility did not ensure the temperatures in residents' rooms were comfortable.

FINDINGS #3:

During the investigation of this allegation, random residents located in their rooms throughout the facility were interviewed, maintenance logs were reviewed and the Administrator and Maintenance director were interviewed.

Between January 26, 2015 and January 27, 2015, six residents were asked if their room temperature was

Stephen Farnsworth, Administrator

March 20, 2015

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warm enough during the winter and cooler seasons and cool enough during the summer and warmer times. The residents were also asked if their room temperature could be adjusted, if needed and if staff were willing to help with this. Two of the four residents residing on the rehabilitation unit stated they had only been at the facility since December 2014 and had no concerns with their room temperature. They stated there had been no need to adjust it. One of the four remaining residents stated the only time he had concerns with his room temperature was when the season was changing from cool to warm or warm to cold. This resident stated staff helped him adjust the thermostat in his room when needed.

On January 27, 2015, the Administrator was interviewed regarding room temperatures. The Administrator stated that each resident's room had its own thermostat and could easily be adjusted up or down. When asked if he had received any reports or complaints that a resident's rooms was too cold or too hot and the thermostat could not be adjusted, the Administrator stated that when the newly remodeled rehabilitation unit reopened in Fall 2015, there were some difficulties with the thermostats in residents' rooms. The Administrator said the thermostats would freeze at times, when staff tried to adjust them. This meant that staff need to wait for 15 - 20 minutes before they could successfully adjust the room's temperature. The maintenance department was involved in looking at the thermostats and talking to staff about how to adjust them.

On January 27, 2015, the Maintenance Director confirmed that the thermostats worked in all rooms throughout the facility, but the thermostats on the newly remodeled rehabilitation unit took a while for staff to become accustomed to them. The Maintenance Director stated he received no complaints or work orders specific to any one room between December 1, 2014 and January 31, 2015.

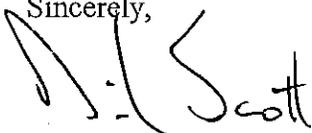
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large initial "D" and "S".

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj