



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

**CERTIFIED MAIL: 7012 1010 0002 0836 1581**

June 23, 2014

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

Provider #: 135011

Dear Mr. Farnsworth:

On **June 13, 2014**, a Recertification and State Licensure 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 one that comprises a pattern 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 3). **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

Stephen Farnsworth, Administrator  
June 23, 2014  
Page 2 of 4

CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 7, 2014**. Failure to submit an acceptable PoC by **July 7, 2014**, may result in the imposition of civil monetary penalties by **July 28, 2014**.

The components of a Plan of Correction, as required by CMS include:

- 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 in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
  - a. Specify by job title who will do the monitoring.
    - \* It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task.
    - \* The monitoring cannot be completed by the individual(s) whose work is under review.
  - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3.
    - \* A plan for "random" audits will not be accepted.
    - \* Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
  - c. Start date of the audits;
- 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.

Stephen Farnsworth, Administrator  
June 23, 2014  
Page 3 of 4

- 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 **July 18, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 18, 2014**. A change in the seriousness of the deficiencies on **July 18, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 18, 2014** includes the following:

Denial of payment for new admissions effective **September 13, 2014**. [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 **December 13, 2014**, 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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; 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 **June 13, 2014** and continue until substantial

Stephen Farnsworth, Administrator  
June 23, 2014  
Page 4 of 4

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 noncompliance 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 **July 7, 2014**. If your request for informal dispute resolution is received after **July 7, 2014**, 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.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj  
Enclosures

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

PRINTED: 06/23/2014  
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  06/13/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS  The following deficiencies were cited during the annual federal recertification survey of your facility.  The surveyors conducting the survey were: Susan Gollobit RN, Team Coordinator Judy Atkinson RN, Sherri Case, LSW, QMRP Brad Perry BSW, LSW.  The survey team entered the facility on 6/9/14 and exited on 6/13/14.  Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed ADON=Assistant director of Nursing	F 000		
F 241 SS=0	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview it was determined the facility failed to	F 241		

**RECEIVED**  
JUL 31 2014  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X5) DATE 7-3-14
--	-----------------------------	---------------------

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.

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 241	<p>Continued From page 1</p> <p>provide 1 of 15 (#8) sampled residents, care in a manner which promoted dignity and individuality for the resident. The deficient practice had the potential to cause more than minimal psychological harm when the resident was dressed in a hospital gown instead of a nightgown. Finding's included:</p> <p>On 6/11/14 at 10:30 AM, 1:15 PM, and 2:05 PM, Resident #8 was observed in bed with a hospital gown on.</p> <p>On 6/11/14 at 4:25 PM, the resident was observed in bed with a hospital gown on. The resident was asked why she was wearing a hospital gown. The resident stated, "I wasn't feeling well." The resident was asked if she had a night gown of her own and she stated, "Yes." She was asked if she would rather have a nightgown on and she stated, "Yes I would."</p> <p>On 6/11/14 at 5:00 PM, LN #4 was asked if the resident always wore a hospital gown or was it because she was not feeling well. LN #4 stated, "No, I think that's what she always has on when she is in bed." LN #4 was asked if the resident had her own nightgowns, and she stated, "I don't know if she has any or not." CNA #5 was asked if the resident had any nightgowns of her own. CNA #5 replied, "Yes she does. She has two." CNA #5 was asked if the resident had asked to have the hospital gown on today. CNA #5 stated, "She wears a hospital gown when they [her own night gowns] are dirty." At 5:10 PM, CNA #5 returned to the nurse's station and stated to the surveyor and LN #4, "They are both dirty. The one that is in there has a broken zipper and we don't put it on her. Her gowns are really nice, actually." LN #4 stated they would get a hold of the resident's</p>	F 241	<p>F241 Dignity and respect of individuality.</p> <ol style="list-style-type: none"> <li>1. Patient was provided a pajama set from the facility while her clothing was being washed. Patient's personal items were returned after being washed.</li> <li>2. All patients who choose to be in their personal clothing have the potential to be affected.</li> <li>3. Nursing staff will be educated on 7/9/14 on facility P&amp;P regarding patient dignity and personal effects. Staff to be educated on 7/9/14 on P&amp;P for the use of the facility supply of donated clothing.</li> <li>4. Housekeeping will conduct an all patient audit for the adequacy of personal clothing/effects to ensure each patient has sufficient clothing between facility wash cycles. Housekeeping will conduct an audit on all new admissions for the adequacy of personal clothing/ personal effects 1 x week for two months. Results to be reported to QA monthly. Audits to begin Audits to begin 7/7/14</li> <li>5. Date of Compliance 7/14/14.</li> </ol>	

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE	
F 241	<p>Continued From page 2</p> <p>family as, "They are real good about bringing her things. We can see if they will bring her some." LN #4 was asked who washed the resident's laundry and verified that the facility did. At that time the HS [Housekeeping Supervisor] walked by the nurse's station. When asked when the resident's laundry was washed, the HS stated, "Monday, Wednesday, Friday." LN #4 asked the HS when the resident would get her gowns back, and the HS stated, "Friday, she has more than 2 doesn't she." LN #4 verified to the HS the resident had 2 nightgowns. The HS stated, "I will get it back to her tomorrow [Thursday]."</p> <p>NOTE: The HS had identified the resident would have been without her nightgowns from Wednesday until Friday. The resident would have had to wear a hospital gown for 2 days.</p> <p>On 6/11/14 at 5:15 PM, the HS approached the surveyor and LN #4 at the nurse's station and stated the resident's nightgowns were clean, and continued down the hall with the gowns to the resident's room. The Social Worker was asked by LN #4 if she could get the resident more nightgowns and she stated, "Sure absolutely, we can do that."</p> <p>On 6/11/14 at 5:42 PM, the resident was observed in bed with a blue nightgown on. The resident was asked if she liked having the nightgown on instead of the hospital gown, and she stated, "Yes, yes I do."</p> <p>On 6/12/14 at 3:20 PM, the DON was asked what the policy was for the facility with residents wearing hospital gowns. The DON replied, "Some wear them to bed, we try not to have them wear them very much. If they come without clothes or if something happens and they are in the laundry</p>	F 241			

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE	
F 241	Continued From page 3 we have to put them in a gown until we get their clothing back from the laundry. We do have some donated clothes...." The DON stated they had a closet with clothes in it, and the staff could get clothes from it for residents who may need clothing items.  On 6/12/14 at 5:30 PM, the Administrator, DON and ADON were informed of the findings. No additional information was provided.	F 241			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 280	F280 Right to Participate Planning Care-Revise CP  1. Patients # 2, 4, 5, 7&8 care plans were immediately updated to reflect the current plan of care with current interventions. 2. All patients have the potential to be affected. 3. a. All Licensed Nursing staff will be educated on 7/9/14 on facility P&P's for updating resident care plans for specific physician orders, patient's change of condition, refusal of care and defining frequency intervals for toileting. b. IDT will review in daily clinical meeting the past 24 hours of physician's orders and update the residents care plan as necessary. c. IDT will review in daily clinical meeting the newly created 24 hour change of condition log and IDT will update resident's care plan as appropriate. d. Residents that refuse cares or medical treatment will have a care plan that will direct staff on what to do when the resident refuses care. Staff will document all refusal of care on the facility's refusal of care form and will be turned in to the		

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 280	<p>Continued From page 4</p> <p>interview, it was determined the facility failed to revise care plans for 5 of 13 sampled residents (#'s 2, 4, 5, 7, &amp; 8). The care plans:</p> <ul style="list-style-type: none"> <li>*contained information related to a hypnotic medication and a fall intervention which were no longer in use;</li> <li>*did not define time or frequency intervals for sleep and toileting interventions;</li> <li>*contained information related to a skin intervention which was no longer in use; and</li> <li>*contained information related to isolation precautions which were no longer in use.</li> <li>*did not include interventions related to a resident's refusal of care to prevent pressure ulcers. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in the care plan. Findings included:</li> </ul> <p>1. Resident #4 was admitted to the facility on 10/9/13 with multiple diagnoses including muscle weakness and difficulty in walking.</p> <p>The resident's Hypnotic Therapy care plan dated 10/18/13 and revised on 1/20/14, documented a focus of, "...is on Ambien" with interventions dated 10/18/13 which documented, "May cause drowsiness, confusion, loss of appetite in the morning, increased risk of falls and fractures, dizziness. Observe for possible side effects q [every] shift."</p> <p>The resident's Physician's Order dated 1/16/14, documented, "DC [discontinue] Ambien."</p> <p>On 6/12/14 at 11:00 AM, the DON and ADON were interviewed. When asked about the Ambien the DON said, "It's DC'd...We can fix that when we get back to the office."</p>	F 280	<p>DNS or RN designee. Staff will be educated on July 9, 2014 on facility policy and procedure for documenting resident refusals on the facility's refusal form. Staff will also be educated on procedure for care planning resident refusals in their clinical record. Care plans will include time frequencies for toileting individual residents.</p> <p>4.</p> <ul style="list-style-type: none"> <li>a. DNS or RN designee will audit physician orders and compare them to the resident's care plan daily x 4 weeks then weekly for 4 weeks then monthly ongoing.</li> <li>b. IDT to review physician orders daily ongoing. DNS or RN designee will audit resident change of condition log and compare them to resident's care plan daily x 4 weeks then weekly for 4 weeks then monthly ongoing.</li> <li>c. IDT to review physician orders daily ongoing. DNS or RN designee will audit refusal of care forms and compare them to the resident's care plan daily x 4 weeks then weekly for 4 weeks then monthly ongoing. IDT to review physician orders daily ongoing.</li> <li>d. All audits to begin July 7, 2014</li> </ul> <p>5. Date of compliance July 14, 2014</p>	

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 5</p> <p>b. Resident #4's Fall care plan dated 10/18/13, documented an intervention for, "Bed in lowest position."</p> <p>On 6/10/14 at 8:30 AM, 9:50 AM, 11:22 AM, and several other observations throughout the survey, the resident's bed was observed to be at a normal height.</p> <p>On 6/12/14 at 11:00 AM, the DON and ADON were interviewed. When asked about the care plan, the DON said that intervention had not be used since the DON attended a fall prevention training last year and, "I just need to take that out of her care plan."</p> <p>2. Resident #2 was admitted to the facility on 3/18/11 and readmitted on 2/18/14 with diagnoses which included mastoiditis (middle ear infection), depression and muscle weakness.</p> <p>a. Resident #2's 10/21/13 bowel/bladder incontinence care plan included an intervention to "Assist with toileting as needed at frequent intervals." The care plan included no further directions as to what frequent intervals meant such as upon rising, before and after meals etc.</p> <p>On 6/11/14 at 2:10 p.m. the DON was informed the care plan did not have specific interventions to address the resident's needs for toileting. The DON stated the care plan would be revised.</p> <p>b. The resident's care plan for nutrition at risk, revised on 1/28/14 had interventions of: -Monitor and report to physician emaciation, muscle wasting and significant weight loss. -Provide assistance or cueing with meals as needed.</p>	F 280			

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 6</p> <ul style="list-style-type: none"> <li>-Provide, serve diet as ordered and to monitor meal intake.</li> <li>-The Registered Dietitian to evaluate and make diet changes.</li> <li>-If eats less than 50% of the meal offer a meal replacement.</li> <li>-Obtain and monitor lab/diagnostic work and report results to the physician.</li> </ul> <p>The resident's 6/4/14 Nutrition Update included in the Progress/Status section, "...Receives whole milk TID (3 times) with meals and yogurt TID at snacks to boost protein intake for dialysis and healing."</p> <p>On 6/10/14 at 8:20 a.m. a container of yogurt with a label which documented a date of 6/10/14 and 10:00 a.m. snack was in the resident's room in his personal refrigerator. At 12:35 p.m. the resident was observed to be eating the mid-day meal which included milk.</p> <p>On 6/11/14 at 10:15 a.m. the Dietitian was informed the care plan did not include the resident was to receive whole milk and yogurt 3 times daily. She stated the intervention had been added around the beginning of the year.</p> <p>On 6/13/14 at 10:00 a.m. the Administrator, DON and the ADON were informed of the above concern. The facility provided no further information.</p> <p>3. Resident #7 was admitted to the facility on 11/4/13 with diagnoses which included chronic kidney disease and senile dementia.</p> <p>The resident's 1/3/14 care plan for skin integrity included an intervention "sheep skin to arm rest."</p>	F 280			

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)  (X5) COMPLETION DATE
F 280	<p>Continued From page 7</p> <p>During observations on 6/10/14 at 8:15 a.m. and 10:15 a.m. and throughout the survey the arm rest of the resident's wheelchair did not have a sheepskin on it.</p> <p>On 6/12/14 at 10:30 a.m. the DON stated the sheepskin had been used prior to the resident receiving therapy for positioning as the resident had leaned to the side. The DON stated the care plan needed to be revised as the sheepskin was no longer used.</p> <p>4. Resident #8 was readmitted to the facility on 4/10/14 with diagnoses which included Multiple Sclerosis and muscle weakness.</p> <p>The resident's care plan documented: Focus: "Has MRSA [Methicillin Staphylococcus Aureus]-in nares." Date Initiated: 4/11/14. Revision on: 4/11/14 Interventions with date initiated as 4/11/14, documented: **"Make sure that she wears a mask when she comes out of her room." **CONTACT ISOLATION: Wear gowns and masks when changing contaminated linens...." **"Give antibiotic therapy as ordered." **"Instruct family/visitors/caregivers to wear disposable gown and gloves during physical contact with resident...." *Mask/face shield to be worn during procedures with risk of splashes or droplet contamination of body fluids."</p> <p>The resident's Progress note dated 4/28/14, documented: **"Res.[ident] culture from nares came back with a result of no MRSA. Faxed results to [Name of physician] and resident was able to go to the</p>	F 280	

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 280	<p>Continued From page 8</p> <p>dining room for her dinner. Stated that she was very happy to not have to wear her mask anymore and able to come out of her room."</p> <p>The resident's Physician order dated 4/29/14, documented: *DC [discontinue] MRSA precautions due to neg[ative] culture to nares 4/28/14. NSG [nursing] order." NOTE: The resident's care plan had not been revised to reflect the discontinued MRSA precautions.</p> <p>On 6/10/14 at 3:00 PM, LN #4 was asked if the resident was still on MRSA precaution. LN #4 stated they had been discontinued and provided the physician order to discontinue the precautions.</p> <p>On 6/12/14 at approximately 5:30 pm, the Administrator, DON and ADON were informed of the findings. No additional information was provided.</p> <p>5. Resident #5 was readmitted to the facility on 11/11/13 with diagnoses that included acute Osteomyelitis.</p> <p>The resident's Braden scale for predicting pressure ulcers documented: 11/11/13- Moderate risk. 11/18/13- High risk. 11/15/13 and 12/2/13- Moderate Risk. 1/6/14 and 2/14/14- High Risk. 4/29/14- Moderate Risk.</p> <p>The resident's quarterly MDS dated 4/29/14, documented: *BIMS score: 15, cognition intact.</p> <p>The resident's Refusal of Care Form</p>	F 280		

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)  (X5) COMPLETION DATE
F 280	<p>Continued From page 9 documented, *11/12/13. "Approached resident several times. About getting out of wheel chair resident stated he did not want to lay down that was at 8 or 9 that I approached for the last time and explained that staying up so long could cause serious skin break down and I really needed to lay him down. At that time resident stated it would be ok." "3rd attempt:" was marked on the form. *Similar documentation was provided for 11/18/13, 11/23/13, and 11/26/13.</p> <p>The resident's care plan, documented: *Focus:"Potential for skin breakdown. HX (History) of pressure ulcers, sheering to gluteal fold, needs assist with mobility, has a dx (diagnosis) of DM (Diabetes Mellitus), has venous insufficiency to LE (lower extremity), Anemia, dry flaky skin on body and scalp, hypothyroidism and some incontinence. Has decreased sensation to buttocks." Date initiated: 5/7/13 Revision on 4/23/14. *Interventions included: -"Needs assistance to turn/reposition at frequent intervals." Date initiated: 5/7/13 -"Float heels or heel protectors while in bed as he allows. Also refer to edema/stasis dermatitis care plan." Date initiated: 10/2/13 revision 4/2/14. -"limit [sic] time spent up in w/c [wheelchair], to help reduce pressure to coccyx et glutial [sic] areas." Date initiated: 6/11/14. NOTE: On 6/11/14, during the survey, the care plan was up dated with the intervention to limit time spent up in w/c. The care plan did not document interventions for what staff were to do when the resident refused to follow the plan to prevent pressure ulcers.</p> <p>On 6/12/14 at 8:20 AM, the Administrator, DON,</p>	F 280	

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE	
F 280	Continued From page 10 ADON and Wound nurse were interviewed regarding the resident's pressure ulcers. When asked what, "turn and reposition at frequent intervals" meant, the DON stated, "Our staff knows ... it's no more than 2 hours." The DON verified the intervention for the resident being up in his w/c had not been care planned until 6/11/14. The ADON stated on 11/25/13 the resident's w/c cushion was changed. The DON stated the resident was refusing to lay down or change his position when he was up in his w/c, and they had, "Documentation showing the resident was educated." The DON stated, "The care plan could definitely be worked on."  On 6/12/14 at approximately 9:05 AM, the resident was asked if he had been up in his chair a lot when the sores on his buttocks first started. The resident stated, "A couple of days there I was, but that was 6-8 months ago so I don't know what happened there."  On 6/12/14 at approximately 5:30 PM, the Administrator, DON and ADON were informed of the findings. No additional information was provided.	F 280			
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 and plan of care.	F 309			

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure care planning and monitor of a dialysis access site and and ensure elevation of lower extremities related to edema and renal insufficiency. This was true for 2 of 13 sample residents (#s 2, and 7 ). This practice had the potential to result in restricted blood flow and pain or numbness in extremities.</p> <p>1. Resident #2 was admitted to the facility on 3/18/11 and readmitted on 2/18/14 with diagnoses which included mastoiditis (middle ear infection), depression and muscle weakness.</p> <p>*The resident's 10/21/13 Care Plan for dialysis included in the intervention section to monitor the access site, encourage to go to dialysis, monitor intake, output, labs, edema and signs and symptoms of infection. The Care Plan did not include to monitor the bruit (sound of blood moving) or thrill (vibration on artery of blood moving).</p> <p>The resident's medical record did contain documentation the facility was monitoring the bruit or thrill.</p> <p>*The resident's 10/21/13 Care Plan for edema to his legs included in the intervention section to "Elevate legs when sitting or sleeping."</p> <p>During observations on 6/10/14 at 8:20 a.m., 11:20 a.m., 12:35 p.m., on 6/11/14 at 9:35 a.m. and throughout the survey the resident was observed sitting in his wheelchair without his legs elevated.</p>	F 309	<p>F309-Provide Care/Services for highest well being</p> <ol style="list-style-type: none"> <li>1.) Resident #2 care plan was updated to include monitoring for a thrill and bruit. A refusal care plan was initiated to direct nursing staff on steps to take when resident #7 refuses to elevate his lower extremities.</li> <li>2.) All residents on hemodialysis and all residents with edema have the potential to be effected.             <ol style="list-style-type: none"> <li>a. All residents receiving hemodialysis will have a care plan directing staff on monitoring the resident's fistula for a thrill and bruit. Staff will be educated on July 9, 2014 on proper documentation for monitoring thrills and bruits for hemodialysis patients.</li> <li>b. All residents that refuse cares or medical treatment will have a care plan that will direct staff on what to do when the resident refuses care. Staff will document all refusal of care on the facility's refusal of care form and will be turned in to the DNS or RN designee. Staff will be educated on July 9, 2014 on facility policy and procedure for documenting resident refusals on</li> </ol> </li> <li>3.)</li> </ol>		

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 309	Continued From page 12 On 6/11/14 at 2:10 p.m. the DON was informed of the above concerns and stated she had forgotten to include to monitor the bruit and thrill in the care plan for dialysis and the resident often refused to elevate his legs. When asked for documentation of the refusals, the DON stated the refusals had not been documented.  2. Resident #7 was admitted to the facility on 11/4/13 with diagnoses which included chronic kidney disease and senile dementia.  Resident #7's 11/12/13 Care Plan for renal insufficiency included an intervention to encourage the resident to elevate her feet when sitting up in a chair.  During observations on 6/10/14 at 8:35 a.m., 10:15 a. m., 2:35 p.m., 3:05 p.m., on 6/11/14 at 9:30 a.m. and throughout the survey the resident was observed sitting in her wheelchair without her legs elevated.  On 6/11/14 at 1:30 p.m. the DON was informed of the above concern and stated the resident would often refuse to elevate her legs, however the refusals were not documented.	F 309	the facility's refusal form. Staff will also be educated on procedure for care planning resident refusals in their clinical record.  4.) a. DNS or RN designee will audit all care plans for hemodialysis to ensure they include monitoring for a thrill and bruit once a week for 2 months. Audits to begin July 7, 2014. Reported to QA monthly. b. DNS or RN designee will audit refusal of care forms and ensure that a care plan was initiated and/or updated for the refusal of cares. Audits will be completed twice a week x 4 weeks then once a week for 4 weeks then monthly ongoing. Audits to begin July 7, 2014. Reported to QA monthly.  5.) Date of compliance July 14, 2014	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314		

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  06/13/2014	
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 314	<p>Continued From page 13 prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure measures to prevent the development of an avoidable unstageable pressure ulcer were included in a resident's care plan. This was true for 1 of 9 sample residents (#7) reviewed for pressure ulcer and put the resident at risk for reoccurring pressure ulcers. Findings included:</p> <p>Resident #7 was admitted to the facility on 11/4/13 with diagnoses which included chronic kidney disease and senile dementia.</p> <p>The 11/11/13 Admission MDS assessment and the 5/14/14 quarterly MDS assessment for Resident #7 documented: * Extensive assistance needed for bed mobility and transfers; * At risk for pressure ulcer development with no pressure ulcers and, * Mobility devices of a walker and a wheelchair</p> <p>Resident #7's Care Plan, dated 11/6/13, documented: * Focus: "...Potential for pressure ulcer development r/t (related to) immobility/confusion." * Interventions: Note: All interventions were initiated on 11/6/13 unless indicated below. - Administer treatments as ordered and monitor for effectiveness. Revised on 5/31/14. - Barrier cream with each attend (incontinence brief) change and prn (as needed) for any redness. Revised on 5/31/14.</p>	F 314	<p>F314-Treatment/SVCS to prevent/Heal Pressure Ulcers</p> <ol style="list-style-type: none"> <li>1.) Resident #7's son was contacted and he brought in appropriate fitting hard soled shoes. Shoes were assessed by the wound nurse and determined they were safe for the resident and provided protection against skin breakdown when the resident propels herself in her wheelchair. Resident will be seen by a physician on 7-3-14 to be fitted for diabetic shoes. Care plan was updated to include wearing these shoes until diabetic shoes arrive.</li> <li>2.) All residents at risk for skin breakdown have the potential to be effected.</li> <li>3.) All residents that are at high risk for skin breakdown will be evaluated monthly by the wound nurse for proper footwear. These residents will also be reviewed weekly by the IDT skin committee to ensure proper interventions (such as heel protectors, air beds, wheelchair cushions etc.) are in place and on the care plan to avoid skin breakdown.</li> </ol>	

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 314	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>- Heel lift boots while in bed as resident allows. Revised on 5/31/14</li> <li>- Call light within reach.</li> <li>- Daily body checks during cares. Revised on 2/8/14.</li> <li>- Educate resident, family/caregivers as to causes of skin breakdown: including transfer/positioning requirements; importance of taking care during ambulating, good nutrition and frequent repositioning.</li> <li>- Encourage fluids, if refuses treatment try alternative methods,</li> <li>- Monitor nutritional status,</li> <li>- Out of bed unless contraindicated,</li> <li>- Pressure reducing device on bed and wheel chair,</li> <li>- Use draw sheet and reposition at frequent intervals.</li> <li>- Heel protectors on while in bed. Initiated on 4/2/14.</li> </ul> <p>Note: The care plan identified an intervention on 11/6/13 for heel lift boots while in bed and heel protectors on while in bed on 4/2/14.</p> <p>An accident/incident report dated 3/27/14 documented that during a skin assessment a black area was found, "on the right heel (laying on the bed) approximately 0.5 cm."</p> <p>Weekly Skin Pressure Ulcer assessments were documented on 3/27/14, 4/3/14, and 4/10/14. The wound was documented as 1 cm by 1.5 cm on 3/27/14, without tunneling, drainage or pain and staged as a Suspected Deep Tissue Injury. The wound decreased in size each week and was documented as resolved on 4/10/14.</p> <p>On 6/11/14 at 11:20 a.m. the Wound Nurse (WN) stated Resident #7 had a pressure ulcer on the</p>	F 314	<p>4.) ADON or RN designee will audit the wound nurse's assessments for proper footwear monthly ongoing. ADON will audit care plans for high risk residents to ensure interventions discussed in the IDT skin committee meeting are initiated and are included in the resident's care plan to prevent skin breakdown. Audits will be done weekly for 4 weeks, then every 2 weeks for 4 weeks, then monthly ongoing. All audits will begin on July 7, 2014.</p> <p>5.) Date of compliance July 14, 2014</p>	

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

PRINTED: 06/23/2014  
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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 314	<p>Continued From page 15</p> <p>"back" side of her right heel caused by propelling her self in her wheel chair and her shoes not fitting well. The WN stated the resident's record did not document the resident's shoes had been assessed to ensure they fit properly. The WN stated the resident had an appointment for diabetic shoes on 6/26/14. The surveyor expressed concern the resident's care plan had not been revised to include preventative measures after the pressure ulcer on 3/27/14.</p> <p>On 6/11/14 at 1:25 p.m. the ADON, WN, and the Administrator met with the surveyor. The ADON stated there was no documentation the resident's shoes were assessed on admit but as a diabetic Resident #7's shoes should have been assessed to ensure they fit properly. The ADON stated the preventative measure to prevent a future wound on the resident's heel was diabetic shoes, and an appointment to pursue diabetic shoes was in progress. The ADON stated he realized the resident's CP had not been revised to include a preventative intervention after the pressure ulcer on 3/27/14.</p>	F 314		
F 318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 318		

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 318	<p>Continued From page 16</p> <p>Based on record review, staff and resident interview, it was determined the facility failed to ensure the provision of ROM (range of motion) services for 2 of 9 (#5 &amp; 8) residents sampled for ROM. The deficient practice had the potential to cause more than minimal harm when residents with extremity weakness were not provided exercises to promote strengthening of the extremities. Findings included:</p> <p>1. Resident #8 was readmitted to the facility on 4/10/14, with diagnoses that included Multiple Sclerosis, and muscle weakness.</p> <p>The resident's quarterly MDS dated, 4/17/14 documented: *BIMS score: 11, cognition moderately impaired. *Rejection of cares: Did not occur. *Limitation of range of motion: Upper extremity, impairment on one side. Lower extremity, impairment on both sides.</p> <p>The resident's Physician Recapitulation orders dated, 6/5/14 documented: **PT [Physical therapy] Clarification Order: Pt. [patient] to be seen 3 x/week until 5/13/14 for there[apy] ex[ercise], there[apy] act[ivity], manual therapy, and modalities prn [as needed]. Diagnosis: muscle weakness and lack of coordination secondary to 427.31 [Atrial Fibrillation] and 599.0 [Urinary tract infection], in order to decrease dependence upon caregivers. Pt. [patient] will transition to restorative therapy on 5/13/14."</p> <p>On 6/11/14 at 2:50 pm, the Restorative Nurse Aide (RNA) was asked if the resident was receiving the facility's restorative program. The RNA replied, "No she is not" in the program.</p>	F 318	<p>F318- Increase/Prevent Decrease in Range of Motion</p> <ol style="list-style-type: none"> <li>1.) Resident #5 and #8 were placed on a restorative program to provide exercises to promote strengthening of extremities.</li> <li>2.) All residents with limited range of motion have the potential to be affected.</li> <li>3.) All patients will be screened by therapy on the joint mobility evaluation tool quarterly to assess range of motion. Residents will be reviewed for the need of therapy or restorative program at that time. Once therapy screens have been completed, recommendations will be given to the ADON. ADON will ensure that the recommendations are followed and residents are placed in an appropriate ROM program.</li> </ol>	

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 318	<p>Continued From page 17</p> <p>On 6/11/14 at 4:25 pm, the resident was asked if the facility provided a ROM program for her. The resident stated, "Yes, they do." The resident was asked when the program was provided, and she stated, "I don't know, I just know they do movements with me."</p> <p>On 6/12/14 at approximately 3:20 pm, the DON was interviewed and was asked if the resident was being provided a ROM program. The DON stated, "She is not on a restorative program at this time."</p> <p>2. Resident #5 was readmitted to the facility on 11/11/13 with diagnoses that included acute Osteomyelitis.</p> <p>The resident's quarterly MDS dated 4/29/14, documented: *BIMS score: 15, cognition intact. *Limitation of ROM: Lower extremity, impairment on both sides.</p> <p>The resident's care plan, documented: *Focus: "Requires assistance for mobility with need for total 2 person assist for transfers and 2 person extensive w [with] /bed mobility. Currently nonambulatory." Date initiated: 5/7/13 Revision on: 6/9/14. *Goals: "Will have no complications r/t [related to] impaired mobility through review date." Date initiated: 5/7/13 Target date: 7/28/14. *Interventions: "Supervise/ provide active/passive range of motion exercises." Date initiated: 5/7/13.</p> <p>On 6/10/14 at approximately 10:30 AM, the resident was asked if he was receiving any type of exercise therapy. The resident stated, "When I</p>	F 318	<p>4.) Director of rehab will audit therapy screens for accuracy and recommendations once a week for 4 weeks then monthly for 4 months. DNS will audit therapy recommendations to ensure residents are placed in a proper ROM program weekly for 4 weeks then monthly for 4 months. Audits to begin July 7, 2014. Report to QA monthly.</p> <p>5.) Date of compliance July 14, 2014</p>	

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)
F 318	Continued From page 18 first came here I had therapy, but haven't had any since it ran out." The resident was asked if the CNA's do any exercises with him. The resident stated, "No, no one is doing therapy with me."  On 6/11/14 at approximately 2:50 PM, the RNA was asked if the resident was on a restorative program. The RNA stated, "He is not. I do not know if PT works with him or not."  On 6/12/14 at approximately 12:00 PM, the DON was interviewed and was asked why the resident was not on a ROM program. The DON stated, "We were waiting for the wounds to heal. We did not want rubbing and movement of his coccyx until they were healed."  On 6/12/14 at approximately 5:30 PM, the Administrator, DON and ADON were informed of the findings. No additional information was provided.	F 318	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced	F 328	

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 328	<p>Continued From page 19</p> <p>by:</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents who used oxygen received the liter flow as ordered by the physician and that care plans and physician order identified the same liter flow rates. This was true for 3 of 8 residents sampled for oxygen therapy (#s 2, 4, &amp; 10). This created the potential for harm, should residents receive oxygen therapy at different concentrations than ordered by the physician. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 10/9/13 with multiple diagnoses including muscle weakness and hypertension.</p> <p>The resident's Physician's Order dated 10/9/13 documented, "Oxygen [at] 3 L[iters] [per] min[ute] via N/C [nasal cannula]..."</p> <p>The resident's care plan dated 10/18/14, documented a focus of, "Has oxygen Therapy r/t [related to] periods of SOB [shortness of breath] with hx [history] of CHF [congestive heart failure] and COPD [chronic obstructive pulmonary disease]" and an intervention of, "Oxygen Settings: O2 at 3 liters via nasal cannula continuously."</p> <p>On 6/10/14 at 8:30 AM, 11:22 AM, and 2:30 PM, the resident was observed in her room with a N/C on and the oxygen concentrator set at 2.5 liters.</p> <p>On 6/10/14 at 2:37 PM, LN #9 was asked to observe the liter flow on the resident's oxygen concentrator and she stated, "I would say 2.5 [liters]." LN #9 then looked in the resident's MAR, said the order was for 3 liters and stated, "She</p>	F 328	<p>F328-Treatment/Care for Special Needs</p> <ol style="list-style-type: none"> <li>1.) Residents #2, 4 and 10 oxygen liter flow was immediately adjusted to the physician's order liter flow.</li> <li>2.) All residents that receive oxygen have the potential to be affected.</li> <li>3.) All residents that receive oxygen will have stickers placed on their concentrators that indicate the physician's order for oxygen liter flow rate. The charge nurse or licensed nurse directing the patient's care will update the stickers if the physician's order changes. Licensed staff will assess the liter flow to ensure it is set at the proper liter flow.</li> <li>4.) DNS or RN designee will audit oxygen liter flow 3 x per week for 2 weeks, then once a week for 4 weeks, then monthly ongoing. Audits to begin July 7, 2014. Reported to QA monthly.</li> <li>5.) Date of compliance July 14, 2014.</li> </ol>	

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	
F 328	<p>Continued From page 20</p> <p>needs to be bumped up a little." LN #9 was then observed in the resident's room adjusting the concentrator.</p> <p>On 6/11/14 at 9:42 AM, the resident was observed in her room with a N/C on with the oxygen concentrator set at 3 liters.</p> <p>2. Resident #10 was readmitted to the facility on 6/28/13 with multiple diagnoses including unspecified myalgia and myositis.</p> <p>The resident's June 2014 Physician's Order Summary Report (recapitulation orders) signed on 6/6/14, documented, "O2 2L Keep Sat[uration]s greater than 88% Per NC..."</p> <p>On 6/11/14 at 4:40 PM and 6/12/14 at 9:10 AM, the resident was observed in her room with a NC on with the oxygen concentrator set at 1.5 liters.</p> <p>On 6/12/14 at 9:30 AM, LN #10 was asked to observe the liter flow on the resident's oxygen concentrator and she said it was bouncing between 1.5 to 2 liters and stated, "It's suppose to be at 2 [liters]." LN #10 then adjusted the liter flow and stated, "It's set at 2 [liters] now."</p> <p>3. Resident #2 was admitted to the facility on 3/18/11 and readmitted on 2/18/14 with diagnoses which included mastoiditis, depression and muscle weakness.</p> <p>The resident's 2014 Physician's Order Summary Report, signed on 6/5/14 included an order for, "O2 at 3 liters to keep Sats greater than 88%."</p> <p>The resident's 10/30/13 Care Plan for oxygen therapy documented in the intervention section, "Oxygen settings: titrate up to 4 liters....to keep</p>	F 328		

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

PRINTED: 06/23/2014  
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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE	
F 328	Continued From page 21 saturations above 90%." <p>On 6/11/14 at 2:10 p.m. the DON was informed the Care Plan was different than the Physician orders for oxygen. The DON stated the Care Plan had the standing orders for the facility.</p>	F 328			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews it</p>	F 329	F329-Drug regimen is free from unnecessary drugs <p>1.)</p> <p>a. Resident #2 and 11 medication regimen was reviewed by the pharmacist and the physician. Documentation for the benefits vs. the risks was placed in resident #2 and 11 chart. Medication regimen was not changed as the physician believes the benefits outweighed the risks in these patients. The risks and benefits for these medications were discussed with the residents and their families and they agreed to continue with the current medication regimen.</p>		

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 329	<p>Continued From page 22</p> <p>was determined the facility failed to ensure residents did not receive unnecessary medications. This was true for 3 of 9 sampled residents (#s 2, 7 and 11). The facility failed to:</p> <ul style="list-style-type: none"> <li>*Ensure medication regimens were evaluated for the need for duplicate therapies (#2 and #11),</li> <li>*Ensure appropriate indications and monitoring for the use of psychotropic medications (#s 2, 7 and 11),</li> <li>*Identify non-pharmacological interventions (#11.)</li> </ul> <p>These failures created the potential for harm should the medication regimen result in an unanticipated decline or newly emerging or worsening symptoms. Findings included:</p> <ol style="list-style-type: none"> <li>1. Resident #2 was admitted to the facility on 3/18/11, hospitalized and readmitted on 2/18/14 with diagnoses which included major depression with psychosis.</li> </ol> <p>Resident #2's 6/5/14 Physician Order Summary Report included orders for:</p> <ul style="list-style-type: none"> <li>*Trazodone HCL (antidepressant) 100 mg at bedtime for sleep,</li> <li>*Risperdal (antipsychotic) 0.5 mg for depression (mood), and</li> <li>*Sertraline HCL (antidepressant) 100 mg for depression.</li> </ul> <p>All of the medications had a start date of 2/19/14.</p> <p>Note: The Nursing 2015 Drug Handbook, 35th edition, states the indications for use of Risperdal include schizophrenia, Tourette's syndrome and obsessive-compulsive disorder.</p> <p>On 6/11/14 at 2:10 p.m. the DON was asked about the use of Risperdal for depression. The DON stated the facility became aware of the</p>	F 329	<ol style="list-style-type: none"> <li>b. Indications for the use of psychotropic medications for residents #2, 7 and 11 were reviewed with the physician, resident and family. Target behaviors were identified and updated on the behavior monitoring sheets.</li> <li>c. Care plans for resident #11 were updated to include non-pharmacological interventions to help reduce target behaviors in addition to or in place of medications.</li> </ol> <p>2.) All residents that receive psychotropic medications have the potential to be effected.</p> <p>3.)</p> <ol style="list-style-type: none"> <li>a. A licensed pharmacist will review the complete medication regimen of each resident each month to ensure duplicate drug therapy is avoided when appropriate and that appropriate indications for the use of the medications are in place, monthly ongoing.</li> </ol>	

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

PRINTED: 06/23/2014  
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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 23</p> <p>issue about 1 week prior and had requested a change in the diagnosis from the physician. (The following day the DON provided a phone order which included in the order summary, "Risperdal....give 0.5 mg by mouth at bedtime for Psychosis and delusions..." signed and dated on 6/12/14.) The DON was asked if the facility had looked at the risk and benefits for the use of 2 antidepressants and if the physician had provided justification for the need for the dual therapy. The DON stated the Trazodone was used for insomnia, but the facility did not provide documentation the duplicate therapy had been evaluated for risks and benefits.</p> <p>2. Resident #7 was admitted to the facility on 11/4/13 with diagnoses which included chronic kidney disease, altered mental status, and senile dementia.</p> <p>Resident #7's 6/5/14 Physician Order Summary Report included an order for Quetiapine Fumarate (antipsychotic) 150 mg daily for psychosis with a start date of 11/4/13.</p> <p>The resident's 11/12/13 Care Plan for psychotropic medications related to "end stage Alzheimer's with psychosis" included the following interventions: *Administer medications and monitor side effects and effectiveness, *Educate resident, family about risks and benefits. *Monitor behaviors of "target behavior symptoms (specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, yelling out and etc.)"</p>	F 329	<p>b. Facility clinical resource or RN designee will audit a sample of 5 residents that receive psychotropic medications to ensure there is no duplicate drug therapy. If there is duplicate drug therapy, the resource will audit to make sure there is documentation to justify the duplicate therapy in the resident's clinical record. Resource will also audit resident's care plan to ensure target behaviors are identified and non-pharmacological interventions are in place. Audits will be done once a week for 4 weeks then once a month for 3 months. Audits to begin July 7, 2014.</p>		

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 329	<p>Continued From page 24</p> <p>The 5/2014 and 6/2014 "Behavior Monthly Flow Sheet" (BMFS) documented behaviors of yelling and restlessness.</p> <p>On 6/11/14 at 1:30 p.m. the DON stated the BMFS did not document all of the behaviors included in the Care Plan. When asked what the signs and symptoms of the resident's psychosis were, the DON stated the resident was fearful of things she saw and would yell out and would refuse care. The surveyor asked about the disrobing and wandering behaviors. The DON stated the resident had a history of those behaviors.</p> <p>3. Resident #11 was admitted to the facility on 5/6/14 with diagnoses which included closed fracture and senile dementia.</p> <p>The resident's 6/5/14 Physician Order Summary Report included orders for: *Seroquel (antipsychotic) 50 mg for psychosis (start date of 5/19/14), *Haloperidol (antipsychotic) 1 mg for psychosis (start date 5/19/14) and *Ativan (anxiolytic) 1 mg as needed for anxiety (start date of 5/17/14).</p> <p>The resident's Care Plan for Psychotropic medication use related to anxiety, racing thoughts, restlessness and mood changes included behaviors of aggression towards others, anxiety, agitation, rejecting cares and abusive language. It was unclear how racing thoughts would be observed/monitored or how restlessness was displayed (fidgeting, wandering etc.). Interventions included to administer medications, educate the resident on risk/benefits, provide opportunities to express fears and to monitor the identified behaviors.</p>	F 329	<p>c. Care plans will be updated with any change in the resident's condition or change in the resident's psychosocial condition. Care plans will be reviewed at least quarterly to make changes and ensure current interventions are still meeting the resident's needs. The resident and their family members will be included in the process of identifying the resident's target behaviors and non-pharmacological interventions that will help the resident and potentially reduce the use of these medications.</p> <p>4.)</p> <p>a. The director of nursing will audit the licensed pharmacist's review</p>	

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  06/13/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 329

Continued From page 25

Note: The Care Plan did not include that the resident had delusions/hallucinations.

The BMFs documented behaviors of hitting/kicking, abusive language, and delusions/hallucinations (which were not identified in the Care Plan). The Care Plan identified racing thoughts but did not identify if abusive language, rejecting cares etc. were symptoms of the racing thoughts or anxiety. Additionally the Care Plan did not include what triggered the resident's behaviors.

On 6/12/14 at 12:05 p.m. the Social Worker (SW) stated the resident had delusions of being held prisoner at a hospital which were stressful to him. The SW also stated the resident resisted cares by hitting and kicking at staff. The SW stated the resident did not have hallucinations only delusions, but the delusions were not identified in the care plan. The surveyor also noted there was no justification for the use of dual therapy (2 antipsychotics) and the care plan did not include non-pharmacological interventions. The SW stated she usually included non-pharmacological interventions, but had "missed" it on this care plan.

F 333  
SS=D

The Administrator, DON and ADON were informed of these concerns on 6/13/14 at 10:00 a.m. The facility provided no further information.  
483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of any significant medication errors.

F 329

b. The IDT, which includes the facility medical director, a licensed pharmacist, the director of nursing and the facility social worker, will review all psychotropic medications quarterly to ensure appropriateness of medications, provide documentation when duplicate therapy is needed, identify specific target behaviors for individual residents and identify specific non-pharmacological interventions for each individual resident.

c. The facility social worker will audit resident's care plans to ensure current target behaviors are identified and on the behavior monitoring sheets. Non-pharmacological interventions will also be audited to ensure they are on the resident's care plan. Audits will be completed 3 days a week for 4 weeks, then weekly for 4 weeks, then monthly for 2 months. Audits to begin July 7, 2014.

F 333

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE	
F 333	Continued From page 26  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview it was determined the facility failed to ensure 1 random resident (#16) received an accurate dose of a hypertension medication. The deficient practice had the potential to cause more than minimal harm when LN #8 prepared to administer 3 times the dosage of Nifedipine, a hypertension medication, to the resident. Findings included:  Resident #16 was admitted to the facility on 5/20/14 with diagnoses that included hypertension.  The resident's Physician Recapitulation orders dated 6/5/14, documented: "Nifedipine capsule 20 mg [milligrams]. Give 3 capsules by mouth one time a day for HTN [hypertension]."  The resident's medication dispensing bubble pack documented: **"Nifedipine 60 mg ER[extended release] tab[let]". **"Take 1 tablet by mouth daily ***for: Hypertension."  On 6/12/14 at 10:00 AM, LN #8 was observed to perform the medication pass. LN #8 reviewed the resident's MAR. LN #8 was observed to dispense 3 tablets from the Nifedipine 60 mg ER bubble pack into the medication cup with the resident's other medications. When LN #8 had all the resident's medications ready to administer and prepared to walk into the resident's room, the surveyor stopped LN #8 and reviewed the bubble pack with her. LN#8 stated "It's an ER tablet."	F 333	F333- Residents Free of Significant Med Errors  1.) LN #8 was immediately educated on the 6 rights of medication administration. The pharmacy sent a new card of medication with proper label that matches the order on the medication administration record to reduce confusion.  2.) All residents receiving medications at the facility have the potential to be affected.  3.) All licensed nursing staff will be educated on July 9, 2014 on the 6 rights of medication administration. Medication cards will be compared to the medication administration record to ensure they match when the medication is delivered to the facility from the pharmacy.  4.) DNS or RN designee will audit medication cards randomly throughout the medication cart 3 x weekly for 2 weeks, then once a		

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 333	Continued From page 27 The surveyor stated giving the 3 tablets would make it 180 mg instead of 60 mg. LN #8 agreed and stated, "It should have said 20 mg give 3 tablets on here. I see exactly what you are saying." LN #8 took 2 of the tablets from the medication cup and proceeded into the resident's room to administer the medications.	F 333	week for 4 weeks, then monthly ongoing. Reported to QA monthly. DNS or RN designee will audit licensed nursing staff during medication pass to ensure they are following the 6 rights of medication administration 3 x weekly for 2 weeks, then once a week for 4 weeks, then monthly ongoing. Reported to QA monthly.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure food was prepared in a sanitary environment. This had the potential to effect any residents who ate meals in the facility including 13 out of 13 sampled residents (#s 1-13). Insufficient hand washing created the potential for cross-contamination and exposed residents to potential sources of pathogens. Findings included:  On 6/12/14 at 9:45 AM, during an observation of	F 371	5.) Date of compliance July 14, 2014. F371- Food Procure, Store/Prepare/Serve-Sanitary 1.) Dietary manger educated the dietary aide on proper hand washing techniques, education was provided on 6/13/14 2.) All patients that eat in the facility have the potential to be affected. 3.) Staff is to properly wash hands prior to handling food. In-service will be completed for all nutrition staff on proper hand washing procedures on 6/13/14. 4.) Weekly audit will be completed by the dietary manager to ensure proper hand washing techniques are being used. Audit to begin on 7/7/14 and will continue once weekly for two months. Results reported to QA. 5.) Date of compliance July 14, 2014	

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE	
F 371	Continued From page 28 the kitchen, Kitchen Aide #1 was observed to load dirty trays (returned from use in the dining room) into the dishwasher. Kitchen Aide #1 then washed his hands for less than 5 seconds and returned to remove the clean trays from the dishwasher. This was observed a second time and the Dietary Manager was asked to watch Kitchen Aide #1. The Dietary Manager observed the third time this occurred and stated that Kitchen Aide #1 had not washed his hands for 20 seconds as required. The Dietary Manager then informed the Aide he needed to wash his hands again for 20 seconds.  On 6/13/14 at 10:00 AM, the Administrator and DON were made aware of the kitchen concerns. No further information was received from the facility.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	F431- Drug Records, Label/Store drugs and Biologicals  1.) Resident #3's pain medication bubble pack was relabeled to reflect the accurate physician order. The medications for resident #17 were sent back to the pharmacy and the pharmacy sent new medication with the label stating the expiration date.  2.) All residents who receive medications in the facility have the potential to be affected.		

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 431	<p>Continued From page 29</p> <p>locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure 1 of 3 (<del>#1</del>, #3, <del>#7</del>) sampled resident and 1 of 3 (<del>#16</del>, <del>#18</del>, <del>#19</del>) random residents medications were labeled in a safe manner. The deficient practice had the potential for more than minimal harm when Resident #3's pain medication's bubble pack was labeled inaccurately and there was the potential for the resident to receive less pain medication than was ordered to control her pain. Resident #17 had a prescribed medication that did not have an expiration date on it, which had the potential to be given to the resident after it was expired and the resident would not get the full benefits of the medication. Findings included:</p> <p>1. Resident #3 was readmitted to the facility on 1/8/14 with diagnoses that included Multiple Sclerosis (MS).</p>	F 431	<p>3.)</p> <p>a. Medication cards will be compared to the medication administration record to ensure they match when the medication is delivered to the facility from the pharmacy.</p> <p>b. Medications will be assessed by a licensed nurse when they are delivered from the pharmacy to ensure they have an expiration date.</p> <p>4.)</p> <p>a. DNS or RN designee will audit medication cards for accurate labeling to match physician orders. Audits will be done randomly throughout the medication cart 3 x weekly for 2 weeks, then once a week for 4 weeks, then monthly ongoing. Reported to QA monthly.</p>	

Changes made with administrator  
via phone on 7/31/14 at 10:20am  
J. A. A. A.

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 30</p> <p>The resident's physician recapitulation orders dated 6/5/14, documented: **Hydrocodone-Acetaminophen [Hydroco/APAP] Tablet 5-325 mg.[milligram] Give 5.325 mg by mouth four times a day for two tabs[let] every 6 hours for chronic pain d/t [due to] MS."</p> <p>The resident's medication bubble pack for Hydroco/APAP, documented: **Hydroco/APAP 5-325 mg tab[let]. Take 1-2 tablets every six hours *** for pain."</p> <p>On 6/12/14 at approximately 11:15 AM, the DON was interviewed and verified the discrepancies of the medication bubble pack and the Physician order.</p> <p>2. Resident #16 was admitted to the facility on 5/20/14 with diagnoses that included hypertension and chronic kidney disease (CKD).</p> <p>The resident's physician recapitulation orders dated 6/5/14, documented: **Fosrenol Tablet chewable (Lanthanum Carbonate). Give 750 mg by mouth four times a day for CKD."</p> <p>On 6/12/14 at approximately 10:00 AM, LN #8 was observed to administer medications to Resident #16. The surveyor checked the Fosrenol bottle after LN#8 had dispensed the medication into the medication cup. The bottle did not have an expiration date on it. The surveyor asked LN #8 how she would know if the medication was expired. LN #8 replied, "It is suppose to be written right on it." LN #8 verified the bottle did not have an expiration date.</p> <p>On 6/12/14 at approximately 5:30 PM, the</p>	F 431	<p>b. DNS or RN designee will audit medications for expiration dates randomly throughout the medication cart 3 x weekly for 2 weeks, then once a week for 4 weeks, then monthly ongoing. Reported to QA monthly.</p> <p>5.) Date of compliance July 14, 2014</p>		

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)
F 431  F 441 SS=D	<p>Continued From page 31 Administrator, DON and ADON were informed of the findings. No additional information was provided.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and</p>	F 431  F 441	<p>F441- Infection Control, Prevent Spread, Linens</p> <ol style="list-style-type: none"> <li>1.) Activity director was immediately educated on proper hand washing prior to serving food or drinks in the dining room. Bedpan was immediately discarded and a new bed pan was hung in the resident's bathroom in a plastic bag. Staff will be educated on July 9, 2014 on proper storage of bedpans and proper hand washing while in the dining room.</li> <li>2.) All resident's who are served food or uses a bedpan have the potential to be affected.</li> <li>3.) Staff will appropriately wash their hands prior to rendering assistance to patients in the dining room. Bedpans will be stored hanging in the bathroom contained in a plastic bag.</li> </ol>

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 32</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff performed hand washing in an accepted professional manner while assisting residents with meals. Also, a bedpan was not stored appropriately when found on the bathroom floor. This effected 2 of 13 (#'s 2 and 6) sampled residents and one random resident (#17). Failure to follow standard infection control measures placed the residents at risk for infections. Findings included:</p> <p>1. On 6/11/14 at 5:15 pm, the Activity Director was observed entering the dining room and adjusting the hair on her head with both hands. She then obtained two cups of coffee, grabbing the mugs with both hands near the rim area and placed them in front of Resident #6 and #17. She also tore open a package of dry coffee creamer with both hands and handed it to Resident #6. Throughout the entire observation, the Activity Director was not observed to wash her hands.</p> <p>On 6/11/14 at 5:20 pm, the Activity Director was asked if she washed her hands prior to obtaining the coffee mugs and she stated, "I sure did not."</p> <p>2. On 6/9/14 at 2:45 pm, Resident #2's bathroom was observed and a bedpan was found lying on the floor surface with half of the bedpan in an overturned wash basin and the other half in direct contact with the floor surface.</p>	F 441	<p>4.) Administrator will audit proper hand washing technique 3 x weekly for 4 weeks then once weekly for 2 months. Audits to begin July 7, 2014. Administrator will audit bedpan storage 3 x weekly for 4 weeks then once weekly for 2 months.</p> <p>5.) Date of compliance July 14, 2014</p>		

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  06/13/2014
NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETION DATE
F 441	<p>Continued From page 33</p> <p>On 6/9/14 at 2:50 pm, Housekeeper #1 was shown the bedpan and she stated, "it needs to be bagged and put somewhere else."</p> <p>On 6/11/14 at 9:40 am, CNA #2 was interviewed and was asked if the resident used the bedpan and she said the resident used the bedpan at night.</p> <p>On 6/12/14 at 5:10 pm, the Administrator and DON were informed of the findings. No additional information was provided.</p>	F 441		

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  06/13/2014
--	---	--	--

NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Susan Gollobit RN, Team Coordinator Judy Atkinson RN, Sherri Case, LSW, QMRP Brad Perry BSW, LSW.</p> <p>The survey team entered the facility on 6/9/14 and exited on 6/13/14.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed ADON=Assistant director of Nursing</p>	C 000		
C 125	<p>02.100,03,c,ix Treated with Respect/Dignity</p> <p>ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F 241 relaed to dignity and resident.</p>	C 125	<p>Please refer to F241 plan of correction.</p>	

**RECEIVED**  
JUL 31 2014  
FACILITY STANDARDS

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE  
*Executive Director*

(X6) DATE  
7-3-14

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  06/13/2014
--	---	--	--

NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETE DATE
C 125	Continued From page 1 individuality.	C 125		
C 671	02.150,03,b Handling Dressings, Linens, Food  b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Refer to F441 related to hand hygiene and bedpan storage.	C 671	Please refer to F441 plan of correction.	
C 782	02.200,03,a,iv Reviewed and Revised  iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 regarding care plans not revised.	C 782	Please refer to F280 plan of correction.	
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 care.	C 784	Please refer to F309 plan of correction.	
C 789	02.200,03,b,v Prevention of Decubitus  v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or	C 789		

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  06/13/2014
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

C 789	Continued From page 2  wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F 314 related to pressure sore prevention not care planned.	C 789	Please refer to F314 plan of correction.	
C 796	02.200,03,b,xii Rehabilitative Nursing Standards  xii. Rehabilitative nursing current with acceptable professional practices to assist the patient/resident in promoting or maintaining his physical functioning. This Rule is not met as evidenced by: Refer to F 318 related to Range of Motion for residents.	C 796	Please refer to F318 plan of correction.	
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders  04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following:  a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Please refer to F328 as it relates to oxygen administration in accordance with physician order. See F333 for Significant medication error.	C 798	Please refer to F328 plan of correction.   Please refer to F333 plan of correction.	
C 821	02.201,01,b Removal of Expired Meds  b. Reviewing all medications in the	C 821		

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  06/13/2014
--	---	--	--

NAME OF PROVIDER OR SUPPLIER  GATEWAY TRANSITIONAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, 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)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

C 821	Continued From page 3  facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days.  This Rule is not met as evidenced by: refer to F431 for medication without expiration date, and labeled accurately.	C 821	Please refer to F431 plan of correction.	
-------	--	-------	--	--