



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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October 21, 2014

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

FILE COPY

Provider #: 135011

Dear Mr. Farnsworth:

On **August 26, 2014**, a Complaint Investigation survey was conducted at Gateway Transitional Care Center. Susan Gollobit, R.N. and Amy Barkley, R.N. conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006594

ALLEGATION #1:

The responsible party (RP) stated the resident was admitted to the facility on February 10, 2014, and the RP told the "main nurse" they needed to "watch him closely because he kept trying to get up and walk."

FINDINGS #1:

During the investigation, the resident's record was reviewed, and the DoN and ADoN were interviewed.

The resident was admitted to the facility on February 5, 2014. A resident's Fall Risk Assessment was completed on the day the resident was admitted, which placed the resident at moderate risk

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for falls. The facility was aware the resident had fallen prior to arrival at the facility and had an admission care plan in place related to falls to keep the resident safe. The night shift nurse's note written for February 5, 2014, documented the resident was confused, and the bed was in low position with mats in place on the floor next to the bed.

The allegation was substantiated but not cited as the resident was a moderate risk for falls, but the facility put measures in place upon admission to the facility.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

The RP stated she was told by the CNA caring for the resident that the resident had fallen out of bed twice on February 10, 2014, and twice out of the wheelchair that morning.

FINDINGS #2:

During the investigation, the resident's chart was reviewed, the facility's Incident and Accident reports for the month of February were reviewed and the DoN and ADoN were interviewed.

The resident had one Incident and Accident report dated January 6, 2014, which documented the resident had slid out of his wheelchair by the nurses' station. The resident stated he was "getting the trucks." On August 26, 2014, the DoN and ADoN clarified the report was for February 6, 2014, as the resident was not in the building in January. The DoN and ADoN verified this was the only fall the resident had while in the facility. A nurse's note written on February 6, 2014, documented the resident had slid out of the wheelchair. There were no other falls documented in the resident's record.

The allegation was not substantiated due to lack of evidence that the resident had more than one fall while in the facility.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The RP reported the RP was not notified when the resident fell.

FINDINGS #3:

The resident slid from the wheelchair on February 6, 2014. The Incident and Accident form completed on that day documented the fall at 8:10 a.m., and the family was notified at 9:40 a.m.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The RP alleged the facility did not check on the resident to see if any bones were broken after the falls. "They didn't think his falls were serious and I had to force it, sending him to the ER."

FINDINGS #4:

The resident's chart was reviewed, and the Incident and Accident report for a fall on February 6, 2014, was reviewed. The Incident and Accident report and the nurse's note documented the resident was assessed for pain, bone deformities and vital signs taken, which included a blood sugar. The resident was assisted back into his wheelchair by staff with use of a Hoyer lift. The resident began having an increase in pain and was taken to the local hospital's Emergency Room for treatment.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The RP stated the resident was hospitalized because his left hip/femur was fractured. The resident could not have surgery because of an infection around his catheter and because he was elderly. The resident went home on Hospice.

FINDINGS #5:

The facility's and hospital's records were reviewed for the resident. The resident was admitted to the Emergency Room on February 6, 2014, the day the resident fell in the facility. In the Emergency Room, the resident was diagnosed with a right minimally displaced hip fracture. The resident was admitted to the hospital and discharged on February 10, 2014, with the final diagnosis of right hip fracture with non-operative management on transfer to Hospice.

The resident was hospitalized with a right hip fracture, which probably occurred at the time the

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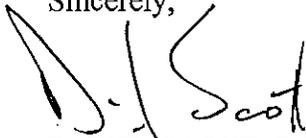
resident slid out of the wheelchair and landed on the floor. Surgery was not performed on the resident, and the resident went home on Hospice. The facility was not cited as they identified that the resident was a moderate risk for falls, the resident had falls before coming in the facility and the facility had a plan in place to keep the resident as active as possible, as well as safe. The resident was in his wheelchair near the nurses' station when he slid out of the wheelchair and landed on the right side.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

As some of the complaint's allegations were substantiated, but not cited, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

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

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

DS/dmj



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527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Farnsworth:

On **August 26, 2014**, a Complaint Investigation survey was conducted at Gateway Transitional Care Center. Amy Barkley, R.N. and Susan Gollobit, R.N. conducted the complaint investigation.

The following documents were reviewed:

- The identified resident's closed record along with the complete records of four other sampled residents;
- Discharge Summaries for three sampled residents;
- Grievances from February 2014 through August 2014;
- Incident/Accident Reports from February 2014 through August 2014;
- Admissions, Transfers, and Discharges from February 2014 through August 2014;
- The facility's Policies and Procedures for falls and notification of physician and/or responsible party;
- The hospital admission record for July 28, 2014; and
- The X-ray, Cat Scan (CT) and MRI results for July.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006611

ALLEGATION #1:

The complainant stated the identified resident fell and hit his/her head at the facility. The facility told the complainant the resident did not sustain any injuries, but he/she was taken to the hospital the next day and admitted.

FINDINGS #1:

The complaint covered the admission date of June 30, 2014 to July 28, 2014.

Grievances were reviewed and did not document concerns related to resident's falls.

The Incident Report, dated July 27, 2014, was reviewed and documented the resident was in the dining room, attempted to stand up, tripped over his/her wheelchair foot pedals and fell to the floor.

The resident's Progress Note dated July 27, 2014, documented the resident was noted to have a bruise to his/her left forehead. The resident's oxygen saturation at the time of the fall was eighty-five percent on room air. The facility applied oxygen to the resident, per facility protocol, and the resident's oxygen saturation increased to ninety-seven percent. The medical doctor and the family were notified of the new plan for the resident.

The resident's Progress Note dated July 28, 2014, documented the resident had been lethargic, and the facility called the physician to request a Magnetic Resonance Imaging (MRI). The physician instructed the facility to transport the resident to the Emergency Room for evaluation.

On July 28, 2014, the following Cat Scans and x-rays were taken:

The Cervical Spine Cat Scan documented "No cervical spine fracture."
The Head Cat Scan documented "No hemorrhage is identified."; and
The shoulder x-ray documented "Degenerative changes without humeral fracture..."

The resident's admission note dated July 28, 2014, documented the resident was admitted for observation related to altered mental status, and his/her condition was stable.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant was concerned that the physician was not notified in a timely manner after the

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resident fell.

FINDINGS #2:

The Incident and Accident report dated July 27, 2014, documented the physician was notified of the resident's fall at 6:20 p.m., and the complainant was notified at 7:40 p.m.

The Progress Notes dated July 27, 2014, documented the incident report was completed, medical doctor notified and the complainant notified and informed of the updated plan for the resident.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated on the day the resident fell, the complainant observed the resident wearing oxygen, which was new for the resident.

FINDINGS #3:

The facility's standing orders for administration of oxygen were:

- Oxygen at two liters per minute via nasal cannula as needed for oxygen saturations less than ninety percent on room air;
- Titrate to keep oxygen saturations greater than ninety percent; and
- Call physician if needing greater than five liters a minute.

Progress Notes dated July 27, 2014, documented the resident had an oxygen saturation of eighty-five percent on room air; therefore, oxygen was applied at two liters via nasal cannula. The resident's oxygen saturation increased to ninety-seven percent with the oxygen.

The resident's oxygen saturations at the Emergency Room on July 28, 2014, from 5:00 p.m. to 7:00 p.m. documented the resident's oxygen saturation was between ninety-four and ninety-five percent on room air.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant was concerned the identified resident was dropped off at the Emergency Room

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without report from the facility staff as to why the resident was there.

FINDINGS #4:

The facility's revised policy, dated May 2007 related to transferring resident's out of the facility documented the following:

Contact 911/EMS Transport;
Contact primary care physician;
Send only personal items; and
Document the entire process in the nursing notes

The Director of Nursing was interviewed on August 26, 2014, and stated the identified resident was transported to the hospital via ambulance due to his/her decreased level of consciousness. She stated it is the facility's policy to give a report to the paramedics/emergency medical technicians and then a call to the hospital. The resident's face sheet, advance directives, current physician's orders, history and physical and pertinent labs/x-rays are sent in a packet with the resident. The Director of Nursing stated the paramedics also call en-route to the hospital and give a report on the resident.

Three other residents', who were discharged from the facility to the hospital, records were reviewed. Each record documented the facility followed its policy and procedure related to transfers.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated he/she attempted to contact the administrator regarding his/her concerns about the resident, and he/she did not received a call back in a timely manner.

FINDINGS #5:

Six months of grievances were reviewed, which did not document any issues related to the administrator not addressing a resident's concerns in a timely manner or not returning phone calls to complainants.

On August 26, 2014, the Administrator was interviewed related to the grievance process for discharged residents. The Administrator stated he checks his voice mail every day and returns calls. He stated he listens to the complainant's concern(s), explains the investigation process and

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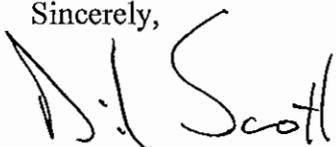
tells the complainant that he/she will receive a call based on the findings of the complaint. Then the administrator notifies the management team, which include Social Services, Director of Nursing, Assistant Director of Nursing, Unit Manager and any other department head involved. The Interdisciplinary Team discusses the complaint and each person is delegated the portion of the complaint that pertains to his/her department. The team meets after information is compiled and discusses if the incident was an isolated event, a system issue, a training opportunity or a breakdown in communication. The Interdisciplinary Team presents the issue to the Quality Assurance Program for continued monitoring until the issue is resolved. The administrator or designee will then contact the complainant with the facility's findings.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

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

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

DS/dmj