



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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July 8, 2016

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

Provider #: 135011

Dear Mr. Farnsworth:

On **June 24, 2016**, a 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. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 18, 2016**. Failure to submit an acceptable PoC by **July 18, 2016**, may result in the imposition of penalties by **August 5, 2016**.

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

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

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

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

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 29, 2016 (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 **September 22, 2016**. A change in the seriousness of the deficiencies on **August 8, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **September 22, 2016** includes the following:

Denial of payment for new admissions effective **September 22, 2016**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 21, 2016**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 22, 2016** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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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 18, 2016**. If your request for informal dispute resolution is received after **July 18, 2016**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



Nina Sanderson, LSW, Supervisor
Long Term Care

NS/pmt
Enclosures

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

PRINTED: 08/02/2016
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 06/24/2016
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 federal recertification and complaint survey conducted at the facility from June 20, 2016 to June 24, 2016. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Pietershanki, LSW Patricia Kurywka, RN Survey Definitions: ADON = Assistant Director of Nursing CC = Cubic Centimeter CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record PRN = As Needed TAR = Treatment Administration Record	F 000			
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced	F 167		7/11/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/14/2016

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

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F 167	Continued From page 1 by: Based on observation and visitor and staff interview, it was determined the facility failed to ensure the results of the most recent surveys were readily accessible to residents. This deficient practice was true for any resident or their representative or visitors who may want to review the survey results, including 13 of 13 sample residents (#s 1-13). Findings included: On 6/20/16 at 1:55 pm, a survey results binder was observed on the wall near the nurses' station in Hallway C. The binder contained the results of the last annual recertification survey, dated 6/13/14. The results of two complaint surveys, dated 1/27/15 and 2/11/15, were not located in the binder. On 6/21/16 at 9:10 am, the DON said he did not see the two complaint surveys in the binder. On 6/22/16 at 12:30 pm, Visitor A was observed to read the survey results, which also included the two newly placed complaint surveys. She said she had been visiting facilities and reading survey results in order to make a decision on where to find the right home for a family member. The complaint survey results were not available to Residents #1 - #13, or others who may wish to review the results.	F 167	1. Facility administrator placed both missing complaint surveys in the public survey folder located on C hall on 6/20/2016. Lead Surveyor observed that both surveys were placed into the binder. 2. This deficient practice was true for any resident or their representative or visitors who may want to review the survey results, including 13 of 13 sample residents. 3. The missing surveys were immediately placed in the public survey binder on 6/20/2016. Administrator/designee will ensure that the public survey binder is updated with all required surveys at all times. 4. Administrator/designee will monitor the public survey binder to ensure/audit all required surveys are maintained within the binder one time per week for one month, then monthly on-going. Audits to begin 6/29/2016. 5. Date of Compliance 6/29/2016		
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	F 309		7/11/16	

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F 309	<p>Continued From page 2 accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's hospice agreement, and staff and resident interview, it was determined the facility failed to ensure hospice communications were available for staff, and physician orders were clarified regarding catheter size and catheter balloon fill amounts. This was true for 1 of 2 (#11) residents reviewed for hospice care and 2 of 3 (#1 & #14) residents reviewed for catheters. This failure had the potential for more than minimal harm if residents did not receive appropriate services based on lack of coordination of hospice care or experienced pain due to improper catheter size or improper inflation of catheter balloons: Findings include:</p> <p>1. The facility's Hospice Agreement, dated 10/1/06, stated:</p> <p>"Documentation of Services. Both parties shall maintain appropriate documentation of services provided under this Agreement in accordance with applicable state and federal laws and regulations...Patient medical records and documentation maintained by each Party shall be available for review and inspection by the other Party..."</p> <p>Resident #11 was admitted to the facility on 9/20/14, with multiple diagnoses including dementia.</p>	F 309	<p>1. Facility contacted all PCP's by 6/29/2016 of affected residents with catheters to clarify the appropriate catheter size and balloon fill amount and ensured that this information/ orders are properly documented in the medical record.</p> <p>2. This deficiency has the potential to affect all residents that are receiving hospice services or have a current catheter.</p> <p>3. A. The hospice agencies involved were contacted on 6/24/2016 to provide the appropriate education regarding the importance of maintaining all hospice communication in the hospice binder at a weekly minimum. The facility ward clerk was educated on 6/24/2016 regarding the importance of auditing the hospice charts to ensure timely communication is maintained in the chart per federal regulation. DON/Designee will conduct a weekly meeting with facility ward clerks to ensure hospice communication is accurate, current and available to staff. DON/Designee will conduct a monthly meeting with hospice agencies that are providing services in the facility to ensure timely communication is provided to the</p>		

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F 309	<p>Continued From page 3</p> <p>Resident #11's 10/12/15 physician's orders documented an ongoing order for hospice services.</p> <p>Resident #11's hospice care plan documented an intervention, dated 7/15/15 of, "Work cooperatively with hospice team to ensure [Resident #11's] spiritual, emotional, intellectual, physical and social needs are met..."</p> <p>Resident #11's clinical record did not contain hospice visit notes from 5/21/16 to 6/22/16.</p> <p>On 6/23/16 at 11:35 am, LN #3 said she coordinated with hospice staff when they provided services for residents on hospice. She said if she did not receive a verbal update from the hospice staff, she would review hospice nurse and CNA visit notes.</p> <p>On 6/23/16 at 11:40 am, the DON said the hospice notes from 5/21/16 through 6/22/16 were just received from Resident #11's hospice agency and had not been available to staff until that morning.</p> <p>2. Resident #14 was admitted to the facility on 10/5/15 with multiple diagnoses, including neuromuscular dysfunction of the bladder.</p> <p>Resident #14's 10/6/15 physician's orders documented, "Change suprapubic catheter monthly and PRN every... every 30 day(s)..."</p> <p>Resident #14's 10/9/15 physician's progress note documented, "She has had several incidents of catheter pulling, which has increased tissue</p>	F 309	<p>facility and is available.</p> <p>B. DON/Designee will identify and clarify with resident PCP appropriate catheter size and balloon fill amount upon admission or for any new catheter order.</p> <p>4. A. DON/Designee will audit all hospice communication to ensure that timeliness and accuracy is maintained with hospice communication 2 x week for 4 weeks. Weekly thereafter continuous. B. DON/Designee will audit any resident with an order for a catheter to ensure that catheter size and balloon amount are specified and updated in EMR weekly x 4 weeks, monthly on-going or with any new order for catheter. Audits to begin 6/29/2016.</p> <p>5. Date of Compliance 6/29/2016.</p>		

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F 309	<p>Continued From page 4 damage in the past."</p> <p>Resident #14's October and November 2015 TARs documented the catheter was changed as ordered.</p> <p>On 6/23/16 at 3:30 pm, LN #4 said when changing a catheter she would determine the size of the catheter and how full to fill up the balloon with water by checking the size written on the order. LN #4 showed the surveyor various sizes of catheter packages in a storage room. Each package documented the size and how many CC's to fill the catheter balloon, which is inserted into the bladder.</p> <p>On 6/23/16 at 3:40 pm, the DON reviewed Resident #14's catheter order and said the order was not clear regarding the size or how many CC's of water were to be used to fill the balloon. The DON said the order should have been clarified.</p> <p>3. Resident #1 was initially admitted to the facility on 7/21/14, with diagnoses of quadriplegia, status post cervical fracture of the C7 vertebrae, and neuromuscular dysfunction of the bladder. Resident #1 was readmitted to the facility from the hospital on 3/5/16 post back surgery.</p> <p>Resident #1's annual MDS assessment, dated 8/8/15, and quarterly MDS assessment, dated 3/7/16, documented he had a BIMS of 15, did not ambulate, used a wheelchair for locomotion with the assistance of 1 person, and had a suprapubic catheter.</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>The 6/2016 Physician's Orders included an order to change the suprapubic catheter every month (every 30 days) on the night shift. The order did not specify the size of the catheter or the amount of water to be instilled to inflate the balloon of the suprapubic catheter.</p> <p>A Nurses' Progress Note, dated 6/1/16, did not include documentation of changing Resident #1's suprapubic catheter, the size of the suprapubic catheter that was inserted, or the amount of water instilled.</p> <p>Resident #1's 6/2016 TAR documented his suprapubic catheter was changed on 6/1/16. There was no note regarding the size of the catheter used or the amount of water instilled to inflate the balloon of the suprapubic catheter.</p> <p>Resident #1's record included a Care Plan for the Suprapubic Catheter, with the Focus Area Titled: "Has Suprapubic Catheter, Diagnosis Neurogenic Bladder at Risk for Incontinence." The goals were: Resident #1 will show no signs or symptoms of urinary infection through the review date, and Resident #1 will remain free from catheter related trauma through the review date. A Care Plan intervention documented to change the suprapubic catheter monthly and as necessary, however, the size of the suprapubic catheter and the amount of water to instill to inflate the balloon of the catheter were not documented.</p> <p>During an interview with Resident #1 on 6/23/16, at approximately 2:00 pm, he stated he may have an occasional small amount of leakage from the suprapubic catheter when he was having some</p>	F 309			

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F 309	Continued From page 6 spasms. In addition, he stated there had been no problems or pain when the suprapubic catheter was changed. LN #2 who changed the suprapubic catheter on 6/1/16, was not available for interview. During an interview on 6/23/15, at approximately 5:00 pm with LN #1, who said she took care of the resident in the past, stated if the physician's order did not specify what size catheter to use or the amount of water to instill, she would check the size of the catheter to be removed and instill the amount of water documented on the bulb connector of the suprapubic catheter. LN #1 also stated if the resident was complaining of pain or having a problem with leakage (unrelated to presence of spasms) or the suprapubic catheter was not draining, she would notify the physician and obtain an order for the size of the suprapubic catheter and the amount of water to instill to inflate the balloon of the suprapubic catheter. During an interview with the ADON on 6/24/16, at approximately 9:30 am, the ADON stated the Physician's Order documented for the month of 6/2016, did not include the size of the suprapubic catheter or the amount of water to instill to inflate the balloon of the suprapubic catheter. The ADON showed the surveyor several different sized catheters used as suprapubic catheters and said the amount to be instilled is listed on the catheter.	F 309			
F 431 SS=E	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	F 431		7/11/16	

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F 431	<p>Continued From page 7</p> <p>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.</p> <p>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.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in 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 and staff interview, the facility failed to ensure the safe and secure storage of drugs including narcotics and Schedule 2 controlled drugs in a locked storage</p>	F 431	<p>1. Facility purchased retractable key chains that are worn by the nurses. These devices allow the nurses to unlock and lock the med carts while keeping the</p>		

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F 431	<p>Continued From page 8</p> <p>area, and failed to permit only authorized personnel to have access to the keys. This created the potential for more than minimal harm to residents if they were to ingest the medications, and for diversion of medications by individuals present in the facility. Findings include:</p> <p>The medication cart on R Hall on 6/22/16 at 11:00 am, was observed to be was unattended with the keys left in the lock of the medication cart. The key to gain access to the medication cart and a separate/different key to gain access to narcotics and other controlled drugs in a locked drawer were kept on the same key ring holder. The medication cart was left in the hallway of R Hall near room 88, which was a few feet away from the R Hall doorway leading into the facility lobby. There were no residents, visitors, or staff observed in the R Hall at the time. After observing the medication cart continuously for 3 minutes, LPN #2 was observed walking at a rapid pace from the lobby to the medication cart, then removing the keys and locking the medication cart.</p> <p>During an interview with LN #2 on 6/22/16 at 11:05 am, LN #2 stated that she had left the medication cart to take a medication to a resident who was in the Physical Therapy/Occupational Therapy Department. LN #2 stated that she was away from the medication cart for approximately 3 minutes and that while she was in the therapy department she realized she left the keys in the lock of the medication cart when she reached into her pocket and the keys were not in her pocket. LPN #2 also stated the keys to the medication cart and the locked drawer were</p>	F 431	<p>keys attached to their person at all times.</p> <p>2. This citation has the potential to affect all residents that reside in the facility.</p> <p>3. Facility nurses were educated on the facility directive of using the retractable key chains while on shift. This key chain does not allow the nurse to walk away form the med cart without the keys attached to their person.</p> <p>4. DON/Designee will audit to ensure all med pass LN's are utilizing the retractable key chains while on shift, at all times daily x 2 weeks, 3 x week for 2 weeks then weekly thereafter. Audits will begin on 6/29/2016.</p> <p>Date of Compliance: 6/29/2016</p>		

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

PRINTED: 08/02/2016
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 06/24/2016
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	Continued From page 9 never to be left in the lock of the medication cart except when the nurse was pouring medications and if she had to leave the medication cart, the medication cart was to be locked and the keys removed. During an interview with the DON on 6/22/16 at approximately 1:00 pm, the DON stated the medication cart ws to be locked when unattended and the keys were never to be left in the lock.	F 431			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P. O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

July 25, 2016

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

Provider #: 135011

Dear Mr. Farnsworth:

On **June 24, 2016**, an unannounced on-site complaint survey was conducted at Gateway Transitional Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007225

Catheter care was observed for two residents. Meal trays were observed for fourteen residents during four meals.

The clinical record of the identified resident and thirteen other residents' records were reviewed for Quality of Care and Dietary concerns. The facility's Grievance file from June 2015 to June 2016 was reviewed. Resident Council minutes from March to May 2016 were reviewed.

Several individual residents and several residents in the Group Interview were interviewed for Quality of Care and Dietary concerns. Several nurses and the Director of Nursing were interviewed regarding catheter care concerns. The Dietary Manager was interviewed regarding Dietary concerns.

Allegation #1: The Reporting Party said nurses were not aware of how full to fill an identified resident's catheter balloon and a nurse temporarily overfilled it causing the resident pain.

Findings #1: The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from June 20, 2016 to June 24, 2016. The identified resident was no longer residing in the facility at the time the complaint was investigated.

Stephen Farnsworth, Administrator
July 25, 2016
Page 2 of 2

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F309.

Conclusion #1: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2: An identified resident's food choices were not honored and he/she was served foods which were contrary to the resident's diet and which upset the resident's stomach.

Findings #2: Fourteen residents' meal trays were observed for accuracy for food preference, correct diet choices and food allergies and no concerns were identified.

The identified resident's clinical record was reviewed for diet orders, food preference and food allergies and no concerns were identified. Ten other residents' records were reviewed for diet orders, food preference and food allergies and no concerns were identified. The facility's Grievance file and Resident Council minutes did not document concerns regarding food preferences.

Several individual residents and residents in the Group Interview did not have concerns with diet orders, food preference and food allergies. The Dietary Manager said diet orders, food preferences and food allergies were followed correctly.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

DAVID SCOTT, RN, Supervisor
Long Term Care

Stephen Farnsworth, Administrator
July 25, 2016
Page 3 of 2

DS/pmt



IDAHO DEPARTMENT OF
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July 25, 2016

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

Provider #: 135011

Dear Mr. Farnsworth:

On **June 24, 2016**, an unannounced on-site complaint survey was conducted at Gateway Transitional Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007245

Call lights were observed throughout the survey. Staff and resident interactions were observed throughout the survey. Resident brief changes were observed. Two residents with pressure ulcers were observed for appropriate prevention. Residents in therapy and Restorative Aide programs were observed. Residents were observed for dignity issues throughout the survey. Staff were observed for attentiveness throughout the survey. Food temperatures were observed and a test tray was sampled. Several residents' meals were observed.

The clinical records for the identified resident was reviewed for Quality of Care and Quality of Life concerns. Twelve other residents' records were reviewed for Quality of Care and Quality of Life concerns. The facility's Grievance file from June 2015 to June 2016 was reviewed. The facility's missing items reports were reviewed. Resident Council minutes were reviewed from March to May 2016. The facility's Incident and Accident reports from October 2015 to June 2016 were reviewed. The facility's Allegation of Abuse reports for 2015 and 2016 were reviewed.

The identified resident and three other residents were interviewed for Quality of Care and Quality of Life concerns. Several residents in the Group Interview were asked about Quality of Care and Quality of Life concerns. Several staff members were interviewed for Quality of Care and Quality of Life concerns. The Director of Nursing, the Administrator, the Social Worker and the Dietary Manager were interviewed regarding Quality of Care and Quality of Life concerns.

Allegation #1: The Reporting Party said an identified resident may have experienced abuse by a staff member.

Findings #1: The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from June 20, 2016 to June 24, 2016.

Staff and resident interactions were observed throughout the survey and no concerns were identified.

The identified resident was interviewed and did not identify abuse as a concern. Three other residents were interviewed and said there were no issues regarding abuse. Several residents in the Group Interview said they were not aware of any abuse in the facility. Several staff members were interviewed for abuse allegations and said if there were any abuse allegations they would report them immediately. The Administrator said abuse allegations are treated seriously and are investigated immediately.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: An identified resident had a deep red sore on his/her leg where catheter tubing is located.

Findings #2: The identified resident and one other resident were observed for catheter tubing placement and no concerns were identified. Two other residents were observed for pressure ulcer prevention and no concerns were identified. Resident brief changes were observed and no skin issues were identified.

The clinical records for the identified resident were reviewed for catheter tubing placement and pressure ulcers and no issues were identified.

The identified resident and one other resident with a catheter were interviewed and no concerns regarding catheter tubing was identified. Several staff were interviewed and said the facility practices pressure ulcer prevention.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: An identified resident's incontinent brief was soiled for more than four hours, though staff knew he/she needed to be changed.

Findings #3: Call lights were observed throughout the survey and no concerns were identified. Resident brief changes were observed and no concerns were identified. Staff were observed for attentiveness throughout the survey and no concerns were identified.

The clinical records for the identified resident were reviewed for incontinent care and no concerns were identified. Twelve other residents' records were reviewed for incontinent care and no concerns were identified. The facility's Grievance file from June 2015 to June 2016 was reviewed and there were no concerns for incontinent care identified. Resident Council minutes were reviewed from March to May 2016 and incontinent care issues were not identified.

The identified resident and three other residents were interviewed regarding incontinent care and no issues were identified. Several residents in the Group Interview were interviewed for Quality of Care concerns and incontinent care was not identified as an issue. Several staff members were interviewed and said incontinent care is completed according to residents' care plans.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: An identified resident is not receiving any form of therapy, which has led to a decline in the resident's legs and feet.

Findings #4: The identified resident was observed for range of motion and no concerns were identified. Eight other residents were observed receiving therapy or Restorative Aide assistance for range of motion and no concerns were identified.

The clinical records for the identified resident were reviewed for the range of motion restorative nursing program and no concerns were identified. Eight other residents' records were reviewed for therapy and/or the range of motion restorative nursing program and no concerns were identified.

Three other residents were interviewed and said they were receiving either therapy and/or the range of motion restorative nursing program and no concerns were identified. Several therapy staff said residents receive the appropriate care and services to prevent declines.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: An identified resident's personal belongings and money were missing and facility staff did not resolve the issues.

Findings #5: The clinical records for the identified resident were reviewed for missing items and no concerns were identified. Twelve other residents' records were reviewed for missing items and no concerns were identified. The facility's Grievance file from June 2015 to June 2016 was reviewed and no concerns were identified. The facility's missing items reports were reviewed and no concerns were identified. Resident Council minutes were reviewed from March to May 2016 and no concerns were identified. The facility's Allegation of Abuse reports for 2015 and 2016 were reviewed and no concerns were identified regarding missing property.

The identified resident said the facility has replaced missing items when they could not be found. Three other residents were interviewed and missing items was not a concern. Several residents in the Group Interview said the facility works hard to look for missing items and will replace items when appropriate. The Social Worker said the facility will replace items that could not be located.

Based on record review, and resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: An identified resident frequently receives cold food.

Findings #6: Food temperatures during tray line were observed to be within appropriate guidelines. A test tray was sampled and was determined to be within appropriate guidelines. Several residents' meals in the dining room and in resident rooms were observed to be delivered warm and those residents who let their meal cool off were observed and staff offered to reheat their meals. The identified resident was observed to be served hot food but left it on his/her tray table for an extended period of time without eating it.

The facility's Grievance file from June 2015 to June 2016 was reviewed and no concerns regarding cold food were identified. Resident Council minutes were reviewed from March to May 2016 and cold food was not identified as a concern.

Three other residents were interviewed and said their meals were delivered hot and if they cooled down, then staff would heat them up for them. Several residents in the Group Interview said their meals were delivered hot and if they cooled down, then staff would heat them up for them.

The Dietary Manager said meals were delivered with appropriate temperatures.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #6: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: An unidentified resident walks around with his/her pants falling down and staff does not do anything about it.

Findings #7: Residents were observed for dignity issues throughout the survey and no concerns were identified. Staff were observed for attentiveness throughout the survey and no concerns were identified.

The facility's Grievance file from June 2015 to June 2016 was reviewed and no dignity issues were identified. Resident Council minutes were reviewed from March to May 2016 and no dignity issues were identified.

Four residents were interviewed for dignity issues and no concerns were identified. Several residents in the Group Interview said no dignity issues were identified. Several staff members were interviewed and said they treated residents with dignity and respect.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #7: Unsubstantiated. Lack of sufficient evidence.

Allegation #8: An unidentified resident yelled for help for more than an hour before staff responded.

Findings #8: Call lights were observed throughout the survey and no concerns were identified. Staff were observed for attentiveness throughout the survey and no concerns were identified.

The facility's Grievance file from June 2015 to June 2016 was reviewed and no concerns were identified. Resident Council minutes were reviewed from March to May 2016 and no concerns were identified.

Five individual residents were interviewed and said there could always be more staff, but they have enough staff to meet their needs. Several residents in the Group Interview were interviewed and said there could always be more staff, but they have enough staff to meet their needs. Several staff members, the Director of Nursing and Administrator were interviewed and said they had enough staff to meet the residents' needs.

Stephen Farnsworth, Administrator
July 22, 2016
Page 6 of 6

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #8: Unsubstantiated. Lack of sufficient evidence.

As none of the 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 "D. Scott". The signature is written in a cursive, slightly slanted style.

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt



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July 22, 2016

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

Provider #: 135011

Dear Mr. Farnsworth:

On **June 24, 2016**, an unannounced on-site complaint survey was conducted at Gateway Transitional Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007266

Call lights were observed throughout the survey. Odors were monitored throughout the survey. Staff attentiveness was observed throughout the survey. Resident brief changes were observed. Two residents with pressure ulcers were observed for appropriate prevention.

The clinical records for the identified residents were reviewed for Quality of Care concerns. Seven other residents' records were reviewed for Quality of Care concerns. Four weeks of staffing records were reviewed for adequate staff. The facility's Grievance file from June 2015 to June 2016 was reviewed. Resident Council minutes were reviewed from March to May 2016. The facility's Incident and Accident reports from October 2015 to June 2016 were reviewed. The facility's Allegation of Abuse reports for 2015 and 2016 were reviewed.

Two of the identified residents and three other residents were interviewed for Quality of Care concerns. Several residents in the Group Interview were asked about Quality of Care and neglect concerns. Several staff members were interviewed for Quality of Care and neglect concerns. The Director of Nursing and Administrator were interviewed regarding Quality of Care and neglect concerns.

Allegation #1: The Reporting Party said many residents were not provided incontinent brief changes for over twelve hours due to overworked staff.

Findings #1: The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from June 20, 2016 to June 24, 2016.

A few of the identified residents were no longer residing in the facility at the time the complaint was investigated.

Soiled incontinent brief odors were not noted throughout the survey and no concerns were identified. Brief changes were observed to be completed in a timely manner.

The clinical records of the identified residents were reviewed for incontinent care and neglect issues and no concerns were identified. The records of seven other residents' records were reviewed for incontinent care and neglect issues and no concerns were identified. The facility's Grievance file from June 2015 to June 2016 was reviewed and incontinent care and neglect issues were not identified as concerns. Resident Council minutes were reviewed from March to May 2016 and incontinent care and neglect issues were not identified as concerns. The facility's Incident and Accident reports from October 2015 to June 2016 were reviewed and incontinent care and neglect issues were not identified as concerns. The facility's Allegation of Abuse reports for 2015 and 2016 were reviewed and neglect regarding incontinent care was not identified as an issue.

Two of the identified residents were interviewed and said they were not left soiled for long periods of time. Three other residents were interviewed regarding incontinent care and neglect and no concerns were identified. Several residents in the Group Interview were asked about incontinent care and neglect and no concerns were identified. Several staff members were interviewed and said residents' incontinent needs were properly completed and residents were not neglected. The Director of Nursing and Administrator were interviewed regarding Quality of Care and neglect concerns and said residents' needs are taken care of appropriately.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: There are not enough staff on all shifts.

Findings #2: Staff attentiveness was observed throughout the survey and no concerns were identified. Call lights were observed throughout the survey and no concerns were identified.

Four weeks of staffing records, including an identified day, were reviewed for adequate staffing levels and no concerns were identified.

The facility's Grievance file from June 2015 to June 2016 was reviewed and lack of staff was not an identified concern. Resident Council minutes were reviewed from March to May 2016 and lack of staff was not an identified concern.

Five individual residents were interviewed and said there could always be more staff, but they have enough staff to meet their needs. Several residents in the Group Interview said there could always be more staff, but they have enough staff to meet their needs. Several staff members, the Director of Nursing and Administrator were interviewed and said they had enough staff to meet residents' needs.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: An identified resident developed a pressure ulcer in the facility because he/she was not toileted or changed frequently enough.

Findings #3: The identified resident was no longer residing in the facility at the time the complaint was investigated.

A few residents' brief changes were observed and no concerns were identified. Two other residents with pressure ulcers were observed for appropriate prevention and no concerns were identified.

The clinical records for the identified resident were reviewed and no concerns were identified. Two other residents' records were reviewed for pressure ulcers and no concerns were identified.

One resident with pressure ulcers said he/she received appropriate pressure ulcer care. Several staff members and the Director of Nursing were interviewed regarding pressure ulcer prevention and said residents were provided appropriate treatment.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Stephen Farnsworth, Administrator
July 22, 2016
Page 4 of 4

As none of the 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 "D. Scott". The "D" is stylized with a vertical line through it, and "Scott" is written in a cursive-like font.

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt