



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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April 26, 2019

Tory Bosworth, Administrator
Gateway Transitional Care Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Bosworth:

On **April 12, 2019**, 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 a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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.

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 **May 6, 2019**. Failure to submit an acceptable PoC by **May 6, 2019**, may result in the imposition of penalties by **May 29, 2019**.

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 **May 17, 2019 (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 11, 2019**. A change in the seriousness of the deficiencies on **May 27, 2019**, may result in a change

Tory Bosworth, Administrator
April 26, 2019
Page 3

in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 12, 2019** includes the following:

Denial of payment for new admissions effective **July 12, 2019**. [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 **October 12, 2019**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, LTC, 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 **July 12, 2019** 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:

Tory Bosworth, Administrator
April 26, 2019
Page 4

<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:

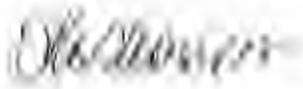
- BFS Letters (06/30/11)

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

This request must be received by **May 6, 2019**. If your request for informal dispute resolution is received after **May 6, 2019**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

lt/dr

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

PRINTED: 05/17/2019
FORM APPROVED
OMB NO. 0938-0391

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|---|---|---|---|----------------------|---|
| 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 04/12/2019 |
| 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 April 8, 2019 to April 12, 2019. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Wendi Gonzales, RN Karen George, RN Survey Abbreviations: ADON = Assistant Director of Nursing CNA = Certified Nursing Assistant DA = Dietary Aide DM = Dietary Manager DON = Director of Nursing ICN = Infection Control Nurse LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set | F 000 | | | |
| F 565 SS=E | Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for | F 565 | | 5/3/19 | |

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

TITLE

(X6) DATE

Electronically Signed

05/06/2019

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 565 | <p>Continued From page 1</p> <p>providing assistance and responding to written requests that result from group meetings.</p> <p>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.</p> <p>(A) The facility must be able to demonstrate their response and rationale for such response.</p> <p>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.</p> <p>§483.10(f)(6) The resident has a right to participate in family groups.</p> <p>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on Resident Council meeting minutes, Resident Group interview, policy review, and staff interview, it was determined the facility failed to address Resident Council concerns. This was true for 8 of 8 residents (#3, #8, #17, #26, #36, #45, #60, and #64) who participated in the Resident Group interview. The deficient practice had the potential to cause psychosocial harm for residents frustrated by the perception their concerns were not valued or addressed by the facility. Findings include:</p> <p>The facility's Grievance policy, revised on 1/2018, documented the facility would make prompt efforts to resolve grievances, including Resident</p> | F 565 | <p>1. Corrective action for residents found to be affected by the deficient practice are: Resident Council Liaison met with affected residents to discuss concerns and emailed a summary of concerns to the corresponding IDT members for resolution. Response from the identified IDT members for intervention were collected, put in place and reported back to the affected residents.</p> <p>2. All residents have the potential to be affected by the deficient practice. Corrective action includes updating Resident Council Meeting Minutes to</p> | | |

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| F 565 | <p>Continued From page 2</p> <p>Council concerns, and to keep residents notified of progress toward resolution.</p> <p>Resident Council minutes, dated 2/28/19, documented complaints of cold meals and coffee, and long wait times for response to call lights. Resident Council minutes, dated 3/28/19, documented the residents wanted follow through with the issues they talked about in the meetings and still wanted hot coffee. The facility did not document what actions were taken to resolve the concerns identified at the 2/28/19 meeting.</p> <p>On 4/10/19 at 10:10 AM, during the Resident Group interview, Residents #3, #8, #17, #26, #36, #45, #60, and #64 said the food concerns were not addressed, the food was still cold, and did not taste good. Residents #3, #26, #36, #45, #60, and #64 said the call light concern was not addressed and was still an issue.</p> <p>On 4/11/19 at 8:52 AM, the Resident Council Liaison said she emailed the Resident Council minutes and concerns to the department head so they could respond back to her. She said not all of the department heads responded back to the concerns.</p> <p>On 4/11/19 at 2:18 PM, the DM said she received the Resident Council minutes, attempted to fix the concerns, but did not respond to the emails or notify the Resident Council Liaison or the Resident Council of her response.</p> <p>On 4/11/19 at 2:44 PM, the DON said he received the Resident Council minutes, had completed call light audits due to the concerns, and verbally reported the results to the Resident</p> | F 565 | <p>include a review of old business including timely follow-up.</p> <p>3. Measures / systemic changes to ensure the deficient practice does not re-occur are to in-service the IDT to the updated Resident Council Meeting format and the importance of prompt follow-up with appropriate interventions.</p> <p>4. Resident Council Liaison / Designee will monitor Resident Council concerns and to help ensure they were addressed in a timely manner and Resident Council Members are updated on responses and interventions and indicate this process in the Resident Council meeting minutes. In addition, the Administrator or DNS will monitor the Resident Council Liaison to ensure effective resolution of resident council concerns. This will be monitored monthly and PRN, indefinitely.</p> | | |

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| F 565 | Continued From page 3 Council Liaison and to the Resident Council President. The DON said he had not considered the concerns from the Resident Council as grievances. | F 565 | | | |
| F 585 SS=D | Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally | F 585 | | 5/3/19 | |

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| F 585 | Continued From page 4 (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions | F 585 | | | |

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| F 585 | <p>Continued From page 5</p> <p>include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, resident, resident representative, and staff interview, it was determined the facility failed to document, investigate, and report complaints expressed by 1 of 19 residents (Resident #227) whose complaints were reviewed. This failure created the potential for harm if residents' verbal grievances were not acted upon and residents did not receive appropriate care or were at risk for abuse or neglect. Findings include:</p> <p>The facility's Grievance Policy, dated 1/2018, documented residents had the right to file a grievance orally or in writing and the right to obtain a review in writing; and when a grievance</p> | F 585 | <ol style="list-style-type: none"> 1. Corrective Action for the affected resident: Resident has since discharged from facility without incident. 2. All Residents have the potential to be affected by the deficient practice. Corrective Action to ensure the deficient practice does not re-occur are to update Policy and Procedure and grievance form. New grievances will be discussed in morning stand-up meeting...and clarification on who can complete the grievance process. 3. Systemic change to be made to | | |

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| F 585 | <p>Continued From page 6</p> <p>was voiced to a staff member a grievance form would be completed and the grievance would be evaluated and investigated.</p> <p>The facility's Grievance file did not include a grievance for Resident #227.</p> <p>On 4/10/19 at 9:56 AM, Resident #227 and his representative stated they reported incidents to the facility staff, as well as other concerns that were medical in nature, as follows:</p> <ul style="list-style-type: none"> - A nurse answered the call light and said she could not help Resident #227 but was going to get a CNA to help. The CNA never came, and Resident #227 had to sit in urine and feces for an extended period of time causing skin issues in his peri-area. - A nurse yelled at Resident #227 and "chewed him out" when his representative called the DON to complain about the care the nurse had given to Resident #227. The representative said she used her cell phone and a land line phone to connect the DON directly to Resident #227's room so the DON could hear the way Resident #227 was treated by a particular nurse. - Resident #227 received rough care by a CNA who had transferred him, unassisted, using a Hoyer lift (a mechanical lift). During the transfer, Resident #227 was bumped against the Hoyer lift and the foot board of the bed which caused "damage" to his knee, which was the site of a recent surgical procedure. Resident #227 reported the same CNA picked up his leg, jerked the stump away from his body and dropped his stump on the bed causing extreme pain. | F 585 | <p>ensure deficient practice do not occur will be to in-service all staff to the updated policy and procedure and the new grievance form.</p> <p>4. LSW / Designee will audit 3x/week for two weeks and weekly thereafter. This will ensure the updated policy is being followed.</p> | | |

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| F 585 | Continued From page 7 Resident #227 said this same CNA also positioned his urinal in a rough manner, which caused him pain. On 4/9/19 at 11:09 AM, the DON said he had not documented the complaints made by Resident #227 and said Resident #227 was very particular in his care needs. The DON said when Resident #227 made complaints, the staff tried to meet his needs. The DON recalled the partial conversation he overheard by phone between Resident #227 and the nurse, and said he could not substantiate that abuse had occurred. The DON said he had not conducted a formal investigation into the nurse's behavior but had reassigned the nurse to prevent other complaints and incidents. The DON said he had not documented any of the incidents reported by Resident #227, nor had he documented the resolution of the complaints and he was not aware of some of the complaints. The DON said he had responded to several complaints by the resident but had not felt the complaints had risen to the level of abuse or neglect. The facility failed to provide documented evidence Resident #227's concerns reported by him and/or his representative were investigated, reported, and acted upon. | F 585 | | | |
| F 657 SS=D | Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that | F 657 | | 5/3/19 | |

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| F 657 | <p>Continued From page 8 includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, resident interview, and staff interview, it was determined the facility failed to ensure residents' care plans were revised as needed. This was true for 1 of 21 residents (Resident #67) whose care plans were reviewed. This failure had the potential for harm if cares and/or services were not provided due to inaccurate information. Findings include:</p> <p>The facility's Care Planning policy, undated, directed staff to develop a comprehensive care plan for each resident and care plans were to be updated quarterly and as needed.</p> <p>Resident #67 was readmitted to the facility on</p> | F 657 | <p>1. Corrective action for affected residents are that care plan was updated to include referenced resident is now a 2-person extensive assist with toileting and transfers. History of fractures and sling use, and has counseling services provided.</p> <p>2. All residents have the potential to be affected by the deficient practice. Corrective action is to ensure deficient practice does not re-occur are to update the policy and procedure to include change of condition and Incident and Accident are care-planned, per policy and</p> | | |

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| F 657 | <p>Continued From page 9</p> <p>12/18/18, with multiple diagnoses including depression, anxiety, generalized muscle weakness, and reduced mobility.</p> <p>a. Resident #67's quarterly MDS assessment, dated 3/21/19, documented she required the assistance of two staff with toilet use and transfers, and the assistance of one person with eating.</p> <p>Resident #67's care plan documented she required one-person assist with toilet use and transfers. The care plan was not consistent with the MDS assessment for Resident #67 which documented she required the assistance of two staff with toilet use and transfers and the assistance of one staff for eating.</p> <p>b. An Incident and Accident report, dated 1/21/19, documented Resident #67 had a fall and fractured her right shoulder.</p> <p>A hospital evaluation, dated 1/21/19, documented Resident #67 had a right shoulder fracture and directed staff to provide a sling for comfort.</p> <p>Resident #67's MAR, dated 1/30/19 through 3/18/19, documented a sheepskin sleeve was to be placed around the strap of the sling, in the neck area, for comfort.</p> <p>Resident #67's physician's progress notes, dated 2/6/19, 3/6/19, and 4/3/19, directed staff to provide a sling for her right shoulder fracture.</p> <p>Resident #67's care plan, documented she was at risk for falls and had a history of falls with a fracture. Resident #67's care plan did not include</p> | F 657 | <p>procedure. Also, that the quarterly review involves a comprehensive review of resident status to ensure all appropriate items are care-planned.</p> <p>3. Systemic changes made to ensure the deficient practice does not re-occur are to in-service all staff to the updated policies and procedures.</p> <p>4. DNS / Designee to audit quarterly care plan reviews to ensure a comprehensive review of resident status is performed and that all appropriate items are care-planned. This will be done 1x/week indefinitely. DNS / Designee to audit change of condition to ensure care plans are updated 3x/week for two weeks and weekly thereafter.</p> | | |

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| F 657 | Continued From page 10 documentation she fractured her right shoulder and she required the use of a shoulder sling with a sheepskin sleeve over the strap of the sling. c. Resident #67's progress notes, dated 3/21/19, documented she received counseling services through a local mental health provider. The notes documented she was treated for depression and anxiety. Resident #67's care plan did not include she received counseling services. On 4/12/19 at 8:28 AM and 10:52 AM, The ADON stated Resident #67's ADLs care plan should have been revised to include her need for two-person assistance related to toilet use and transfers and one person assistance with eating. The ADON stated Resident #67's care plan was not revised to include her fractured right shoulder and her need for a sling with a sheepskin cover. The ADON stated Resident #67 continued to receive counseling from a local counseling provider and the care plan did not include this service. | F 657 | | | |
| F 804 SS=E | Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced | F 804 | | 5/3/19 | |

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| F 804 | <p>Continued From page 11</p> <p>by:</p> <p>Based on observation, policy review, review of Resident Council minutes, resident interview, Resident Group interview, test tray evaluation, and staff interview, it was determined the facility failed to ensure palatable food was served. This was true for 15 of 18 residents (#1, #3, #8, #17, #20, #26, #27, #36, #38, #41, #45, #53, #54, #60, and #64) reviewed for food and nutrition. This failed practice had the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include:</p> <p>The facility's Food Quality and Palatability policy, revised 9/2017, documented food will be palatable and served at an appetizing temperature.</p> <p>Resident Council minutes, dated 2/28/19, documented complaints of cold meals and coffee. Resident Council minutes, dated 3/28/19, documented the residents wanted follow through with the issues they talked about in the meetings and still wanted hot coffee. The facility did not document what actions were taken to resolve the concerns identified at the 2/28/19 meeting.</p> <p>On 4/10/19 at 10:10 AM, during the Resident Group interview, Residents #3, #8, #17, #26, #36, #45, #60, and #64 said the previously mentioned food concerns were not addressed, the food was still cold, and did not taste good.</p> <p>Residents were interviewed regarding the food served at the facility. Examples include:</p> <p>* On 4/8/19 at 4:18 PM, Resident #38 stated she did not like the greasy noodles that were served</p> | F 804 | <p>1A. Immediate corrective action is to have Dietary Manager to hold food counsel with the available and affected residents to discuss concerns and interventions.</p> <p>1B. Pellet plate warmer was stocked and plugged in for the duration of the serve-out period.</p> <p>1C. Re-calibrated all thermometers for a more accurate temperature control leading to increased palatability; Dietary staff was in-serviced on correct seasonings and approved recipes.</p> <p>2. All residents have the potential to be affected by the deficient practice. Corrective action is: All kitchen staff re-in-serviced on policies of food temperature and palatability in relation to food preparation. Policies will also be posted in kitchen for all to see.</p> <p>3. Refer to corrective action in F-565 for appropriate response to resident concerns. Food Council will be initiated monthly to address specific concerns with resident council and ensure policy and procedures are followed and concerns were addressed. This meeting will be in conjunction with a monthly Resident Council.</p> <p>4. Dietary Manager / Designee will monitor to ensure food concerns are addressed appropriately, temperatures</p> | | |

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| F 804 | <p>Continued From page 12 by the facility.</p> <p>* On 4/8/19 at 4:30 PM, Resident #54 stated the facility put Mrs. Dash and garlic on everything, and the food was lukewarm 90 percent of the time.</p> <p>* On 4/8/19 at 4:44 PM, Resident #27 stated the chicken was pasty. She stated the only fruit the facility had were apples, canned peaches, and fruit cocktail, and they were not very flavorful. She stated she told the DM her concerns with the food, and the DM told her everyone had told her that they liked the food.</p> <p>* On 4/8/19 at 5:58 PM, Resident #53 stated he did not like the food.</p> <p>* On 4/8/19 at 6:11 PM, Resident #41 stated the food was monotonous.</p> <p>* On 4/9/19 at 8:23 AM, Resident #17 stated the food could be better. She stated the broccoli and carrots were not cooked through and were rubbery. She said the pasta was also rubbery.</p> <p>* On 4/9/19 at 8:29 AM and on 4/11/19 at 9:20 AM, Resident #20 stated the food was cold sometimes. She stated she had tried to voice her concerns with kitchen staff but they did not address her food concerns. She stated she had difficulty eating her pancake the morning of 4/11/19, because part of the crust was too hard to cut.</p> <p>* On 4/9/19 at 10:45 AM, Resident #26 stated the food "sucks!" He said the food quality was poor and was often cold.</p> | F 804 | <p>are appropriate per policy and food is palatable. 3x/week for 2 weeks; weekly for 1 month, then monthly thereafter. Residents will also be intermittently interviewed to allow them to voice any additional feedback regarding food palatability.</p> | | |

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| F 804 | <p>Continued From page 13</p> <p>* On 4/9/19 at 11:10 AM, Resident #36 stated the regular and alternate meals were served lukewarm and tasted "terrible."</p> <p>* On 4/9/19 at 11:55 AM, Resident #1 stated the food was always the same and they put too much pepper on the food.</p> <p>On 4/10/19 at 11:45 AM, two test tray lunch meals were requested for the regular and alternate meals. The DM plated residents' meals and took one plate and one warming pellet at a time out of the top of the unplugged plate warmer which was opened at the top. At 12:07 PM, the last of the warming pellets were used and the DM plugged in the plate warmer and asked DA #2 to place new pellets into the warmer. DA #2 took a stack of pellets that had been on a nearby counter and placed them in the warmer. The DM then plated two more residents' meals and the two test tray meals with the new warming pellets underneath them and were delivered down the C and D hallways.</p> <p>On 4/10/19 at 12:15 PM, the two test trays were evaluated by three surveyors along with the District Manager of Dietary (DMD). The alternate meal included Swedish meatballs which had a temperature of 129 degrees F (Fahrenheit), parsley noodles which were 106 degrees F, and broccoli which was 93.5 degrees F. The regular meal included garlic and rosemary roasted red potatoes which were 111 degrees F and sauteed zucchini which was 110 degrees F. The DMD said the noodles, broccoli, potatoes, and zucchini were lukewarm. The surveyors evaluated the meals and found the meatballs to lack flavor, the</p> | F 804 | | | |

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| F 804 | Continued From page 14 noodles were cool and greasy, the broccoli was cool and tough, the potatoes were lukewarm, and the zucchini was lukewarm and chewy. | F 804 | | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to a) date items in the freezer and refrigerator, b) ensure staff contained all hair with a hair net, c) ensure infection control practices were implemented when gathering ice to be used to keep foods cool and d) clean and maintain the kitchen floor. These deficient practices placed 18 of 18 sample residents (#1, #2, #11, #22, #23, #26, #27, #36, #42, #43, #44, #62, #65, #67, | F 812 | | 5/3/19 | |
| | | | 1. Immediate corrective actions: 1A. Labeling and Dating of Food: Staff immediately in-serviced to the policy and procedure on appropriate labeling and dating of food. Food items in fridge and freezer were inventoried and labeled and dated according to policy. 1B. Hair Containment: Staff in-serviced | | |

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| F 812 | <p>Continued From page 15</p> <p>#71, #76, #228, and #229) who dined in the facility, and the other 61 residents who dined in the facility, at risk food borne illness or other disease-causing pathogens. Findings include:</p> <p>The facility's food labeling and dating policy, dated 2017, directed staff to date food upon receipt before being stored. The policy also documented food moved from the freezer to the refrigerator for thawing was to be labeled with the removal date and a use by date.</p> <p>The facility's Staff Attire policy, dated 9/2017, directed staff members to have their hair off the shoulders and confined in a hair net or cap.</p> <p>On 4/8/19 from 4:00 to 4:30 PM, during a tour of the kitchen the following were observed:</p> <p>* An open half bag of brussel sprouts was in the freezer. The bag was not dated when it was opened. Five other bags of brussel sprouts were found in the refrigerator without labels or dates as to when they were moved from the freezer to the refrigerator.</p> <p>* DA #1 had on a baseball cap in the kitchen. The lower half of her hair was loose and hung almost to her shoulders.</p> <p>* A plastic pitcher was face down on top of the ice machine. DA #1 took the plastic pitcher and filled it with ice and walked across the kitchen to a plastic tub with milk and juice cartons in it and poured the ice into the plastic tub. At that time, the DM told DA #1 to use the ice scoop and not the pitcher. The DM then instructed DA #1 to place the plastic pitcher in the dish washing area.</p> | F 812 | <p>to policy for hair containment and hair nets were required to be worn by all kitchen staff.</p> <p>1C. Sanitation (ice-scoop): Staff in-serviced to cleaning and sanitization policy and instructed to only use designated ice-scoop for the transfer of ice.</p> <p>1D. Cleaning (Floor maintenance): Floor, Doors, walls, door frames and stationary equipment were cleaned.</p> <p>2. All residents have the potential to be affected by the deficient practice. Corrective action to ensure deficient practice does not re-occur. Prep and pull sheets will be used to track food used for menu offerings and to ensure foods are dated appropriately. Job flow sheets will be used to direct appropriate floor cleaning. Deep cleaning lists will be used to ensure appropriate deep cleaning practices happen throughout the kitchen.</p> <p>3. All staff to follow policy and procedures for kitchen attire (specifically hairnets) and kitchen sanitation techniques (ie: ice-scoops). Kitchen staff in-serviced to prep and pull sheets, job flow sheets, and deep cleaning lists.</p> <p>4. Dietary Manager / Designee to monitor appropriate labeling and dating, staff attire (hairnets), kitchen sanitation (ice-scoops) and kitchen cleanliness. This will be done 3x/week for two weeks,</p> | | |

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| F 812 | <p>Continued From page 16</p> <p>* The floor throughout the kitchen and storage areas was dirty, with grime build up along the walls, door frames, drains, and stationary equipment. Various cracks and divots were observed in the flooring in multiple areas throughout the kitchen and storage areas.</p> <p>On 4/8/19 at 4:00, 4:26, and 4:30 PM, the DM said the brussel sprouts found in the freezer should have been dated when they were opened, and the brussel sprouts found in the refrigerator should have been dated when they were moved from the freezer to the refrigerator. She said the brussel sprouts were thawing for the next day's meal and said she moved them from the freezer to the refrigerator and had not dated them because she was in a hurry. The DM said she believed dietary staff could either wear a hair net or a baseball cap, and hair in a cap could reach the shoulders. The DM said she expected staff to use the ice scoop next to the ice machine instead of the plastic pitcher.</p> <p>On 4/9/19 at 8:22 AM, the kitchen floor was not completely clean. There was build up along all the walls and around legs of stoves, cabinets, preparation tables, ice machine, and almost all items stationary in the kitchen. The floor tile had divots and cracks throughout the kitchen, especially in the grill area. All areas of the kitchen and storage areas had tiles that were worn and cracked.</p> <p>On 4/9/19 at 8:22 AM, the DM said the facility was aware of the condition of the floor and planned to replace the floor last July but had not completed that project. She said the surface of</p> | F 812 | weekly for 1 month, then monthly thereafter. | | |

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| F 812 | Continued From page 17 the floor was uncleanable and they did the "best that we can" to keep it clean. On 4/9/19 at 8:56 AM, the Facility Operations Manager said the kitchen floor had been identified for replacement last October and he believed the floor would be replaced in June or July of this year. He said a solid plan for when the floor would be replaced would depend on the facility's ability to hire a mobile kitchen to use for the period the floor would be replaced. | F 812 | | | |
| F 880 SS=E | Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; | F 880 | | 5/3/19 | |

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| F 880 | <p>Continued From page 18</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> | F 880 | | | |

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| (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 880 | <p>Continued From page 19</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to implement appropriate infection control practices when assisting residents during dining and after a Hoyer lift transfer of a resident on contact precautions. This was true for 2 of 6 residents (#33 and #42) observed in the assisted dining room and 1 of 4 residents (Resident #16) in contact precaution rooms. These deficient practices created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include:</p> <p>The facility's Infection Control policy, dated 9/29/17, directed staff to disinfect equipment after each use for residents in contact precaution rooms.</p> <p>1. Resident #16 was admitted to the facility on 4/2/18. Resident #16's record included a physician's order, dated 3/28/19, which documented she was to be on contact precautions due to a Vancomycin-resistant Enterococci (specific types of antimicrobial-resistant bacteria that are resistant to Vancomycin, the drug often used to treat infections caused by enterococci) infection found during a urinalysis test.</p> <p>On 4/11/19 at 2:00 PM, CNA #2 and CNA #3 assisted Resident #16 in a Hoyer lift transfer. All staff persons in the room wore personal protective equipment during the transfer. After</p> | F 880 | <p>1. Corrective Action:</p> <p>A. A corrective action for identified residents included immediately notifying / education of staff that the Hoyer lift needed sanitized before next use and ensuring it was sanitized. This occurred the same day it was found and brought to our attention (4/11/2019).</p> <p>B. Corrective action for identified resident include immediate education to the implicated staff to either use only one hand for one resident, when assisting with eating. And/or to sanitize or wash hands if needing to use 1 hand to assist between residents. Each resident has been monitored to ensure no adverse side-effects have occurred, due to this deficient practice.</p> <p>2. All residents have the potential to be affected by the deficient practice. Corrective actions implemented to ensure deficient practice does not re-occur include:</p> <p>A. Updating policy and procedures to direct staff to sanitized assistive devices (ie: Hoyer) immediately after the use on a resident on isolation.</p> <p>B. Updating dining assistive policy to</p> | | |

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| F 880 | <p>Continued From page 20</p> <p>the task was completed, CNA #2 removed the Hoyer lift from the room and took it down the hall to the shower room. CNA #2 placed the Hoyer lift in the shower room and left the room.</p> <p>On 4/11/19 at 2:30 PM, CNA #2 said she did not cleaned the Hoyer lift after it was used to transfer Resident #16. CNA #2 said she should have cleaned it as the Hoyer lift could have been used for other residents. The Hoyer lift was left in the shower room for use by other staff for other residents without being properly sanitized between uses.</p> <p>On 4/11/19 at 3:10 PM, RN #1 said the Hoyer lift should be disinfected after each use.</p> <p>On 4/11/19 at 3:15 PM, LPN #2 said she thought the Hoyer lift should be cleaned before and after use with each resident.</p> <p>On 4/11/19 at 4:00 PM, the DON said he expected staff to clean the Hoyer lift between resident use.</p> <p>2. On 4/9/19 at 12:19 PM, CNA #1 sat between Resident #33 and Resident #42 at the assisted dining table in the dining room. CNA #1 assisted both residents using her gloved right hand on the residents' utensils to offer bites of food. She then picked up each resident's napkins from the table and wiped their mouths with their napkins, using her right hand. CNA #1 then continued to assist both residents with the utensils. This process continued through-out the entire meal. CNA #1 did not change her gloves or sanitize her hands when moving between the two residents.</p> | F 880 | <p>ensure that when assisting two(2) residents that only 1 hand is designated to one resident during assistance or to sanitize/wash hands in-between assisting the two separate residents. This will ensure cross contamination does not occur.</p> <p>3. All staff have been in-serviced to the updated policy and procedures.</p> <p>4. DNS / Designee will audit isolation rooms and dining room assistive residents during meals to ensure the updated policies and procedures are being followed appropriately 3x/week for two weeks; 1x week for 1 month, then monthly thereafter.</p> | | |

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| F 880 | Continued From page 21 On 4/10/19 at 08:38 AM, CNA #1 said she should not have assisted Resident #33 and Resident #42 with wiping their mouths without sanitizing her hands. On 4/10/19 at 9:12 AM, the DON said when assisting residents, he expected staff to only use the left side of their body to assist the person on the left, and the right side their body to assist the person on the right. | F 880 | | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or | F 883 | | 5/17/19 | |

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| F 883 | <p>Continued From page 22 refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on policy review, record review, and staff and resident interview, it was determined the facility failed to ensure residents were offered the pneumococcal vaccine and information and education consistent with current Centers for Disease Control and Prevention recommendations. This was true for 1 of 7 residents (Resident #23) reviewed for pneumococcal immunizations. This failure</p> | F 883 | <p>1. Corrective actions for identified resident is that she will be monitored for signs and symptoms of pneumonia and educated on risks vs. benefits of receiving the pneumococcal vaccine, as directed by policy and CDC. Resident 23 declined receiving Prevnar 13 vaccination.</p> <p>2. All residents have the potential to be</p> | | |

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| F 883 | <p>Continued From page 23</p> <p>created the potential for harm to residents should they acquire, transmit, or experience complications from pneumococcal pneumonia. Findings include:</p> <p>The Centers for Disease Control and Prevention (CDC) website, updated 11/22/16, documented recommendations for Pneumococcal vaccination (PCV 13 or Prevnar13®, and PPSV 23 or Pneumovax23®) for all adults 65 years or older:</p> <p>* "Adults 65 years or older who have not previously received PCV 13, should receive a dose of PCV 13 first, followed 1 year later by a dose of PPSV 23."</p> <p>*If the patient already received one or more doses of PPSV 23, the dose of PCV 13 should be given at least 1 year after they received the most recent dose of PPSV 23."</p> <p>The facility's Immunizations policy and procedures, dated 9/2018, directed staff to minimize the risk of residents acquiring, transmitting, or experiencing complications from pneumococcal pneumonia by assuring that each resident was informed about the benefits and risks of immunizations and had the opportunity to receive, unless medically contraindicated or refused or already immunized, the pneumococcal vaccine.</p> <p>Resident #23 was admitted to the facility on 3/20/19, with multiple diagnoses including hemiplegia (paralysis on one side of the body) and Parkinson's Disease.</p> <p>Resident #23's quarterly MDS assessment, dated</p> | F 883 | <p>affected by the deficient practice. Corrective actions taken to ensure that the deficient practice does not re-occur include and audit of current residents that received pneumococcal vaccinations to ensure they were given according to policy and CDC guidelines; and creating and immunization log to track and ensure influenza and pneumococcal immunizations are given according to policy and CDC guidelines, with the associated info and risks vs. benefits.</p> <p>3. All relevant staff in-serviced to immunization policy and procedure with the new tracking log.</p> <p>4. Infection Preventionist / Designee will audit tracking log to ensure immunizations with their associated risks vs. benefits are being delivered per policy and procedure guidelines. This will be monitored 1x/week for 1 month then monthly thereafter.</p> | | |

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| F 883 | <p>Continued From page 24</p> <p>2/1/19, documented her cognition was intact, and her pneumococcal vaccination was up to date.</p> <p>Resident #23's record documented she received Pneumovax 23 pneumococcal vaccine on 10/10/14. Resident #23's record did not include documentation she received the Prevnar 13 pneumococcal vaccine, consent, or information about the benefits and risks of pneumococcal immunization.</p> <p>On 4/11/19 at 8:10 AM, the ADON stated Resident #23's record did not include documentation she was offered or educated on the Prevnar 13 vaccine and stated she should have been offered and provided the education.</p> <p>On 4/12/19 at 9:17 AM, Resident #23 stated she was not offered the pneumococcal vaccination or informed about the benefits and risks of immunizations on admission or otherwise during her stay in the facility.</p> | F 883 | | | |



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June 21, 2019

Tory Bosworth, Administrator
Gateway Transitional Care Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Bosworth:

On **April 8, 2019** through **April 12, 2019**, an unannounced on-site complaint survey was conducted at Gateway Transitional Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007984

ALLEGATION #1:

The facility did not have adequate staffing.

FINDINGS #1:

During the investigation, 22 records were reviewed, 19 residents were observed, the facility nursing schedule was reviewed, facility grievances and resident council minutes were reviewed, and multiple interviews with staff, residents, and family members were conducted.

Call lights were observed and staff were answering call lights and assisting the residents in a timely manner.

The facility nurse staffing schedule from 3/17/19 to 4/6/19 was reviewed and documented the facility had adequate nursing staff required for the resident census.

Tory Bosworth, Administrator
June 21, 2019
Page 2 of 4

Residents and family members said there were enough nursing staff to take care of their needs. Nurses and Certified Nursing Assistants (CNAs) said there were enough staff to take care of residents' needs. The Director of Nursing (DON) said the facility had enough nurses and staff to take care of residents' needs. The DON said the facility had monitored call lights for the past few months on different shifts and said the call lights were answered within 7 minutes.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents were hospitalized for dehydration due to staff not offering residents fluids. Residents with dementia were not offered or cued to drink fluids.

FINDINGS #2:

During the survey, 19 residents were observed for dehydration and access to liquids, four resident records were reviewed, residents were interviewed, staff were interviewed, and a resident council meeting was attended.

Liquids were accessible to all 19 residents and there were no signs and symptoms of dehydration.

Six of the residents, who were diagnosed with dementia, were offered and assisted to drink fluids. A hydration cart was observed each day which provided residents with fresh ice water and other liquids.

The records of four residents were reviewed for dehydration and documented fluids were encouraged and provided.

On 4/10/19 at 10:10 AM, eight residents in the resident group interview said they had access to fluids to drink. Five individual residents and a resident's family member said staff provided residents with fluids to drink and/or offered and cued residents with dementia to drink.

The Assistant Director of Nursing (ADON) said CNAs and nurses were educated to recognize signs and symptoms for dehydration. The ADON said residents were offered fluids several times a day and residents' fluid intake was monitored.

The DON said the facility had implemented a hydration program specifically for residents with cognitive issues, to make sure they received adequate fluid intake. The DON said the program included a daily report of those residents' fluid intake and output, offering extra water, individualized hydration interventions, and individual staff observations of those residents' fluid needs.

Tory Bosworth, Administrator
June 21, 2019
Page 3 of 4

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Infection control precautions were not followed by staff.

FINDINGS #3:

During the survey observations were conducted for infection prevention practices, facility policy was reviewed, and staff were interviewed.

On 4/11/19, two CNAs assisted a resident with a mechanical lift transfer. The resident was admitted to the facility with a Vancomycin-Resistant Enterococci (a bacterial infection that is resistant to antibiotics). Each staff person in the room wore personal protective equipment during the transfer. After the task was completed, a CNA removed the lift from the room and took it down the hall to the shower room. The CNA placed the lift in the shower room and left the room. The CNA said she did not clean the lift and it could have been used for other residents.

The facility's Infection Control policy directed staff to disinfect equipment after each use for residents' in contact precaution rooms.

Two nurses and the Director of Nursing said mechanical lifts were to be cleaned each time it was used prior to use by another resident.

The allegation was substantiated, and deficiencies were cited at F880 related to the failure of the facility to ensure infection control precautions were followed by staff.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

Residents' wound status was not documented in their records.

Tory Bosworth, Administrator
June 21, 2019
Page 4 of 4

FINDINGS #4:

During the survey observations were conducted, eight resident records were reviewed, residents were interviewed, and staff were interviewed.

The wounds of two residents were observed and the documentation in their records was consistent with their wounds. The care provided to the residents' wounds was appropriate.

The records of eight residents included documentation of their wounds documentation and wound care interventions were in place.

Two residents with wounds said they were pleased with the facility staff and were provided good wound care. Another resident said they did not have any wounds or skin issues. The Wound Care Nurse (WCN) said CNAs and nurses notified the WCN with any skin concerns. The WCN said residents who were admitted with wounds had improved. The DON said a resident who was admitted with a diabetic wound received appropriate wound care.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



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September 16, 2019

Gavin Monteath, Administrator
Gateway Transitional Care Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Monteath:

On **April 12, 2019**, an unannounced on-site complaint survey was conducted at Gateway Transitional Care Center. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00008035

ALLEGATION #1:

When grievances are reported to the facility, there is no follow-up.

FINDINGS #1:

An unannounced recertification survey and complaint investigation was conducted on 4/8/19 through 4/12/19. During the investigation, 22 records were reviewed, the facility's Grievance Policy was reviewed, 19 residents were observed, and interviews were conducted with staff, residents, and resident's representatives.

The facility's Grievance Policy, dated 1/2018, documented residents had the right to file a grievance orally or in writing and the right to obtain a review in writing; and when a grievance was voiced to a staff member a grievance form was completed and the grievance was evaluated and investigated.

In an interview, one resident and his representative stated they reported incidents to the facility staff, as well as other concerns that were medical in nature as follows:

- A nurse answered the call light and said she could not help the resident, but was going to get a CNA to help. The CNA never came, and the resident had to sit in urine and feces for an extended period of time causing skin issues in his peri-area.
- A nurse yelled at the resident and "chewed him out" when his representative called the DON to complain about the care the nurse had given to the resident.
- The resident received rough care by a CNA who had transferred him, unassisted, using a Hoyer lift (a mechanical lift). During the transfer, the resident was bumped against the Hoyer lift and the foot board of the bed causing "damage" to his knee, which was the site of a recent surgical procedure. The resident reported the same CNA picked up his leg, "jerked" it away from his body and dropped it on the bed causing extreme pain. The resident said this same CNA also positioned his urinal in a rough manner, which caused him pain.

In an interview, the DON said he had not documented the complaints made by resident. The DON said when the resident made complaints, the staff tried to meet his needs. The DON said he did not conduct a formal investigation into the nurse's behavior but had reassigned the nurse to prevent other complaints and incidents. The DON said he did not document any of the incidents reported by the resident, nor did he document the resolution of the complaints and he was not aware of some of the complaints.

Six residents at the Resident Group interview said call light concerns they brought up with the facility in their Resident Council meeting on 2/28/19, were not resolved. There was no documentation what actions were taken to resolve the concerns identified by the residents from the Resident Council meeting on 2/28/19. Eight residents said food concerns were not addressed from their 2/28/19 meeting and the food was still cold and did not taste good.

During an interview with the Resident Council Liaison, she said she emailed the Resident Council minutes and concerns to the facility's department heads so they could respond back to her. She said not all of the department heads responded.

In an interview with the Dietary Manger, she said she received the Resident Council minutes, attempted to fix the concerns, but did not respond to the emails or notify the Resident Council liaison or the Resident Council of her response.

In an interview, the DON said he received the Resident Council minutes, had completed call light audits due to the call light concerns, and verbally reported the results to the Resident Council Liaison and to the Resident Council President. The DON said he did not consider the concerns from the Resident Council as grievances.

Based on the investigative findings, the allegations were substantiated relating to the facility not responding to resident grievances. The facility was cited at F 565 and F 585, as they relate to the facility's investigation, documentation, and response to resident grievances.

CONCLUSIONS:

Substantiated. Federadeficiencies related to the allegation are cited.

ALLEGATION #2:

The facility did not provide residents with all prescribed medications.

FINDINGS #2:

Medications were reviewed for five residents and 26 medication administration observations were conducted during the survey, with no concerns identified.

One resident had a concern the facility did not transcribe admission orders correctly, and did not provide two medications timely. Review of the admission orders showed the medications were not included as active orders on the admission orders and were discontinued by the physician. The medications were restarted when the resident brought it to the attention of the facility.

Based on the investigative findings, the allegation was substantiated, but not cited as there was no current deficient practice identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility did not provide oral treatments and a soft diet as prescribed.

FINDINGS #3:

Nineteen resident records were reviewed, interviews with residents and resident representatives were conducted.

One resident's record reviewed, documented the resident had concern the facility did not provide oral salt-water swishes and a soft diet (food that is soft and easy to chew and swallow) as ordered by the dentist after teeth extractions.

The dental orders directed staff to provide salt-water swishes, and a soft diet for 24 hours after the teeth extractions. The salt-water swishes and a soft diet were added to the resident's care plan to continue after the 24 hours as requested by the resident.

Meals provided to 10 residents were observed for concerns of dietary consistency. There were no concerns documented in the records and no concerns voiced in the interviews. During observations, appropriate diets were provided to the residents.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility does not recheck a blood glucose level after a low blood glucose level is identified.

FINDINGS #4:

Six resident's records were reviewed for medication administration and follow-up. One resident's record was reviewed for diabetic management, and the resident and staff were interviewed regarding the resident's diabetic management.

Five residents' records reviewed did not document concerns for medication administration and follow-up.

One resident's admission orders included 75 units of insulin to be administered to the resident in the evening for diabetes and to assess his blood glucose (BG) levels before meals and at bed time.

In an interview, the resident said on his first day of admission at the facility, he asked the nurse to check his BG level and she checked it at 5:00 PM. The nurse said the BG was "low." The resident said the nurse brought him a cup of ice cream and never returned to recheck his BG level after he had his ice cream.

The resident's record did not include documentation the resident's BG was rechecked after 5:00 PM, on the date of his admission.

The DON was interviewed and he said he called the resident's nurse and she said she thought she checked the resident's BG level, but did not document the level.

Gavin Monteath, Administrator
September 16, 2019
Page 5 of 5

Based on investigative findings, the allegation was substantiated as it relates to the facility not documenting or rechecking a BG level, however no citations were issued as there was no evidence of current regulatory noncompliance. The facility corrected the problem prior to the survey.

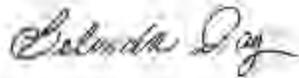
CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj