



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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TAMARA PRISOCK—ADMINISTRATOR  
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3232 Elder Street  
P. O. Box 83720  
Boise, Idaho 83720-0009  
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October 10, 2019

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

Provider #: 135011

Dear Mr. Monteath:

On **October 3, 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 an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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 **October 21, 2019**. Failure to submit an acceptable PoC by **October 21, 2019**, may result in the imposition of penalties by **November 12, 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 **November 7, 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 **January 3, 2020**. A change in the seriousness of the deficiencies on **November 17, 2019**, 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 **January 3, 2020** includes the following:

Denial of payment for new admissions effective **January 3, 2020**. [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 April 3, **2020**, 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 Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 3, 2020** 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 **October 21, 2019**. If your request for informal dispute resolution is received after **October 21, 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/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/03/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>GATEWAY TRANSITIONAL CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>527 MEMORIAL DRIVE</b> <b>POCATELLO, ID 83201</b>		
(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 a complaint investigation conducted from 10/1/19 to 10/3/19.  The survey was conducted by:  Monica Meister, QIDP, Team Coordinator Belinda Day, RN  Survey Abbreviations:  BIMS = Brief Interview for Mental Status CNA = Certified Nurse Assistant DON = Director of Nursing Services MDS = Minimum Data Set POA = Power of Attorney SLP = Speech and Language Therapist RN = Registered Nurse	F 000			
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii)  §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of	F 551		10/11/19	

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

TITLE

(X6) DATE

Electronically Signed

10/18/2019

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 551	<p>Continued From page 1 rights, except as limited by State law.</p> <p>§483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.</p> <p>§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.</p> <p>§483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.</p> <p>§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.</p> <p>(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority.</p> <p>(ii) The resident's wishes and preferences must be considered in the exercise of rights by the</p>	F 551			

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F 551	<p>Continued From page 2 representative.</p> <p>(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure a resident's rights were not delegated to an unauthorized person for 1 of 8 residents (Resident #3) whose records were reviewed. This resulted in the potential for a resident's rights to be violated. The findings include:</p> <p>Resident #3 was admitted to the facility on 8/2/18, with diagnoses which included muscle weakness, abnormalities of gait and mobility, and a lack of coordination.</p> <p>A quarterly MDS assessment, dated 9/12/19, documented Resident #3's BIMS score was 12, indicating she had mild cognitive impairment. The assessment also documented Resident #3 had the ability to express ideas and wants, she had clear comprehension, and she had the ability to understand others.</p> <p>An Advance Beneficiary Notice of Non-coverage (ABN), dated 7/8/19, documented Resident #3 had reached her maximum level of potential with her Physical and Occupational therapies and would benefit from restorative nursing. The ABN stated, "Talked on phone to POA [Power of Attorney] [name of daughter] on 7/8/19 at 2:30 p.m. and is in agreement with plan."</p> <p>Resident #3's Face Sheet, dated 8/2/18, listed her daughter as an emergency contact, not POA.</p>	F 551	<p>F-551 SS=D Resident Right Deciding Advanced Directives</p> <p>The corrective action that has been accomplished for the resident that was effected by the deficient practice is that her POST form was immediately updated with her showing her wishes matched that which was in her advanced directives. Clarification of DPOA status was made to the residents profile in her chart.</p> <p>All residents have the potential to be affected by the deficient practice. Corrective actions taken to ensure this has not happened with anyone else are, SS audited Advanced Directives of all residents to ensure all Advanced Directives were being coordinated with the resident or confirmed DPOA or resident appointed representative.</p> <p>Systemic changes made to ensure the deficient practice does not reoccur are that upon admission the resident is interviewed about Advanced Directive and offered information pertaining to Advanced Directives. Any Advanced Directive decisions are addressed by the resident themselves or by a resident DPOA/resident appointment representative/guardian that is confirmed</p>		

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F 551	Continued From page 3  Resident #3's record included a document which stated her end of life treatment wishes and was signed by Resident #3 and dated 12/5/87. The document included a section to designate a representative for Resident #3 if she was unable to make her own decisions, which was left blank.  On 10/3/19 at 7:25 AM, the DON was asked whether Resident #3 had a POA. The DON stated the facility was trying to figure it out.  The facility failed to ensure Resident #3's rights were not delegated to an unauthorized person.	F 551	via appropriate documentation. Policy and procedure updated to reflect the aforementioned interventions. SS department, admissions team, care plan team, in serviced to the said policy.  SS/Designee will assure upon admission, quarterly, annually, and in any other situations necessitating the coordination of Advance Directives that such decisions are coordinated by the resident themselves, or a resident representative, that is confirmed by legal documentation. 3X/week for one week, Weekly for 1 month, then per policy thereafter.  Date of Compliance 10/11/2019		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6)  §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.  §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.  §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure residents	F 559	F-559 SS=D Room Change Notification	10/11/19	

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F 559	<p>Continued From page 4</p> <p>received a written notice prior to a change in their room for 1 of 1 resident (Resident #3) who was reviewed for a room change. This resulted in a lack of information being provided to a resident necessary to make an informed decision. Findings include:</p> <p>Resident #3 was admitted to the facility on 8/2/18, with diagnoses which included muscle weakness, abnormalities of gait and mobility, and a lack of coordination.</p> <p>A quarterly MDS assessment, dated 9/12/19, documented Resident #3's BIMS score was 12, indicating she had a mild cognitive impairment. The assessment also documented Resident #3 had the ability to express ideas and wants, she had clear comprehension, and she had the ability to understand others.</p> <p>Resident #3's record included an untitled document, dated 9/1/19, which stated Resident #3 was moved to a different hall and room that day. The comments section of the document stated "DON requested due to Resident altercation. Family notified &amp; patient agreed."</p> <p>An investigation report, dated 9/6/19, included a statement from an RN about an incident which occurred on 9/1/19. The RN statement documented "[Resident #3] was moved into a different room on another hall around 10am [sic]. [Resident #3] is confused as to what is going on and where her new room is."</p> <p>On 10/3/19 at 7:25 AM, the DON stated there was no additional information related to Resident #3's room change.</p>	F 559	<p>The corrective action that was accomplished for the resident that was affected by the deficient practice is that the resident was moved back into her original room after being informed of the room change and explained as to why and risk vs benefits.</p> <p>All residents needing a room change have the potential to be affected by the deficient practice. Corrective actions taken where that no further room moves were made until policy and procedure could be updated so as to include appropriate notification of room change. A "notification of room or roommate changes" document was created to include the resident's name, what room to move to, the reason for the change, risks/benefits of the change, and resident's signature. This document has been implemented with each room change and will be scanned into the resident's chart.</p> <p>Measures/systemic changes that have been made to ensure that the deficient practice does not reoccur are that the policy and procedure has been updated to include the "notification of room or roommate changes" be issued with each room change that will indicate the resident has been informed what room to move to, the reason of the change, and the risk and benefits of the change. Admission staff and room coordinators have been inserviced to the said policy. Admissions coordinator/ designee will assure that the updated policy is being</p>		

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F 559	Continued From page 5  The facility failed to ensure Resident #3 received a written notice prior to her room change.	F 559	followed 3x/ week for 1 week, weekly for 1 month, then as needed thereafter.  Date of compliance 10/11/2019		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		10/11/19	

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F 578	<p>Continued From page 6</p> <p>individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure a resident's advance directives were recognized and her physician's order regarding code status was consistent with her end of life wishes for 1 of 6 residents (Resident #3) whose advance directives were reviewed. This resulted in the potential for a resident's choices for end of life treatment not being honored. Findings include:</p> <p>Resident #3 was admitted to the facility on 8/2/18, with diagnoses which included muscle weakness, abnormalities of gait and mobility, and a lack of coordination.</p> <p>Resident #3's record included a document which stated her end of life treatment wishes and was signed by Resident #3 and dated 12/5/87. The document stated Resident #3 did not want electrical or mechanical resuscitation if her heart stopped beating, naso-gastric tube feeding if she was unable to take nourishment by mouth, mechanical respirations if she was unable to sustain breathing, and if she was declared brain dead, she did not want mechanical means to prolong her life.</p> <p>Resident #3's current Physician Order and Face</p>	F 578	<p>F-578 SS=D POST Form/Code status not consent with advanced directive</p> <p>The corrective action was accomplished for the resident that was affected by the deficient practice is that her POST form and code status were immediately updated so as to be consistent with her Advanced Directive.</p> <p>All resident's have the potential to be affected by the deficient practice. Corrective actions taken were SS audited all resident's to compare and ensure the ordered code status and POST form were consistent with any Advanced Directives or with resident wishes.</p> <p>Measures/systemic changes that have been made to ensure the deficient practice does not reoccur are: the policy and procedure has been updated to include that upon admission and any other instance necessitating coordination of Advanced Directives and code status, include a review POST form and code status with Advanced Directive/resident wishes to ensure they are consistent. SS,</p>		

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F 578	Continued From page 7 Sheet, documented as of 8/2/18, she was "CPR/Full Code" (all interventions will be implemented to attempt to save a person from dying).  On 10/3/19 at 7:25 AM, the DON was asked about Resident #3's code status. The DON stated the facility was trying to figure it out.  The facility failed to ensure Resident #3's advance directives were honored.	F 578	admitting staff, and care plan team have been in-serviced to said policy.  SS/designee will review code status and Advanced Directives/resident wishes to ensure consistency 3X/week for 1 week, weekly for 1 month, then per policy thereafter.  Date of compliance 10/11/2019		
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 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary	F 657		10/11/19	

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NAME OF PROVIDER OR SUPPLIER  <b>GATEWAY TRANSITIONAL CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>527 MEMORIAL DRIVE</b> <b>POCATELLO, ID 83201</b>		
(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 657	<p>Continued From page 8</p> <p>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 observation, record review, and staff interview, it was determined the facility failed to ensure resident care plans were appropriately revised for 2 of 8 residents (#1 and #3) whose care plans were reviewed. This failure had the potential for residents to not receive care and services which met their needs. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 8/2/18, with diagnoses which included muscle weakness, abnormalities of gait and mobility, and a lack of coordination.</p> <p>A quarterly MDS assessment, dated 9/12/19, documented Resident #3's BIMS score was 12, indicating she had a mild cognitive impairment. The MDS documented Resident #3 had no behaviors.</p> <p>An investigation, dated 9/6/19, stated on 9/1/19 at 3:00 AM, Resident #5 reported to a CNA on duty Resident #3 was yelling out and he (Resident #5) went into Resident #3's room and found her without covers. The investigation stated Resident #5 replaced the covers on Resident #3 and then reported it to the CNA.</p> <p>The investigation included 3 statements from residents, dated 9/1/19, whose rooms were near Resident #3. The statements documented the following:</p> <p>- One resident (Room B21) statement</p>	F 657	<p>F-657 SS=D Care Plan Timing and Revision</p> <p>A. The corrective action accomplished for resident #3 affected by the deficient practice is behavior monitoring was implemented and care plan updated with interventions for the behaviors.</p> <p>B. The corrective action accomplished for resident #1 affected by the deficient practice is that his care plan was updated to reflect current and appropriate interventions for care including discontinuing the intervention to not be left alone in his room while in his chair.</p> <p>All resident's have the potential to be affected by the deficient practice. Corrective action taken were, the full care plans of both affected residents were reviewed and revised as indicated so as to reflect the current and most appropriate plan of care being implemented.</p> <p>Measures/systemic changes made to ensure the deficient practice does not reoccur are:</p> <p>A. The policy and procedures have been updated to include direction that when revisions are made to the care plan, the person making the revisions needs to</p>		

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F 657	<p>Continued From page 9</p> <p>documented "Resident reported he is often awake at night and can hear [Resident #3] yell out frequently throughout the night. Resident stated she [Resident #3] often repeats 'help me, help me.'"</p> <p>- The second resident (Room B18) statement documented "Resident stated her neighbor [Resident #3], often yells at night and will often yell 'help me, help me.' Resident stated she and [Resident #5] have visited with this resident [Resident #3] at night to help calm her down."</p> <p>- The third resident (Room B23) statement documented "Resident stated there is a resident [Resident #3] who calls out throughout the night. Resident stated...she yells out for a long time."</p> <p>Resident #3's care plan did not include a care area or interventions related to nighttime behaviors.</p> <p>On 10/3/19 at 7:25 AM, the DON stated Resident #3's care plan did not address nighttime behaviors and no concerns were reported by the staff.</p> <p>The facility staff did not revise and update Resident #3's care plan to include her nighttime behaviors.</p> <p>2. Resident #1 was readmitted to the facility on 5/21/19, with diagnoses which included Huntington's disease (a progressive breakdown of nerve cells in the brain), paraplegia, and depression.</p> <p>Resident #1's care plan related to falls, dated</p>	F 657	<p>review the rest of the care plan to ensure any duplicate and contradicting information is resolved from the care plan and the information in the care plan is current to the cares being provided. All clinical staff have been in-serviced to the updated policy.</p> <p>B. All clinical staff have been educated on behavior reporting to the appropriate clinical staff so that any changes can be care planned with corresponding interventions. All clinical staff have been in-serviced to the updated policy.</p> <p>DNS/designee will audit random care plans to ensure they are current of the cares and interventions being provided. They will also audit change of condition process to ensure behaviors are being monitored and care planned appropriately 3X/ weekly for 1 week, weekly for 1 month, as needed thereafter.</p> <p>Date of compliance 10/11/2019</p>		

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F 657	Continued From page 10 5/21/19, stated "Do not leave [Resident #1] in room in chair unattended."  Resident #1 was observed to be sitting in his wheelchair in his room, watching television. No staff were present in the room with him.  On 10/3/19 at 7:25 AM, the DON stated Resident #1 could be left alone in his room and his care plan needed to be revised.  The facility failed to ensure Resident #1's care plan was revised to meet his current needs.	F 657			
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a resident's care plan was implemented for 1 of 8 residents (Resident #3) whose care plans were reviewed. This resulted in a resident not consuming most of her lunch meal. Findings include:  Resident #3 was admitted to the facility on 8/2/18, with diagnoses which included muscle weakness, abnormalities of gait and mobility, and	F 684	F-684 SS=D Quality of Care  The corrective action accomplished for the resident affected by the deficient practice is that the resident's care plan was updated to have her assisted with meals.  All residents have the potential to be affected by the deficient practice. Corrective actions taken are, the	10/11/19	

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F 684	<p>Continued From page 11 a lack of coordination.</p> <p>Resident #3's care plan related to eating, dated 2/27/19, stated Resident #3 was to be provided with frequent cueing to eat as much as possible of her meals.</p> <p>Resident #3 was observed eating lunch on 10/2/19 from 12:15 PM to 12:40 PM. The lunch consisted of a tuna salad sandwich, pasta salad, water, juice, and ice cream.</p> <p>At 12:20 PM, Resident #3 was sitting at the table in the dining room for lunch service. She picked up her tuna salad sandwich. As she was moving the sandwich to her mouth, the contents of the sandwich fell onto her clothing protector. Resident #3 appeared to be unaware that the tuna salad had fallen from the sandwich and she proceeded to eat the bread. Resident #3 then placed her bowl of pasta salad on her plate and a styrofoam container of ice cream on her plate. Resident #3 picked up both her fork and spoon and held them in her right hand, the utensils were held in a crisscrossed position. She then used her fork, which was upside down, to scoop ice cream from the cup. Resident #3 was noted to obtain approximately ½ teaspoon of ice cream on her fork and eat it. She repeated this a second time. On the third scoop, 2 tines of the fork became inserted and stuck into the side of the styrofoam cup. Resident #3 let go of the fork and it remained stuck in the side of the cup. Resident #3 then used her spoon and retrieved a large scoop of ice cream. As she lifted the spoon to her mouth, the ice cream fell onto her lap. Resident #3 retrieved a second scoop of ice cream from the cup and as she lifted the spoon to her mouth,</p>	F 684	<p>identified CNA and SLP were educated to be more observant during meals and to ensure the interventions outlined in the care plan are being followed.</p> <p>Measures/systemic changes that have been made to ensure the deficient practice does not reoccur are, the policy and procedure have been updated to include that clinical staff are reviewing the care plan on a regular basis and cares provided are in accordance with the current plan of care. All clinical staff have been in-serviced to the updated policy.</p> <p>DNS/Designee will audit random areas of the care plans of random residents to ensure staff are reviewing the care plans on a regular basis and the cares provided are in accordance with the current plan of care. 3X/week for 1 week, weekly for 1 month, and as needed thereafter.</p> <p>Date of compliance 10/11/2019</p>		

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F 684	<p>Continued From page 12 the ice cream fell onto her lap.</p> <p>At 12:40 PM, Resident #3 requested help to leave the dining room. A nearby SLP assisted Resident #3 to remove her clothing protector and then used a cloth napkin to wipe the ice cream from Resident #3's lap. The SLP then requested a CNA be paged to help Resident #3 leave the dining room and get cleaned up. At 12:42 PM, the DON came into the dining room and assisted Resident #3 to her room.</p> <p>During the lunch meal, a CNA was observed sitting across from Resident #3 and the CNA was feeding two other residents. The SLP was observed approximately 10 feet from Resident #3 during the lunch meal. The CNA and the SLP did not assist or cue Resident #3 during her lunch.</p> <p>On 10/3/19 at 7:25 AM, the DON stated Resident #3's care plan was not implemented and she should have been assisted with her lunch.</p> <p>The facility failed to ensure Resident #3's care plan was implemented.</p>	F 684			



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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January 17, 2020

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

Provider #: 135011

Dear Mr. Monteath:

On **October 1, 2019** through **October 3, 2019**, an unannounced on-site complaint survey was conducted at Gateway Transitional Care Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008178**

**ALLEGATION #1:**

The facility is not providing a safe and clean environment, is not ensuring that residents receive adequate supervision and assistance devices to prevent accidents and residents are not receiving treatment and care in accordance with professional standards of practice and their care plans.

**FINDINGS #1:**

During the survey, observations, record review, and interviews were conducted with the following results.

Observations were conducted in the facility on 10/1/19 and 10/2/19. The facility was noted to be clean and no safety hazards were observed. Resident rooms were noted to be clean and clutter-free and contained large mugs of water near their beds. No foul odors were noted, and no concerns related to the facility's environment were identified during observations.

Additionally, residents were noted to be provided with supervision as needed as well as assistance devices including, but not limited to, Hoyer lifts, wheelchairs, walkers, palm-button call lights, and adaptive eating equipment. During observations, staff were noted to use appropriate infection control practices and keep residents' personal health information confidential in accordance with professional standards of practice. No concerns were identified during observations.

During observations, five cognitively intact residents were interviewed about the cleanliness of the facility, the use of assistant devices, and their care plans. The residents stated the facility was kept clean and they were provided with fresh water throughout the day. The residents stated if they required assistant devices, the facility was quick to obtain them. The residents stated they were involved in the development of their care plans and they were pleased with their services. No concerns were expressed by the residents.

Four Certified Nurse Assistants (CNAs), five Licensed Practical Nurses (LPNs), two Registered Nurses (RNs), and the supervisor over housekeeping, laundry and central supplies were interviewed. When asked, the staff stated they had not heard nor had they witnessed safety hazards in the facility or the facility being less than clean. The staff stated residents were provided supervision and assistance devices according to their care plans and if there were concerns, they were reported to the Director of Nursing and/or the Administrator.

Eight residents' records were selected for review. Resident's records documented the level of assistance and supervision they required as well as the use of assistance devices including Hoyer lifts, wheelchairs, walkers, palm-button call lights, and adaptive eating equipment. The residents' incident reports, dated 7/2019 - 9/2019, were also reviewed and no concerns related to the facility's environment, supervision, or assistance devices were identified.

It could not be determined that the facility was not providing a safe and clean environment, was not ensuring residents received adequate supervision and assistance devices to prevent accidents and that residents were not receiving treatment and care in accordance with professional standards of practice and their care plans. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The facility is not providing residents with necessary care and services and are not ensuring that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

FINDINGS #2:

Observations were conducted in the facility on 10/1/19 and 10/2/19. Residents were observed to be assisted with activities of daily living including, but not limited to, dressing, re-positioning, ambulating, and eating. Three residents were observed to be fed in the dining room during the breakfast and lunch meals on 10//2/19. During observations, several residents were noted in the facility's therapy room and were receiving physical and occupational therapies. No concerns related to care and services were identified during observations.

During observations, five cognitively intact residents were interviewed about the facility's care and services. The residents stated their needs were met and received whatever assistance they needed. The residents stated they were pleased with the care and services they received in the facility and no concerns were expressed.

Four Certified Nurse Assistants (CNAs), five Licensed Practical Nurses (LPNs), two Registered Nurses (RNs), and the supervisor over housekeeping, laundry and central supplies were interviewed. When asked, the staff stated they had not heard nor had they witnessed residents' needs not being met. The staff stated if a resident required assistance to carry out activities of daily living, it was included in their care plan and documented in their daily treatment record. No concerns related to the facility's care and services were expressed.

Eight residents' records were selected for review. One resident's record documented he required extensive assistance to dress and undress, extensive assistance to position and re-position himself and transfer from his bed to his wheelchair, he required oral care three times a day, and he required a staff to feed him. The resident's treatment record documented he received the care and services that were identified in his care plan.

A second resident's record documented he was admitted to the facility on 6/11/19 from a local hospital. The resident's care plan documented he required extensive assistance to complete his activities of daily living including, but not limited to, bathing, toileting, dressing, positioning, and oral care. The resident's admitting physician order documented the resident was NPO (nothing by mouth) due to a high risk of aspiration. The physician order and medication administration record documented the resident received all nutrition and fluids via a gastronomy tube. The resident's care plan, treatment record, and medication administration record were consistent with the physician order. The resident discharged on 7/3/19.

It could not be determined the facility was not providing residents with necessary care and services and were not ensuring residents received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

## CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

## ALLEGATION #3:

The facility is not ensuring residents maintain acceptable parameters of nutritional status including being offered sufficient fluids and that residents who are fed by enteral methods (a method of feeding that uses the gastrointestinal tract to deliver part or all of a person's caloric requirements) are not receiving the appropriate treatment and services to restore oral eating skills.

## FINDINGS #3:

Observations were conducted in the facility on 10/1/19 and 10/2/19. The breakfast and lunch meal were observed on 10/2/19. Three residents were observed in the dining room and were noted to be fed by staff and one resident's food items were noted to be a pureed texture. During the meal observations, residents were offered and consumed various kinds of juices, water, milk and coffee. Many of the residents requested additional fluids throughout the meal observations and staff quickly responded to their requests.

During observations, five residents were interviewed about their diets and being offered sufficient fluid intake. The residents stated they received plenty of food at each meal and sometimes, they could not eat everything that was served. The residents stated there was always a large selection of juices available as well as ice water and coffee. The residents stated they were pleased with the facility's dietary services. No dietary concerns were expressed by the residents.

Four Certified Nurse Assistants (CNAs), five Licensed Practical Nurses (LPNs), two Registered Nurses (RNs), the supervisor over housekeeping, laundry and central supplies, a Speech and Language Therapist, and a Dietitian were interviewed. When asked, the staff stated they had not heard nor had they witnessed residents' nutritional and hydration needs not being met. The staff stated if a resident was not maintaining an acceptable weight or if their laboratory reports showed abnormal results, the physician would review the information and prescribe changes to the resident's diet and/or nutritional supplements. The staff stated if changes were prescribed by the physician, the resident's care plan was updated and implemented.

Eight residents' records were selected for review. One resident's record documented the use of a gastronomy tube and the resident's care plan documented weekly weights were to be obtained. The resident's treatment record documented a slow but steady weight gain, and the resident had no abnormal laboratory reports.

A second resident record documented he was admitted to the facility on 6/11/19 from a local hospital and his weight was 90.6 pounds. The resident's admitting physician order documented the resident was NPO (nothing by mouth) due to a high risk of aspiration and weekly laboratory values were to be obtained. The physician order and medication administration record documented the resident received all nutrition (Jevity 1.5 formula at 64 cc/hour for continuous 24 hours) and fluids (180 milliliters water six times a day) via a gastronomy tube (g-tube). The resident's care plan, treatment record, and medication administration record were consistent with the physician order.

The resident's record documented that on the evening of 6/14/19, the resident was cleared to have a pureed/thin diet for "pleasure feedings for oral gratification" as well as the nutrition and fluids he received via his g-tube, with ongoing monitoring of weights and labs for nutrition.

A 6/14/19 progress note documented the resident received applesauce with a 1-person physical assistance and the resident coughed when presented with it.

A 6/19/19 progress note documented the resident continued continuous feeding of Jevity 1.5 at 64 cc/hour which was held during meals. Additionally, high protein snacks and nutritionally enhanced shakes were added to his oral intake. A 6/19/19 weight record documented his weight at 91.6 pounds.

A 6/21/19 progress note documented the resident continued on the pureed diet with thin liquids and continuous feeding of Jevity 1.5 at 64 cc/hour (which was held during meals) without complications. A 6/21/19 weight record documented his weight at 91.6 pounds.

A 6/22/19 progress note documented the resident's diet was upgraded to mechanical soft and his continuous feeding of Jevity 1.5 was changed to 100 cc/hour for 13 hours during the night.

A 6/25/19 physician order documented fortified pudding three times a day and Ensure Plus every 4 hours was added to the resident's diet.

A 6/26/19 weight record documented his weight at 92 pounds.

A 6/29/19 progress note documented the resident had a productive cough when drinking Ensure and did better with pudding, yogurt, and a nutritionally enhanced shake. His Jevity 1.5 was changed to 100 cc/hour for 13 hours during the night. A 6/29/19 weight record documented his weight at 93 pounds.

A 6/30/19 weight record documented his weight at 94 pounds.

A 7/1/19 progress note documented the resident's Jevity 1.5 was changed to 84 cc/hour for 13 hours during the night and the resident was eating 100% of fortified pudding and 100% of nutritionally enhanced shakes. The progress note stated the resident would not drink 100% of Ensure Plus although he was encouraged to do so.

A 7/2/19 weight record documented his weight at 94.4 pounds.

The resident discharged on 7/3/19. During the resident's stay at the facility, he continued to gain weight and tolerate upgrades to his diet.

It could not be determined that the facility was not ensuring residents maintain acceptable parameters of nutritional status including being offered sufficient fluids and that residents who were fed by enteral methods did not receive the appropriate treatment and services to restore oral eating skills. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #4:

The facility does not have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

#### FINDINGS #4:

Observations were conducted in the facility on 10/1/19 and 10/2/19. During the observations, residents were noted to be clean and well groomed. Staff were noted to respond to residents' call lights within 2 minutes. Staff were also noted to be assisting residents to the activity room, dining rooms, and shower rooms in addition to checking on each resident on a rounding schedule. No concerns related to sufficient nursing staff were identified.

During observations, five residents were interviewed about sufficient numbers of nursing staff. The residents stated there were sufficient numbers of staff and they did not have to wait long before their call lights were answered. The residents stated they were pleased with the services provided by the facility and no concerns were expressed.

The facility's as-worked schedules, dated July 2019 - September 2019 were reviewed, and no concerns related to insufficient numbers of staff were identified.

Four Certified Nurse Assistants (CNAs), five Licensed Practical Nurses (LPNs), two Registered Nurses (RNs), and the supervisor over housekeeping, laundry and central supplies were interviewed. When asked, the staff stated they had not heard nor had they witnessed the facility being short staffed. No concerns related to sufficient nursing staff were expressed.

Eight residents' records were selected for review. The residents' treatment records documented they were receiving bathing, oral care, activities, positioning and transfers as specified in their care plans. No concerns related to insufficient numbers of staff were identified in the records.

It could not be determined that the facility did not have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #5:

The facility is not providing residents with a nourishing, palatable, well-balanced diet that is prepared in a form designed to meet individual needs and is not providing special eating equipment and utensils and assistance to residents who require assistance.

#### FINDINGS #5:

Observations were conducted in the facility on 10/1/19 and 10/2/19. During observations, the breakfast and lunch meal were observed. The food items appeared palatable and the meals were well balanced. For example, cereal (hot and cold), eggs (fried, scrambled, or omelet), toast (white and wheat), various juices, coffee, and milk were served for breakfast. During observations, three residents were observed to be fed by facility staff. One resident had a pureed diet and adaptive plates and bowls were used with the resident. Several residents who ate their meals in the dining room were noted to use adaptive eating devices including, but not limited to, scoop plates, high-sided divided plates, built-up handles on their eating utensils, and adaptive drinking glasses. No concerns related to special eating equipment and utensils and assistance to ensure the residents could use the assistive devices were identified. No concerns related to palatable and well-balanced diets, prepared in a form designed to meet individual needs, special eating equipment and utensils, and assistance were identified during observations.

During observations, five residents were interviewed about the food served by the facility, special eating equipment and utensils, and assistance from staff. The residents stated the food was very good and sometimes, they could not eat everything that was served. The residents stated they had a selection of foods to choose from at each meal and if they needed help to eat, all they had to do was ask and there were staff available to help them. No concerns about special eating equipment and utensils were expressed by the residents.

Four Certified Nurse Assistants (CNAs), five Licensed Practical Nurses (LPNs), two Registered Nurses (RNs), the supervisor over housekeeping, laundry, and central supplies, a Speech and Language Therapist, and a Dietitian were interviewed. When asked, the staff stated they had not heard nor had they witnessed residents not receiving a nourishing, palatable, well-balanced diet. The CNAs reported each resident has a meal card on their meal tray which was prepared by kitchen staff and then reviewed again by dining room staff prior to serving the resident to ensure each resident had the correct diet and necessary eating equipment and utensils. No concerns related to the quality of food, appropriate diets, and special eating equipment and utensils were expressed.

Eight residents' records were selected for review. Two residents' records documented the use of adaptive eating devices including the use of a straw and adaptive plates and bowls. One resident's record documented he had a pureed diet and he required eating assistance for all meals and snacks.

A third resident's record documented he was admitted to the facility on 6/11/19 and his admitting physician order documented the resident was NPO (nothing by mouth) due to a high risk of aspiration. The physician order and medication administration record documented the resident received all nutrition (Jevity formula at 64 cc/hour continuously 24 hours) and fluids (180 milliliters water six times a day) through a gastrostomy tube (g-tube). The resident's care plan, treatment record, and medication administration record were consistent with the physician order. The resident's record documented on the evening of 6/14/19, the resident was cleared to have a pureed/thin diet for "pleasure feedings for oral gratification" as well as the nutrition and fluids he received via his g-tube.

A 6/14/19 progress note documented the resident received applesauce with a 1-person physical assistance and the resident coughed when presented with it.

A 6/19/19 progress note documented the resident continued continuous feeding of Jevity 1.5 at 64 cc/hour which was held during meals. Additionally, high protein snacks and nutritionally enhanced shakes were added to his oral intake.

A 6/21/19 progress note documented the resident continued the pureed diet with thin liquids and continuous feeding of Jevity 1.5 at 64 cc/hour (which was held during meals) without complications.

A 6/22/19 progress note documented the resident's diet was upgraded to mechanical soft and Jevity 1.5 was changed to 100 cc/hour for 13 hours during the night.

A 6/25/19 physician order documented fortified pudding three times a day and Ensure Plus every 4 hours was added to the resident's diet.

A 6/29/19 progress note documented the resident had a productive cough when drinking Ensure and did better with pudding, yogurt, and a nutritionally enhanced shake.

A 7/1/19 progress note documented the resident's Jevity 1.5 was changed to 84 cc/hour for 13 hours during the night and the resident was eating 100% of fortified pudding and 100% of nutritionally enhanced shakes. The progress note stated the resident would not drink 100% of Ensure Plus although he was encouraged to do so.

The resident's record documented he required feeding assistance for all meals and snacks. However, there was no documentation the resident required special eating equipment and utensils. The resident discharged on 7/3/19.

It could not be determined that the facility was not providing residents with a nourishing, palatable, well-balanced diet, prepared in a form designed to meet individual needs, and was not providing special eating equipment and utensils and assistance to residents who required assistance. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #6:

The facility is not documenting reported accidents including falls.

#### FINDINGS #6:

Four Certified Nurse Assistants (CNAs), five Licensed Practical Nurses (LPNs), two Registered Nurses (RNs), the supervisor over housekeeping, laundry, and central supplies, a Speech and Language Therapist, and a Dietitian were interviewed. When asked, the staff stated they had not heard nor had they been told to not document all accidents including falls.

Gavin Monteath, Administrator  
January 17, 2020  
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Eight residents' records and their incident reports, dated 7/2019 - 9/2019, were selected for review. One resident's record contained documentation of a fall on 6/22/19 and no incident report for the fall could be found. However, the fall incident was incorporated into a change of condition evaluation which was completed on 6/23/19.

It could not be determined that the facility was not documenting reported accidents including falls. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

#### CONCLUSIONS:

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.

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



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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January 22, 2020

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

Provider #: 135011

Dear Mr. Monteath:

On **October 1, 2019** through **October 3, 2019**, an unannounced on-site complaint survey was conducted at Gateway Transitional Care Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008263**

**ALLEGATION #1:**

The facility failed to ensure each resident's right to receive written notice before a room change occurred was upheld.

**FINDINGS #1:**

During the survey, record review and interviews were conducted with the following results.

An investigation, dated 9/6/19, documented on 9/1/19 at 3:00 AM, a male resident reported to a Certified Nurse Assistant (CNA) on duty that a female resident was yelling out and the male resident went into the female resident's room and found her without covers. The investigation stated the male resident replaced the covers on the female resident and then reported it to a CNA. The investigation documented two CNAs, who were on duty, went into the female resident's room and found her in a disheveled manner and her attends were unfastened and part way down, without being fully exposed.

The investigation included a typed statement, dated 9/1/19, from a Registered Nurse (RN) who was on duty at the time of the incident. The RN statement documented "(###) was moved into a different room on another hall around 10am (###). (###) is confused as to what is going on and where her new room is."

Eight residents were selected for review. One resident's record included an untitled document, dated 9/1/19, that documented the resident was moved to a different hall and room on that day. The Comments section of the document stated "DON (###) requested due to Resident altercation. Family notified & patient agreed."

The untitled document was not signed by the resident and the document did not include additional information related to the resident's right to refuse the room change, potential risks versus the benefits associated with the room change, unintended consequences of changing rooms including psychological ramifications, or alternative options for the resident. Additionally, there was no evidence that the resident received an explanation in writing of why the move was required or evidence that the resident was provided the opportunity to see the new location and ask questions about the move.

When asked, the DON stated during an interview on 10/3/19 from 7:25 - 8:05 AM, there was no additional information related to the resident's room change.

Based on investigative findings, the allegation was substantiated and the facility was cited F559 as it relates to providing residents a written notice and obtain a resident's consent for room changes.

#### **CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

#### **ALLEGATION #2:**

The facility failed to provide necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of residents in accordance with their comprehensive assessments and plans of care, including, but is not limited to, the prevention and treatment of nighttime behaviors.

#### **FINDINGS #2:**

The investigation included 3 typed statements from residents, all dated 9/1/19, whose rooms were near to the female resident. The statements documented the following:

- One resident statement documented "Resident reported he is often awake at night and can hear (###) yell out frequently throughout the night. Resident stated she (###) often repeats 'help me, help me.'"
- The second resident statement documented "Resident stated her neighbor (###), often yells at night and will often yell 'help me, help me.' Resident stated she and (###) have visited with this resident (###) at night to help calm her down."
- The third resident statement documented "Resident stated there is a resident (###) who calls out throughout the night. Resident stated...she yells out for a long time."

However, the resident's care plan, initiated on 8/13/18, did not include information related to nighttime behaviors.

When asked, the DON stated during an interview on 10/3/19 from 7:25 - 8:05 AM, the resident's care plan did not address nighttime behaviors and no concerns were reported by the Certified Nurse Assistants.

Based on investigative findings, the allegation was substantiated and the facility was cited at F740 as it relates to ensuring residents' care plans are updated to ensure residents receive care individualized to their needs.

### **CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

### **ALLEGATION #3:**

The facility does not have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of residents in accordance with their comprehensive assessments and plans of care, including, but not limited to, residents who wander into/out of others' rooms.

### **FINDINGS #3:**

The facility's as-worked schedules, dated July 2019 - September 2019 were reviewed. No concerns related to insufficient numbers of staff were identified.

Four CNAs, 2 RNs, 5 Licensed Practical Nurses (LPNs), and the supervisor over housekeeping, laundry and central supplies were interviewed. No concerns related to insufficient numbers of nursing staff or residents wandering into/out of others' rooms were expressed.

Eight residents were selected for review. No concerns related to insufficient numbers of staff were identified.

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

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #4:**

The facility failed to ensure all allegations of abuse, neglect, exploitation, or mistreatment are thoroughly investigated.

**FINDINGS #4:**

The facility's investigations were reviewed. One investigation, dated 9/6/19, documented on 9/1/19 at 3:00 AM, a male resident reported to a CNA on duty that a female resident was yelling out and the male resident went into the female resident's room and found her without covers. The investigation documented the male resident replaced the covers on the female resident and then reported it to a CNA. The investigation documented two CNAs on duty went into the female resident's room and found her in a disheveled manner and her attends (adult brief) was unfastened and part way down, without being fully exposed.

The investigation included both resident and staff statements, a physical assessment of the resident, an investigation report from the local police department, 15-minute bed checks from 9/1/19 - 9/4/19, and a summary. The investigation stated that abuse was unsubstantiated. The investigation also stated that residents expressed concerns with the timeliness of answering call lights during the night. The investigation documented a nighttime call-light audit was conducted by the DON and staff were re-serviced on the facility's abuse policy as well as being mindful of residents' extremities during transfers.

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

Gavin Monteath, Administrator  
January 22, 2020  
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**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,

A handwritten signature in cursive script that reads "Belinda Day". The signature is written in black ink and is positioned above the typed name and title.

Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj