October 21, 2019

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

Provider #: 135011

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Monteath:

On October 3, 2019, a Facility Fire Safety and Construction survey was conducted at Gateway Transitional Care Center by the Department of Health & Welfare, 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 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. Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must
be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by November 4, 2019. Failure to submit an acceptable PoC by November 4, 2019, may result in the imposition of civil monetary penalties by November 25, 2019.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

- Include dates when corrective action will be completed.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may 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 1, 2020. A change in the seriousness of the deficiencies on November 17, 2019, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by November 7, 2019, 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 noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (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 October 3, 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:
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 **November 4, 2019**. If your request for informal dispute resolution is received after **November 4, 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, please contact us at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures
**Statement of Deficiencies and Plan of Correction**

**Name of Provider or Supplier:** Gateway Transitional Care Center  
**Street Address, City, State, Zip Code:** 527 Memorial Drive, Pocatello, ID 83201

<table>
<thead>
<tr>
<th>ID</th>
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<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
</tr>
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<tbody>
<tr>
<td>K000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td>The facility is a multi story, type II (222) fire resistive structure originally constructed in 1963. The building is fully sprinklered, with an interconnected fire alarm/Smoke detection system. The facility is located within a municipal fire district, with both county and state EMS services available. There is both an on-site, diesel-fired Emergency Power Supply System (EPSS) generator and piped in medical gas. Currently the facility is licensed for 88 SNF beds, and had a census of 71 on the date of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on October 3, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The surveyor conducting the survey was: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</td>
<td></td>
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| K211 | Means of Egress - General | | **Means of Egress - General**  
Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1  
This REQUIREMENT is not met as evidenced by:  
Based on operational testing and interview, the facility failed to ensure means of egress were |

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

**(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:** 135011

**(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING ___________**

**(X3) DATE SURVEY COMPLETED:** 10/03/2019

**NAME OF PROVIDER OR SUPPLIER:** GATEWAY TRANSITIONAL CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 527 MEMORIAL DRIVE POCAHETTO, ID 83201

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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>K 211</td>
<td>Continued From page 1 maintained to allow immediate use in an emergency. Failure to ensure exit door latches do not require special knowledge to release, has the potential to trap persons inside, hindering safe evacuation during an emergency. This deficient practice affected staff on the date of the survey. Findings include: During the facility tour conducted on 10/3/19 from 2:00 - 3:00 PM, operational testing of the Mechanical Room door to the corridor on the B2 level, revealed the door latch would only release if activated in an upward motion and not if activated in both directions as designed. Interview of the Maintenance Supervisor at approximately 2:30 PM, revealed he was aware the door latch was not working as designed. Actual NFPA standard: 19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted. 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.</td>
<td>K 211</td>
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<tr>
<td>K 293</td>
<td>Exit Signage</td>
<td>SS=F</td>
<td>CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.</td>
<td>K 293</td>
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</table>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 135011

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - ENTIRE BUILDING
B. WING

(X3) DATE SURVEY COMPLETED: 10/03/2019

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

K 293 Continued From page 2
with less than 30 occupants where the line of exit travel is obvious.)
This REQUIREMENT is not met as evidenced by:
Based on observation, the facility failed to ensure exits were marked in accordance with NFPA 101. Failure to ensure exits were provided with signage that clearly identifies the path of travel to an exit, has the potential to hinder evacuation during an emergency. This deficient practice affected 34 residents, staff and visitors on the date of the survey.

Findings include:

During the facility tour conducted on 10/3/19 from 11:00 AM - 2:00 PM, observation of installed exit signs revealed the following:

- In the "B" hall, an exit sign was observed at the corridor intersection outside room 18. Observation of the installed sign's chevrons, established the directional arrow indicated travel to the west, through a pair of smoke barrier doors. When activated, travel in this direction through the smoke barrier failed to identify the path to the exit access, but directly toward and into the doors of Assisted Dining.
- In the "R" hall, a pair of smoke barrier doors at room(s) 62 and 63, failed to readily identify the path of travel through these doors to the exit access when activated and closed on either side.

Actual NFPA standard:

19.2.10 Marking of Means of Egress.
19.2.10.1 Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4.
# State of Deficiencies and Plan of Correction

**Provider/Supplier/CLA Identification Number:** 135011  
**Multiple Construction:** A. Building 01 - Entire Building  
**Date Survey Completed:** 10/03/2019

## Name of Provider or Supplier
**Gateway Transitional Care Center**  
**Address:** 527 Memorial Drive  
**City:** Pocatello  
**State:** ID  
**Zip Code:** 83201

## Summary Statement of Deficiencies

### K 293 Continued From page 3

- **7.10.1.5 Exit Access.**
  - Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants.

### K 353 Sprinkler System - Maintenance and Testing

- **CSS=F CFR(s): NFPA 101**
  - Sprinkler System - Maintenance and Testing  
  - Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.  
  - a) Date sprinkler system last checked  
  - b) Who provided system test  
  - c) Water system supply source

- Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.  
- 9.7.5, 9.7.7, 9.7.8, and NFPA 25  
- This REQUIREMENT is not met as evidenced by:  
  - Based on record review and observation, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25.  
  - Failure to ensure fire suppression systems were maintained free of obstructions and inspected as required, has the potential to hinder system performance during a fire event. This deficient practice affected 71 residents and staff on the date of the survey.

## Findings Include:

**Form CMS-2567(02-99) Previous Versions Obsolete**  
**CKCT21**  
**If continuation sheet Page 4 of 17**
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<tr>
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| K353 | Continued From page 4 | K353 | 1) During review of provided maintenance and inspection records conducted on 10/3/19 from 8:45 - 11:00 AM, records did not demonstrate monthly inspections of control valves were conducted.  
2) During the facility tour conducted on 10/3/2019 from 11:00 AM - 1:00 PM, observation of the storage closet at the Activities room revealed the sprinkler pendant at the back of the closet was blocked by storage, providing approximately 8 inches of clearance from the bottom of the deflector to the top of combustible storage on the top shelf.  
3) During the facility tour conducted on 10/3/19 from 1:00 - 3:00 PM, observation of the South riser revealed one (1) painted sprinkler pendant.  
Actual NFPA standard:  
Finding 1.  
13.3 Control Valves in Water-Based Fire Protection Systems.  
13.3.2 Inspection.  
13.3.2.1 All valves shall be inspected weekly.  
13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.  
Finding 2  
5.2.1.2* The minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors.  
NFPA 13 |
<table>
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<th>(X5) COMPLETION DATE</th>
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<tr>
<td>K 353</td>
<td>Continued From page 5 8.5.6* Clearance to Storage. 8.5.6.1* Unless the requirements of 8.5.6.2, 8.5.6.3, 8.5.6.4, or 8.5.6.5 are met, the clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. Finding 3 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer</td>
<td>K 353</td>
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<td>K 363</td>
<td>Corridor - Doors SS=D CFR(s): NFPA 101  Corridor - Doors  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor</td>
<td>K 363</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** 135011

**MULTIPLE CONSTRUCTION**

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<th>A. BUILDING 01 - ENTIRE BUILDING</th>
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**DATE SURVEY COMPLETED:** 10/03/2019

**NAME OF PROVIDER OR SUPPLIER**

**GATEWAY TRANSITIONAL CARE CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

527 MEMORIAL DRIVE

POCATELLO, ID 83201

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**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

**K 363 Continued From page 6**

Covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area of fire resistance of glass or frames in window assemblies.

19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485

Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.

This REQUIREMENT is not met as evidenced by:

Based on observation and operational testing, the facility failed to ensure doors entering resident rooms from the corridor stayed latched when closed. Failure to ensure doors entering resident rooms from the corridor would close and latch has the potential to allow fire, smoke and dangerous gases to pass between compartments and affect the safe evacuation of residents. This deficient practice affected 19 residents, staff and visitors during the survey.

**Findings include:**

During the facility tour conducted on 10/3/19 from 11:00 AM - 3:00 PM, observation and operational testing of doors entering resident rooms from the
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER:** GATEWAY TRANSITIONAL CARE CENTER  
**STREET ADDRESS, CITY, STATE, ZIP CODE:** 527 MEMORIAL DRIVE, POCATELLO, ID 83201

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<th>(X5) COMPLETION DATE</th>
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| K 363             | Continued From page 7 corridor revealed the door(s) to room 32/34 and 56/58 would not stay latched when closed.  
Actual NFPA standard:  
19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply:  
(1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door.  
(2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7. | K 363 | |
| K 511             | Utilities - Gas and Electric  
CFR(s): NFPA 101  
Utilities - Gas and Electric  
Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.  
18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 | K 511 | |

This REQUIREMENT is not met as evidenced by:  
Based on observation, operational testing and interview, the facility failed to ensure safe electrical installations were maintained in accordance with NFPA 70. Failure to maintain listed assemblies and provide enclosures for open electrical connections has the potential to allow contact with live parts and increase the
K 511 Continued From page 8

exposure of surrounding areas to the risk of arc fires. This deficient practice affected 32 residents and staff on the date of the survey.

Findings include:

1) During the facility tour conducted on 10/3/19 from 1:00 - 3:00 PM, observation of facility electrical installations revealed the following:

- On the B2 level, two exposed wires were observed projecting out of a conduit mounted on the west wall.
- In the ceiling area of the B2 level, an open four inch by four inch junction box with exposed wiring.

Interview of the Maintenance Supervisor at approximately 2:30 PM established he was not aware of the exposed live wiring on this level prior to the date of the survey.

2) During the facility tour conducted on 10/3/19 from 1:00 - 2:00 PM, observation of the Dietary office and the MDS office revealed each had a wall-mounted, electric radiant heater installed. Further observation revealed each had a safety label on the top of the unit, indicating to keep a clearance of three (3) feet from the unit front and sides.

Observation of the unit in the Dietary office at approximately 1:30 PM revealed a chair placed directly in front of it and observation of the unit in the MDS office at approximately 1:40 PM revealed the unit was blocked by a desk. Operational testing of the wall-mounted thermostat directly above the unit(s) revealed both units were operational and producing heat.
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA
IDENTIFICATION NUMBER: 135011

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - ENTIRE BUILDING
B. WING __________________________

(X3) DATE SURVEY COMPLETED 10/03/2019

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)

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<td>K 511</td>
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3) Above the ceiling inspection(s) at the smoke barriers by rooms 8 and 83 conducted on 10/3/19 from 2:00 - 3:00 PM, three (3) Heating Ventilation and Air Conditioning (HVAC) air handlers were observed with missing protective covers for the controls, wiring and compressor area of the unit(s).

Actual NFPA standard:

NFPA 70

110.3 Examination, Identification, Installation, and Use of Equipment.

(A) Examination. In judging equipment, considerations such as the following shall be evaluated:

(1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling.

(2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided

(3) Wire-bending and connection space

(4) Electrical insulation

(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service

(6) Arcing effects

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FORM CMS-2567(02-99) Previous Versions Obsolete

CKCT21

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## Statement of Deficiencies and Plan of Correction

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<th>(X3) Date Survey Completed</th>
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<td>135011</td>
<td>A. Building 01 - Entire Building</td>
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<td>B. Wing __________________</td>
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### Name of Provider or Supplier

**Gateway Transitional Care Center**

527 Memorial Drive

POCATELLO, ID 83201

### Summary Statement of Deficiencies

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| K 511         | Continued From page 10

1. Classification by type, size, voltage, current capacity, and specific use
2. Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment.
3. Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.
4. Guarding of Live Parts.
   - **(A) Live Parts Guarded Against Accidental Contact.** Except as elsewhere required or permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved enclosures or by any of the following means:
     1. By location in a room, vault, or similar enclosure that is accessible only to qualified persons.
     2. By suitable permanent, substantial partitions or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them.
     3. By location on a suitable balcony, gallery, or platform elevated and arranged so as to exclude unqualified persons.
     4. By elevation of 2.5 m (8 ft) or more above the floor or other working surface.
   - **(B) Prevent Physical Damage.** In locations where electrical equipment is likely to be exposed to physical damage, enclosures or guards shall be so arranged and of such strength as to prevent such damage.
   - **(C) Warning Signs.** Entrances to rooms and other guarded locations that contain exposed live parts shall be marked with conspicuous warning signs.
#### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:** 135011

**Multiple Construction**

- **A. Building:** 01 - Entire Building
- **B. Wing:**

**Date Survey Completed:** 10/03/2019

**Name of Provider or Supplier:** Gateway Transitional Care Center

**Street Address, City, State, Zip Code:** 527 Memorial Drive Pocatello, ID 83201

### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

1. **K 511**
   - **Continued From page 11**
   - Forbidding unqualified persons to enter. Informational Note: For motors, see 430.232 and 430.233. For over 600 volts, see 110.34.

2. **K 911**
   - **Electrical Systems - Other**
   - **SS=F**
   - **CFR(s): NFPA 101**

   Electrical Systems - Other
   
   List in the Remarks section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)

   This requirement is not met as evidenced by:

   Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station in accordance with NFPA 110. Failure to provide a remote manual stop station for the EES generator, potentially hinders staff ability to shut down the generator if required during an emergency. This deficient practice affected 71 residents and staff on the date of the survey.

   Findings include:

   During the facility tour conducted on 10/3/19 from approximately 1:00 - 3:00 PM, a remote manual stop for the EES generator was not located.

   When asked at approximately 2:45 PM if he was aware if the generator was equipped with a remote manual stop, the Maintenance Supervisor stated he thought it was the key switch control on the transfer switch housing.

   Actual NFPA standard:

   FORM CMS-2567(02-99) Previous Versions Obsolete

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CKCT21

If continuation sheet Page 12 of 17
<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>135011</td>
<td></td>
<td>10/03/2019</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

GATEWAY TRANSITIONAL CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

527 MEMORIAL DRIVE
POCATELLO, ID 83201

<table>
<thead>
<tr>
<th>(X4) ID</th>
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</thead>
<tbody>
<tr>
<td>K 911</td>
<td></td>
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<tr>
<td></td>
<td>Continued From page 12</td>
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</tr>
<tr>
<td></td>
<td>NFPA 110</td>
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<tr>
<td></td>
<td>5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>(X4) ID</th>
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<th>TAG</th>
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<tbody>
<tr>
<td>K 926</td>
<td>SS=E</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gas Equipment - Qualifications and Training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CFR(s): NFPA 101</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gas Equipment - Qualifications and Training of Personnel</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment.</td>
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</tr>
<tr>
<td></td>
<td>11.5.2.1 (NFPA 99)</td>
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<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by:</td>
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<tr>
<td></td>
<td>Based on record review, and interview, the facility failed to ensure staff participation in training on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to ensure all direct-care staff involved with the application, maintenance and handling of medical gases are trained on safety and the risks associated with the use of oxygen, has the potential to expose residents to those hazards. This deficient practice potentially affected oxygen dependent residents and staff on the date of the survey.</td>
<td></td>
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</tbody>
</table>

Findings include:

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**FORM CMS-2567(02-99) Previous Versions Obsolete**

CKCT21

If continuation sheet Page 13 of 17
## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLA Identification Number:** 135011  
**Multiple Construction:** A. Building 01 - Entire Building  
**Date Survey Completed:** 10/03/2019

### Name of Provider or Supplier
GATEWAY TRANSITIONAL CARE CENTER  
527 MEMORIAL DRIVE  
POCATELLO, ID 83201

### Summary Statement of Deficiencies

**K 926 Continued From page 13**

During review of provided inservice training records conducted on 10/3/2019 from 8:45 - 11:00 AM, documentation provided failed to demonstrate all direct-care staff completed training on oxygen safety and the risks associated with medical gases.

Interview of the Maintenance Supervisor at approximately 10:45 AM, established that he was not aware all direct care staff hadn't participated in medical gas safety training.

Actual NFPA standard:

**NFPA 99**

11.5.2 Gases in Cylinders and Liquefied Gases in Containers  
11.5.2.1 Qualification and Training of Personnel.  
11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use.  
11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel.  
11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.

**K 927 Gas Equipment - Transfilling Cylinders**  
**SS=D CFR(s): NFPA 101**

Gas Equipment - Transfilling Cylinders  
Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>K927</td>
<td></td>
<td></td>
<td>Continued From page 14 one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure liquid oxygen (LOX) transfilling was conducted in accordance with NFPA 99. Failure to ensure LOX transfilling was conducted over clean concrete, ceramic flooring or in stainless steel pan, has the potential for cryogenic oxygen to come into contact with dirt, grease or other hydrocarbons, historically increasing the risk of explosions. This deficient practice had the potential to affect staff, structural integrity of the building and protections in place on the date of the survey. Findings include: During the facility tour conducted on 10/3/19 from 11:00 AM to 2:00 PM, observation of the oxygen transfill room located in the north wing of the facility revealed the floor had dirt, broken tile and lint scattered throughout the area where transfilling occurred. Further observation revealed sections of the floor near the door and where staff performed transfilling, were coated with paint. Actual NFPA standard: 11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable. 11.5.2.3.2 Transfilling to liquid oxygen portable containers at 344.74 kPa (50 psi) and under shall...</td>
<td>K927</td>
<td></td>
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</tbody>
</table>

**Provider Information**

**Name of Provider or Supplier:** Gateway Transitional Care Center  
**Street Address, City, State, Zip Code:** 527 Memorial Drive, Pocatello, ID 83201

**Identification Number:** 135011  
**Multiple Construction:** A. Building 01 - Entire Building  
**Completion Date:** 10/03/2019
<table>
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>K 927</td>
<td>Continued From page 15 include the following:</td>
<td>K 927</td>
<td>PROVIDER'S PLAN OF CORRECTION</td>
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<tr>
<td>(1)</td>
<td>The area is well ventilated and has noncombustible flooring.</td>
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<td>EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY</td>
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<td>(2)</td>
<td>The area is posted with signs indicating that smoking in the area is not permitted.</td>
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<td>(3)</td>
<td>The individual transferring the liquid oxygen portable container has been properly trained in the transferring procedure.</td>
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<tr>
<td>(4)</td>
<td>The guidelines of CGA P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, are met.</td>
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<tr>
<td>K 930</td>
<td>Gas Equipment - Liquid Oxygen Equipment CFR(s): NFPA 101</td>
<td>K 930</td>
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<tr>
<td>SS=D</td>
<td>Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99).</td>
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<td>11.7 (NFPA 99)</td>
<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on observation, the facility failed to ensure liquid, or cryogenic, oxygen cylinders were secured in accordance with NFPA 99. Failure to ensure cryogenic oxygen cylinders are secured by either a cart or chain, has the potential to expose to tipping or damages, increasing resident's risk to explosions. This deficient practice affected staff on the date of the survey.</td>
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<tr>
<td>Findings include:</td>
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<td></td>
<td>During the facility tour conducted on 10/3/19 from 11:00 AM - 2:00 PM, observation of the oxygen transfill and storage room, revealed 7 of 7 cryogenic oxygen cylinders were not secured by a chain or placed in a rack or cart.</td>
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<tr>
<td>Actual NFPA standard:</td>
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<tr>
<td>ID</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
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<tr>
<td>K930</td>
<td>Continued From page 16</td>
<td></td>
<td>11.7.3 Container Storage, Use, and Operation, 11.7.3.1* Containers shall be stored, used, and operated in accordance with the manufacturer's instructions and labeling. 11.7.3.2 Containers shall not be placed in the following areas: (1) Where they can be tipped over by the movement of a door (2) Where they interfere with foot traffic (3) Where they are subject to damage from falling objects (4) Where exposed to open flames and high-temperature devices 11.7.3.3* Liquid oxygen base reservoir containers shall be secured by one of the following methods while in storage or use to prevent tipping over caused by contact, vibration, or seismic activity: (1) Securing to a fixed object with one or more restraints (2) Securing within a framework, stand, or assembly designed to resist container movement (3) Restraining by placing the container against two points of contact</td>
<td>K930</td>
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</table>
K 211

Corrective Action:
Gateway TCC replaced the defective door latch to the B1 mechanical room with a new industrial door latch on 10/10/2019

Identification of others affected:
The deficiency had the potential to affect all employees and vendors who may have used or worked in the mechanical room.

Systemic changes to ensure deficient practice doesn’t repeat:
The maintenance director learned that door latches could not require special knowledge to operate. Doors will be inspected with the understanding that the latch must open without special knowledge of how to operate.

Monitor of corrective action:
During monthly door inspections, latches will be tested to ensure that they open by turning both directions and with no special knowledge to operate.

Corrective Action Completed: 10/10/2019

K 293

Corrective Action:
Gateway TCC added additional emergency exit signs outside of the therapy gym (with chevron directing toward exit) and on each side of the bulk head on “D” hall outside of rooms 68 & 63.

Identification of others affected:
The deficiency had the potential to affect all employees, residents and visitors who may need to exit the building during an emergency.

Systemic changes to ensure deficient practice doesn’t repeat:
Permanent emergency exit signs were placed with directional indicators in order to comply with NFPA 101.7.10. These signs were wired into the facilities emergency power system and will direct traffic to the exits in the event of an emergency.

Monitor of corrective action:

The new emergency exit signs will be added to the monthly emergency lighting test conducted by the maintenance director.

Corrective Action Completed: 10/8/2019

1. A monthly control valve inspection document has been added to the North and South riser room. The control valves will be inspected and then documented at least once a month.
2. The storage shelves in the activities closet, where storage was blocking the sprinkler pendant in the back of the closet has been permanently removed in order to obtain no less than 18 inches of clearance.
3. The sprinkler pendant in the South riser room with paint on it was replaced by 3D Fire, with a new pendant on 10/14/2019.

Identification of others affected:

These deficiencies had the potential to affect all 71 residents and all of the staff present on the date of the survey.

Systemic changes to ensure deficient practice doesn’t repeat:

1. The control valves will be inspected monthly and documented on a hard copy located in each riser room, as well as digitally in the preventative maintenance program TELS.
2. Tape on the activities closet storage shelves has been placed 18 inches below the sprinkler pendant and staff has been instructed to never store anything above the tape line.
3. During monthly inspections of the sprinkler system the maintenance director will use a flashlight to better inspect the sprinkler pendants for paint, debris or corrosion.
Monitor of corrective action:

1. The control valve inspection document will keep a record to ensure that the inspections have taken place.
2. The activities storage closet will be checked weekly for 3 months and then monthly thereafter to ensure that the sprinkler pendant does not become obstructed by storage.
3. Sprinkler pendants will continue to be inspected monthly with the addition of a flashlight to ensure that paint and debris are easier to spot from the ground.

Corrective Action Completed: 10/16/2019

K 363

Corrective Action:

The strike plates for the resident rooms at C 32/34 and C 56/58 were adjusted so that the doors will now close and latch with less than 5 lbs. of pressure.

Identification of others affected:

The residents staying in rooms C 32/34 and C 56/58 as well as all employees and visitors who may enter the rooms could be affected by a deficient door.

Systemic changes to ensure deficient practice doesn’t repeat:

Doors will be more thoroughly inspected for swelling, shrinking or warping to ensure that they will close with less than 5 lbs. of pressure.

Monitor of corrective action:

All doors will be inspected monthly for the next 3 months and then annually thereafter. Staff will be instructed to report any deficient or non-operable door to be repaired immediately.

Corrective Action Completed: 10/15/2019
Corrective Action:

1. Electrical wires that were exposed on the wall and ceiling of the storage area on B2 were covered by junction box covers which hid and secured the wires.
2. The electric wall heaters found in the dietary and MDS offices were removed of obstructions and 3 ft. of clearance was obtained.
3. HVAC units with protective covers removed in the ceiling were inspected and had the covers put into place to protect units and cover exposed wiring and compressors.

Identification of others affected:

These deficiencies had the potential to affect all residents, employees and vendors who may have come in contact with exposed wiring.

Systemic changes to ensure deficient practice doesn’t repeat:

1. The facility was inspected for any additional exposed wiring.
2. Tape was placed on the floor in the dietary and MDS offices indicating 3 ft. of clearance for the electric wall heaters. Office staff was instructed to not place anything inside of the taped lines.
3. A full inspection of the ceiling HVAC units was performed and any units found with missing protective coverings were replaced or put into place. HVAC vendors were instructed that when finished with all future work that protective covers must be replaced on HVAC units.

Monitor of corrective action:

1. Vendors will be instructed to not leave any exposed wiring when finished working in the building. All electrical work will be inspected by the maintenance director to ensure no wiring was left exposed.
2. The dietary and MDS offices will be inspected on a monthly basis to ensure that nothing is within 3 ft. of the wall heaters.
3. All work done by the HVAC vendors will be inspected by the maintenance director to ensure that protective covers are replace on all HVAC units.

Corrective Action Completed: 10/18/2019
K 911

Corrective Action:

An emergency remote manual stop station was placed in the room outside of the generator housing by Western States on 10/23/2019.

Identification of others affected:

The deficiency had the potential to affect all employees, residents and visitors on the date of the survey as staff would have been potentially hindered in stopping the generator if required.

Systemic changes to ensure deficient practice doesn’t repeat:

The remote manual stop station has been permanently placed in the room outside of the generator housing and can be used by any member of staff during an emergency where the generator would need to be turned off.

Monitor of corrective action:

The remote manual stop will be inspected weekly as part of the regular generator inspection to ensure that it is functional and not damaged.

Corrective Action Completed: 10/23/2019

K 926

Corrective Action:
During survey it was discovered that not all of the staff had participated in a medical gases training. Trainings were set up, in which multiple shifts would be able to attend, on the safe handling of medical gases. A staff roster was used to ensure that every single employee received training, regardless if they had already been through a training. The PowerPoint located on the Idaho Fire and Safety website was used to conduct the training and test the knowledge of those being trained.

**Identification of others affected:**

The deficiency had the potential to affect all residents who are dependent on the use of oxygen as well as the employees who were untrained on the risks of handling oxygen.

**Systemic changes to ensure deficient practice doesn’t repeat:**

In the future, medical gases training will be a part of the orientation process so all new employees will receive appropriate training on the safe handling of medical gases. Also an effort will be made to increase the attendance to future trainings, with multiple training being performed so all shifts may be able to attend.

**Monitor of corrective action:**

A staff roster will be used, that must be signed by each employee upon the completion of their medical gases training. This roster will be evaluated on an annual basis to ensure that every employee is receiving the proper training.

**Corrective Action Completed: 10/24/2019**

**K 927**

**Corrective Action:**

The oxygen room was cleaned of all lint, dirt and debris. The leftover paint in the corners of the concrete floor by the door was permanently removed and cleaned.

**Identification of others affected:**

Due to the hazard created when liquid oxygen comes into contact with debris this deficiency put the entire facility at risk as well as all of those located within it.

**Systemic changes to ensure deficient practice doesn’t repeat:**

A weekly inspection of the oxygen room will be performed and documented by the housekeeping staff. The room will be cleaned and kept free of dust, lint, dirt and other debris on a weekly basis.

**Monitor of corrective action:**

A document will placed inside the oxygen room that will be signed by the housekeeper in charge of each weekly cleaning when it is completed. The environmental services director will check the log on a weekly basis for the first 3 months and monthly thereafter.

**Corrective Action Completed: 10/16/2019**
K 930

Corrective Action:

All 7 of the cryogenic oxygen cylinders in the oxygen room have been secured onto rolling carts to comply with NFPA 99.

Identification of others affected:

This deficiency put the entire staff at risk due to the potential for tipping which could damage the cylinders and increase the risk of explosions.

Systemic changes to ensure deficient practice doesn’t repeat:

The vendor “Norco” which the facility uses for all of its oxygen needs has been instructed that no oxygen is to be brought into the facility that is not first secured onto a cart.

Monitor of corrective action:

As part of the weekly inspection of the oxygen room by the housekeeping staff previously mentioned, all oxygen cylinders will be inspected to ensure that they are secured onto carts. If any cylinder is found to be unsecured on a cart, it is to be reported to the maintenance director or the director of environmental services to be remedied.

Corrective Action Completed: 10/10/2019
October 21, 2019

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

Provider #: 135011

RE:  EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Monteath:

On October 3, 2019, an Emergency Preparedness survey was conducted at Gateway Transitional Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosure
The facility is a multi-story, type II (222) fire resistive structure originally constructed in 1963. The building is fully sprinklered, with an interconnected fire alarm/smoke detection system. The facility is located within a municipal fire district, with both county and state EMS services available. There is both an on-site, diesel-fired Emergency Power Supply System (EPSS) generator and piped in medical gas. Currently the facility is licensed for 88 SNF beds, and had a census of 71 on the date of the survey.

The facility was found to be in substantial compliance during the Emergency Preparedness Survey conducted on October 3, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The surveyor conducting the survey was:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety and Construction