

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Gateway Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 527 Memorial Drive Pocatello, ID 83201	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a bed hold notice was provided to residents or their representatives upon transfer to the hospital. This was true for 2 of 2 residents (#10 and #24) reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include:</p> <p>The facility's Bed Hold policy, dated 12/2023, states It is the policy of this facility to inform the resident or resident's representative in writing of the right to exercise the bed hold provision of 7 days upon admission and provide a second notice before transfer to a general acute care hospital or before the resident goes on therapeutic leave. In the event of an emergency transfer, the second notice will be provided within 24 hours. A copy of this notification shall become a part of the resident's health record at the time of transfer.</p> <p>1. Resident #24 was originally admitted to the facility on [DATE], and readmitted on [DATE] and 4/17/24 with multiple diagnoses including sepsis (extreme reaction to an infection that can lead to organ failure, tissue damage and death if not treated promptly), diabetes, respiratory failure (develops when the lungs cannot get enough oxygen into the blood making it difficult to breathe), hemiplegia and hemiparesis (paralysis and or weakness on one side of the body) following a stroke, and Parkinson's Disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves).</p> <p>a. A progress note, dated 4/12/24 at 5:05 PM documented Resident #24 had hypotension (low blood pressure) and respiratory issues and was sent out to the hospital emergency department with a critical lab value. The note documented Resident #24's first two emergency contacts were not available, so a friend was notified.</p> <p>A social services progress note, dated 4/12/24 at 4:19 PM stated, a bed hold notification was delivered to Resident #24's daughter via telephone.</p> <p>b. A progress note, dated 7/7/24 at 10:27 AM, documented Resident #24 was sent to the hospital with respiratory issues and a critical lab value. The note stated, Call placed to emergency contacts 1 and 2 with no answer. Message left with callback information to both.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Bed Hold Notification provided by the DNS for Resident #24's 7/7/24 transfer documented the bed hold was provided on 7/8/24 at 3:15 (no AM or PM) with the name of the facility representative. When asked when the written bed hold notice was provided to Resident #24 and her representative, the DNS stated the notices were not provided in writing.</p> <p>During an interview on 7/11/24 at 12:56 PM, the Community Relations Liaison staff member (CLS) was asked about the 7/7/24 written bed hold notice for Resident #24 and her representative, that had her signature. The CLS stated she did not do the bed hold notices and when queried if provided by mail or email, the CLS stated nope, just calling them.</p> <p>2. Resident #10 was admitted to the facility on [DATE] with multiple diagnoses including chronic respiratory failure, Parkinson's Disease, and repeated falls.</p> <p>Resident #10's record documented he was his own responsible party and his sister was listed as his emergency contact.</p> <p>An annual MDS assessment, dated 2/3/24, documented Resident #1 was cognitively intact.</p> <p>A progress note, dated 4/7/24 documented Resident #10 was sent to the local hospital related to not feeling well increased temperature, and an episode of projectile vomiting. The note documented Resident #10's sister was notified by phone of his transfer to the hospital. The note also documented Resident #10's sister would be notified by phone of any additional changes.</p> <p>Resident #10's record did not include documentation a bed hold notice in writing was provided to him or his sister.</p> <p>During an interview on 7/11/24 at 11:02 AM, regarding provision of a written bed hold notice upon a resident's emergent transfer, LPN #2 stated if the resident was cognizant, he would have the resident sign it, and if the resident asked, he would make a copy. LPN #2 then unsuccessfully attempted to find the form at the facility's A/B hall Nurse's Station. Unable to find the bed hold notice form, LPN #2 went to speak to the DNS. At 11:22 AM, LPN #2 provided a blank bed hold policy and stated, the form was in the admission packet and he did not give the notice to a resident or their representative.</p> <p>During an interview on 7/11/24 at 11:18 AM, when asked if residents and representative are provided a written bed hold notice, LPN #3 stated, I notify social services and they handle the bed hold.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154</p> <p>Based on observation, record review, and resident and staff interview, the facility failed to ensure residents' Minimum Data Set (MDS) had correct assessment information. This was true for 1 of 19 residents (Resident #39) reviewed for accuracy of MDS assessments. This deficiency created the potential for residents to not have their care needs met due to inaccurate assessments. Findings include:</p> <p>Resident #39 was admitted to the facility on [DATE], with multiple diagnoses including diabetes, and hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following a stroke.</p> <p>a. During an interview with Resident #39 on 7/8/24 at 11:15 AM, in response to the question if he had any issues with his teeth, gums, or dentures, Resident #39 stated he did not have teeth and wanted dentures.</p> <p>A Nutrition - Admission Evaluation, dated 2/20/20, documented Resident #39 was edentulous (lacking teeth) of both the upper and lower jaws.</p> <p>Annual MDS assessments dated 7/20/23, and 4/20/24, and a significant change of status MDS assessment, dated 5/7/24, did not include documentation Resident #39 had no natural teeth or tooth fragment(s) (edentulous).</p> <p>During an interview on 7/10/24 at 1:12 PM, the MDS Coordinator confirmed that Resident #39's MDS assessments were incorrectly coded and should have included Resident #39 was edentulous.</p> <p>b. A physician order, dated 4/23/24, documented Resident #39 was to be admitted to hospice care.</p> <p>A significant change of status MDS assessment, dated 5/7/24, did not include documentation Resident #39 was on hospice care or that he had a terminal prognosis (life expectancy of six months or less).</p> <p>During an interview on 7/10/24 at 1:19 PM, the MDS Coordinator confirmed Resident #39 should have been coded for a terminal prognosis and on hospice, that was the intent of the significant change assessment.</p> <p>During an interview on 7/11/24 at 5:06 PM, the DNS stated it was an expectation that MDS assessments would be coded accurately.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 4 residents (Resident #33) reviewed for quality of care. This created the potential for Resident #33 to have decreased caloric intake and weight loss when physician's orders were not followed to provide a specific dietary supplement. Findings include:</p> <p>Resident #33 was admitted to the facility on [DATE] with multiple diagnoses including dementia, adult failure to thrive, and dysphagia (impaired swallowing) after a stroke.</p> <p>A quarterly MDS assessment, dated 6/13/24, documented Resident #33 was 61 inches tall (5 feet, 1 inch) tall and weighed 85 pounds. The assessment documented Resident #33 experienced a significant unplanned weight loss. The assessment further documented Resident #33 was severely cognitively impaired.</p> <p>A Weight Summary, dated 9/30/22 - 7/9/24, documented on 7/2/24 Resident #33 weighed 83.6 pounds and had a body mass index (BMI) of 16.4 indicating she was underweight. The summary documented on 4/11/24, Resident #33 weighed 106.2 pounds and had lost 22.6 pounds since that time.</p> <p>A physician order, dated 5/29/24, documented Resident #33 was to be provided a Mighty Shake to be administered three times a day to Resident #33 for weight loss.</p> <p>Resident #33's care plan, dated 9/17/22, documented Resident #33 had a nutritional problem. Interventions included to provide Resident #33 a Mighty Shake three times a day.</p> <p>During an interview on 7/8/24 at 10:02 AM, the DS stated the dietary staff made house shakes from a recipe and served them instead of Mighty Shakes. The DS stated there were no Mighty Shakes in the facility several months ago the facility switched from using Mighty Shakes to making and providing house shakes. The DS stated the dietary staff served the house shakes at meals and put the shakes on residents' trays during tray line meal service.</p> <p>Review of the undated Recipe Analyzer Results for House Shake provided by the facility, documented the house shake provided 166 calories in a four-ounce serving.</p> <p>Review of the undated Hormel Foods Product Fact Sheet for Mighty Shake, documented there were 220 calories in a four-ounce serving.</p> <p>Resident #33 was served 498 calories daily from the Health Shakes instead of 660 calories daily from Mighty Shakes.</p> <p>During dining observations in the dining room on 7/8/24 for lunch from 11:31 AM through 12:54 PM, on 7/9/24 for breakfast at 8:43 AM, and on 7/10/24 at 12:31 PM, Resident #33 was served the house shake with her meals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/10/24 at 5:19 PM, the RD verified the dietary department served house shakes instead of Mighty Shakes. The RD verified that Mighty Shake was a specific name brand product. The RD stated she did not have the nutritional analysis for the house shake and did not know if the nutritional content was the same. The RD stated the residents' orders had not been adjusted to reflect that residents were receiving a different product than what was prescribed (Mighty Shake).</p> <p>During an interview on 7/11/24 at 8:55 AM, the RD stated Mighty Shake provided 220 calories per serving whereas the house shake provided 166 calories. The RD verified the house shake was not equivalent in calories to Mighty Shake and provided less calories.</p> <p>During an interview on 7/11/24 at 12:43 PM, the ADN and LPN #4 who was the charge nurse, stated it was important for orders to match the medication/supplement being administered, and if an order did not match, it should be clarified with the physician. The ADNS and LPN #4 verified Resident #33 received the house shake and not Mighty Shake as prescribed.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406</p> <p>Based on policy review, record review, facility fall reports, observation, and staff interview, the facility failed to ensure residents were adequately supervised and had interventions in place to prevent falls. This was true for 2 of 6 residents (#22 and #67) reviewed for falls. The failure to implement adequate supervision and interventions created the potential for Resident #22 and Resident #67 to sustain significant injuries from falls. Findings include:</p> <p>The facility's Fall Prevention/Investigation and Falling Star policy, dated January 2024, documented, it was the facility's policy to prevent falls and investigate the circumstances surrounding each resident fall and implement actions to reduce the incidence of additional falls and minimize potential for injury. The policy documented if the resident sustained a fall, an Incident Report was completed by the nurse which included:</p> <ul style="list-style-type: none"> - A brief description of the fall by staff and by the resident. - Identification of medications, environmental conditions, equipment involved, contributing medical factors, and any other factors that may be related to the fall. - Identification of an action plan or approaches to be taken in an attempt to prevent further falls based on newly identified facts or risk factors. - The care plan would be updated with each fall. <p>1. Resident #67 was admitted to the facility on [DATE], with multiple diagnoses including partial amputation of her right and left toes, seizures, unsteadiness on her feet, difficulty walking, lack of coordination, and dementia.</p> <p>A quarterly MDS assessment, dated 5/29/24, documented Resident #67 was severely cognitively impaired, and her bilateral lower extremities range of motion was impaired. The assessment documented Resident #67 was dependent on staff for toileting/hygiene, required substantial/maximum assistance for putting on and taking off footwear and lower body dressing. The assessment further documented Resident #67 required partial/moderate assistance for transferring from the bed to chair and back and getting on and off the toilet. Resident #67 required supervision or touching assistance to walk 10 feet and required partial/moderate assistance to walk 50 feet.</p> <p>A physician order, dated 6/8/23, documented Resident #67 was to have a wireless pressure alarm applied to her wheelchair and bed.</p> <p>Resident #67's care plan, initiated on 2/6/23 documented Resident #67 was at risk for falls related to weakness, dementia, seizures, impulsiveness, and frequent attempts to self-transfer.</p> <p>The goal was for Resident #67 to be free of falls through the review date. Current interventions included:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> -Anti roll back breaks to wheelchair to help prevent it from rolling back when Resident #67 attempted to self-transfer (initiated on 1/13/23). - Anticipate and meet Resident #67 needs. (initiated on 2/9/23). - Ensure the call light is within Resident #67's reach and encourage her to use it to call for assistance as needed (initiated on 2/9/23). - Bed in lowest position (initiated on 2/9/23). - Keep needed items, water, etc., in reach. (initiated on 2/9/23). - Educate Resident #67/family/caregivers about safety reminders and what to do if a fall occurs (initiated on 2/9/23). - Therapy services in place per physician orders (initiated 2/9/23) - Lactose intolerance causing Resident #67 to have loose stool and she is attempting self-transfers to the restroom. Lactose intolerance being treated with lactase and limiting dairy (initiated on 6/23/23). - Encourage Resident #67 to participate in activities that promote exercise, physical activity for strengthening and improved mobility (initiated on 6/30/23). - Resident #67 has dementia and forgets to use call light and she is not safe to self-transfer. Signs have been placed in her room and on call light with her and her family's permission to help remind Resident 67 to use call light and wait for help (initiated on 7/1/23). - Bring Resident #67 to the dining room for each meal (initiated on 7/3/23). - Encourage/check Resident #67 for toileting needs prior to shift change and at mealtime to help reduce self-transfers (initiated on 9/1/23). - Resident #67 educated on waiting for help to the restroom once her call light is turned on (initiated 10/17/23). - Wheelchair to be left outside of Resident #67's room to help avoid room clutter/fall risk as Resident #67 allows (initiated on 10/25/23). - Wireless pressure alarm to Resident #67's wheelchair and bed to help alert staff when she attempted to self-transfer as she is impulsive and does not use call light (initiated on 10/25/23). - Assess and treat Resident #67 for infection/hypotension as indicated (initiated on 6/10/24) <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Encourage to not be left alone in room while in wheelchair (initiated on 6/12/24)</p> <p>- Visual reminder on call light and wall to use call light and wait for assistance (initiated 1/7/24).</p> <p>The facility's fall reports from 7/1/23 - 7/10/24, included reports Resident #67 had 15 falls between 7/1/23 and 7/10/24 as follows:</p> <p>a. A fall report, dated 7/1/23, documented Resident #67 was found sitting on the floor beside her toilet at dinnertime. The report documented Resident #67 self-transferred and fell and the call light was not turned on. The report did not indicate whether the pressure alarm was in place, and whether it was sounding. No injuries were sustained and the intervention was for the resident to eat in the dining room.</p> <p>b. A fall report, dated 7/22/23, documented Resident #67 fell and was sitting on the floor in the hallway. The report documented Resident #67's call light was not turned on and the pressure alarm did not go off. No injuries were sustained. The intervention was for the resident to continue with therapy. There was no documentation why the pressure alarm did not go off (not turned on, dead battery, broken, etc.) and what would be done to address it.</p> <p>c. A fall report, dated 8/10/23, documented Resident #67 was found on the floor in the bathroom. A skin tear to her right foot second toe was documented. Resident #67 was trying to use the toilet. A toileting program was noted to be in place. The report documented Resident #67 had confusion and orders for lab tests were received (urinalysis, complete blood count, comprehensive metabolic panel). There was no documentation related to the effectiveness of the pressure alarm, such as whether it was in place, sounding, or not working.</p> <p>d. A fall report, dated 8/28/23, documented Resident #67 was sitting on the floor in her bathroom. Resident #67 stated she turned the call light on, waited for a minute then tried to go to the bathroom by herself. Resident #67 had an abrasion to her left lower leg. Resident #67's toileting plan was adjusted. There was no documentation related to the effectiveness of the pressure alarm, such as whether it was in place, sounding, or not working.</p> <p>e. A fall report, dated 8/31/23, documented Resident #67 was found sitting on the floor in her room by her door. Resident #67 sustained two small skin tears on her right forearm and Resident #67 reported she bumped her head. The report documented the bed alarm was not going off. Resident #67 stated she turned on the call light but no one came and she toileted herself. The intervention was to put the bed in a low position, increased checks of the bed alarm, and replacement of the bed alarm.</p> <p>f. A fall report, dated 9/28/23, documented Resident #67 was found sitting on the floor in her room and was incontinent. No injuries were noted. Resident #67 stated she was attempting to self-transfer from her bed to the wheelchair. The report documented the bed alarm was in place but did not sound. There was no additional information regarding the alarm that did not sound, such as whether it was working. The previous fall on 8/31/23 noted the need for increased checks of the bed alarm because it did not go off when that fall occurred. The investigation revealed if the wheelchair was not present, Resident #67 would be more prone to use the call light. Intervention was to encourage the wheelchair to not be located at Resident #67's bedside.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>g. A fall report, dated 10/17/23, documented Resident #67 was found sitting on the floor in the bathroom with a scratch on her left knee. Resident #67 stated she was trying to go to the bathroom. No new interventions were documented. There was no documentation related to the effectiveness of the alarm, such as whether it was in place, sounding, or not working.</p> <p>h. A fall report, dated 11/5/23, documented Resident #67 was found sitting on the floor with water spilled on the floor. Resident #67 stated she tried to get up out of bed to transfer herself to the wheelchair and fell . The report documented, Bed alarm needs to be turned back on and put on w/c [wheelchair] or bed, whichever place she is at. There was no documentation regarding the location of the wheelchair such as whether it was placed away from the bed as noted following the fall that occurred on 9/28/23.</p> <p>i. A fall report, dated 11/9/23, documented Resident #67 was assisted to the toilet by a staff member who then left the resident alone for about two minutes. When the staff returned, Resident #67 was on the floor. Resident #67 stated she was done and was trying to get back into her wheelchair. Resident #67 sustained a superficial abrasion to her left hip. No new interventions were implemented and there was no follow regarding the resident being left alone unsupervised on the toilet as documented in her MDS assessment that she required substantial/maximal assistance for toileting hygiene, and her care plan, dated 2/6/23 documenting Resident #67 required extensive assistance of one staff to use the toilet.</p> <p>j. A fall report, dated 11/12/23, documented Resident #67 fell out of bed while trying to grab something off the floor. The report documented Resident #67 had increased confusion and sustained an abrasion to her face and a skin tear to her left elbow. Due to confusion, the provider was contacted and a urinalysis was ordered which was positive for infection and an antibiotic was prescribed.</p> <p>k. A fall report, dated 1/7/24, documented Resident #67 fell in the restroom. Resident #67 stated she had to have a bowel movement. Resident #67 sustained skin tears to her left shoulder, left hand and an old skin tear to the right forearm opened. There was no documentation related to the pressure alarm, such as whether it was in place, sounding, or not working. There was no documentation regarding the location of the wheelchair such as whether it was placed away from the bed. No new interventions were noted.</p> <p>l. A fall report, dated 3/24/24, documented Resident #67 fell at the bedside with the wheelchair behind her, with the appearance that Resident # 67 attempted to self-transfer. The investigation documented Resident #67 slid out of the wheelchair and a new intervention was to have therapy evaluate the wheelchair. There was no documentation related to the pressure alarm, such as whether it was in place, sounding, or not working.</p> <p>m. A fall report, dated 4/2/24 documented Resident #67 was found sitting on the floor by her bed. Resident #67 stated she was trying to get into her chair and was noted to be incontinent. The intervention was an adjustment of her bowel and bladder program around shift change and meals. There was no documentation related to the alarm, such as whether it was in place, sounding, or not working. There was no documentation regarding the location of the wheelchair such as whether it was placed away from the bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>n. A fall report, dated 6/8/24, and documented Resident # 67 was found on the floor in the bathroom with the call light going off. Resident #67 sustained a skin tear on her right forearm. The report documented Resident #67 was hypotensive (low blood pressure) due to infection and Resident #67 would be treated for the infection. There was no documentation related to the alarm, such as whether it was in place, sounding, or not working.</p> <p>o. A fall report, dated 6/10/24, documented Resident #67 was found on the floor in her room and had a skin tear to her left forearm. Resident #67 stated she fell while attempting to stand and close her bedroom door. An x-ray was ordered for acute right wrist pain. The new intervention was for Resident #67 not to be left in her room while in her wheelchair. There was no documentation related to the alarm, such as whether it was in place, sounding, or not working.</p> <p>The fall investigations did not address provision of sufficient supervision of Resident #67, ensuring the alarm was applied and functioning properly, and placement of the wheelchair in Resident #67's room. Furthermore, the investigations failed to identify if previous interventions were in place at the time of subsequent falls to determine the effectiveness of current interventions.</p> <p>During observations on 7/8/24 at 12:50 PM, 7/9/24 at 8:41 AM, 7/9/24 at 9:52 AM, and 7/10/24 at 10:56 AM, Resident #67 was in her wheelchair with anti-tip bars in place and with the pressure alarm in the chair. On 7/8/24 at 3:36 PM, Resident #67 was observed lying in bed with her wheelchair in the room near the bed.</p> <p>During an interview on 7/10/24 at 10:44 AM, NA #1 stated Resident #67 had dementia and she was transferred with the Sara lift (mechanical lift) by two persons. NA #1 stated Resident #67 tried to get out of bed at times and forgot she could not walk. NA #1 stated current interventions were to lower the bed, use the pressure alarm in the bed and chair, and wear non-skid socks. NA #1 did not mention the wheelchair intervention of not being left near the resident when she was in bed.</p> <p>During an interview on 7/11/24 at 12:10 PM with LPN #4, the charge nurse, and the ADNS, they stated Resident #67 had dementia, was impulsive and tried to transfer herself. They stated there was a sign in her room to wait for help once the call light was activated. They stated the wheelchair was to be away from the bed when Resident # 67 was in the bed, as she allowed. They stated Resident #67 was to be toileted per schedule, use a low bed, and wear nonskid socks. The ADNS stated there were several falls in which the alarms were not sounding, not functioning, or had not been moved between the bed and chair once the resident changed location. The ADNS verified many of the fall investigations did not document the status of the alarm at the time the fall occurred. The ADNS stated Resident #67 should not have been left unattended on the toilet on 11/9/23 when the fall occurred on that date.</p> <p>During an interview on 7/11/24 at 3:21 PM, CNA #5 stated Resident # 67 had a pad alarm that was wireless and should be transferred with the resident from bed to chair and chair to bed depending on where the resident was. He stated the bed was to be in a low position. The wheelchair was supposed to be left out of reach/out of room since Resident #67 has tried to move from bed to chair when in bed. CNA #5 stated Resident # 67 was more or less on a toileting program and they did take her to the toilet about every two hours but she was very confused and sometimes did not go.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/11/24 at 4:02 PM, DNS stated falls were reviewed by the interdisciplinary team after a fall occurred. He stated the fall investigations should indicate whether the alarms were working and there was a section for documenting potential problems. The DNS stated Resident #67 should not have been left alone on the toilet. The DNS stated Resident #67 had impaired memory and she did not always remember to use the call light. The DNS also stated Resident #67 had issues with her left knee.</p> <p>2. Resident #22 was admitted to the facility on [DATE], with multiple diagnoses including history of stroke, hemiplegia/hemiparesis related to stroke, brain cancer, visuospatial deficit, and repeated falls.</p> <p>A quarterly MDS assessment, dated 5/22/24, documented Resident #22 was severely cognitively impaired. The assessment documented Resident #22 had no falls since her admission to the facility.</p> <p>Resident #22's care plan for falls, undated, documented Resident #22 was at high risk to experience falls related to her confusion, hearing and vision deficits, behaviors, and gait and balance problems. The care plan documented Resident #22's bed was to be in the lowest position while she was in bed, her call light was to be within reach, and fall mats were to be placed on the floor next to her bed.</p> <p>On 7/9/24 at 2:41 PM and 7/10/24 at 1:57 PM, Resident #22 was observed laying in her bed, which was in the low position and had raised 1/3 side rails on each side of the head of the bed. Resident #22's bed was in the lowest position; however, the floor mats were not in place on either side of her bed per her plan of care.</p> <p>During an observation of Resident #22 conducted with the DNS on 7/10/24 at 1:57 PM, the DNS confirmed the mats were not in place next to Resident #22's bed as care planned and stated he expected care planned interventions for falls for residents to be in place consistently.</p> <p>18947</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure a resident received oxygen therapy per physician's orders. This was true for 1 of 1 resident (Resident #39) reviewed for oxygen therapy. This failure created the potential for Resident #14 to experience hyperoxia (cells, tissues, and organs are exposed to an excess supply of oxygen. Findings include:</p> <p>The facility's policy, Oxygen Administration, revised 1/2024, stated it was the policy of the facility that oxygen therapy is administered as ordered by the physician or as an emergency measure until the order can be obtained. The policy documented the procedure as follows:</p> <ul style="list-style-type: none"> - Oxygen per MD/NP [Medical Doctor/Nurse Practitioner] orders - Reassess oxygen flowmeter for correct liter flow. <p>Instructions for Tubing and Humidifier Changes:</p> <ul style="list-style-type: none"> - Oxygen tubing is to be replaced every seven (7) days. Oxygen masks or nasal prongs are to be replaced every seven (7) days. - Humidifiers are not required if flow of oxygen is two (2) liters or less per minute. <p>Resident #39 was admitted to the facility on [DATE], and readmitted on [DATE] and 9/29/23, with multiple diagnoses including chronic respiratory failure with hypoxia (low oxygen levels in the blood), hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following a stroke, congestive heart failure, and obstructive sleep apnea.</p> <p>A physician order, dated 9/29/23, documented Resident #39 was to receive oxygen at 0-2 liters per minute (LPM) via a nasal canula.</p> <p>During an interview on 7/8/24 at 11:13 AM, Resident #39 was observed to be on oxygen via nasal canula. Resident #39 stated he was supposed to be 3 or 4 LPM of oxygen. Resident #39's oxygen concentration flow meter was observed at a flow rate of 4 LPM.</p> <p>During observations of Resident #39's oxygen concentrator on 7/9/24 at 9:07 AM and 3:03 PM, and on 7/10/24 at 10:55 AM and 1:23 PM, the oxygen flow rate on the oxygen concentrator was at 4 LPM.</p> <p>During an observation on 7/10/24 at 1:48 PM with the ADNS confirmed the oxygen flow rate was at 4 LPM.</p> <p>Resident #39's MAR/TAR for July 2024, included a line for Oxygen at 0-2 liters via NC with an order date of 9/29/23 at 12:44 PM. Instead of an entry of the flow rate there was an x in each of the boxes. Resident #39's MAR/TAR for June 2024 also had an x in each of the boxes for the month instead of a flow rate.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A physician order, dated 7/10/24, documented a new order for Resident #39's oxygen to be at 0-4 LPM.</p> <p>During an interview on 7/11/24 at 11:00 AM, LPN #2 stated he tried to document the flow rate in a note or the daily assessment, and that he checked the physician's order for the flow rate.</p> <p>During an interview on 7/11/24 at 12:45 PM, the DNS confirmed the oxygen flow rate should be documented. When advised of all x's on the MAR/TAR, the DNS stated, that only usually happens when an order is discontinued. The DNS then reviewed Resident #39's June and July 2024 MAR/TARs and confirmed the documentation was all x's. The DNS pulled up the July MAR/TAR with the new order and it also had all x's. The DNS went into the oxygen order in Resident #39's record and made changes so the order then showed up on MAR/TAR with daily spaces for documentation. At 12:55 PM, the DNS stated the oxygen flow should be checked and documented by the nurses.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154</p> <p>Based on policy review, record review, observation, and staff interview, it was determined the facility failed to ensure that prior to the placement of bed rails, alternatives to bed rails were attempted and individual residents were thoroughly assessed for the risk of entrapment. This was true for 1 of 2 residents (Resident #31) reviewed for bed rails. This failure created the potential for harm due to the risk for injury, entrapment and/or death due to lack of opportunity for the resident and/or their representative to make an informed decision regarding the use of bed rails. Findings include:</p> <p>The facility's policy, Bed Rails, revised 1/2022, stated it was the policy of the facility to attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail was used, the facility must ensure correct installation, use, and maintenance of bed rails. The policy documented after the facility attempted alternatives to bed rails and determined the alternatives failed to meet the resident's assessed needs, the facility's interdisciplinary team assessed the resident for risks of entrapments and possible benefits of using bed rails. The risks and benefits of bed rails would be considered for each resident.</p> <p>Resident #31 was admitted to the facility on [DATE] with multiple diagnoses including multiple fractures, protein calorie malnutrition, dementia, insomnia, and history of transient ischemic attacks (when blood flow to a part of the brain stops for a brief time).</p> <p>During an interview on 7/8/24 at 4:23 PM, Resident #30 was observed with bilateral upper side rails. Resident #31 stated she did not really use the side rails and they were put up and she sometimes used them to turn in bed.</p> <p>A Licensed Nurse - Restraint / Enabling Device/Safety Device Evaluation, dated 5/23/24, documented Resident #31 used side rails for mobility and security. The evaluation documented in the section for alternatives attempted prior to side rail use was she was a new admission and there were no previous measures.</p> <p>Resident #31s care plan documented, #Bed mobility (Roll left and right, sit to lying, lying to sitting on side of bed: Requires 2 substantial staff participation to reposition and turn in bed, initiated 5/16/24.</p> <p>During an interview on 7/10/24 at 5:38 PM, while reviewing the facility policy, the DNS stated, No alternates were attempted. The DNS confirmed the policy was not followed and expressed an expectation that alternatives would be attempted prior to side rail use.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>28154</p> <p>Based on observation, policy review, record review, and staff interview, the facility failed to ensure the required nursing staff posting accurately reflected the actual staff hours to care for the 76 current residents and failed to ensure the posting included an updated census for each shift. This failure had the potential to inaccurately inform any resident, family member, or visitor to the facility of the available nursing staff caring for residents. Findings include:</p> <p>On 7/9/24 at 3:05 PM, a posted nurse staffing was not observed in the R and D/C hall Nurse's Stations. There were white boards located at or near the nurse's stations with staff assignments for the halls.</p> <p>On 7/9/24 at 3:15 PM, the DNS showed the nursing staff posting for 7/8/24 and 7/9/35 on the wall across from the A/B Nurse's Station. The postings included the date, the number of CNAs, RNs, and LPNs, and the anticipated hours to be worked. The nursing staff posting did not include the actual number of hours worked for each nursing staff category or the updated census to account for any admissions, discharges, or transfers to acute care.</p> <p>On 7/11/24 at 8:30 AM, the nurse staffing posting on the wall across from the A/B Nurse's Station had the anticipated hours for 7/10/24 and 7/11/24.</p> <p>During an interview on 7/11/24 at 1:10 PM, the Administrator and RNC stated there was no policy regarding the nurse staff posting and confirmed where it was currently posted by the A/B Nurse's station residents and visitors for the R and D halls would probably never see it.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947</p> <p>Based on record review, policy review, and staff interview, the facility failed to ensure the medical necessity of psychotropic medication administration. This was true for 1 of 6 residents (Resident #7) reviewed for psychotropic medication administration. This failure created the potential for Resident #7 to experience negative side effects related to receiving more psychotropic medication than necessary. Findings include:</p> <p>The facility's Psychotropic Medications Policy, revised 12/2023 stated, Residents who use psychotropic drugs receive gradual dose reductions (GDR), and behavioral interventions, unless clinically contradicted, in an effort to discontinue these drugs.</p> <p>Resident #7 was admitted to the facility on [DATE], with multiple diagnoses including paraplegia (the inability to voluntarily move the lower parts of the body), anxiety disorder, insomnia, and depression.</p> <p>A quarterly MDS assessment, documented Resident #7 was cognitively intact. The assessment documented Resident #7 was receiving antipsychotic, antidepressant, and antianxiety medications routinely. The assessment further documented during the assessment period Resident #7 did not exhibit behaviors but did sometimes socially isolate himself.</p> <p>An Orders Summary Report, dated 7/11/24, documented Resident #7 was to receive duloxetine (an antidepressant medication) delayed release particles 60 mg by mouth one time a day for depression, risperidone (an antipsychotic medication) 0.5 mg by mouth at bedtime for depression, trazadone (an antidepressant medication) 300 mg by mouth at bedtime for insomnia, and buspirone (an antianxiety medication) 10 mg by mouth two times a day for Anxiety.</p> <p>Review of Resident #7's MAR/TAR, dated 4/1/24 through 7/11/24, documented Resident #7's routine medications were administered per physician orders. The record documented Resident #7 did not exhibit side effects related to the administration of the drugs during that time frame. Behavior monitoring related to the identified behaviors related to administration of the medications in the MAR/TAR documented Resident #7 exhibited one episode of anxiety related behaviors in April, no episodes of anxiety related behavior in May, one episode in June, and two episodes in July. The record documented Resident #7 exhibited one behavior related to the administration of his antipsychotic medication in April, one episode in May, no episodes in June, and four episodes (two of irritability and two of negative statements) in July. The record documented Resident #7 was generally receiving 7 to 12 hours of sleep during each twenty-four-hour period.</p> <p>Resident #7's comprehensive care plan, undated, documented Resident #7 was receiving antidepressant medication related to outbursts of anger, inability to sleep and self-isolation, antianxiety medication related to restlessness, and antipsychotic medication related to depression related irritability and negative statements. The care plan documented behaviors and side effects were to be monitored related to the administration of each of the medications.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Psychotropic Interdisciplinary Team (IDT) progress note, dated 6/17/24, documented Resident #7 was reviewed by the psychotropic IDT. The note documented Resident #7 had a long history of depression and PTSD [Post Traumatic Stress Disorder]. The note further documented Resident #7 would be scheduled with a psychiatric provider to assess for GDR [Gradual Dose Reduction] of risperidone related to duplication of therapy for depression.</p> <p>Resident #7's record did not include documentation the facility follow-up related to scheduling Resident #7 with a psychiatric provider to attempt to reduce the resident's antipsychotic medication.</p> <p>During an interview on 0/10/24 at 3:58 PM with the SSD, the SSA, and the Corporate Social Services Director, the SSD and SSA confirmed a recommendation was made to refer Resident #7 to a psychiatric provider during the IDT meeting on 6/17/24 to potentially reduce his antipsychotic medication related to duplicative therapy. The SSA stated she thought she sent a referral out for Resident #7 but was not able to locate a referral in Resident #7's or facility records.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>28154</p> <p>Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medications available for residents were labeled and had not expired. This was true for 2 of 5 insulin pens in a medication cart. This failure created the potential for insulin pens to be used for different residents presenting a risk for cross-contamination or to receive expired medications with decreased efficacy for blood glucose levels. Findings include:</p> <p>The facility's policy titled Labeling of Medications and Biologicals, revised 5/2020 stated t was the policy of the facility that medications and biologicals were labeled in accordance with facility requirements, state, and federal laws. The policy stated, Only the provider and pharmacy modifies or changes prescription labels. The policy stated the procedure was as follows:</p> <p>Each prescription medication label includes at the minimum:</p> <ul style="list-style-type: none"> - Resident's name. - Medication name -Prescribed dose and strength of medication - Expiration date - Route of administration - Specific Directions or Instructions for use, as applicable - For medications designed for multiple administration (inhalers, eye drops), the label should indicate for which resident it was prescribed for. <p>The policy further stated improperly labeled medications are rejected and returned to supplier, multi-dose vials that have been opened or accessed: the vial should be dated and discarded within 28 days unless otherwise specified by manufacturer, and medication containers having soiled, damaged, incomplete, illegible, or makeshift labels are returned to the issuing pharmacy for re-labeling or destroyed in accordance with medication destruction policy.</p> <p>During an observation on 7/11/24 at 8:20 AM with LPN #1, a zip lock biohazard bag with a date of 7/8/24 was observed that contained two insulin pens rubber banded together. One pen was Lantus (long-acting insulin) with a label for Resident #13, the second was an Admelog (fast-acting insulin) pen with no label. LPN #1 confirmed neither pen had an open date on it and only one pen was labeled. A second zip lock biohazard bag was observed dated 7/8/24, with three insulin pens rubber banded together; the Admelog and Novolog (fast-acting) insulin pens had labels for Resident #60 and a third pen without a label. LPN #1 confirmed the observation.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/11/24 at 9:20 AM, the DNS stated an expectation that each insulin pen would have a pharmacy resident label on it.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>15406</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure the kitchen was maintained in a sanitary manner when sanitizer solutions were had inadequate strength, rust was observed on the inside of the ice machine, and the dishwashing area contained caulking that was peeling off with food particles entrapped creating a surface that was uncleanable on the stainless counter. These deficiencies had the potential to affect all 76 residents residing in the facility who consumed food prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include:</p> <p>1. The initial kitchen inspection was conducted on 7/8/24 from 9:45 AM through 10:28 AM with the DS. The following was observed:</p> <p>a. The stainless-steel counter where the dish machine sprayer hose was located was observed with a brown and black rubbery substance (caulking) partially adhered to two pipes coming up through the stainless counter and was also partially adhered to the stainless counter around where the pipes penetrated the counter. There were food particles adhered under the partially affixed caulking. The partially adhered excess caulking created a surface that was not cleanable. DA #1 and the DS stated there was a leak in the pipes and maintenance staff applied the caulking around the pipes to seal the leak. DA #1 stated the leak was ongoing since approximately October 2023. The DS stated the leaking pipes were a problem since she started in her position in December 2023.</p> <p>b. Three buckets of wiping rag sanitizer solution (Oasis 146 Multi-Quat Sanitizer) were tested by the DS using quat test strips. The two sanitizer buckets for wiping cloths that were currently in use by dietary staff to sanitize kitchen surfaces were inadequate in parts per million (ppm) of quaternary ammonia (quat). The first bucket did not have any sanitizer present in the solution and read zero ppm. The solution in the second bucket read 100 ppm per the test strip, both sanitizer levels verified by the DS. The DS stated there might be a problem with the test strips. The DS filled a new bucket with the Oasis 146 Multi-Quat solution that was dispensed from a hose in the three-sink pot washing area. The ppm of the freshly mixed bucket of quat solution was 200 ppm; the DS stated this was the correct level and verified the test strips were working. The DS stated the desired level of quat was 200 ppm.</p> <p>c. The interior of the ice machine had a plastic panel in which the ice would touch as ice was made and fell into the interior ice bucket. The panel was attached on one side with a significantly rusted screw; the screw on the other side was missing. The DS stated she was not aware of the rusted screw and verified ice would make contact with the rusted screw when tumbled into the interior ice storage area.</p> <p>2. A second kitchen inspection was conducted on 7/10/24 at 4:50 PM with the DS. The following was observed:</p> <p>(continued on next page)</p>		

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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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>a. Two buckets of wiping rag sanitizer solution, currently in use, were tested by the DS using quat test strips. One of the sanitizer buckets for wiping cloths was inadequate in ppm of quat. The bucket of sanitizer solution was tested by the DS and it read 100 ppm of quat. The DS tested a second bucket and it was at the proper concentration of 200 ppm of quat, verified by the DM. [NAME] #1 stated she changed the buckets of sanitizer solution about an hour ago. The DS took an empty bucket to the spigot for the Oasis 146 Multi-Quat Sanitizer and dispensed a new bucket. The DS checked the level of the newly mixed bucket of solution and the concentration was 250 ppm indicating the solution was being mixed and dispensed out of the hose at the correct concentration and that the test strips worked properly. The DS stated the concentration of quat in the wiping rag buckets decreased over time indicating the buckets should be changed regularly which may have accounted for the drop in concentration in the first bucket to 100 ppm.</p> <p>b. The ice machine was observed and had been fixed with new screws. The rusted screw was gone; there was a small area of rust remaining around the area where the new screw was affixed to the metal plate. The DS stated the rusted screw had been replaced.</p> <p>c. The caulking around the pipes and on the counter in the dish washing area had been removed. The DS stated the leak was repaired and excess caulking removed, getting rid of the nasty stuff on the counter.</p> <p>During an interview on 7/9/24 at 10:46 AM, the Administrator stated the new Maintenance Director fixed the pipe and removed the caulking in the dish pit following the surveyor's observation on 7/8/24. The Administrator stated the Maintenance Director had first become aware of the problem with leaking pipes in the dish pit area on 7/5/24.</p> <p>During an interview on 7/10/24 at 6:11 PM, the Registered Dietitian stated the sanitizer solution should be at a minimum concentration of 150 PPM to effectively sanitize surfaces.</p> <p>On 7/11/24 at 10:00 AM, the Maintenance Director and Administrator were interviewed. The Maintenance Director stated he was in his position as Maintenance Director for approximately four months and Maintenance Staff worked as his assistant. The Maintenance Director stated he came to work on 7/5/24 and fixed the leak in the pipes in the dish pit area on that date after being notified of the leak. The Maintenance Director stated the caulking on top of the counter and attached to the pipes were there for a while and previously was applied by Maintenance Staff. The Maintenance Director stated he had not removed the excess caulking on 7/5/24 when he fixed the leak. The Maintenance Director stated there was food constantly in that area (where the pipe leaked and caulking was located) due to debris from the sprayer. The Maintenance Director stated the ice machine broke last week and they called a contractor who came and put new washers in the machine.</p> <p>During an interview on 7/11/24 at 7:33 AM, the DS stated when she tested the sanitizer level in the buckets of Oasis 146 Multi-Quat solution on 7/8/24 and 7/10/24, she had not held the test strip in the sanitizer solution long enough accounting for the inadequate levels recorded on the test strips. The DS verified the test strips read adequate levels of sanitizer in the newly mixed buckets on 7/8/24 and 7/10/24 and in one bucket on 7/10/24 using the same technique and holding the test strip in the solution for the same amount of time, indicating the test strips were in the solution long enough to get a reading.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947</p> <p>Based on record review, observation, and staff interview, it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment. This was true for 3 of 19 residents (#10, #163, and #182) observed for infection control. These failures put residents at risk for cross contamination and infection. Findings include:</p> <p>1. Resident #10 was admitted to the facility on [DATE], with multiple with diagnoses including Chronic Obstructive Pulmonary Disease (COPD - a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe).</p> <p>A quarterly MDS assessment, dated 4/29/24, documented Resident #10 was moderately cognitively impaired. The assessment further documented he was receiving continuous oxygen therapy.</p> <p>A physician order, dated 4/10/24, documented Resident #10 was to receive Ipratropium-Albuterol Inhalation Solution 0.5-2.5 mg per 3ml via nebulizer every six hours for shortness of breath and wheezing.</p> <p>Resident #10's MAR/TAR, dated 7/1/24 through 7/11/24, documented Resident #10 was receiving the nebulizer treatments every six hours round the clock as ordered.</p> <p>On 7/9/24 at 9:18 AM and 2:35 PM, and on 7/10/24 at 8:46 AM, 11:05 AM, 12:42 PM, and 1:48 PM, Resident #10's nebulizer equipment was observed in his room. Residual nebulizer solution was observed in the nebulizer basket and the mask and basket were observed on Resident #10's television stand, unbagged, during each of the observations.</p> <p>On 7/10/24 at 1:48 PM, with the DNS present, Resident #10's respiratory equipment was observed. The DNS confirmed the equipment was not appropriately cleaned or bagged after use to prevent potential collection of pathogens on the equipment.</p> <p>2. Resident #63 was admitted to the facility on [DATE], with multiple diagnoses including chronic respiratory failure.</p> <p>An admission MDS assessment, dated 6/13/24, documented Resident #63 was moderately cognitively impaired. The assessment documented Resident #63 was receiving continuous oxygen therapy.</p> <p>A physician order, dated 6/17/24, documented Resident #63 was to have her BiPAP machine (provides positive airway pressure to help breathing) placed when sleeping to ensure adequate oxygenation.</p> <p>Resident #63's MAR/TAR, dated 7/1/24 through 7/11/24, documented Resident #63's BiPAP machine was being placed each night shift as ordered.</p> <p>On 7/8/24 at 2:16 PM, 7/9/24 at 9:29 AM and 2:53 PM, and on 7/10/24 at 8:42 AM and 2:04 PM, Resident #63's BiPAP mask and tubing were observed to be placed on an overbed table next to the Resident #63's bed. The equipment was not bagged.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/10/24 at 2:04 PM, with the DNS and ADNS present, Resident #63's respiratory equipment was observed. The DNS and ADNS confirmed the equipment was not appropriately bagged when not in use to prevent potential collection of pathogens on the equipment. The DNS stated his expectation was BiPAP equipment was to be bagged when not in use.</p> <p>3. Resident #182 was admitted to the facility on [DATE], with multiple diagnoses including obstructive uropathy (occurs when urine cannot drain through the urinary tract).</p> <p>An admission MDS assessment, dated 3/31/24, documented Resident #182 was mildly cognitively impaired. The assessment documented Resident #182 had an indwelling catheter (a thin, flexible tube that is inserted into the bladder to drain urine that attaches to a collection bag outside of the body) placed in his bladder.</p> <p>An order summary report, dated 7/11/24, documented Resident #182's was to have a Foley (indwelling) catheter in his bladder related to his diagnosis of obstructive uropathy.</p> <p>Resident #182's TAR, dated 7/1/24 through 7/11/24, documented Resident #182 had the catheter in place per the physician order.</p> <p>On 7/8/24 at 10:07 AM, 7/9/24 at 2:46 PM, and 7/11/24 at 7:55 AM, Resident #182 was observed either seated in his wheelchair or laying in his bed. The drainage bag and/or the catheter tubing was observed to be laying on/in contact with the floor during each of the observations.</p> <p>During an interview with the DNS on 7/11/24 at 9:19 AM, he stated his expectation was urinary catheter drainage bags and tubing were expected to be kept off the floor to avoid contamination which could potentially lead to infection.</p>

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure beds and bed rails were inspected and maintained as part of an ongoing program. This was true for 2 of 6 residents (#10 and #22) reviewed for bed rails. This failure created the potential for injury or harm if a resident was to become entrapped by unmonitored equipment. Findings include:</p> <p>The facility's Bed Rails policy, revised 1/2022, stated it is the policy of the facility to attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails. Entrapment is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail. The policy stated when installing and using bed rails, the facility shall install bed rails using the manufacturer's instructions to ensure a proper fit and safe spacing. It further stated regardless of mattress width, length, and/or depth, the bed frame, bed rail and mattress, no gaps wide enough to entrap a resident's head, body, or limbs should be present post-installation or during the course of use.</p> <p>1. Resident #10 was admitted to the facility on [DATE] with multiple diagnoses including Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), arthritis, weakness, and repeated falls.</p> <p>A quarterly MDS assessment, dated 4/29/24, documented Resident #10 was moderately cognitively impaired. The assessment documented Resident #10 required substantial to maximum assistance from staff to roll from one side to the other in bed and to transfer in and out of bed. The assessment documented bed rails were not in use for Resident #10.</p> <p>An order summary report, dated 7/11/24, included an order for Resident #10 to have upper bed rail to assist with bed mobility and repositioning.</p> <p>Resident #10's care plan for Activities of Daily Living, undated, documented Resident #10 had a self-care deficit related to arthritis and weakness. The care plan documented Resident #10 required extensive assistance from two staff members and a Hoyer (mechanical) lift to transfer in and out of his bed. The care plan documented Resident #10 resident required one staff member assist to roll left and right in his bed/to reposition and turn in his bed. The care plan further documented Resident #10 may have upper bed rail to assist with bed mobility and repositioning. The care plan did not include specifics related to the size or type of the bed rail to be used on his bed.</p> <p>A side rail assessment, dated 5/29/24, documented Resident #10's use of side rails. The assessment documented Resident #10 provided informed consent for the use of the rails.</p> <p>Documentation of routine physical bed checks of Resident #10's bed to ensure there were no gaps between the bed and side rails or within the side rails themselves, large enough to potentially allow entrapment of Resident #10's body parts could be found in the facility's records.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #10 was observed seated in his wheelchair either in his room or about in the facility during the survey and was not observed in his bed.</p> <p>On 7/9/24 at 9:06 AM and 2:35 PM, and 7/10/24 at 8:33 AM, 11:05 AM, 12:42 AM, and 1:48 PM, Resident #10's bed was observed to be pushed up against the wall on one side. A 1/3 bed rail was in the raised position on the outer side of the bed during all the observations. During all the observations, the mattress on Resident #10's bed was pushed all the way up against the wall, creating a large gap measuring approximately 5 to 6 inches wide between the rail on the outer side of his bed and the mattress.</p> <p>During an observation on 7/10/24 at 1:48 PM, with the DNS and Maintenance Director present, the gap between Resident #10's mattress and the side rail was confirmed. The gap between the rail and the mattress was measured by the Maintenance Director and confirmed the gap was 5 1/4 inches wide.</p> <p>2. Resident #22 was admitted to the facility on [DATE], with multiple diagnoses including history of stroke, hemiplegia/hemiparesis (paralysis and weakness on one side of the body) related to stroke, brain cancer, visuospatial deficit (difficulty interpreting what a person sees to respond appropriately), and repeated falls.</p> <p>A quarterly MDS assessment, dated 5/22/24, documented Resident #22 was severely cognitively impaired. The assessment documented Resident #22 required substantial to maximum assistance from staff to roll from one side to other in bed and to transfer in and out of bed. The assessment documented bed rails were not in use for the resident.</p> <p>An order summary report, dated 7/11/24, included an order for Resident #10 to have upper bed rails to assist with bed mobility and repositioning.</p> <p>Resident #22's care plan for Activities of Daily Living, undated, documented Resident #22 had a self-care deficit related to poor nutrition and history of stroke. The care plan documented Resident #22 required assistance from one staff member to roll left and right in her bed and to transfer in and out of her bed. The care plan further documented Resident #22 may have upper bed rail to assist pt (patient) with bed mobility and repositioning. The care plan did not include specifics related to the size or type of the bed rail to be used on the Resident #22's bed.</p> <p>A side rail assessment, dated 4/1/24, documented Resident #22's use of side rails. The assessment documented the Resident #22's representative provided informed consent for the use of the rails.</p> <p>Documentation of routine physical bed checks of Resident #22's bed to ensure there were no gaps between the bed and side rails or within the side rails themselves, large enough to potentially allow entrapment of Resident #10's body parts could be found in the facility's records.</p> <p>On 7/9/24 at 9:02 AM and 2:41 PM, 7/10/24 at 8:38 AM, 11:03 AM, 12:44 PM, and 1:57 PM, Resident #22 was observed laying in her bed, which was in the low position and had raised 1/3 side rails on each side of the head of the bed. Two horizontal gaps within each rail were observed to be approximately 12 to 13 inches long. Vertical gaps within each rail were observed to be approximately three to four inches tall.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/10/24 at 1:57 PM, with the DNS and Maintenance Director present, Resident #22 was observed in her bed. The Maintenance Director measured the gaps in each rail and confirmed each vertical gap was 4 inches tall and each horizontal gap was 12 inches long.</p> <p>During an interview with the Maintenance Director on 7/10/24 at 2:25 PM, he showed the surveyor the facility's program (the TELS system) used to direct the maintenance team regarding physical bed evaluations. Review of the system documentation included a directive to ensure the gap between a resident's mattress and side rail was to be no larger than 4 1/4 inches. The Maintenance Director confirmed general bed types used by the facility were physically assessed for safety, but the bed/mattress/rail combination of each residents' bed was not being assessed. The Maintenance Director stated there were too many beds in the facility to check each bed individually for physical safety of bed rails and so had not been done.</p> <p>During an interview with the DNS on 7/10/24 at 2:28 PM, he stated his expectation was all beds with rails installed on them were expected to be maintained in a safe and functional manner to prevent the risk of entrapment.</p>		