STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents were assessed to determine if they were safe to self-administer medications for 1 of 6 residents (Resident #83) reviewed for self-administration of medications. This failure created the potential for adverse effects if residents self-administered medications inappropriately. Findings include: Resident #83 was admitted to the facility on [DATE], with multiple diagnoses including atrial fibrillation (irregular heartbeat that may cause the heart to beat faster) and diabetes.On 7/23/25 at 11:54 AM, observed a bottle of artificial tears on Resident #83's bedside table.Review of Resident #83's medical record contained a Self-Administration of Medications - Initial Evaluation dated 9/15/23, documented for eye drops- Can correctly administer eye drops or eye ointments according to proper procedure Not Applicable. On 7/23/25 at 12:00 PM, LPN #5 stated the artificial tears in Resident #83's room should not have been in his room because he did not have an order for them and a self-administration of medication assessment was not done.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, record review, and resident and staff interview, it was determined the facility failed to ensure resident's call light device in their room was within reach for 2 of 19 Residents (#42 and #84) whose rooms was observed. This deficient practice had the potential to cause harm if residents experienced falls, accidents, or had other needs and could not reach the call light device. Findings include:The facility Call Light/Bell policy dated 8/30/21, documented before leaving the room, staff will place the call light device within the resident’s reach. a. Resident #42 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) and hypertension. On 7/21/25 at 2:56 PM, Resident #42 while sitting in her wheelchair stated the call light device had been placed up high on the trapeze bar by staff when they made her bed and now it was out of her reach. On 7/21/25 at 3:00 PM, LPN #1 stated Resident #42's call light device was supposed to be attached to the bed covers to allow easy access for her and was not. On 7/23/25 at 10:23 AM, the DON stated the call light device should have been attached to the bed covers and was not. b. Resident #84 was admitted to the facility on [DATE], with multiple diagnoses including polyosteoarthritis (condition in which multiple joints are affected by inflammation and damage to the tissue that cushions the ends of bones), and obesity. On 7/23/25 at 10:42 AM, Resident #84 while sitting in her wheelchair stated the call light device was wrapped around the overbed light and out of her reach. On 7/23/25 at 10:51 AM, NA #1 stated Resident #84's call light device was supposed to be attached to the blankets for easy access for her and was not. On 7/23/25 at 3:23 PM, the DON stated the call light device should have been attached to her covers and was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure the MDS assessment accurately reflect resident's status. This was true for 1 of 19 residents (Resident #47) whose MDS assessments were reviewed. This deficient practice had the potential for negative outcomes if the resident was not assessed and/or monitored due to inaccurate assessments. Findings include: Resident #47 was admitted to the facility on [DATE], with multiple diagnoses including spina bifida (a birth defect in which an area of the spinal column does not form properly, leaving a section of the spinal cord and spinal nerves exposed through an opening in the back), anxiety, major depression, and PTSD.Resident #47's admission MDS assessment dated [DATE], documented: Section A: -1500 Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? Yes.-1510 Level II PASRR conditions: Serious Mental Illness = No.Section I: Psychiatric/Mood Disorder: -I6100. Post Traumatic Stress Disorder (PTSD) = No.0n 7/23/25 at 2:01 PM, Social Services Supervisor stated PTSD should have been on Resident #47's admission MDS assessment and was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interviews, the facility failed to include a resident's mental and psychosocial needs in their Baseline Care Plan. This was true for for 1 of 19 residents reviewed for baseline care plans (Resident #47). Findings include:The facility's Comprehensive Person-Centered Care Planning policy revision date April 2025, documented it was the policy of the facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meets professional standards of quality care.Resident #47 was admitted to the facility on [DATE], with multiple diagnoses including spina bifida (a birth defect in which an area of the spinal column does not form properly, leaving a section of the spinal cord and spinal nerves exposed through an opening in the back), anxiety, major depression, and PTSD.Record review of Resident #47's Baseline care plan, Section 1.a. Cognition, was not answered for focus, goal, or intervention. On 7/23/25 at 2:05 PM, Social Services Supervisor stated Resident #47's anxiety, depression, and PTSD diagnoses should have been on her baseline care plan but was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure resident care plans were revised to reflect current needs and interventions. This was true for 5 of 19 residents (#3, #28, #47, #59, #82) whose care plans were reviewed. This placed resident at risk of adverse outcomes if care and services were not provided due to care plans not being revised as residents' needs changed. Findings include: The facility's Comprehensive Person-Centered Care Planning policy, revision date 4/2025, documented the comprehensive care plan would be reviewed and/or revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. a.Resident #3 was admit to the facility on 4/21/25, with multiple diagnoses including surgical aftercare following surgery on the digestive system and schizoaffective disorder. Resident #3's comprehensive care plan documented the following: - Food preferences: Gravy on meat, enjoys green and yellow vegetables, wheat bread, fruit, ice cream, milk. Dated 5/21/24 -Advance to regular diet. Ensure patient is tolerating well. Date 4/22/25 -Patient prefers full liquid diet. Dated 5/16/25 Resident #3's physician order dated 4/27/25, documented, Full liquid diet, thin liquids consistency. On 7/22/25 at 1:41 PM, the DON stated Resident #3 gets bowel blockages real easy so she is on liquid diet. Her care plan should have been updated. b. Resident #28 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic kidney disease and gait and mobility issues. Resident #28’s care plan dated 7/11/24, documented she was on Enhanced Barrier Precautions (EBP). On 7/21/25 at 11:06 AM, when visiting with Resident #28 in her room, the surveyor noted the lack of EBP posting and EBP PPE outside or inside of her room. On 7/23/25 at 9:27 AM, RN#1 stated she was not sure if Resident #28 was on EBP because she had not been on this hall for a while. RN #1 confirmed there was no EBP sign posting or EBP PPE outside or inside Resident #28’s room. On 7/23/25 at 10:43 AM, RN #1 stated the DON had just let her know the EBP had been discontinued. On 7/23/25 at 2:19 PM, the DON stated Resident #28’s EBP had been previously discontinued, and the care plan should have been updated and had not been. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Resident #47 was admitted to the facility on [DATE], with multiple diagnoses including spina bifida (a birth defect in which an area of the spinal column does not form properly, leaving a section of the spinal cord and spinal nerves exposed through an opening in the back), anxiety, major depression, and PTSD. Review of Resident #47's comprehensive care plan, revision date 10/15/24, documented she required assistance with ADL self care. Her care plan did not document she requested no male caregivers. On 7/22/25 at 3:47 PM, the ADON stated Resident #47 did request no male caregivers due to her history and it was not documented in her care plan and should have been. d. Resident #59 was admitted to the facility on [DATE], with multiple diagnoses including heart failure and respiratory failure. Resident #59’s care plan was not updated with the new oxygen parameter orders. On 7/23/25 at 8:11 AM, the ADON stated the recent change of oxygen parameters for Resident #59 were not listed on his care plan and the care plan should have been updated. e. Resident #82 was admitted to the facility on [DATE], with multiple diagnoses including compression of brain (condition in which something increases the amount of pressure pushing on the brain) and aphasia (language disorder that affects ability to communicate). On 7/24/25 at 8:00 AM, observed a fall mat on the floor at Resident #82’s bed side. On 7/24/25 at 8:03 AM, fall mat had not been documented on Resident # 82's care plan. On 7/24/25 at 8:12 AM, LPN #5 stated the fall mat intervention was not listed on Resident #82’s care plan. On 7/24/25 at 8:15 AM, the ADON stated the fall mat had not been documented on Resident #82’s care plan and the care plan should have been updated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility standing orders, record review, and staff interview, it was determined the facility failed to follow a) facility bowel care standing order of delivering specific medications to residents who have not had a BM due to constipation for 1 of 1 resident (#28) whose record was reviewed for bowel care and b) obtain a physician's order for insertion of an IV and dressing changes. This failed practice created the potential for residents to experience discomfort when medications were not administered according to the physician's standing order and potential harm if a resident had an IV inserted without consulting the physician. Findings include: The facility standing order (undated) documented Dulcolax suppository PRN for constipation, Fleet Enema PRN for constipation, and Milk of Magnesia 30 mg Q4 hours PRN for constipation. a. Resident #28 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic kidney disease and gait and mobility issues. Resident #28’s medical record under CNA tasks Bowel movement/Bowel continence documented she had a bowel movement (BM) on 6/22/25 at 16:33 and not again until 6/27/25 at 16:59 which was 120 hours later. Resident #28’s medical record under CNA tasks Bowel movement/Bowel continence documented she had a BM on 7/3/25 at 14:44 and not again until 7/10/25 at 6:06, which was 180 hours later. Resident #28’s medical record documented she normally had at least one BM each day. Resident #28’s physician order dated 6/31/23, documented Sennosides Docusate Sodium Oral Tablet 8.6 - 50 mg, give 1 tablet by mouth for bowel maintenance. Resident #28’s June 2025 and July 2025, MAR documented Sennoside Docusate Sodium Oral Tablet was administered each day in June and July 2025. Resident #28’s MAR had not documented the use of the three facility standing order medications for constipation during June or July 2025. Resident #28’s care plan dated 7/19/23, documented the following intervention: - Toilet Use: Requires supervision staff participation to use toilet. On 7/23/25 at 10:30 AM, the DON stated nursing staff should be following the facility standing order by given medications for constipation and the physician should be contacted for residents who do not have a bowel movement within 72 hours and had not. b. Resident #89 was admitted to the facility on [DATE], with multiple diagnoses including fracture of the right acetabulum (hip) and COPD (a group of lung diseases that block airflow and make it difficult to breathe). On 7/22/25, observed Resident #89 with an IV inserted in his right arm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/25 at 3:50 PM, a record review of Resident #89's medical record did not document orders for his IV or IV dressing changes. On 7/23/25 at 4:17 PM, the DON stated Resident #89's IV was started on 7/22/25, and he should have had orders for the IV and dressing changes in his medical records but did not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, it was determined the facility failed to assess the risks of transporting residents backwards in Geri-Chairs and had not provided attentive care during resident transports in Geri-Chairs. This was true for 1 of 2 residents (Resident #12) who was observed during transport down the facility's C-Hallway. This deficient practice placed residents at risk for harm when improperly transported and supervision was not provided. Findings include:Resident #12 was admitted to the facility on [DATE], with multiple diagnoses including cerebellar ataxia (a group of neurological disorders that affect the cerebellum, the part of the brain responsible for coordination and balance), cognitive communication deficit, and muscle spasms.On 7/22/25 at 3:37 PM, observed Resident #12 in a Geri-Chair being pulled out of her room backwards. Resident #12 was crying out loudly, kicking her legs, and trying to move about in the chair as the CNA pulled her backwards down the hallway. The surveyor observed the CNA pull the Geri-Chair from the upper left corner of the chair as she led it down the hall and the CNA had not observed the resident during the transport.Resident #12 had three falls involving her wheelchair on 8/10/24, 9/4/24, and 9/13/24 as reported in the facility's Incident and Accident log. Each fall was a result of lack of supervision when Resident #12 was kicking and moving about in her wheelchair. One of the falls resulted in a head injury requiring transportation to the local hospital.On 7/23/25 at 10:43 AM, the DON stated staff must be attentive to Resident #12 during transports in the Geri-Chair and were not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, record review, and interviews, it was determined the facility failed to a) provide respiratory services as ordered by the physician and b) ensure physician orders and resident care plans identified interventions for oxygen therapy. This was true for 5 of 13 residents (#3, #5, #9, #28, and #59) whose records were reviewed for respiratory services. This failure created the potential for residents to experience increased fatigue and low oxygen levels. Findings include: The Centers for Medicare & Medicaid Services website, accessed 7/28/25, stated Section 1833(e) of the Social Security Act precludes payment to any provider of services unless “there has been furnished such information as may be necessary in order to determine the amounts due such provider.” It is expected that the beneficiary’s medical records will reflect the need for the care provided. The beneficiary’s medical records include the physician’s office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request. For items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim. A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain: Beneficiary’s name Physician’s name Date of the order and the start date, if start date is different from the date of the order Detailed description of the item(s) (see below for specific requirements for selected items) Physician signature and signature date for items provided on a periodic basis, including drugs, the written order must include: Item(s) to be dispensed Dosage or concentration, if applicable Route of Administration Frequency of use Duration of infusion, if applicable Quantity to be dispensed Number of refills (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident # 3 was admitted to the facility on [DATE], with multiple diagnoses including surgical aftercare following surgery on the digestive system and schizoaffective disorder. Resident #3's physician order dated 4/21/25, documented Oxygen at 0-10 liters via nasal cannula. Titrate to maintain sats above 90% every shift. Resident #3's oxygen order did not document the frequency of use. 2. Resident #5 was admitted to the facility on [DATE], with multiple diagnoses including fracture right humerus (long bone in the upper arm) and COPD (a group of lung diseases that blocks airflow and makes it difficult to breathe). Resident # 5's physician order dated 6/17/25, documented Oxygen at 0-10 liters via nasal cannula. Titrate to maintain saturations above 90% every shift. Resident #5's oxygen order did not document the frequency of use. 3. Resident #9 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including chronic viral hepatitis C (an infection that causes liver swelling), dependence on renal dialysis, and acute and chronic respiratory failure with hypoxia (when the lungs cannot adequately oxygenate the blood). Resident #9’s physician’s order dated 2/26/25, documented “oxygen at 0-4 liters via nasal cannula – every shift”. Resident #9’s MAR dated 2/26/25, documented oxygen at 0-4 liters via nasal cannula every shift. Resident #9’s care plan revised 4/11/25, documented oxygen per MD orders. Resident #9’s physician order, MAR, or care plan did not document an indication for use, a baseline SpO2 level, or when to initiate and/or discontinue oxygen therapy. On 7/22/25 at 2:38 PM, the DON stated Resident #9’s oxygen order was written generically because he does not always need oxygen; however, the order should have clarified when to use or discontinue use of oxygen on Resident #9. 4. Resident #28 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic kidney disease and gait and mobility issues. On 7/21/25 at 2:21 PM, Resident #28’s physician oxygen order documented oxygen at 0 to 10 lpm, every shift PRN to maintain O2 at or greater than 88%. Resident #28’s care plan documented oxygen per MD orders. Resident #28’s daily oxygen saturation logs documented the following: 7/11/25 at 22:34 SpO2 82% on RA per LPN #2 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/7/25 at 18:26 SpO2 67% on O2 per RN #2 4/26/25 at 22:06 SpO2 86% on RA per RN #2 4/26/25 at 15:07 SpO2 86% on RA per LPN #4 Resident #28’s medical record had not contained any documentation of nursing interventions when her oxygen saturation dropped below 88%. On 7/21/25 at 10:48 AM, the DON stated the nursing staff should have addressed Resident #28’s low oxygen saturations below 88% and had not. 5. Resident #59 was admitted to the facility on [DATE], with multiple diagnoses including heart failure and respiratory failure. The facility's policy for Oxygen Administration, revision date 7/2024, documented oxygen tubing is to be replaced every seven (7) days. Oxygen masks or nasal prongs are to be replaced every seven (7) days. Resident #59's medical record included physician orders for oxygen 0-5 liters per minute via nasal cannula for titrate to maintain above 90% every shift. The order started on 4/11/25. The orders also documented to change oxygen tubing, label and date every seven (7) days as per policy. On 7/24/25 at 8:17 AM, Resident #59's oxygen tubing and humidifier were not dated and Resident #59 stated he did not know when it was last changed. On 7/24/25 at 8:18 AM, the ADON stated Resident #59’s oxygen tubing and humidifier should have been dated when changed and had not been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined the facility failed to ensure nursing staff removed meal trays from resident rooms in a timely manner for which they had the knowledge, skills, and competencies. This was true for 1 of 1 resident (Resident #28) whose breakfast meal tray was observed in her room prior to lunch. This had the potential to create dissatisfaction with meals and decrease residents' quality of life. Findings include:Resident #28 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic kidney disease and gait and mobility issues.On 7/21/25 at 7:58 AM, observed Resident #28's uneaten breakfast meal tray on her overbed table.On 7/21/25 at 11:06 AM, observed Resident #28's uneaten breakfast meal tray still on her overbed table over 3 hours since it had been delivered. Resident #28 stated she does not know why the nursing staff sometimes wait to pick up the breakfast tray when they deliver the lunch meal tray.On 7/22/25 at 3:54 PM, the DON stated the meal trays should be picked up within 2 hours of delivery and had not been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on review of the State Operations Manual, Appendix PP, staffing schedules, personnel files, and staff interviews, it was determined the facility failed to ensure full-time employees working as a nurse aide successfully completed a State approved training and competency evaluation program within 4 months of being hired. This was true for 4 of 10 nurse aides whose personnel files were reviewed. This failure had the potential to result in negative outcomes for all residents living in the facility. Findings include:On 7/23/25, personnel files for 10 Nurse Aides (NAs) were reviewed. Four of the 10 NAs had not completed a State approved training and competency evaluation program within 4 months of being hired. - NA #2 was hired on 12/11/24. Had not completed a course- NA #3 was hired on 1/10/25. Had not completed a course- NA #4 was hired on 11/12/24. Had not passed test. Must take course again.- NA #5 was hired on 11/7/24. Had not completed a course. On 7/23/25 at 2:00 PM, the Executive Director stated NA #2, NA #3, NA #4, and NA #5 were not certified nursing assistance and the facility needs to get better about ensuring NAs become certified within the required 4 months of hire date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders without errors for 1 of 6 residents (Resident #68) observed to receive medication during the survey. This had the potential to affect the resident's health if she did not receive the medications that were ordered. This resulted in a facility medication error rate of 6.9%. Resident #68 was admitted to the facility on [DATE], with multiple diagnoses including fractured left humerus (long bone in the upper arm) and diabetes.Resident #68's physician order dated 6/13/25, documented Cranberry Oral Tablet. Give 500 mg by mouth one time a day for supplement.Resident #68's physician order dated 6/13/25, documented Multivitamin Oral Tablet. Give 1 tablet by mouth one time a day for supplement.On 7/23/25 at 9:25 AM, observed LPN #6 administer Cranberry oral 450mg tablet and Multi-vit with minerals to Resident #68.On 7/23/25 at 9:36 AM, LPN #6 stated the Cranberry tablet was the wrong dose and the Multiple vitamin was the wrong medication and she would have to get the orders clarified with the doctor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, policy review, and staff interview, it was determined the facility failed to ensure stored medications had not passed their expiration date and ensure medication carts were kept locked when not attended by authorized staff in an area where residents could access it. These failed practices affected a) 1 of 3 medication storage rooms creating the potential for residents to receive expired medications with decreased efficacy and b) 1 of 4 medication carts which had the potential for residents to gain access and ingest medications that can cause significant adverse outcomes. Findings include:The facility’s Pharmacy Services Drug Storage policy dated 10/24, documented medication and treatment carts will be kept locked when unattended. On 7/21/25 at 11:00 AM, observed the Hall-B medication cart had been left unlocked and unattended. On 7/21/25 at 11:08 AM, LPN #1 stated the Hall-B medication cart had been left unlocked when unattended and should not have been. On 7/23/25 at 10:55 AM, the DON stated medication carts should not be left unlocked when unattended and had been. On 7/23/25 at 9:00 AM, a vial of Novolog solution with the expiration date of 1/9/25, was observed in the A/B Hall medication room. On 7/23/25 at 9:02 AM, LPN #5 stated the Novolog was expired and should have been discarded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, policy review, and review of the Idaho Food Code, the facility failed to ensure food items were dated, labeled, and stored at a safe temperature. These deficient practices had the potential to impact all residents who received meals prepared in the facility's kitchen. This placed residents at risk for potential contamination and use of spoiled foods, and adverse health outcomes including food-borne illnesses. Findings include:The FDA Food Code Section 3-501.17 stated, Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, states refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded. Review of the facility's Foods Brought by Family or Visitor policy revision date January 2019, documented food items should be labeled with date it was prepared, if known, and a discard/use by date.a. Resident #28 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic kidney disease and gait and mobility issues. On 7/21/25 at 7:58 AM, observed Resident #28’s uneaten breakfast meal tray on her overbed table. On 7/21/25 at 11:06 AM, observed Resident #28’s uneaten breakfast meal tray still on her overbed table over 3 hours since it had been delivered. Resident #28 stated she does not know why the nursing staff sometimes wait to pick up the breakfast tray when they deliver the lunch meal tray. On 7/22/25 at 3:54 PM, the DON stated the meal trays should be picked up within 2 hours of delivery and had not been. b. On 7/21/25 at 8:15 AM, observed in the kitchen with the Dietary Supervisor #1 (DS) present: -Three bags of English muffins not dated. -A box of frozen sliced carrots not covered. On 7/21/25 at 8:25 AM, DS #1 stated the bags of English muffins should have been dated and the frozen carrots should have been covered and had not been. On 7/23/25 at 1:49 PM, the following were observed in the dry food storage area with DS #1 and RD present: - - Six cans of evaporated milk with a use by date 2/6/25 On 7/23/25 at 2:43 PM, the following were observed in the resident unit refrigerators, with RD present: - Three cans of Glucerna with an expiration date of February 2025. - A container of applesauce with an expiration date of May 2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A box of pizza not dated. On 7/23/25 at 2:49 PM, the RD stated the food items should have been discarded from the refrigerators.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and U.S. Food and Drug Administration 2022 Food Code review, the facility failed to ensure garbage cans were properly closed with lids to minimize attracting pests and rodents into the kitchen. This deficient practice had the potential to affect all residents and staff in the facility. Findings include:U.S. Food and Drug Administration 2022 Food Code, 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (A) Inside the FOOD ESTABLISHMENT if the receptacles and units: (1) Contain FOOD residue and are not in continuous use; or (2) After they are filled.On 7/21/25 at 8:18 AM, observed in the kitchen, next to the freezers a garbage can with a hole in the lid.On 7/21/25 at 8:21 AM, the DS #1 stated she was unaware the garbage can should have had a solid lid on it.On 7/23/25 at 3:05 PM, the ED stated the garbage can should have had a solid lid and did not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control and prevention practices were maintained to provide a safe and sanitary environment when staff did not store oxygen supplies in a sanitary manner. This was true for 4 of 9 Residents (#5, #47, #72, and #84). These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include: 1. Resident #5 was admitted to the facility on [DATE], with multiple diagnoses including fracture right humerus (long bone in the upper arm) and COPD (a group of lung diseases that block airflow and make it difficult to breathe). On 7/21/25 at 9:07 AM, observed Resident #5's nasal cannula draped on bedside table without a cover. 2. Resident #47 was admitted to the facility on [DATE], with multiple diagnoses including spina bifida (a birth defect in which an area of the spinal column does not form properly, leaving a section of the spinal cord and spinal nerves exposed through an opening in the back), anxiety, major depression, and PTSD. On 7/21/25 at 9:13 AM, observed in Resident #47's room, her CPAP mask was on the floor, next to her bed. Resident #47 stated the staff got her out of bed this morning and must have not put the CPAP mask on her dresser. 3. Resident #72 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and emphysema (a chronic lung disease that damages the air sacs in the lungs making it difficult to breathe). On 7/21/25 at 9:16 AM, observed Resident #72's oxygen tubing and nasal cannula hanging on the wall, not covered. On 7/22/25 at 2:27 PM, the DON stated the oxygen supplies and the cpap tubing and mask should not have been on the floor, and should have been stored appropriately when not in use. 4. Resident #84 was admitted to the facility on [DATE], with multiple diagnoses including polyosteoarthritis (condition in which multiple joints are affected by inflammation and damage to the tissue that cushions the ends of bones) and obesity. A physician order dated 6/20/24, documented Resident #84 was to have her don her CPAP mask (provides positive airway pressure to help breathing) at night when sleeping to ensure adequate oxygenation. On 7/21/25 at 2:16 PM and 7/22/25 at 10:43 AM, Resident #84's CPAP mask and tubing were observed on a pile of linens and pillows in the chair next to Resident #84's bed. The equipment was not bagged. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135011	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Transitional Care Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/25 at 2:29 PM, the DON stated the CPAP equipment should not have been in the chair and should have been stored appropriately and placed in a bag when not in use.