IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

March 4, 2015

Stephen Farnsworth, Administrator
Gateway Transitional Care Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Farnsworth:

On **February 11, 2015**, a Complaint Investigation survey was conducted at Gateway Transitional Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. **This survey demonstrated new findings of non-compliance, with continued non-compliance from the survey that was conducted on January 27, 2015.** This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form

CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 17, 2015.** Failure to submit an acceptable PoC by **March 17, 2015**, may result in the imposition of civil monetary penalties by **April 6, 2015.**

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 3, 2015 (Opportunity to Correct).** Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **March 3, 2015.** A change in the seriousness of the deficiencies on **March 3, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 3,**

2015 includes the following:

Denial of payment for new admissions effective **April 27, 2015.** [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 27, 2015**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option #2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 11, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

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

This request must be received by **March 17, 2015**. If your request for informal dispute resolution is received after **March 17, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,

NINA SANDERSON, Supervisor
Long Term Care

NS/lj
Enclosures

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 _____	C 02/11/2015

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

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F 000	INITIAL COMMENTS The following deficiencies were cited during the annual federal recertification survey of your facility. The surveyors conducting the survey were: ----Lauren Hoard, RN BSN - Team Coordinator Ashley Henscheid The survey team entered the facility on February 9, 2015 and exited on February 11, 2015. Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CM = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed	F 000	This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F 252 1. A. Housekeeping supervisor cleaned/extracted all rooms and halls on C hall to comprise of rooms 42-70. Housekeeping supervisor cleaned the bathrooms in rooms 43 and 45 to ensure there was no odor of urine. B. Housekeeping department cleaned the entire facility grounds to ensure there were no signs of cigarette butts or debris. 2. All residents may be affected by a similar alleged practice. 3. A. Housekeeping supervisor and administrator have evaluated the current housekeeping assignments and have changed the assignments to ensure the facility has one housekeeper assigned to one specific hall; the housekeeping supervisor will also be assigned to one specific hall as well. B. Staff has been educated regarding the facility non smoking policy and procedure by the administrator. New admissions and their families will be informed by the admissions coordinator of the facility non smoking policy and procedure as well to ensure that the facility grounds remain free from debris.	
F 252 SS=C	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the environment was kept sanitary and in good repair for 10 of 10 sampled	F 252		

RECEIVED MAR 10 2015 FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/9/15

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

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F 252	Continued From page 1 residents (Residents #1 - #10), and all other residents residing in the facility. This resulted in the facility being kept unclean. The findings include: 1. An environmental review was conducted with the Facility Operations Manager on 2/10/15 from 1:37 - 3:11 p.m. During that time, the following concerns were identified: - Hall C had a urine-like odor between rooms 43 and 57. - Room 70 had a urine-like odor. - The bathroom of rooms 43 and 45 had a urine-like odor. During a follow-up environmental review on 2/11/15 at approximately 3:30 p.m., the following concerns were identified: - The grassy area on the side of the facility between the cooling fans and the side entrance was littered with cigarette butts. - The fence around the cooling fans was lined with cigarette butts. - The grassy area between the street and the temporary main entrance was littered with cigarette butts. The facility failed to ensure the environment was maintained in a clean and sanitary manner. On 2/11/15 at 4:30 PM, the Administrator and DON were informed of the environmental concerns. No further information was provided.	F 252	Continue from page #1 4. A. Housekeeping supervisor/designee will perform daily room rounds to check for odors ongoing. Report results to QA. Audits began on 2/17/15. B. Housekeeping supervisor/designee will conduct weekly facility grounds audits to check for cigarette butts and debris. Ongoing, report to QA. Audits began on 2/17/15 5. POC Date 3/18/15	

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interview, it was determined the facility failed to keep a resident safe from experiencing 3 falls when a resident sleeping in a wheelchair was not laid down, and wheelchair equipment was not placed correctly. Additionally, a full body assessment was not completed after the resident fell to identify an injured finger. This was true for 1 of 2 (#1) sampled residents reviewed for falls. This deficient practice had the potential for harm should a resident fall out of the wheelchair and sustain a fracture. Findings included: The facility's Policy and Procedure - Falls Checklist, revised on 05/2007, documented: "1. Do full body assessment before moving resident from the floor A. Check head for injuries B. Perform neuro checks [Neurological assessment] C. Check vital signs D. Perform ROM [Range of Motion] on all extremities E. Ask the resident 'where does it hurt?' If the resident c/o [complains of] of leg or hip pain don't move him/her - transfer to the nearest	F 323	F 323 1. Facility ensured/verified that the wheelchair cushion was properly placed by staff for resident #1. 2. Other residents in wheel chairs may be affected by a similar alleged deficient practice. 3. A. DNS/DNS or designee to conduct a one-time facility wide audit to identify which residents are currently utilizing a specialty wheelchair cushion. IDT will label these identified cushions on the back side of cushion that reads "this side in the back." B. IDT will identify and review all residents assessed to be high fall risk and update the care plans to include: "staff to encourage residents to lie down if showing signs of fatigue while in wheelchair." Education provided to staff to monitor for fatigue for residents in wheelchairs and encourage them to lie down. Education provided on 3/18/15. C. IDT will review and ensure that a head to toe assessment is completed on any future resident falls during the facility daily IDT meeting. Nursing staff educated on facility policy and procedure regarding falls. Education on 3/18/15.	

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F 323	Continued From page 3 emergency room F. Check for skin tears, abrasions 2. Chart in nurses notes the details of the assessment you performed 3. Notify MD and family, on call person immediately following the incident 4. Chart on the resident for the next seventy-two (72) hours following the incident 5. If there is a head injury, do neuro checks per facility policy." Resident #1 was admitted to the facility on 10/5/14 with multiple diagnoses which included chronic kidney disease, abnormality of gait and unspecified backache. The admission MDS assessment, dated 11/18/14, documented Resident #1 had moderately impaired cognition with a BIMS of 12, displayed no behaviors, required extensive assistance for bed mobility, transfers and toileting. The resident had at least one fall in the preceding 2-6 months prior to admission to the facility. The resident's Care Plan for bowel and bladder incontinence, dated 11/21/14, documented interventions to encourage fluids during the day, ensure unobstructed path to the bathroom, establish voiding patterns, check as required for incontinence and monitor for signs and symptoms of urinary tract infections. Resident #1's Care Plan for falls related to impaired mobility, dated 11/9/14, documented interventions to anticipate and meet needs, ensure the call light was in reach, encourage afternoon nap (12/15/14), ensure proper footwear when ambulating or wheeling in wheelchair	F 323	Continue from page # 3 4. A. DNS/Designee to ensure proper placement of specialty cushions in the wheelchairs of identified residents at the beginning of day shift. 5 days per week x 2 weeks 3 days per week x 2 weeks Weekly for one month. Report to QA. Audits begin 3/10/15. B. DNS/Designee to conduct a one-time audit to identify residents who trigger for high fall risk, and ongoing audits with new residents that flag for high fall risk, to ensure care plans include "encouragement of resident to lay down when fatigue is observed while in wheelchair." Audits begin 3/10/15. C. DNS/Designee to ensure a full body assessment is performed by LN on any reported falls per facility policy & procedure; this will be done during the daily IDT morning meeting. Staff educated on 3/18/15. 5 days per week x 2 weeks 3 days per week x 2 weeks Weekly for one month. Ongoing. Audits begin 3/10/15. POC 3/18/15.	

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F 323	Continued From page 4 (11/20/14), follow facility fall protocol (11/20/14), keep needed items in reach (11/20/14), to have an anti-thrust cushion on the wheelchair (1/14/15), tab alarm on while in the wheelchair and bed (1/14/15), no foot pedals on wheelchair due to them causing a trip hazard (2/4/15). A Fall Risk Assessment, dated 11/7/14, documented Resident #1 was at high risk for falls. A Fall Scene Investigation Report, dated 12/13/14 at 4:10 PM, documented Resident #1 slid from the wheelchair to the floor while sitting near the nurse's station. The resident was wearing gripper socks, no alarm was in place and was toileted at 1:00 PM. The re-creation of the preceding 3 hours before the fall documented, "Around 1:00 [PM] I toileted her, and put her back in her chair. Then I put her at the C D nurses station and she slept until her fall at 4:10 p.m." The resident stated that she fell asleep in her chair with a pillow behind her back. The determined root cause of the fall documented, "Patient tired, was not layed down, no pressure alarm in place, confusion, pillow behind back." The initial interventions put in place to prevent future falls included a tabs alarm, remove pillow, lay the resident down, and educate staff. The conclusion of the falls team meeting documented the care plan was followed, an alarm on the wheelchair would not have prevented the fall and abuse and neglect were ruled out. The addition care plan update documented to encourage afternoon nap in the resident's bed and assess for foot pedals. A Progress Note, dated 12/13/14 at 4:15 PM, documented, "Was out at nsg [nursing] station at 4:10 pm and slid out of w/c onto floor. Just had	F 323		

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F 323	Continued From page 5 visit from carolers and she was tired and slid out of chair...hospice nurse was out at nsg station and witnessed the fall. No injury noted except for some mild pain in right shoulder right after fall later denied pain. Placed alarm on w/c and bed and assisted to lay down due to being tired. Has been active this day visiting with staff and has been confused." A second Fall Scene Investigation Report, dated 1/14/15 at 9:40 AM, documented Resident #1 leaned forward in wheelchair while the foot pedals were up near the nurse's station. The resident was wearing gripper socks and did not have an alarm in place. The fall was witnessed and the resident did not say what she was trying to do prior to the fall. The re-creation of the preceding 3 hours before the fall documented, "Pt was assisted out of bed and dressed. Pt had breakfast in dinning [sic] room. Pt then watched TV at C D nurses station. "The re-enactment of the fall documented, "Pt leaned forward in wc [wheelchair] with foot pedals evaluated [sic] and the wc tipped forward causing pt to fall to the floor." The initial interventions put in place to prevent future falls included an anti-thrust cushion applied to wheelchair. The conclusion of the falls team meeting documented abuse and neglect were ruled out, the care plan was followed, and the root cause was that the wheelchair tipped forward. The additional care plan update documented the anti-thrust cushion was applied to the wheelchair and proper positioning in the wheelchair. A Progress Note, dated 1/14/15 at 10:00 AM, documented, "Pt had a fall this morning at 940am. Pt was sitting in wc at CD nurses station watching TV. It was witnessed that pt leaned	F 323		

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F 323	Continued From page 6 forward which caused her wheelchair to tip forward causing pt to fall. Fall committee reviewed fall report and care plan. Abuse and neglect ruled out. Care plan followed. No injury noted. no c/o [complaints of] pain at time of fall. Root cause of fall determined to be that pt is able to lean to [sic] far forward in chair causing the chair to tip. Interventions put into place included placing an antitrust[sic] cushion in WC and proper position in wc." A third Fall Scene Investigation Report, dated 1/31/15 at 3:25 PM, documented Resident #1 fell due to environmental factors of clutter and "reaching out." The resident was wearing shoes, had an alarm in place which was working, and was last toileted at 12:00 PM. The re-creation of the preceding 3 hours before the fall documented, "Res. was at lunch, then at Activities. Just walked by res. et was sleeping in w/c." The re-enactment of the fall documented, "Res. sleeping in w/c, cushion in wrong position et backward. Awoke et reached for kleenex on floor." The initial root cause documented the resident was reaching out, and the cushion was not placed properly. Initial interventions put in place to prevent future falls included education provided to staff on cushion placement, toilet timing and the trash needed to be off of the floor. The conclusion of the falls team meeting documented the care plan was followed, abuse/neglect were ruled out, the resident reached forward in the w/c which caused the resident to fall onto the floor. The additional care plan update documented the foot pedals were removed from the w/c, proper w/c cushion placement and continue to use alarm. A Progress Note, dated 1/31/15 at 3:50 PM,	F 323		

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F 323	Continued From page 7 documented, "resident was sitting at c/d nurse station after lunch. resident noted to reach out for Kleenex on floor. resident noted to have change in elevation at this time 1525 [3:25 PM]. [Nurse's name] was a witness incident at the time occurred. resident is a/o [alert and oriented] x3 and is able to voice needs at this time. resident noted to have pain level of 3/10. vitals at time of incident...resident noted to have contusion to right forehead and abrasion to right cheek, ice was applied to right forehead to help with swelling. grandson...was in building after the incident and was notified, hospice was notified and came into [sic] assess resident. ADON [Assistant Director of Nursing] notified. tab alarm sounding at time of incident." Proceeding Progress Notes on 2/1 and 2/2/15 documented neuro checks and monitoring were performed for Resident #1 with no adverse findings and no further injuries noted. A Hospice Incident Report Form, dated 1/30/15 (Date on document incorrect per interview with Hospice Case Manager on 2/11/15 at 4:10 PM), documented a CNA placed the cushion in the wheelchair wrong. The resident leaned forward and the cushion slipped out causing the resident to fall on her face with a resulting hematoma (bruise) to the forehead. An ice pack was applied and the facility started neuro checks. The physician was notified on 1/30/15 (Date incorrect). Hospice Nurse's Notes after the fall on 1/31/15 documented further monitoring for complications related to the fall. No injuries other than to the face were documented.	F 323		

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F 323	Continued From page 8 On 2/10/15 at 2:05 PM, the hospice LN was interviewed during her visit with Resident #1. The LN touched the resident's right ring finger and said the swelling and bruising had gone way down since the fall on 1/31/15. She said she did not know if the facility was aware of the bruised/swollen finger until she brought it up to them. The LN said the Hospice Case Manager was called regarding the resident's fall and went to the facility and assessed the resident. She said the MD was notified, and the finger was not suspected to be broken because the resident did not experience pain when the finger was bent. On 2/10/15 at 2:05 PM, with the hospice LN present, the resident was asked about the fall on 1/31/15. She remembered she fell but did not know how or why or when. On 2/11/15 at 8:20 AM, the DON was interviewed. He said he was not directly involved with Resident #1's fall on 1/31/15, but in the IDT (Interdisciplinary Team) meeting discussed the fall. The protocol was followed, the physician and family were notified and abuse and neglect were ruled out. The DON said if the resident's neuro checks were abnormal, they would send her to the hospital, but if the neuro checks were within normal limits, the checks would continue. For the resident, the facility was given the instruction to perform neuro checks, which were within normal limits, and the resident was not sent to the hospital. The DON described the resident's injuries as an abrasion to the right forehead which turned into a bruise. The treatment included an assessment by the nurse, wound care and monitoring. When asked if the resident had any other injuries, the DON stated, "Not that we assessed, no. It was ever reported to me."	F 323		

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	135011	A. BUILDING _____ B. WING _____	C 02/11/2015

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

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F 323	Continued From page 9 Resident #1 experienced 3 falls in 2 months. Two of those falls occurred while the resident slept in her wheelchair and was not laid down to sleep. For the fall on 1/31/15, an injured finger was not discovered, assessed, treated or monitored. In addition, the anti-thrust cushion was placed incorrectly resulting in a fall, and the care plan did not address how to properly place the cushion. On 2/11/15 at 4:30 PM, the Administrator and DON were informed of the concerns related to Resident #1's falls. No further information was provided.	F 323		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interview, it was determined the facility failed to ensure it maintained a medication error rate less than 5 percent when medications were administered late. This was true for 19 of 26 medications (72%) during the medication pass observation which affected 4 of 4 (#s 6, 8, 9 & 10) random residents. This failure created the potential for the affected residents to receive less than optimum benefit from prescribed medication. Findings included: The facility's Policy and Procedure for Medication Pass Times, revised 3/2008, documented,	F 332	F 332 1. ADNS and charge nurse assisted with the completion of the med pass for that day. 2. Other residents on C hall may be affected by a similar alleged deficient practice. 3. Systematic changes were carried out to identify the root cause of the late med pass to be un-equal nursing assignments to which these assignments were re- aligned to ensure med passes were completed within policy and procedure time frame. 4. DNS/Designee will audit med pass times to ensure compliance per facility policy and procedure. 5 days per week x 2 weeks 3 days per week x 2 weeks Weekly for one month. Audits begin 3/10/15. 5. POC 3/18/15	

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F 332	Continued From page 10 "Medication pass time may be considered 1 hour before to 1 hour after scheduled time." On 2/9/15 at 1:35 PM, during the initial tour of the facility, Resident #2 told the surveyor, "[The] meds are kinda late" because the facility was short of nurses. The resident said the medications were late every day, especially during the morning hours. 1. Resident #6's Order Summary Report for February 2015, included an order for Nitrofurantoin Macrocrystal Capsule 50 mg by mouth one time a day for prophylaxis UTI (Urinary Tract Infection). The February 2015 MAR (Medication Administration Record) for Resident #6 documented Nitrofurantoin was to be administered at 7:00 AM. The facility utilized a computerized MAR system which the LN's used for medication pass. On 2/10/15 at 8:30 AM, the Nitrofurantoin for Resident #6 was highlighted red, and when LN #2 was asked what it meant, she stated, "[The] color means overdue. [It is] hard to get everyone at one time." On 2/10/15 at 8:30 AM, LN #2 was observed to administer Nitrofurantoin to Resident #6, 1.5 hours after it was scheduled to be administered, or 30 minutes past the 1 hour window per the facility's policy. During the medication pass observation, the computer screen displayed 16 resident names highlighted in red. LN #2 said it meant, "They all have at least one med overdue."	F 332		

STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 332	Continued From page 11 2. Resident #8's Order Summary Report for February 2015, included orders for a Multivitamin by mouth one time a day for supplement, Colace capsule 100 mg by mouth two times a day for constipation, and Gabapentin 300 mg by mouth three times a day for neuropathy in bilateral hands. The February 2015 MAR for Resident #8 documented the aforementioned medications were to be administered at 7:00 AM. On 2/10/15 at 9:00 AM, the computerized MAR had the medications highlighted in red. When asked what the red color meant, LN #3 said, "That they're late." On 2/10/15 at 9:00 AM, LN #3 was observed to administer the Multivitamin, Colace and Gabapentin to Resident #8, 2 hours after it was scheduled to be administered, or 1 hour past the 1 hour window per the facility's policy. 3. Resident #9's Order Summary Report for February 2015, included orders for Gabapentin 800 mg by mouth three times a day for neuropathy, Humalog Solution inject 8 units subcutaneously three times a day for DM (Diabetes Mellitus), Humalog Solution inject as per sliding scale subcutaneously three times a day for DM, Lantus Solution inject 35 units subcutaneously one time a day for DM, Methocarbamol 750 mg by mouth three times a day for muscle spasms, and Morphine Sulfate Extended Release 30 mg by mouth every 12 hours for pain. The February 2015 MAR for Resident #9 documented the aforementioned medications	F 332		

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F 332	Continued From page 12 were to be administered at 8:00 AM. On 2/10/15 at 9:10 AM, LN #3 was observed to administer Gabapentin, Humalog insulin, Lantus insulin, Methocarbamol and Morphine Sulfate to Resident #9, 1 hour and 10 minutes after it was scheduled to be administered, or 10 minutes past the 1 hour window per the facility's policy. LN #3 stated, "She likes to have her meds when she wants. I try to accommodate her." On 2/10/15 at 9:10 AM, during the medication pass observation, the computer screen displayed 11 resident names highlighted in red. 4. Resident #10's Order Summary Report for February 2015, included orders for Novolin 70/30 Suspension inject 15 units subcutaneously one time a day for DM, Zyprexa 10 mg by mouth one time a day for Schizophrenia, Benztropine Mesylate 0.5 mg by mouth two times a day for tardive dyskinesia, Celexa 20 mg by mouth one time a day for depression, Cinacalcet HCl 60 mg by mouth one time a day for supplement, Colace 100 mg by mouth two times a day for constipation, Humalog Solution inject 1 unit subcutaneously in the morning for DM, Humalog Solution inject as per sliding scale subcutaneously three times a day for DM, Miralax Power 17 grams by mouth one time a day for constipation, and a Multivitamin by mouth one time a day for supplement. The February 2015 MAR for Resident #10 documented the aforementioned medications were to be administered at 8:00 AM. On 2/11/15 at 10:00 AM, LN #3 was observed to administer Novolin 70/30 insulin, Zyprexa,	F 332		

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F 332	Continued From page 13 Benztropine Mesylate, Celexa, Cinacalcet HCl, Colace, Humalog Insulin, Miralax Power and a Multivitamin to Resident #10, 2 hours after it was scheduled to be administered, or 1 hour past the 1 hour window per the facility's policy. On 2/11/15 at 11:54 AM, the DON was interviewed. When asked if there were any complaints from residents related to medications passed late, the DON said, "Yes," and identified a particular resident, and others periodically. The DON stated, "I've been told they're in that time frame of the hour window." He encouraged nurses to ask himself, the ADON and the charge nurse for help if they were running late, but the nurses had not been asking for help with medication pass, it had been to do other things for them while they pass the medications. When asked how many residents the medication nurses were responsible for, the DON said anywhere between 20 and 25. On 2/11/15 at 3:25 PM, LN #3 said she was responsible for 26 to 27 residents. She said it took an average of 10 minutes per resident, with 26 or 27 residents, that equals 4 to 4.5 hours for the morning medication pass. The LN said it would be nice to have another medication cart and medication nurse. On 2/11/15 at 3:30 PM, LN #2 said she was responsible for 22 residents, and it depended on various things how long the medication pass would take. The LN said some days she couldn't catch everyone. On 2/11/15 at 3:35 PM, LN #4 said she was responsible for 22 residents, and the morning medication pass could take 2 hours to 6 hours.	F 332		

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F 332	Continued From page 14 On 2/11/15 at 4:30 PM, the Administrator and DON were informed of the late medications concern. No further information was provided.	F 332	F 353	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on medication pass observations, resident and staff interview, and Resident Council Meeting Minutes review, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of all residents. This was true for 4 of 4 (#s 6, 8, 9 &	F 353	1. ADNS and charge nurse assisted with the completion of the med pass for that day. 2. Other residents may be affected by a similar alleged deficient practice. 3. DNS/ADNS and lead nurse aide reviewed and adjusted the nurse staff assignments so med pass times will fall within facility policy and procedure, call lights are answered in a timely manner and any resident concerns are addressed. Staff was educated on med pass, call light and resident concerns/care per facility policy and procedure. Education completed on 3/18/15. 4. DNS/Designee will audit the effectiveness of the nursing assignments for med pass. Administrator will randomly audit call light response times by interviewing residents. Social Service will randomly interview residents for any concerns and if those concerns are being addressed. 5 days per week x 2 weeks 3 days per week x 2 weeks Weekly for one month. Audits begin 3/10/15. 5. POC 3/18/15	

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F 353	Continued From page 15 10) random residents, and 1 of 6 (#2) sampled residents. And, it had the potential to affect all other residents who lived in the facility who required staff assistance. This failure created the potential for psychosocial and physical harm to the residents in the facility. Findings included: 1. Observations Please refer to F332 regarding delayed medication pass due to low staffing levels. 2. Documentation: On 2/9/15 the Resident Council Meeting Minutes were requested. Upon review, the following concerns were documented: a. On 11/12/14, the Previous Item Follow-Up category documented, "Residents reported some nursing staff is in a hurry and doesn't give residents the time and attention needed to resolve any concerns, issues, or questions at that time. Ongoing concern - readdressed with staff." b. On 1/14/15, the New Business category documented, "...4.) Call lights - answered timely during the day, an issue with call lights being answered at night. Residents reported they wait a long time for assistance after 7 pm. 5.) Residents expressed concern that medications are not being passed timely during NOC [Nocturnal - meaning night] med pass..." The Resident Council Follow-Up documented the response for the above concerns: * "Call lights - answered timely during day, but reported an issue with call lights being answered after about 7pm. Stated long wait (beyond 15 minutes) for assistance;" and, * "I made some adjustments to the schedule for Feb 2015. I added a float every night to try [and]	F 353		

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F 353	Continued From page 16 help with this issue (census permitting)." c. On 2/4/15, the Previous Item Follow-Up category documented, "4.) Call lights - answered timely during the day, an issue with call lights being answered at night. Residents reported they wait a long time for assistance after 7pm. - NOC continues to be an issue; discussed Lead CNA's plan for addressing call lights (i.e. float position), residents feel this will help immensely. 5.) Residents expressed concern that medications are not being passed timely during NOC med pass. - Going much better; new nurses are learning and becoming better at med pass..." 3. Resident Interview: On 2/9/15 at 1:35 PM, during the initial tour of the facility, Resident #2 told the surveyor, "[The] meds are kinda late" because the facility was short of nurses. The resident said the medications were late every day, especially during the morning hours. 4. Staff Interviews: a. On 2/11/15 at 3:25 PM, LN #3 said she was responsible for 26 to 27 residents. She said it took an average of 10 minutes per resident, with 26 or 27 residents, that equals 4 to 4.5 hours for the morning medication pass. The LN said it would be nice to have another medication cart and medication nurse. b. On 2/11/15 at 3:30 PM, LN #2 said she was responsible for 22 residents, and it depended on various things how long the medication pass would take. The LN said some days she couldn't catch everyone.	F 353		

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F 353	Continued From page 17 c. On 2/11/15 at 3:35 PM, LN #4 said she was responsible for 22 residents, and the morning medication pass could take 2 hours to 5 hours. On 2/11/15 at 4:30 PM, the Administrator and DON were informed of the staffing concern. No further information was provided.	F 353		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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FILE COPY

April 6, 2015

Stephen Farnsworth, Administrator
Gateway Transitional Care Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Farnsworth:

On **February 11, 2015**, an unannounced on-site complaint survey was conducted at Gateway Transitional Care Center.

During the investigation, observations, review of records, review of significant incidents and residents' interviews were completed with the following results. The complaint allegations, findings and conclusions are as follows:

Complaint #6855

ALLEGATION #1:

The complainant said residents are not provided with treatment for injuries or illnesses.

FINDINGS #1:

Observations were completed during the investigation. A contract employee stated a resident acquired injuries to her face and ring finger after a fall. The employee was unsure if the injuries had been assessed or monitored by the facility. No concerns with treatment of resident injuries or illnesses were noted during the observations.

Incident and accident reports and fall reports, dated July 1, 2014 through February 9, 2015, were

reviewed. The reports documented appropriate response, including treatment as needed, for all incidents. For example, a fall report, dated December 7, 2014, documented a resident fell in an attempt to self-transfer to the restroom and sustained a head contusion. The facility re-trained staff to assist the resident to the restroom after meals and implemented head checks for the resident.

Six residents were selected for further review. Each resident's progress notes from November 1, 2014 through February 10, 2015, were reviewed. Progress notes documented development of resident's illnesses and injuries with appropriate treatment. For example, a progress note, dated November 26, 2014, documented a resident was behaving differently and had a declined mental status. The facility took the resident to the emergency room immediately for assessment and treatment of her symptoms.

Physician's orders, medication administration records and treatment administration records, dated November 1, 2014 through February 10, 2015, were reviewed. The records documented residents received routine care, in addition to treatment for illnesses and injuries as indicated in the progress notes.

Interviews were conducted with seventeen residents in the facility. All residents stated they were pleased with their care and their needs were being met.

It could not be determined that residents were not provided with treatment for injuries or illnesses. Therefore, the allegation was unsubstantiated due to a lack of sufficient evidence.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainants said residents are involved in significant incidents that the facility fails to report as required.

FINDINGS #2:

During observations in the facility, no significant incidents were observed.

Incident and accident reports as well as fall reports, dated July 1, 2014 through February 9, 2015, were reviewed. One report did not include documentation of physician's notification; however, the facility was able to provide supplement information, which documented the notification had been made. No other concerns with facility reporting were noted.

Six residents were selected for further review. Each resident's progress notes from November 1, 2014 - February 10, 2015, were reviewed. The progress notes included documentation of family contact,

including the summary of in-person meetings as well as phone calls.

During the exit conference on February 11, 2015, the Administrator was notified of the findings.

It could not be determined that the facility failed to report significant incidents. Therefore, the allegation is unsubstantiated due to a lack of sufficient evidence.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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April 6, 2015

Stephen Farnsworth, Administrator
Gateway Transitional Care Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Farnsworth:

On **February 11, 2015**, an unannounced on-site complaint survey was conducted at Gateway Transitional Care Center.

During the investigation, observations, review of records and residents and staff interviews were completed with the following results. The complaint allegations, findings and conclusions are as follows:

Complaint #6861

ALLEGATION #1:

Residents are not adequately groomed or dressed in clean clothing.

FINDINGS #1:

Observations were completed between February 9 and February 11, 2015. No resident was noted to be poorly groomed. One resident was observed in the same nightgown two days in a row. However, when asked during observations, the Housekeeping Supervisor stated the resident chose her own clothing and preferred to wear a nightgown two to three times before washing it.

Six residents were selected for further review. Each resident's bathing tracking from November 1, 2014 through February 10, 2015. No concerns with bathing frequency were noted.

Interviews were conducted with seventeen residents of the facility on February 9 and February 11, 2015. All of the residents stated they were pleased with their care and their needs were being met.

During the exit conference on February 11, 2015, the Administrator was notified of the findings.

It could not be determined that residents were not being groomed or dressed adequately. Therefore, the allegation was unsubstantiated due to a lack of sufficient evidence.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant said residents are not provided with treatment for injuries or illnesses.

FINDINGS #2:

Incident and accident reports, dated July 1, 2014 through February 10, 2015, were reviewed. The reports included appropriate response, including treatment as needed, for all incidents.

Observations were completed between February 9 and February 11, 2015. During that time, a contract employee stated a resident acquired injuries to her face and ring finger after a fall. The employee was unsure if the injuries had been assessed or monitored by the facility. No concerns with treatment of resident injuries or illnesses were noted during the observations.

Fall reports, dated July 1, 2014 through February 10, 2015, were reviewed. The reports included appropriate response, including treatment as needed, for all incidents. For example, a fall report, dated December 7, 2014, documented a resident fell in an attempt to self-transfer to the restroom and sustained a head contusion. The facility re-trained staff to assist the resident to the restroom after meals and implemented head checks for the resident.

Six residents were selected for further review. Each resident's progress notes from November 1, 2014 through February 10, 2015, were reviewed. Progress notes documented development of resident illnesses and injuries with appropriate treatment. For example, a progress note, dated November 26, 2014, documented a resident was behaving differently and had a declined mental

status. The facility took the resident to the emergency room immediately for assessment and treatment of her symptoms.

Physician's orders, medication administration records and treatment administration records, dated November 1, 2014 through February 10, 2015, were reviewed. The records documented residents received routine care, in addition to treatment for illnesses and injuries as indicated in the progress notes.

Residents who were interviewed stated they were pleased with their care and their needs were being met.

It could not be determined that residents were not provided with treatment for injuries or illnesses. Therefore, the allegation was unsubstantiated due to a lack of sufficient evidence.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant said the physical environment of the facility is dirty and odorous.

FINDINGS #3:

Interviews were conducted with residents of the facility. None of the residents had concerns with the physical environment of their rooms.

Resident Council Meeting Minutes from November 12, 2014 through February 4, 2015, were reviewed. Meeting minutes, dated December 3, 2014, documented residents voiced their concern about bed linens not being changed at the November 12, 2014, meeting and the issue was now resolved. No other issues related to physical environment could be found in the Resident Council Meeting Minutes.

On the afternoon of February 10, 2015, an environmental tour was conducted with the Facility Operations Manager. During that time, the following concerns were identified:

- Hall C had a urine-like odor between rooms 43 and 57.
- Room 70 had a urine-like odor.
- The bathroom of rooms 43 and 45 had a urine-like odor.

During a follow-up environmental review on February 11, 2015, at approximately 3:30 p.m., the following concerns were identified:

- The grassy area on the side of the facility between the cooling fans and the side entrance was littered with cigarette butts.
- The fence around the cooling fans was lined with cigarette butts.
- The grassy area between the street and the temporary main entrance was littered with cigarette butts.

During the exit conference on February 11, 2015, the Administrator was notified of the findings.

The allegation was substantiated and deficient practice was cited at F252.

CONCLUSIONS:
Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The complainant said residents are involved in significant incidents that the facility fails to report as required.

FINDINGS #4:

During observations in the facility, no significant incidents were observed.

Incident and accident reports as well as fall reports, dated July 1, 2014 through February 9, 2015, were reviewed. One report did not include documentation of physician's notification; however, the facility was able to provide supplement information, which documented the notification had been made. No other concerns with facility reporting were noted.

Six residents were selected for further review. Each resident's progress notes from November 1, 2014 - February 10, 2015, were reviewed. The progress notes included documentation of family contact, including the summary of in-person meetings as well as phone calls.

It could not be determined that the facility failed to report significant incidents. Therefore, the allegation is unsubstantiated due to a lack of sufficient evidence.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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April 6, 2015

Stephen Farnsworth, Administrator
Gateway Transitional Care Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Farnsworth:

On **February 11, 2015**, an unannounced on-site complaint survey was conducted at Gateway Transitional Care Center. Facility staff and residents were interviewed and observations were made. Residents' records, Resident Council Meeting Minutes and facility's policies were reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #6862

ALLEGATION #1:

The complainant expressed concerns about the number of facility acquired infections that residents experienced.

FINDINGS #1:

The facility's infection control policy included goals to decrease the risk of infections in residents and personnel and a plan to monitor for the occurrences of infection and implement appropriate control measures. The policy included the need for the surveillance and prevention of infections.

Observations completed during the survey did not identify breaches in infection control nor did records review reveal infection control concerns.

Interviews were conducted with seventeen residents in the facility February 9 through February 11, 2015. None of the residents expressed concerns with infection control practices.

Resident Council Meeting Minutes from November 12, 2014 through February 4, 2015, were reviewed. Meeting minutes, dated December 3, 2014, documented residents voiced their concern about bed linens not being changed at the November 12, 2014, meeting and the issue was now resolved. No other issues related to infection control were identified.

It could not be determined that the facility had significant breaches in infection control practices. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated that residents' medications are administered late.

FINDINGS #2:

Based on observations, records review and staff and residents interviews, it was determined the facility failed to ensure it maintained a medication error rate less than five percent when medications were administered late. This was true for 19 of 26 medications (72%) during the medication pass observation, which affected four of four random residents. This failure created the potential for the affected residents to receive less than optimum benefit from prescribed medication.

The allegation was substantiated and the facility was cited at F332.

CONCLUSIONS:
Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated the physical environment of the facility is dirty.

FINDINGS #3:

Interviews were conducted with residents of the facility. None of the residents had concerns with the physical environment of their rooms.

Resident Council Meeting Minutes from November 12, 2014 through February 4, 2015, were reviewed.

Meeting minutes, dated December 3, 2014, documented residents voiced their concern about bed linens not being changed at the November 12, 2014, meeting and the issue was now resolved. No other issues related to physical environment could be found in the Resident Council Meeting Minutes.

On the afternoon of February 10, 2015, an environmental tour was conducted with the Facility Operations Manager. During that time, the following concerns were identified:

- Hall C had a urine-like odor between rooms 43 and 57.
- Room 70 had a urine-like odor.
- The bathroom of rooms 43 and 45 had a urine-like odor.

During a follow-up environmental review on February 11, 2015, at approximately 3:30 p.m., the following concerns were identified:

- The grassy area on the side of the facility between the cooling fans and the side entrance was littered with cigarette butts.
- The fence around the cooling fans was lined with cigarette butts.
- The grassy area between the street and the temporary main entrance was littered with cigarette butts.

During the exit conference on February 11, 2015, the Administrator was notified of the findings.

The allegation was substantiated and deficient practice was cited at F252.

CONCLUSIONS:
Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The complainant said biohazardous items are not properly stored.

FINDINGS #4:

Resident Council Meeting Minutes from November 12, 2014 through February 4, 2015, were reviewed. None of the meeting minutes included concerns related to the storage of biohazardous items.

Observations were completed between February 9 and February 11, 2015. Biohazards were noted to be stored behind a locked door throughout the observations.

On February 10, 2015, from 1:37 - 3:11 p.m., an environmental review was conducted with the Facility Operations Manager. During that time, the biohazards were observed to be locked up.

During an interview on February 11, 2015, from 3:17 - 3:27 p.m., the Housekeeping Supervisor stated biohazardous items were immediately removed from residents' rooms and stored in a locked storage room.

During the exit conference on February 11, 2015, from 4:30 - 4:45 p.m., the Administrator was notified of the findings.

It could not be determined that biohazardous items were improperly stored. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant said "tab alarms" are not used consistently.

FINDINGS #5:

Fall reports, dated July 1, 2014 through February 19, 2015, were reviewed. The reports documented alarms were used for the residents who required them.

During observations conducted February 9 through February 11, 2015, alarms, including tab and pressure, were noted to be in use with no concerns.

It could not be determined that residents were not provided with assistive devices, such as bed and chair alarms, as planned. However, it was determined the facility failed to keep a resident safe from experiencing three falls when a resident sleeping in a wheelchair was not laid down, and wheelchair equipment was not placed correctly.

Additionally, a full body assessment that identified an injured finger was not completed after the resident fell.

Therefore, the allegation was substantiated and the facility was cited at F323 for failure to provided adequate supervision to prevent accidents.

CONCLUSIONS:
Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #6:

The complainant said the daily staffing is not posted accurately.

FINDINGS #6:

Resident Council Meeting Minutes from November12, 2014 through February 4, 2015, were reviewed. None of the meeting minutes included concerns related to the posting of the daily staffing.

Observations were completed between February 9 and February 11, 2015. During that time, the daily staffing was posted and updated with no concerns noted.

It could not be determined that daily staffing was not posted accurately. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/dmj