



IDAHO DEPARTMENT OF
HEALTH & WELFARE

.BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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

February 13, 2020

Shauna Kraus, Administrator
Serenity Healthcare
1134 Cheney Dr. West
Twin Falls, ID 83301-1202

Provider #: 135143

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT
COVER LETTER**

Dear Ms. Kraus:

On **February 5, 2020**, a Facility Fire Safety and Construction survey was conducted at **Serenity Healthcare** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5)

Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 26, 2020**. Failure to submit an acceptable PoC by **February 26, 2020**, may result in the imposition of civil monetary penalties by **March 19, 2020**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 11, 2020**, (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 **May 5, 2020**. A change in the seriousness of the deficiencies on **March 21, 2020**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **March 11, 2020**, includes the following:

Denial of payment for new admissions effective **May 5, 2020**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 5, 2020**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 5, 2020**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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<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:

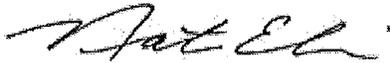
BFS Letters (06/30/11)

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

This request must be received by **February 26, 2020**. If your request for informal dispute resolution is received after **February 26, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 02/12/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135143	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2020
NAME OF PROVIDER OR SUPPLIER SERENITY HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1134 CHENEY DR WEST TWIN FALLS, ID 83301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>The facility consists of a single story, Type V (111) structure with a partial basement. The building is fully sprinklered with an interconnected fire alarm/smoke detection system throughout. The facility equipment lift from the basement level is separated to the main building by a 1-hour construction. The facility backup power is provided with an on-site, diesel-fired Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 60 SNF/NF beds with a census of 48 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on February 5, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>K 161 - Facility has replaced the intumescent sealant to seal off the conduits on 2/8/2020. All other conduits have been inspected by the Plant Manager with no findings. A weekly audit to be completed by the Physical Plant Manager has been added to the Preventative Maintenance System (PMS) to ensure that there are no penetrations that all penetrations are sealed.</p>	3-10-2020
K 161 SS=E	<p>Building Construction Type and Height CFR(s): NFPA 101</p> <p>Building Construction Type and Height 2012 NEW Building construction type and stories meets Table 18.1.6.1, unless otherwise permitted by 18.1.6.2 through 18.1.6.7. 18.1.6.4, 18.1.6.5</p> <p>Construction Type 1 I (442), I (332), II (222) Not allowed non-sprinklered Any number of stories</p>	K 161	<p>The Administrator monitors the PMS monthly to ensure records are accurate and up to date. Review of these audits will be presented to the QAPI Committee through May 2020.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Shauna Kous* TITLE: Administrator (X6) DATE: 2-24-2020

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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K 161	Continued From page 1 2 II (111) Not allowed non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 1 story sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 18.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the fire and smoke resistive properties of the structure were maintained. Failure to maintain penetrations between floors from conduits used for data sources, has the potential to allow smoke, fire and dangerous gases to pass between compartments and levels, affecting the safe egress of residents during a fire. This deficient practice potentially affected those residents and staff on the ground floor on the date of the survey.	K 161		

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K 161	<p>Continued From page 2</p> <p>Findings include:</p> <p>During the facility tour conducted on 2/5/20 from 1:00 - 3:00 PM, observation of the basement level mechanical room, revealed three (3) approximately 2-1/2 inch diameter metal data conduits penetrating into the ceiling. Further observation revealed two (2) of these conduits were missing the protective firestopping around the cabling. This missing firestopping was observed to be on the floor, directly below the cabling conduits.</p> <p>Interview of the Director of Plant Operations at the time of this observation established he was not aware the required firestopping was missing from the conduit(s).</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>8.3.5 Penetrations. The provisions of 8.3.5 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations in fire walls, fire barrier walls, and fire resistance-rated horizontal assemblies. The provisions of 8.3.5 shall not apply to approved existing materials and methods of construction used to protect existing through-penetrations and existing membrane penetrations in fire walls, fire barrier walls, or fire resistance-rated horizontal assemblies, unless otherwise required by Chapters 11 through 43.</p> <p>8.3.5.1* Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and</p>	K 161		

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K 161	Continued From page 3 communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m ²) between the exposed and the unexposed surface of the test assembly.	K 161	K 325 – All Housekeeping staff were re-trained to proper ABHR inspection and monitoring by 2/25/20. On 2/20/20 Plant Manager was re-educated to completion of weekly audits of ABHR inspections and monitoring. All Housekeeping staff will individually demonstrate Competencies for ABHR inspection and monitoring by 2/26/20. The ABHR outside room 39 was re-inspected on 2/5/20 and was operational per manufacturer recommendations.	3-10-2020
K 325 SS=F	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: *Corridor is at least 6 feet wide. *Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. *Dispensers shall have a minimum of 4 foot horizontal spacing. *Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. *Storage in a single smoke compartment greater than five gallons complies with NFPA 30. *Dispensers are not installed within one inch of an ignition source. *Dispensers over carpeted floors are in sprinklered smoke compartments. *ABHR does not exceed 95 percent alcohol. *Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11). *ABHR is protected against inappropriate access.	K 325		

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K 325	<p>Continued From page 4 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on record review, operational testing, observation and interview, the facility failed to ensure Alcohol-Based Hand Rub (ABHR) dispensers were maintained in accordance with NFPA 101. Failure to test and document operation of automatic ABHR dispensers under manufacturer's recommendations and in accordance with the standard, has the potential of increasing the risk of fires from flammable liquids. This deficient practice affected 48 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>1) During the review of facility maintenance and inspection records conducted on 2/5/20 from 8:30 - 11:00 AM, ABHR inspection and testing records did not demonstrate the facility was completing required testing and inspection of ABHR dispensers during the refilling process, but was initialing and dating the refill.</p> <p>2) During the facility tour conducted on 2/5/20 from 11:00 AM - 3:00 PM, observation of installed ABHR dispensers revealed automatic dispensers were installed throughout the facility. At approximately 2:15 PM, operational testing of the ABHR dispenser outside room 39 failed to dispense hand sanitizer on initial placement of an object (hand) under the dispensing nozzle. Further observation of the "inspection" tag attached to the refill, revealed the date of replacement was February 4, 2020 and the label was initialed.</p> <p>3) At approximately 2:30 PM, when</p>	K 325	<p>K325 Continued Until 2/25/20 when Housekeeping staff initialed and dated that the dispenser refill had been placed, this was also the documentation that the dispenser had been inspected to the manufacture's recommendation. Effective 2/25/20, Housekeeping staff will inspect and monitor the ABHR by 1) initialing and dating upon refill as previously done and document on the newly implemented inspection log which will be kept inside each dispenser. Weekly inspections of the ABHR, which includes random inspection of no less than 10% of dispensers by the Plant Manager will be added to the PMS.</p>	

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K 325	Continued From page 5 Housekeeping staff outside room 39 was asked what actions she took when replacing the hand sanitizer refills, she stated she would check to see if the battery was "green" and if the hand sanitizer activated. Actual NFPA standard: 19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met: (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm). (2) The maximum individual dispenser fluid capacity shall be as follows: (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms (3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA 30 B, Code for the Manufacture and Storage of Aerosol Products. (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm). (5) Not more than an aggregate 10 gal (37.8 L) of alcohol based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6). (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be	K 325	K325 Continued These inspections will also be documented on the logs maintained in each dispenser. The Administrator monitors the PMS monthly to ensure records are accurate and up to date. Review of these audits will be presented to the QAPI Committee monthly through May 2020.	

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K 325	Continued From page 6 included in the aggregated quantity addressed in 19.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized.	K 325		

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K 325	Continued From page 7	K 325		
K 345 SS=F	<p>(f) The dispenser shall be tested in accordance with the manufacturer ' s care and use instructions each time a new refill is installed.</p> <p>Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101</p> <p>Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire alarm systems were maintained in accordance with NFPA 72. Failure to ensure fire alarm systems are maintained and tested as required, has the potential to hinder system response during a fire event. This deficient practice affected 48 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the review of provided fire alarm inspection and testing reports conducted on 2/5/20 from 8:30 - 11:00 AM, no record was available demonstrating the documentation of a sensitivity testing of the fire alarm was completed one year after the new installation. Further review of the annual report dated January 17, 2020, the report revealed 22 devices were documented as "untested". Those devices were:</p> <ul style="list-style-type: none"> - One (1) door holder at the Kitchen - Twenty (20) smoke detectors - The Kitchen hood 	K 345	<p>K 345 – Webster Fire Protection completed the sensitivity testing on 2/07/2020. Strobes were repaired/replaced on 2/07/2020.</p> <p>The original report was completed on 1/17/2020 by our contracted fire monitoring company, Webster Fire Protection. Conversation with the Technician indicates, he tested all devices, however failed to “click the right button, when the report was produced. This has been verified with his Supervisor also.</p> <p>PMS alerts Plant Manager to ensure fire monitoring contractor has completed inspections according to CMS and NFPA guidelines.</p>	3-10-2020

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K 345	Continued From page 8 Additionally, two (2) horn strobe devices were noted as deficient; one (1) was noted as missing and one (1) as "failed". Interview of the Director of Plant Operations at approximately 10:00 A.M., established he was not aware of the requirement for the sensitivity test or the devices that had not been tested, but was aware of the deficiencies noted on the report regarding the horn strobe devices. Actual NFPA standard: NFPA 72 Chapter 14 Inspection, Testing, and Maintenance 14.1 Application. 14.1.1 The inspection, testing, and maintenance of systems, their initiating devices, and notification appliances shall comply with the requirements of this chapter. 14.2.1.2 Impairments. 14.2.1.2.2 System defects and malfunctions shall be corrected. 14.2.1.2.3 If a defect or malfunction is not corrected at the conclusion of system inspection, testing, or maintenance, the system owner or the owner's designated representative shall be informed of the impairment in writing within 24 hours. 14.4.5.3* In other than one- and two-family dwellings, sensitivity of smoke detectors and single- and multiple-station smoke alarms shall be tested in accordance with 14.4.5.3.1 through 14.4.5.3.7. 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation.	K 345	K345 Continued Plant Manager has reviewed and updated PMS to ensure all requirements are accurately reflected. Regional Plant Manager will review and verify. Administrator monitors the PMS monthly to ensure records are accurate and up to date. Review of these audits will be presented to the QAPI Committee monthly through May 2020.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 02/12/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135143	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2020
NAME OF PROVIDER OR SUPPLIER SERENITY HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1134 CHENEY DR WEST TWIN FALLS, ID 83301		
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K 345	Continued From page 9 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years.	K 345			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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

February 13, 2020

Shauna Kraus, Administrator
Serenity Healthcare
1134 Cheney Dr. West
Twin Falls, ID 83301-1202

Provider #: 135143

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Kraus:

On **February 5, 2020**, an Emergency Preparedness survey was conducted at **Serenity Healthcare** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 26, 2020**. Failure to submit an acceptable PoC by **February 26, 2020**, may result in the imposition of civil monetary penalties by **March 19, 2020**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 11, 2020**, (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 . A change in the seriousness of the deficiencies on **March 29, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 11, 2020**, includes the following:

Denial of payment for new admissions effective **May 5, 2020**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 5, 2020**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 5, 2020**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

Shauna Kraus, Administrator
February 13, 2020
Page 4 of 4

This request must be received by **February 26, 2020**. If your request for informal dispute resolution is received after **February 26, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 02/12/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135143	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2020
NAME OF PROVIDER OR SUPPLIER SERENITY HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1134 CHENEY DR WEST TWIN FALLS, ID 83301		
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E 000	Initial Comments The facility consists of a single story, Type V (111) structure with a partial basement and is located within a municipal fire district, with both county and state EMS services available. The building is fully sprinklered with an interconnected fire alarm/smoke detection system throughout. The facility equipment lift from the basement level is separated to the main building by a 1-hour construction. The facility backup power is provided with an on-site, diesel-fired Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 60 SNF/NF beds with a census of 48 on the date of the survey. The following deficiencies were cited during the annual emergency preparedness survey conducted on February 5, 2020. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	E 000	E 006 - A copy of the Community plan was obtained on 2/5/2020 The Facility EP was reviewed and updated accordingly on 2/20/2020. The Plant Manager and Administrator participate in the Southern Idaho Coalition meetings and workgroups. The Facility EP plan is updated as issues arise and are brought forward. Plant Manager will review with Southern Idaho Coalition annually to identify any updates the Facility may not be aware of.	3-10-2020
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*	E 006		

RECEIVED
FEB 25 2020
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Shauna Kraus* TITLE: *Administrator* (X6) DATE: *2-24-2020*

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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E 006	<p>Continued From page 1</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's</p>	E 006	<p>E006 Continued Any updates made to the EP will be addressed with the QAPI Committee as needed.</p>	

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E 006	Continued From page 2 ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a Hazard Vulnerability Analysis (HVA) for the EP plan that considered a community based risk assessment such as the county all-hazard mitigation plan. Failure to consider available county hazard considerations when developing the facility based HVA and relevant EP policies and procedures, has the potential to hinder EP relevant training and response of staff, by not fully addressing known hazards of the area as identified by county EMS. This deficient practice affected 48 residents, staff and visitors on the date of the survey. Findings include: On 2/5/20 from 8:30 - 10:00 AM, review of the provided EP policies and procedures, revealed the plan did not include documented information as defined under the county all-hazard mitigation plan, or a copy of the county plan. At approximately 11:15 AM, the Director of Plant Operations was asked if the facility had a copy of the county plan, or if it was used when developing the HVA. The Director stated the assessment was completed internally through facility management and staff and the county all-hazard mitigation plan was not used. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006	E013 A copy of the Community plan was obtained on 2/5/2020 The Facility EP was reviewed and updated accordingly on 2/20/2020. A policy for wildfire in alignment with the County plan has been developed. The Plant Manager and Administrator participate in the Southern Idaho Coalition meetings and workgroups. The Facility EP plan is updated as issues arise and are brought forward. Plant Manager will review with Southern Idaho Coalition annually to identify any updates the Facility may not be aware of.	3-10-2020
E 013 SS=F	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the	E 013		

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E 013	<p>Continued From page 3</p> <p>emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure policies and procedures were aligned with a community-based and facility-based HVA. Failure to develop policies and procedures based on relevant community risks, such as those identified in a county all-hazard mitigation plan, has the potential to</p>	E 013	<p>E013 Continued Any</p> <p>updates made to the EP will be addressed with the QAPI Committee as needed.</p>		

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E 013	Continued From page 4 confuse staff and result in irrelevant training on hazards that are not consistent with the facility location. This deficient practice affected 48 residents, staff and visitors on the dates of the survey. Findings include: On 2/5/20 from 8:45 - 11:00 AM, review of the provided EP policies and procedures, failed to demonstrate the facility incorporated or consulted the county all-hazard mitigation plan when developing the required facility based risk assessment, but used information as generated from internal staff and management team discussions. Further review of the county all-hazard mitigation plan available via the internet documentation, revealed the county identified "Wildfire" as the second highest risk for the geographic area, but the facility did not identify it as a risk at all. During interview of the Director of Plant Operations at approximately 11:15 AM, the Director was asked if the facility had a copy of the county hazard mitigation plan, or if it was used when developing the HVA. The Director stated the assessment was completed internally through facility management and staff and the county all-hazard mitigation plan was not used. Reference: 42 CFR 483.73 (b) Additional Reference: E - 0006	E 013	E015 – The Facility has an arrangement with Western Waste Service to provide added dumpsters and provide portable toilets to accommodate our needs during an emergency if needed. A policy for this process has been developed and added to our EP. Any updates made to the EP will be addressed with the QAPI Committee as needed.	3-10-2020	
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must	E 015			

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E 015	<p>Continued From page 5</p> <p>develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:</p> <p>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:</p> <ul style="list-style-type: none"> (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: <ul style="list-style-type: none"> (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <ul style="list-style-type: none"> (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: <ul style="list-style-type: none"> (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: 	E 015		

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E 015	Continued From page 6 (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to develop policies and procedures in the Emergency Plan (EP), which identified the steps or methods for providing sewage and waste disposal should those utilities become compromised in a disaster requiring the need to shelter in place. Lack of policies and procedures for sewage and waste disposal during a disaster, has the potential to limit the ability to provide continuing care for residents housed in the facility. This deficient practice affected 48 residents, staff and visitors on the date of the survey. Findings include: On 2/5/20 from 8:30 - 11:00 AM, review of provided policies and procedures did not reveal a policy or procedure for utilities loss that was relevant to the loss of sewage and waste disposal during a disaster. Reference: 42 CFR 483.73 (b) (1)	E 015	E018 - The Facility did have a tracking system in place in the EP found under section N of the EP binder. The Facility has re-labeled this section as "Resident Sheltered and On-Duty Staff" The Administrator will monitor. Any updates made to the EP will be addressed with the QAPI Committee as needed.	3-10-2020
E 018 SS=D	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this	E 018		

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E 018	<p>Continued From page 7</p> <p>section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:]</p> <p>[(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.</p> <p>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.</p> <p>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are</p>	E 018			

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E 018	<p>Continued From page 8</p> <p>relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.</p> <p>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p> <p>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.</p> <p>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide a policy for tracking of staff and sheltered residents during an emergency. Lack of a tracking policy for sheltered staff and residents has the potential to hinder continuity of care and essential services during an emergency. This deficient practice has the potential to affect the 48 residents, staff and visitors in the facility on the date of the survey.</p> <p>Findings include: On 2/5/20 from 8:30 - 11:00 AM, review of provided EP, failed to demonstrate the facility had</p>	E 018		

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E 018	Continued From page 9 in place a system to track the location of on-duty staff and residents sheltered in the facility during an emergency. Reference: 42 CFR 483.73 (b) (2)	E 018	<p>E024- The Facility has updated the EP to include a policy that addresses the use of volunteers.</p> <p>The Plant Manager will review this policy at the March drills. The Administrator will monitor.</p> <p>Any updates made to the EP will be addressed with the QAPI Committee as needed.</p>	3-10-2020
E 024 SS=D	<p>Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:]</p> <p>(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.</p> <p>*[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.</p>	E 024		

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E 024	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to develop policies and procedures which address the use of volunteers during an emergency. Lack of a plan, policy and procedure specific to the use of volunteers, potentially hinders the facility's ability to provide continuity of care during a disaster. This deficient practice had the potential to affect the 48 residents and staff in the facility on the date of the survey. Findings include: Review of provided EP policies and procedures conducted on 2/5/20 from 8:30 - 11:00 AM, revealed no policy or procedure for the use of volunteers during an emergency. Further review of the documentation provided revealed a section titled "Volunteers", however this section was blank. Reference: 42 CFR 483.73 (b) (6)	E 024	E030- The EP had a list of physicians and any volunteer services that might be utilized. The EP has been updated with a communication plan which includes instructions of how to utilize these contact lists. The Contact list is updated a minimum of quarterly by the Health Information Manager. Any updates made to the EP will be addressed with the QAPI Committee as needed.	3-10-2020
E 030 SS=D	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities].	E 030		

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E 030	<p>Continued From page 11 (v) Volunteers.</p> <p>*[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers.</p> <p>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers.</p> <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the</p>	E 030			

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E 030	<p>Continued From page 12 following:</p> <ul style="list-style-type: none"> (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. <p>*[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following:</p> <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following:</p> <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). <p>This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to document a communication plan which included contact information for resident physicians and applicable volunteer agencies. Failure to have a communication plan which includes contact information for those parties capable of assisting in the facility's response and recovery during a disaster, has the potential to hinder both internal and external emergency response efforts. This deficient practice affected 48 residents, staff and</p>	E 030			

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E 030	Continued From page 13 visitors on the date of the survey. Findings include: On 2/5/20 from 8:45 - 11:00 AM, review of the provided EP policies and procedures, failed to demonstrate a communication plan that included contact information for volunteers or their respective agencies. Reference: 42 CFR 483.73 (c) (1)	E 030	<p>E039 - The Facility did have 2 documented qualifying exercises in February of 2019 and June of 2019. Documentation of the Fire Marshal's Participation had not been included in the records. On 2/18/20 Fire Marshal verified again his participation in the exercise.</p> <p>Exercises have been scheduled for 2020. The Facility will also document any unscheduled exercises including the event, staff involved and assessment of the EP policies and procedures. The Plant Manager will ensure that exercises are conducted and documented per schedule and documented if not scheduled</p>	3-10-2020	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is	E 039			

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E 039	<p>Continued From page 14 not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is</p>	E 039	<p>E039 Continued -The Administrator will monitor.</p> <p>All exercises will be presented to the QAPI Committee within that quarter.</p>		

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E 039	<p>Continued From page 15</p> <p>community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an</p>	E 039			

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E 039	<p>Continued From page 16 emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and</p>	E 039		

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E 039	Continued From page 17 maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's	E 039		

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E 039	<p>Continued From page 18 emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p>	E 039			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135143	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2020
NAME OF PROVIDER OR SUPPLIER SERENITY HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1134 CHENEY DR WEST TWIN FALLS, ID 83301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	<p>Continued From page 19</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to complete two (2) full scale drills as required. Failure to complete two full-scale exercises for the activation of the EP, has the potential to hinder staff performance during an actual emergency. This deficient practice affected 48 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of the provided facility EP conducted on 2/5/20 from 8:45 - 11:00 AM, records demonstrated the facility had documented an actual event in June of 2019, demonstrating completion of 1 of 2 required full-scale events or exercises, that tested the effectiveness of the EP policies and procedures.</p> <p>Reference: 42 CFR 483.73 (d) (1)</p>	E 039		