



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

March 15, 2019

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 **March 5, 2019**, 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

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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 **March 28, 2019**. Failure to submit an acceptable PoC by **March 28, 2019**, may result in the imposition of civil monetary penalties by **April 19, 2019**.

Your PoC must contain the following:

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

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 9, 2019**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **June 3, 2019**. A change in the seriousness of the deficiencies on **April 19, 2019**, 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 **April 9, 2019**, includes the following:

Denial of payment for new admissions effective **June 5, 2019**.
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 **September 5, 2019**, 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 **March 5, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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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:

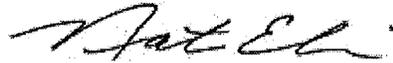
BFS Letters (06/30/11)

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

This request must be received by **March 28, 2019**. If your request for informal dispute resolution is received after **March 28, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 03/15/2019
FORM APPROVED
OMB NO. 0938-0391

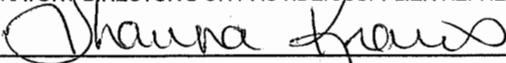
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135143	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2019
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NAME OF PROVIDER OR SUPPLIER SERENITY HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1134 CHENEY DR WEST TWIN FALLS, ID 83301
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(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
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K 000	<p>INITIAL COMMENTS</p> <p>The facility consists of a single story, Type V (111) structure with a 2-hour separated partial basement. The building is fully sprinklered and has a complete fire alarm/smoke detection system including open areas to include audible/visual notification. The facility is equipped with an equipment lift enclosed in a hazardous containment area. Emergency Power is provided by a Type 1 EPSS with an annunciator and emergency stop. Currently the facility is licensed for 60 SNF/NF beds and had a census of 40 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on March 4 - 5, 2019. 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>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000		
K 161 SS=D	<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</p>	K 161	<p>K 161 - Facility has ordered the appropriate intumescent sealant to seal off the conduit. Upon arrival the conduit in the electrical room off the main lobby will be properly sealed. An audit has been completed by the Physical Plant Manager to ensure that there are no other penetrations that need to be addressed. No other penetrations were noted. The Plant Manager has developed an "Exit Checklist" for all contractors that would have the potential to create penetrations of this nature.</p>	

RECEIVED
MAR 27 2019
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 3-25-19
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 161	Continued From page 1 non-sprinklered Any number of stories 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 and interview, the facility failed to ensure the fire and smoke resistive properties of the structure were maintained. Failure to maintain rated construction assemblies, has the potential to allow fire, smoke and dangerous gases to pass into unprotected concealed spaces and between compartments. This deficient practice had the potential to affect	K 161	K161 Continued This checklist will be required any time work has been completed in the Facility to ensure no new penetrations have been created during work addressed by contractors. The Administrator will review all Contractor Exit Checklists a minimum of monthly to ensure we are checking for potential risks for new penetrations being created by this type of work. K 291 – On 3/7/19 Plant Manager conducted a 90-minute annual testing of the emergency lighting. This testing has been scheduled in our PM Tracking System (Preventative Maintenance) to be completed no less than annually effective 3/7/19.	4-9-18

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K 161	Continued From page 2 residents, staff and visitors in the main entry/dining smoke compartment on the dates of the survey. Findings include: During the facility tour conducted on March 5, 2018 from approximately 8:15 AM to 12:00 PM, observation of the electrical room off of the main lobby revealed several conduit pipes penetrating the ceiling with IT cables running through them. The conduit was not properly sealed to resist the passage of smoke. When asked, the Maintenance Director stated the facility was unaware of the penetrations. Actual NFPA standard: 19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.) 8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.	K 161	K291 Continued In addition, the Plant Manager scheduled and began documenting weekly 30-second emergency lighting testing on 3/7/19 to be completed no less than weekly thereafter. The Administrator will review all PM Logs no less than weekly effective 3/7/19 through 6/15/19 and then a minimum of monthly thereafter to ensure that all PM logs are up to date and accurate. The Quality Assurance Performance Improvement Committee (QAPI) will review and monitor all PM logs a minimum of annually to ensure that there are no gaps in required documentation, testing and/or reporting.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced	K 291		

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K 291	<p>Continued From page 3</p> <p>by: Based on record review and interview the facility failed to provide monthly and annual emergency lighting test documentation. Failure to test the emergency lighting could inhibit egress of residents during an emergency. This deficient practice affected 40 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During review of the emergency lighting test logs on March 4, 2019, from approximately 11:00 AM to 1:45 PM, records revealed the last thirty (30) second monthly test of the emergency lighting was conducted in May of 2018. In addition, no documentation could be produced to indicate a ninety (90) minute annual test of the emergency lighting had been conducted since the facility opened in February of 2018. When asked, the Maintenance Director stated the facility was unaware the tests were not completed, or documentation maintained.</p> <p>Actual NFPA reference:</p> <p>NFPA 101 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows:</p>	K 291		

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K 291	<p>Continued From page 4</p> <p>(1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2).</p> <p>(2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.</p> <p>(3) Functional testing shall be conducted annually for a minimum of 1-1?2 hours if the emergency lighting system is battery powered.</p> <p>(4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3).</p> <p>(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows:</p> <p>(1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.</p> <p>(2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.</p> <p>(3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator.</p> <p>(4) A visual inspection shall be performed at intervals not exceeding 30 days.</p> <p>(5) Functional testing shall be conducted annually for a minimum of 1-1?2 hours.</p> <p>(6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1-1?2-hour test.</p> <p>(7) Written records of visual inspections and tests</p>	K 291		

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K 291	Continued From page 5 shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1-1?2 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times.	K 291		
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.	K 325	K 325 – On 3/7/2019 an inservice for all housekeeping staff was provided regarding requirements to test dispensers when a new refill is installed. A new tracking system has been implemented for tracking to show that the dispenser has been tested at the time the refill has been added. This entails a sticker attached to the new bag when installed verifying that the dispenser has been tested at the time of install. The Plant Manager will conduct a weekly audit beginning 3/25/19 of 10% of the dispensers to verify the tracking system is effective.	

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K 325	<p>Continued From page 6</p> <p>*Storage in a single smoke compartment greater than five gallons complies with NFPA 30.</p> <p>*Dispensers are not installed within one inch of an ignition source.</p> <p>*Dispensers over carpeted floors are in sprinklered smoke compartments.</p> <p>*ABHR does not exceed 95 percent alcohol.</p> <p>*Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11).</p> <p>*ABHR is protected against inappropriate access. 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions each time a new refill is installed could result in inadvertently spilling flammable liquids, increasing the risk of fires. This deficient practice affected 40 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the review of facility inspection records on March 4, 2019, from approximately 11:00 AM to 1:45 PM, records indicating ABHR dispensers are tested in accordance with manufacturer's care and use instructions when a new refill is installed were not maintained. The last known documented test of ABHR dispensers was May 2018. ABHR dispensers were observed throughout the facility and when asked, the Maintenance Director stated the facility was</p>	K 325	<p>K325 Continued All staff have been re-educated on 3/25/2019 of the requirement to test the dispensers and their responsibility to notify a housekeeping staff member immediately if a dispenser is not properly working.</p> <p>K 345 – The annual fire alarm testing was completed on 3/10/19 by Webster Fire Protection. The Plant Manager has scheduled the next inspection will be scheduled no later than 2/28/20 through the PM electronic system the Facility currently uses.</p>	4-9-19

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K 325	Continued From page 7 aware of the requirement but had not maintained the documentation. Actual NFPA standard: NFPA 101 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 NFPA30B, 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 included in the aggregated quantity addressed in	K 325			

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K 325	Continued From page 8 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. (25 mm) 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	K 325		

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K 325 K 345 SS=F	<p>Continued From page 9 of the dispensing device is minimized. (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 maintain fire alarm systems could result in a lack of system performance during a fire event. This deficient practice affected 40 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the facility inspection records on March 4, 2019, from approximately 11:00 AM to 1:45 PM, documentation for a current, annual inspection of the fire alarm system could not be produced. The last known annual inspection was October 26, 2017. When asked, the Maintenance Director stated the facility was not aware the annual inspection had been overlooked and was past due.</p>	K 325 K 345	<p>K 345 - The Administrator has required that the fire monitoring company (Webster) will also track the need for annual testing prior to due date. The Administrator has scheduled to review on Outlook Calendar 2/28/20.</p> <p>F 712 - Missing fire drills had been identified by the QAPI Committee in December of 2018. Plant Manager was educated to the importance and requirements of fire drills.</p>	4-9-19

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

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K 345	Continued From page 10 Actual NFPA standard: NFPA 101 19.3.4 Detection, Alarm, and Communications Systems. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. NFPA 72 14.3 Inspection. 14.3.1* Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. (See Table 14.3.1) 14.4 Testing. 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. (See Table 14.4.5)	K 345	F712 - Fire drills have been scheduled according to requirements beginning January 2019. All drills for Q1 2019 have been completed. Plant Manager has scheduled all drills for Q2 of 2019, per regulatory guidelines. Drills for Q3 and Q4 will be scheduled prior to the quarter beginning. Administrator will monitor to ensure that drills are conducted according to schedule. The QAPI Committee will continue to monitor for compliance through 6/30/19 and annually thereafter.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712		4-9-19

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K 712	<p>Continued From page 11</p> <p>conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>18.7.1.4 through 18.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of required fire drills, one per shift per quarter. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected 40 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During record review on March 4, 2019, from approximately 11:00 AM to 1:45 PM, fire drill documentation revealed the facility failed to perform and document the following drills:</p> <ol style="list-style-type: none"> 1.) First and second shift, second quarter 2018. 2.) Second and third shift, third quarter 2018. 3.) First and third shift, fourth quarter 2018. <p>When asked, the Maintenance Director stated the facility was aware of the missing fire drills and had already implemented a Plan of Correction (POC) to include training and scheduling to prevent this from happening again.</p> <p>Actual NFPA standard:</p> <p>19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses,</p>	K 712		

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K 712	Continued From page 12 interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712	<p>K 918 – On 3/4/19 a Weekly Generator inspection and testing log was implemented. Plant Manager was educated to the importance and requirements of weekly generator inspections and monthly load tests. Four-hour generator testing was completed on 2/13/19 by Power Systems West. An automatic non- load emergency generator test runs every Monday at 10 a.m. for 30 minutes. On 3/7/19 Plant Manager initiated a monthly 90-minute load test and will be completed every month thereafter.</p>	
K 918 SS=F	<p>Electrical Systems - Essential Electric System CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new</p>	K 918		

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K 918	<p>Continued From page 13 . installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Emergency Power Supply Systems (EPSS) were maintained in accordance with NFPA 110. Failure to inspect and test generators, could hinder the performance of the equipment during an emergency. This deficient practice affected 40 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>Review of the facility generator inspection and testing records on March 4, 2019, from approximately 11:00 AM to 1:45 PM, revealed the facility had not performed any monthly load tests and failed to provide the following weekly generator inspection logs:</p> <p>February 25, 2018 - March 3, 2018, March 4, 2018 - March 10, 2018, April 8, 2018 - April 14, 2018, May 20, 2018 - May 26, 2018, May 27, 2018 - June 2, 2018, July 29, 2018 - August 4, 2018, August 12, 2018 - August 18, 2018, September 16, 2018 - September 22, 2018, October 28, 2018 - November 3, 2018, December 2, 2018 - December 8, 2018, December 23, 2018 - December 29, 2018, last 3 weeks of January 2019 and all of February 2019.</p> <p>When asked, the Maintenance Director stated the facility was unaware of the requirement for monthly load tests. They believed the annual inspection and load test done by the outside contractor was all that was required. He further</p>	K 918	<p>4-hour load test will be completed prior to February 13, 2020. The Administrator will monitor the inspection and testing logs weekly effective 3/7/19 through 6/15/19 and a minimum of monthly thereafter to ensure compliance. QAPI will review a minimum of annually.</p>	4-9-19

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K 918	Continued From page 14 stated the facility was unaware of the missing weekly inspections. Actual NFPA standard: NFPA 110 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating	K 918			



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

March 15, 2019

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 **March 5, 2019**, 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 **March 28, 2019**. Failure to submit an acceptable PoC by **March 28, 2019**, may result in the imposition of civil monetary penalties by **April 19, 2019**.

Your PoC must contain the following:

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

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 9, 2019**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on . A change in the seriousness of the deficiencies on **April 29, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 9, 2019**, includes the following:

Denial of payment for new admissions effective **June 5, 2019**.
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 **September 5, 2019**, 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 **March 5, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

<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

March 15, 2019

Page 4 of 4

This request must be received by **March 28, 2019**. If your request for informal dispute resolution is received after **March 28, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Nate Elkins". The signature is fluid and cursive, with a prominent initial "N" and a long, sweeping underline.

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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E 000	Initial Comments The facility consists of a single story, Type V (111) structure with a 2-hour separated partial basement. The building is fully sprinklered and has a complete fire alarm/smoke detection system including open areas to include audible/visual notification. The facility is equipped with an equipment lift enclosed in a hazardous containment area. Emergency Power is provided by a Type 1 EPSS with an annunciator and emergency stop. Currently the facility is licensed for 60 SNF/NF beds and had a census of 40 on the dates of the survey. The following deficiency was cited during the annual emergency preparedness survey conducted on March 4 - 5, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The	E 041	E 041 - On 3/4/19 a Weekly Generator inspection and testing log was implemented. Plant Manager was educated to the importance and requirements of weekly generator inspections and monthly load tests. Four-hour generator testing was completed on 2/13/19 by Power Systems West. An automatic non- load emergency generator test runs every Monday at 10 a.m. for 30 minutes.	

RECEIVED
MAR 27 2019
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Shauna Kraus

TITLE

Administrator 3-25-19

(X6) DATE

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 041	<p>Continued From page 1</p> <p>[LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.</p> <p>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the</p>	E 041	<p>E041 - On 3/7/19 Plant Manager initiated a monthly 90-minute load test and will be completed every month thereafter. The next annual 4-hour load test will be completed prior to February 13, 2020. The Administrator will monitor the inspection and testing logs weekly effective 3/7/19 through 6/15/19 and a minimum of monthly thereafter to ensure compliance. QAPI will review a minimum of annually.</p>	4-9-19

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E 041	<p>Continued From page 2</p> <p>Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.</p> <p>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and</p>	E 041		

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

PRINTED: 03/15/2019
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 03/05/2019
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 041	<p>Continued From page 3</p> <p>Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This deficient practice affected 40 residents, staff and visitors on the dates of the survey.</p> <p>Findings Include:</p> <p>During review of the facility maintenance inspection records and emergency preparedness plan, conducted on March 4, 2019 from approximately 11:00 AM - 4:30 PM, records provided for the emergency generator revealed missing documentation for weekly inspections and monthly load testing in accordance with NFPA 110. When asked, the Maintenance Director stated the facility was unaware of the requirement for monthly load tests. They believed the inspection and load test done annually by the outside contractor was all that was required. He further stated the facility was unaware of the missing weekly inspections.</p> <p>Reference:</p> <p>42 CFR 483.73 (e) (2)</p> <p>Additional Reference CMS 2567 K-tag 918</p>	E 041		