



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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3232 Elder Street
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May 24, 2019

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

Provider #: 135143

Dear Ms. Kraus:

On **May 10, 2019**, a survey was conducted at Serenity Healthcare by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 3, 2019**. Failure to submit an acceptable PoC by **June 3, 2019**, may result in the imposition of penalties by **June 26, 2019**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **June 14, 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 **August 10, 2019**. A change in the seriousness of the deficiencies on **June 24, 2019**, may result in a

Shauna Kraus, Administrator
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change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 10, 2019** includes the following:

Denial of payment for new admissions effective **August 10, 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 non-compliance, 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 **November 10, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 10, 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:

Shauna Kraus, Administrator
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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 **June 3, 2019**. If your request for informal dispute resolution is received after **June 3, 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, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

bd/dr

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

PRINTED: 06/06/2019
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 05/10/2019
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	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from May 6, 2019 to May 10, 2019. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Presie Billington, RN Survey Abbreviations: CNA = Certified Nursing Assistant DON = Director of Nursing HIM = Health Information Manager LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment SW = Social Worker	F 000			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		6/14/19	

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

TITLE

(X6) DATE

Electronically Signed

05/31/2019

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

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F 578	<p>Continued From page 1</p> <p>residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a copy of residents' living wills were requested and present in their records and residents' records included documentation advance directives were reviewed with them. This was true to 1 of 4 residents (Resident #32) reviewed for advance directives. This failure created the potential for harm if a resident's medical treatment wishes were not followed due to lack of information in residents' records. Findings include:</p>	F 578	<p>F578 Correction: On 4/10/19 Business Office Manager met with Resident #32 for new admission paperwork and provided an Advance Directive packet to Resident. On 4/26/19 Health Information Manager spoke with the Son of Resident #32 requesting a copy of Advance Directives. Resident #32 discharged on 5/25/2019 to home.</p> <p>Identification: On 5/29/19 an audit was completed of all</p>		

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F 578	<p>Continued From page 2</p> <p>The facility's advance directives policy, dated 2019, documented upon admission the facility would obtain residents' advance directive and place them in residents' records. The facility would inform residents of advanced directives, such as a living will, and inform them of their right to consent or refuse treatment and would document these discussions in the record.</p> <p>Resident #32 was admitted to the facility on 4/9/19, with multiple diagnoses including chronic obstructive pulmonary disease (progressive lung diseases characterized by increasing breathlessness).</p> <p>Resident #32's physician orders for scope of treatment, dated 4/22/19, documented she had a living will and her code status was Do Not Resuscitate.</p> <p>Resident #32's record did not include a living will or documentation the facility's policy for advance directives was provided to, and discussed with, her.</p> <p>On 5/9/19 at 11:06 AM, the Health Information Manager said there was not a copy of a living will in Resident #32's record.</p> <p>On 5/9/19 at 11:14 AM, the Social Worker said there was not a living will or documentation of a discussion regarding a living will or advance directives in Resident #32's record.</p>	F 578	<p>current resident records to determine:</p> <ol style="list-style-type: none"> 1. Advance Directive exists in the record 2. Documentation of Advance Directive being reviewed with resident on admit exists in the record 3. If no Advance Directive, documentation that Advance Directive was offered and declined exists in the record <p>Any missing Advance Directive or documentation of offered and declined will be obtained by June 7, 2019.</p> <p>Measures & Systemic Changes: Business Office Manager or Designee will continue to offer Advance Directive packet to all patients being newly admitted. Social Worker or Designee will continue to review existing Advance Directives with all newly admitted patients, quarterly, annual and change of condition assessments. Social Worker or Designee will continue to document review of Advance Directive and/or declination of Advance Directive in the clinical record.</p> <p>Health Information Manager or Designee performs an audit of all new admission records by next business day to ensure:</p> <ol style="list-style-type: none"> 1. Advance Directive exists in the record 2. Documentation of Advance Directive being reviewed with resident on admit exists in the record 3. If no Advance Directive, documentation that Advance Directive was offered and declined exists in the record 		

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F 578	Continued From page 3	F 578	<p>Audits are discussed routinely in the clinical meeting. Administrator will be notified of missing information to ensure proper correction and education is provided as needed.</p> <p>Monitor Performance: Health Information Manager will develop Advance Directive Log to monitor record of Advance Directives:</p> <ol style="list-style-type: none"> 1. Advance Directive exists in the record 2. Documentation of Advance Directive being reviewed with resident on admit exists in the record 3. If no Advance Directive, documentation that Advance Directive was offered and declined exists in the record <p>This log will be reported monthly to the QAPI Committee for review and determination of further performance improvement through August 2019.</p>		
F 622 SS=D	<p>Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)</p> <p>§483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements-</p> <p>(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-</p> <p>(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;</p> <p>(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;</p> <p>(C) The safety of individuals in the facility is</p>	F 622		6/14/19	

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F 622	<p>Continued From page 4</p> <p>endangered due to the clinical or behavioral status of the resident;</p> <p>(D) The health of individuals in the facility would otherwise be endangered;</p> <p>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;</p> <p>or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical</p>	F 622			

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F 622	Continued From page 5 record must include: (A) The basis for the transfer per paragraph (c) (1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to ensure information was provided to the receiving hospital for 2 of 2 residents (#6 and #32) reviewed for transfers. This deficient	F 622	F622 Correction: Resident #6 was readmitted to Facility on 3/12/19 without incident. Resident #32 was readmitted to Facility on 4/22/19		

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F 622	<p>Continued From page 6</p> <p>practice had the potential to cause harm if the residents were not treated in a timely manner due to lack of information. Findings include:</p> <p>The facility's Transfer and Discharge policy, dated 10/1/18, documented when it was necessary to transfer or discharge a resident to a hospital, staff were to:</p> <ul style="list-style-type: none"> * Obtain a physician's orders for emergency transfer or discharge * Complete a Transfer form to send with the resident * Contact an ambulance service for transportation service * Notify the hospital for admission arrangements * Copies of the Transfer form and Advance Directive were to go with the resident * Copies of the Transfer form and Advance Directive were to be retained in the resident's medical record <p>This policy was not followed. Examples include:</p> <p>1. Resident #6 was admitted to the facility on 10/9/18, with multiple diagnoses including chronic kidney disease and hypertension (high blood pressure).</p> <p>A Nursing Progress Note, dated 3/10/19 at 3:16 PM, documented Resident #6 had a red, painful, and very warm left leg and her right leg was beginning to get red and warm too. Resident #6 was also confused and emotional. The physician was notified and ordered a complete blood count (CBC), D-Dimer (a blood test used to rule out presence of blood clots), and urinalysis (a urine test). The Nursing Progress Note documented</p>	F 622	<p>without incident.</p> <p>By June 7, 2019 all LNs will be educated to the importance and requirement of documenting in the record the specific documents and information provided at the time of transfer/discharge. Training for all newly hired LNs will be updated by June 7, 2019 to include these procedures.</p> <p>Identification: An audit of all transfers/discharges from the Facility 5/11/19 through 5/29/19 was completed on 5/29/19 to ensure documentation included specific documents and information provided at the time of transfer/discharge to ensure a safe and effective transition of care. If any documentation was missing the LN responsible will be educated to proper procedure no later than June 7, 2019.</p> <p>Measures & Systemic Changes: Health Information Manager or Designee will complete an audit of all transfers/discharges weekly through June 30, 2019, and monthly thereafter to ensure documentation of specific documents and information provided at the time of transfer/discharge is present to ensure a safe and effective transition of care. Audits are discussed routinely in the clinical meeting to allow for timely correction and education as needed.</p> <p>Monitor Performance: A compliance report will be provided to the Director of Nursing for any needed education to Licensed Nurses responsible</p>		

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F 622	<p>Continued From page 7</p> <p>Resident #6 was clenching her legs together and the nurse was unable to collect a urine sample. The physician then advised sending Resident #6 to the hospital for possible deep vein thrombosis (DVT) and cellulitis (a common, potentially serious bacterial skin infection). A non-emergent ambulance was called and Resident #6 was sent to the hospital.</p> <p>Resident #6's medical record did not include documentation information was provided to the hospital to ensure a safe and effective transition of care.</p> <p>On 5/8/19 at 12:13 PM, the DON said the facility sent Resident #6's face sheet, Physician's Orders for Scope of Treatment (POST), a Transfer and Discharge form, her medication list, and physician's orders, with her to the hospital. The DON said the facility did not retain a copy of the medical records sent and did not document in Resident #6's record what was sent.</p> <p>2. Resident #32 was admitted to the facility on 4/9/19, and readmitted on 4/22/19, with multiple diagnoses including chronic obstructive pulmonary disease (progressive lung diseases characterized by increasing breathlessness).</p> <p>A Nursing Progress Note, dated 4/18/19 at 12:20 AM, documented Resident #32 experienced altered mental status, was confused, and did not respond to verbal questions. The physician was notified and Resident #32 was sent to the hospital.</p> <p>Resident #32's medical record did not include documentation that information was provided to</p>	F 622	<p>for the documentation not present in the record. Health Information Manager or Designee will report to QAPI Committee in June to determine further performance improvement and quarterly through 9/30/19.</p>		

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F 622	Continued From page 8 the hospital to ensure a safe and effective transition of care.	F 622			
F 625 SS=D	<p>Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing</p>	F 625		6/14/19	

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F 625	<p>Continued From page 9</p> <p>facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident and staff interview, policy review, and record review, it was determined the facility failed to ensure a bed-hold policy and notice were provided to the residents or their representatives upon transfer to the hospital. This was true for 2 of 2 residents (#6 and #32) reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time and may cause psychosocial distress if not informed they may be charged to reserve their bed/room. Findings include:</p> <p>The facility's Bed-Hold policy, updated on 1/10/19, documented the following:</p> <p>*All residents being discharged to the hospital must be offered an option of a bed-hold, regardless of their pay status.</p> <p>*Provide the resident a copy of the bed-hold policy and bed-hold agreement by the discharging nurse.</p> <p>*If not completed at the time of discharge, on the first business day following the discharge, the Social Services should contact the resident's responsible party regarding their choice of holding the bed.</p> <p>This policy was not followed. Examples include:</p>	F 625	<p>F625 Correction: Resident #6 and #32 were informed of our bed hold policy at time of admission and their beds were held without charge. Education will be provided by June 7, 2019 to all LNs, Health Information Manager and Social Worker related to the requirement of informing the resident/patient and/or their responsible party to the bed hold policy at time of discharge. Training for all newly hired LNs has been updated to include these procedures.</p> <p>Identification: An audit of all discharges to the hospital or leave of absences between 5/11/19 and 5/29/19 was completed by the Health Information Manager on 5/30/19 to determine if notice of bed hold policy was documented in the record. No documentation was missing at this time.</p> <p>Measure & Systemic Changes: Business Office Manager or Designee will continue to provide a copy of bed hold policy is in new admission paperwork. Health Information Manager or Designee will complete an audit of all discharges to the hospital and/or leave of absence next business day for documentation that</p>		

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F 625	<p>Continued From page 10</p> <p>1. Resident #6 was admitted to the facility on 10/9/18, with multiple diagnoses including chronic kidney disease and hypertension.</p> <p>A Nursing Progress Note, dated 3/10/19 at 3:16 PM, documented Resident #6 was transferred to the hospital. Resident #6's medical record did not include documentation she or her representative received a bed-hold notification when she was transferred to the hospital.</p> <p>On 5/6/19 at 4:17 PM, Resident #6 said she did not receive a bed-hold notice from the facility.</p> <p>On 5/8/19 at 2:22 PM, the Health Information Manager said, the bed-hold notice and policy was given to the residents upon their admission to the facility and should also be given when they transferred to the hospital.</p> <p>On 5/8/19 at 3:27 PM, the Administrator said residents were informed of the facility's bed-hold policy upon admission. The Administrator said they have many rooms available and they just hold the beds for the residents when they need to be transferred to the hospital.</p> <p>2. Resident #32 was admitted to the facility on 4/9/19 and readmitted on 4/22/19, with multiple diagnoses including chronic obstructive pulmonary disease.</p> <p>A Nursing Progress Note, dated 4/18/19 at 12:20 AM, documented Resident #32 was transferred to the hospital. Resident #32's medical record did not include documentation she or her representative received a bed-hold policy and</p>	F 625	<p>notice of bed hold policy was completed. If documentation does not exist, the Business Office Manager, Social Worker or Designee will contact the resident and/or their responsible party next business day to inform them of the bed hold policy and mail the bed hold notification to the resident and/or their responsible party. Audits are routinely discussed in the clinical meeting to provide timely correction and education as needed.</p> <p>Monitor Performance: Health Information Manager or Designee will summarize and report results of audits to QAPI Committee in June and July and quarterly through 9/30/19 to determine further need for performance improvement.</p>		

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F 625	Continued From page 11 notice when she was transferred to the hospital. On 5/6/19 at 4:27 PM, Resident #32 said she did not remember receiving a bed-hold notice from the facility. On 5/9/19 at 8:41 AM, the DON said the facility did not give Resident #32 a bed-hold notice when she was transferred to the hospital.	F 625			
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure public restrooms, without call lights near the toilets, were securely locked. This was true for 2 of 4 public restrooms. This failure created the potential for harm if residents who used the toilets did not have a way to contact staff for help and experienced falls. Findings include: On 5/7/19 at 10:29 AM, 10:34 AM, 11:23 AM, 12:49 PM, 12:58 PM and 3:04 PM, the doors of the public restrooms in the East and West hallways were opened and ajar. There were no call light cords or call light system near the toilets. The toilets shared a full height wall with a shower stall on the other side that contained a	F 689	F689 Correction: Director of Plant Operations installed Schlege keyless touchscreen doorknobs and Tell commercial door closers (UL listed and 3- hour fire rated conforming to ANSI/BHMA A156.4) to both restroom doors on 5/29/19. Education will be provided to all staff by June 7, 2019 regarding the importance of monitoring for safety hazards, reporting through electronic work order and to Administrator any safety hazard concerns and abiding safety hazard notifications. Identification:	6/14/19	

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F 689	<p>Continued From page 12</p> <p>pull cord call light which was six feet away from the toilets.</p> <p>On 5/7/19 at 10:37 AM, LPN #1 went into the East hallway restroom, washed her hands, and kept the door ajar when she left.</p> <p>On 5/7/19 from 11:08 AM to 11:11 AM, Housekeeper #1 cleaned the East hallway restroom and kept the door ajar when she left.</p> <p>On 5/7/19 at 11:20 AM, Housekeeper #1 said the East and West hallway restrooms were for visitors and were left opened and unlocked.</p> <p>On 5/7/19 at 3:30 PM, LPN #2 said the East and West restrooms were for visitors and the doors were kept open for visitor convenience. LPN #2 said staff occasionally used the restrooms to shower residents because the shower stalls in the visitor restrooms were bigger than the shower stalls found in the bathrooms in residents' rooms.</p> <p>On 5/7/19 at 3:45 PM and 3:51 PM, the Director of Plant Operations (DPO) was shown the open restroom doors in the East and West hallway restrooms and said he had not noticed there were no call lights near the toilets in the visitor restrooms. The DPO said staff sometimes showered residents in the showers in the hallway restrooms and said there were call lights near the showers. The DPO locked both bathroom doors with the privacy locks (locks that can be opened with a flathead screwdriver or similar object).</p> <p>On 5/7/19 at 4:35 PM, the Administrator said she would have the DPO install new door handles that evening which would require a key and</p>	F 689	<p>An audit of the facility for potential safety hazards was completed by the Director of Plant Operations on 5/30/19. Any concerns were addressed at time of audit.</p> <p>Measures & Systemic Changes: Director of Plant Operations will audit and document both restroom doors 3 times daily (weekdays) through 6/3/19 to ensure operational and locked. Director of Plant Operations will continue to audit all safety features weekly during plant audit. Areas of concern will be routinely discussed in clinical/management meetings to provide timely correction and education as needed.</p> <p>Monitor Performance: Director of Plant Operations will summarize safety audits and provide a report to the Administrator weekly through June and every other week through July. Director of Operations will provide a report to the QAPI Committee in June and quarterly through 9/30/19 to determine further need for performance improvement.</p>		

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F 689	Continued From page 13 would have the key kept at the nurses' station. On 5/8/19 at 10:10 AM and 2:01 PM, the East hallway restroom door was closed and was not locked. On 5/8/19 at 10:13 AM and 1:59 PM, the West hallway restroom door was ajar. On 5/8/19 at 2:05 PM, the DPO said he had changed the door locks to the restrooms the previous night and just needed to get extra keys made to place at the nurses' station. On 5/9/19 at 8:52 AM and 8:56 AM, the East and West restrooms had signs on the doors which read "Please Keep Door Locked." The restroom doors were checked by the surveyor and found to be closed, but not locked.	F 689			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure staff cleaned the water chamber, nasal mask, and tubing of residents' Bilevel Positive Airway Pressure (BiPAP) machines and ensured	F 695	F695 Correction: Resident #10's BiPAP, tubing and mask were cleaned on 5/08/19. No indications of adverse effects were noted.	6/14/19	

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F 695	<p>Continued From page 14</p> <p>the BiPAP machines were properly stored. This was true for 1 of 2 residents (Resident #10) reviewed for respiratory care. This failure created the potential for harm from respiratory infections due to the growth of pathogens (organism that cause illness) in oxygen tubing and the humidifier chamber. Findings include:</p> <p>Resident #10 was admitted to the facility on 8/24/18 and was readmitted on 2/15/19, with multiple diagnoses which included obstructive sleep apnea (a sleep disorder that causes temporary stoppage of breathing during sleep).</p> <p>A Significant Change in Status MDS assessment, dated 2/22/19, documented Resident #10 was cognitively intact and he used a BiPAP machine.</p> <p>A physician's order, dated 2/15/19, documented the following:</p> <p>*BiPAP per home setting expiratory positive airway pressure (EPAP) of 5, inspiratory positive airway pressure (IPAP) of 11, back up rate of 12 at bedtime. Add distilled water every night and as needed.</p> <p>*BiPAP: empty any remaining water and then wash the water chamber in the sink with warm soapy water. Rinse well and drain out as much of the water as possible. Let the chamber air dry every day.</p> <p>A care plan, dated 5/7/19, directed staff to administer Resident #10's BiPAP per home setting EPAP of 5, IPAP of 11, back up rate of 12 at bedtime and to add distilled water every night and as needed.</p>	F 695	<p>Education will be provided to all LNs regarding cleaning and storage procedures for CPAPs and BiPAPs by June 7, 2019. Training for all newly hired LNs has been updated to include these procedures.</p> <p>Identification: All CPAPs and BiPAPs were audited by contracted Registered Respiratory Therapy services on 5/28/2019.</p> <p>Measure & Systemic Changes: House Supervisor or Designee will audit all CPAP and BiPAP machines for proper cleaning and storage of masks daily through 6/15/19; weekly through 6/30/19, and a minimum of monthly thereafter through 7/31/19. Audits are routinely discussed in the clinical meeting to provide timely correction and education as needed.</p> <p>Monitor Performance: Director of Nursing or Designee will report results of audits to the QAPI Committee in June and July and quarterly through 9/30/19 to determine further need of performance improvement.</p>		

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F 695	Continued From page 15 Resident #10's TAR, dated 4/1/19 through 5/7/19, directed staff to empty any remaining water from his BiPAP water chamber and then wash the water chamber with soapy water, and to rinse it well. The staff was also directed to drain the water chamber of water as much as possible and let it air dry daily. Resident #10's TAR did not include cleaning of the BiPAP machine's tubing and nasal mask. On 5/6/19 at 2:31 PM and on 5/7/19 at 9:29 AM, Resident #10's nasal mask, which was connected to the tubing, was observed resting on top of his bedside table next to his BiPAP machine. On 5/8/19 at 10:13 AM, LPN #3 said the BiPAP machine's water chamber was emptied and cleaned every day and set to air dry after each use. LPN #2 said the tubing was cleaned weekly, and the nasal mask was cleaned daily and stored in a plastic bag when not in use. On 5/8/19 at 10:15 AM, LPN #2 and the surveyor went to Resident #10's room. LPN #2 removed the water chamber from the BiPAP machine. The water chamber was observed to have chalky appearing white residue at the bottom of the water chamber and along the sides. LPN #2 said the whitish residue at the bottom of the water chamber was difficult to clean. LPN #2 looked at the nasal mask which was on top of the table and said it should be stored inside a plastic bag. LPN #2 then checked Resident #10's physician's order and TAR. LPN #2 said the physician's orders and Resident #10's TAR did not address	F 695			

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F 695	Continued From page 16 cleaning the tubing and nasal mask of the BiPAP machine. On 5/8/19 at 4:37 PM, RN #1 said the facility did not have a policy for cleaning the BiPAP machines accessories. RN #1 said the tubing should be cleaned weekly and the nasal mask cleaned daily. RN #1 said the nasal mask was to be stored in a plastic bag.	F 695			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		6/14/19	

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F 758	<p>Continued From page 17</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the behaviors were routinely monitored for residents receiving psychotropic medications. This was true for 1 of 5 residents (#22) reviewed who received psychotropic medications. This failed practice created the potential for harm should residents receive psychotropic medications that were unnecessary, ineffective, or used for excessive duration. Findings include:</p> <p>Resident #22 was admitted to the facility on 1/10/19, and was readmitted on 4/26/19, with multiple diagnoses which included major depressive disorder.</p>	F 758	<p>F758 Correction: Behavior Monitor and Care Plan for Resident #22 have been updated on 5/30/19 Education will be provided to all staff by June 7, 2019 regarding purpose of tracking and monitoring behaviors. Training for all newly hired LNs was updated to include these updates.</p> <p>Identification: On 5/28/19 an audit was completed of all residents/patients with psychotropic medication ordered to ensure the behavior monitors reflected the behaviors</p>		

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F 758	<p>Continued From page 18</p> <p>A quarterly MDS assessment, dated 4/18/19, documented Resident #22 was moderately cognitively intact, she had no behaviors, and she received antipsychotic and antidepressant medications daily.</p> <p>A physician's order documented Resident #22 was to receive aripiprazole (antipsychotic) 5 milligrams (mg) once a day for depression ordered on 2/2/19 and citalopram hydrobromide (antidepressant) 20 mg once a day for depression ordered on 2/2/19, and staff were to monitor and document her behaviors of self-isolation and embellishing the truth to gain attention from staff and family.</p> <p>A care plan, dated 1/18/19, documented Resident #22 used psychotropic medications related to mood impairment and behaviors. The care plan directed staff to monitor Resident #22's behaviors related to mood state namely: insomnia (inability to sleep), tearfulness/crying, verbal agitation, feelings of worthlessness/guilt, suicidal ideation, social withdrawal, and loss of interest.</p> <p>A care plan, dated 2/27/19, documented Resident #22 had been observed exhibiting behaviors of embellishing the truth to gain attention from staff and family. The care plan directed staff to monitor and document Resident #22's attention seeking behavior.</p> <p>The Behavior Monitoring flowsheet, dated 4/1/19 through 5/7/19, documented Resident #22 was monitored for self-isolation and embellishing the truth to gain attention from staff and family. The other behaviors identified in her care plan related</p>	F 758	<p>the medication is being prescribed to assist the resident/patient with.</p> <p>On 5/29/19 any care plans and/or behavior monitoring was updated to match the medication orders, if needed.</p> <p>Measure & Systemic Changes: House Supervisor or Designee will audit new or changed orders for anti-psychotic or anti-depressant medications weekly to ensure MD Orders, behavior monitoring, and care plan consistently reflect what we are doing and is ordered for the resident/patient. These audits will be done weekly through 6/30/19, every other week through 7/31/19, and monthly through 9/30/19. Audits are routinely discussed in the clinical meeting to provide timely correction and education.</p> <p>Monitor Performance: A summary report of these audits will be provided by the House Supervisor to the QAPI Committee monthly through 9/30/19 to determine further need for performance improvement.</p>		

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F 758	Continued From page 19 to her use of the psychotropic medications were not monitored. On 5/8/19 at 10:48 AM, LPN #3 said Resident #22 was monitored for social isolation and embellishing the truth to gain attention from staff and family. LPN #2 said the other target behaviors were not monitored. On 5/8/19 at 10:53 AM, the SW said Resident #22's target behaviors reflected in the care plan should have been monitored daily. The SW said she printed the care plan and highlighted Resident #22's target behaviors she wanted to be monitored. The SW said she did not know why the other target behaviors were not monitored.	F 758			
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure physician ordered thickened liquids were served to residents. This was true for 1 of 3 residents (#30) reviewed for altered diets. This failure created the potential for harm if residents aspirated or choked due to incorrect fluid consistencies. Findings include: The facility's nutrition services policy, dated 4/2006, documented each resident shall receive the correct diet and nurse aides must check the	F 805	F805 Correction: An incident report with clinical assessment for symptoms was initiated for Resident #30 on 5/06/19. No symptoms noted during assessment period. The Speech Therapist was working with Resident #30 was in the process of testing him with thin liquids. On 5/13/19 Resident #30 was successfully cleared for thin liquids by the Speech Therapist. On	6/14/19	

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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	
F 805	<p>Continued From page 20 tray card to ensure the proper diet was served.</p> <p>Resident #30 was admitted to the facility on 4/19/19, with multiple diagnoses including Parkinson's disease and dysphagia (difficulty swallowing).</p> <p>Resident #30's admission MDS assessment, dated 4/26/19, documented he required the assistance of one staff member with eating.</p> <p>Resident #30's physician orders, dated 4/28/19, documented he was to receive nectar thick liquids.</p> <p>Resident #30's speech therapy notes, dated 5/1/19 to 5/3/19, documented he had tolerated a trial of thin liquids each day with the speech therapist (ST).</p> <p>Resident #30's current care plan directed staff to provide assistance and cueing with meals, and to serve nectar thick liquids.</p> <p>On 5/6/19 from 5:27 PM to 5:44 PM, CNA #1 was cueing Resident #30 to drink from two glasses of nectar thick juice. At 5:44 PM, Resident #30's dinner meal arrived with an 8-ounce plastic container of whole milk. CNA #1 then opened the milk lid for him and he put the lid back on. At 5:50 PM, he opened the milk and drank 10% of the milk. From 5:50 PM to 6:09 PM, he drank small amounts from the milk container without signs of choking or aspiration.</p> <p>Resident #30's tray ticket, dated 5/6/19, documented nectar thick liquids.</p>	F 805	<p>5/28/19 Resident #30 was successfully discharged to home.</p> <p>Dietary and Nursing staff involved in the incident were educated in writing to the risks involved if the diet is not followed by 5/07/19.</p> <p>All staff will be re-educated regarding the significance of following MD orders for all diets by 6/7/19.</p> <p>Identification: A confidential list of all diet orders and Speech Therapy interventions has been placed in an easily accessible area in dining room for all staff to access. This list is updated with any new orders by the Speech Therapist, Certified Dietary Manager or Designee. All residents who have a mechanically altered diet or thickened liquids ordered are highlighted to ensure staff are aware. Staff are to refer to the binder regularly and with any questions.</p> <p>Measures & Systemic Changes: Speech Therapy screens all new admissions and existing Residents observed with potential swallow risks when indicated. Only the trained Restorative Nursing Assistant, specified C.N.A., or Nurse will deliver pre-poured drinks to any resident/patient at the assisted dining table(s). Drinks for residents/patients who have thickened liquids ordered are pre-poured in the Food Service Department. When drinks from the Food Service</p>		

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 05/10/2019
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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F 805	<p>Continued From page 21</p> <p>On 5/6/19 at 6:20 PM, CNA #1 said Resident #30 was on nectar thick liquids and the milk must have been fine for him because the kitchen sent the milk out with his meal.</p> <p>On 5/6/19 at 6:23 PM, Dietary Aide #1 said the facility had nectar thick milk products and dietary staff checked tray tickets before meals were sent out of the kitchen.</p> <p>On 5/6/19 at 6:26 PM, the Certified Dietary Manager (CDM) said she expected tray tickets to be checked by dietary and nursing staff before being served to the residents. The CDM said whole milk was a little thicker but was not nectar thick. The CDM said Resident #30 should not have been served the milk.</p> <p>On 5/7/19 at 2:59 PM, the ST said Resident #30 was admitted with thin liquids but experienced some coughing with thin liquids and was placed on nectar thick liquids. The ST said she had trialed thin liquids with her oversight and said he should not have received the milk unless there was an ST present to make sure he was able to handle thin liquids.</p> <p>The facility did not follow the nutrition services policy and Resident #30's physician orders for nectar thick liquids when he was served regular consistency milk.</p>	F 805	<p>Department are requested, Food Service Staff are required to verify name of resident/patient prior to delivering, at this time the diet is also verified.</p> <p>Choice menus have been updated to appropriately reflect liquid consistency as well as containing a note on the resident/patient tray card.</p> <p>We will continue to have a Licensed Nurse in the dining room for all meals. Speech Therapy is in the dining room for meals when on duty.</p> <p>Monitor Performance: Tray line audits will be completed by the Certified Dietary Manager, Registered Dietician, and/or Speech Therapist weekly through 6/30/19, every other week through 7/31/19, and a minimum of monthly thereafter to verify proper diet/liquid order is served.</p> <p>Administrative Dining Room Managers will complete a weekly audit of dining room staff to verify that dining room staff are verifying diets and liquids according to the diet orders.</p> <p>The Certified Dietary Manager will provide a summary of these audits and report to the QAPI Committee in June and July, and quarterly thereafter through 9/30/19 to determine if any further performance improvement is needed.</p>		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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August 8, 2019

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

Provider #: 135143

Dear Ms. Kraus:

On **May 6, 2019** through **May 10, 2019**, an unannounced on-site complaint survey was conducted at Serenity Healthcare. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008027

ALLEGATION #1:

Residents choked on food due to improper diet textures.

FINDINGS #1:

During the investigation, 5 resident records were reviewed, observations were conducted, facility policy was reviewed, and interviews were conducted with staff.

The facility's nutrition services policy, dated 4/2006, documented each resident shall receive the correct diet and nurse aides must check the tray card to ensure the proper diet was served.

Five resident records were reviewed for proper food textures. Their physician orders, meal tray tickets, care plans, and progress notes were also reviewed.

During the review of records for a resident, admitted April 2019, physician orders, care plan, and tray ticket documented they were to receive nectar thick liquids. Speech therapy notes dated 5/1/19 to 5/3/19, documented the resident had tolerated a trial of thin liquids each day with the speech therapist (ST).

On 5/6/19, a CNA was observed encouraging the resident to drink from two glasses of nectar thick consistency juice. When the resident's dinner meal arrived with an 8-ounce plastic container of whole milk and the CNA opened the milk lid for them. The resident drank 10% of the milk. The resident drank small amounts from the milk container without signs of choking or aspiration.

A CNA was interviewed on 5/6/19 at 6:20 PM and said the resident, admitted in April 2019, was on nectar thick liquids and the milk must have been fine for them because the kitchen sent the milk out with the meal. On 5/6/19 at 6:23 PM, a Dietary Aide said the facility had nectar thick milk products and dietary staff checked tray tickets before meals were sent out of the kitchen. On 5/6/19 at 6:26 PM, the Certified Dietary Manager (CDM) said she expected tray tickets to be checked by dietary and nursing staff before being served to the residents. The CDM said whole milk was a little thicker but was not nectar thick. The CDM said the resident should not have been served the milk. On 5/7/19 at 2:59 PM, the ST said the resident was admitted with thin liquids but experienced some coughing with thin liquids and was placed on nectar thick liquids. The ST said she had trialed thin liquids with her oversight and said the resident should not have received the milk unless there was an ST present to make sure they were able to handle thin liquids.

The allegation was substantiated, and a deficiency was cited at F805 related to the failure of the facility to ensure the correct diet texture was served to residents.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

A staff member was rough when transferring residents and had dropped residents while in the shower.

FINDINGS #2: During the survey residents were observed during transfers by staff and for staff interaction with residents, facility grievances were reviewed, resident records were reviewed, and residents, family members, and staff were interviewed.

Three residents were observed during transfers by facility nursing staff and staff transferred them without being rough and no concerns were identified with how staff transferred the residents.

Shauna Kraus, Administrator
August 8, 2019
Page 3 of 10

Nine other residents were observed for signs and symptoms of abuse and no concerns were identified.

Record review of 16 residents, including a resident admitted to the facility August 2018, did not include documentation of potential abuse, were handled roughly or inappropriately during transfers, or were dropped in the shower.

The facility grievances did not include documentation residents were handled roughly by staff during transfers or staff dropped them in the shower.

Six individual residents, four residents in the group interview, and two family members said there were no concerns with potential abuse by staff, staff being rough with them, or being dropped in the shower.

Four CNAs and three nurses said if they saw abuse, rough handling, or a resident being dropped they reported it immediately to their supervisor or the Director of Nursing (DON). The Social Worker (SW) was interviewed and said a resident, admitted to the facility August 2018, had never expressed concerns about abuse to her or other staff.

The Administrator, who was also the abuse coordinator, said she investigated all abuse allegations and said there were no recent allegations of abuse. The Administrator said residents were free from abuse in the facility.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

A resident fell out of bed which required hospital interventions.

FINDINGS #3:

During the survey resident records were reviewed, Incident and Accident reports were reviewed, observations were conducted, residents were interviewed, and staff were interviewed.

Three residents' records and their Incident and Accident reports were reviewed. The residents' care plan included fall preventions and documentation in their records stated these were implemented.

One of the residents, who was admitted August 2018, had documentation in their record they fell out of bed due to a muscle spasm which was verified by the resident at the time of the fall. The resident's record stated they were not injured and did not need to be transported to the hospital for further interventions. The record did not document the resident was sent to the hospital due to a fall from bed.

Two residents who were at risk of falling and had interventions to prevent falls as part of their care were observed. The residents interventions for fall prevention were implemented.

Two residents said the facility did a good job at keeping them from falling. The DON said facility staff did a good job to prevent resident falls. The DON said a resident, admitted August 2018, fell from bed due to a muscle spasm related to their medical condition and an intervention of a transfer pole for the resident was implemented to help the resident stabilize themselves if the spasms happened again. The DON said the resident also had mattress bolsters on their bed to help prevent them from falling out of bed.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The water was too hot and residents were burned during showers.

FINDINGS #4:

During the survey resident records were reviewed, water temperature was assessed, the water temperature log was reviewed,

On 5/7/19 from 1:10 PM to 1:22 PM, four residents' room shower water was assessed and each were within an appropriate range of 105 to 115 degrees Fahrenheit (F).

The facility's water temperature logs from 11/30/18 to 1/10/19, documented the water temperatures were within range, except for one resident's room on 12/27/18 which was recorded at 120 F. The resident's record, admitted to the facility August 2018, included an Incident and Accident report, dated 12/27/18, which stated the shower water became too hot. The report documented the resident was assessed and no burns were observed. The report documented the Director of Plant Operations (DPO) was immediately notified of the incident and the temperature was corrected.

Four residents in the group interview and two family members said there were no concerns the shower water was too hot. The DPO was interviewed and said he checked the water temperatures in the facility on a weekly basis. The DPO said he was immediately informed of the hot shower incident for the above resident and had checked the water temperature which was too hot. The DPO said the resident did not get burned, he replaced the mixing valve in the shower, and there were no further issues with that shower since.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Residents were reprimanded in care conferences for their behaviors due to staff members lack of dementia training.

FINDINGS #5:

During the survey resident records were reviewed, observations were conducted, staff training records were reviewed, and residents, family members, and staff were interviewed.

Two residents, who were cognitively impaired, were observed for staff interactions and dementia care. Staff were observed to be appropriate in their interactions with the residents.

The staff training records of two CNAs and two nurses documented they received dementia training. Four CNAs and three nurses said they received dementia training.

Three resident records were reviewed including a resident admitted August 2018. Care conference notes, for the resident documented a variety of topics were addressed with the resident and their family, including the topic of refusal of cares by the resident and the resident being verbally abusive to female staff.

Six individual residents, four residents in the group interview, and two family members said there were no concerns with staff reprimanding residents or interacting inappropriately with them.

The SW was interviewed and said the resident, admitted to the facility August 2018, had never expressed abuse concerns to her or other staff.

The SW said she was in attendance during the resident's care conferences and said the resident was not reprimanded by staff and their behaviors were discussed in a general sense. The DON was interviewed and said the staff received dementia training and residents were not reprimanded by staff at any time.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Residents are left in bed and do not receive breakfast or lunch.

FINDINGS #6:

During the survey residents were observed during meal times, resident records were reviewed, Resident Council minutes were reviewed, residents and family members were interviewed, and staff were interviewed.

Twelve residents were observed during morning cares and breakfast service. The residents were assisted getting up and going to the dining room for breakfast or they received breakfast once they woke up in their rooms.

Three resident records did not document concerns with being left in bed without receiving meals or snacks. A progress note for one resident, who was admitted August 2018, documented they did not want to get up out of bed that morning. The note stated staff had tried and were going to continue to try to encourage them to get up.

Resident Council minutes from August 2018 to April 2019 did not document a concern regarding residents being left in bed and missing meals.

Six individual residents, four residents in the group interview, and two family members said there were no concerns with residents being left in bed. Four residents in the group interview said the facility staff respected their choices and they could sleep in when they wanted to and staff provided them food when they woke up. Two CNAs and a nurse said residents were assisted in getting out of bed each morning and if residents wanted to sleep in then they ensure those residents received something to eat once they were awake.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

Residents were left to sleep in their wheelchairs in the hallway.

FINDINGS #7:

During the survey, residents and staff were observed, resident records were reviewed, Resident Council minutes were reviewed, staff were interviewed, and residents and family members were interviewed.

Residents and staff were observed for assisting residents based on their level of need and preferences. There were no residents observed falling asleep in their wheelchairs in the hallway and being left unattended.

Record review of five residents, including a resident admitted August 2018, did not document a concern with being unattended by staff or sleeping in a wheelchair in the hallway. Progress notes for the resident documented on two separate occasions the resident did not want to get up that morning and staff honored their request.

Resident council minutes from August 2018 to April 2019, did not document a concern regarding being left in the hallway in their wheelchairs and being left unattended.

Four individual residents, four residents in the group interview, and two family members said there were no concerns with residents being left unattended and asleep in the hallway. Two CNAs and a nurse said residents were assisted in getting to and from meals and activities and were not left asleep and unattended in the hallways.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

Residents did not receive pain medication as ordered.

FINDINGS #8:

During the survey, residents were observed, staff were observed administering medications, resident records were reviewed, residents were interviewed, and staff were interviewed.

12 residents were observed for pain management and staff were observed to be aware of when residents needed pain medication. Medication pass was observed throughout the survey and there were no observations of late or missing pain medications.

Record review of three residents, including a resident admitted August 2018, did not document a concern with pain medication administration. The resident's progress notes documented for one day the resident was evaluated for pain each shift and pain levels were within range of their normal baseline. The resident's Medication Administration Record (MAR) documented the resident received routine doses of Tylenol and Morphine Sulfate, had been assessed for pain throughout the day, and had not requested any as needed pain medications for that day. Multiple progress notes from August 2018 to January 2019, documented the resident's pain was monitored and addressed. Physician progress notes, dated 8/27/18, 9/12/18, 10/12/18, and 11/12/18, documented their pain medications were monitored, changed, and reassessed. A progress note, dated 1/24/19, documented their responsible party had declined a referral to a pain clinic for the resident. Another resident's record, admitted April 2019, included a MAR which documented they received their routine pain medications as ordered within appropriate time frames.

Six individual residents, said there were no concerns with pain management and they received pain medication when they needed it. A resident, admitted April 2019, said that on a particular day they thought they received their pain medication late one evening but it had only happened one time.

On 5/9/19 at 2:36 PM the DON was interviewed. The DON said the facility and the physician worked together to manage the pain of the resident, admitted August 2018, including different non-pharmacological and medication changes. The DON said they verbalized when they needed pain medication and staff also looked for non-verbal cues like grimacing and increased behavior.

The allegation could not be substantiated related to residents' pain not being managed and treated as ordered.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

The food quality was poor.

FINDINGS #9:

During the survey, a meal tray was sampled, Resident Council minutes were reviewed, residents were interviewed, and staff were interviewed.

On 5/9/19 at 1:02 PM, a food test tray was sampled with the Certified Dietary Manager (CDM) and two surveyors. The chicken strip, baked fish, butternut squash, tater tots, and green bean casserole were all at appropriate temperatures, the food was flavorful, and there were no concerns regarding quality.

Resident Council minutes, dated 9/11/18, 12/11/18, and 1/8/19, documented meals were either cold or were not hot enough. Resident Council minutes, dated 2/5/19, 3/5/19, and 4/2/19, documented meal temperatures and taste of the food had improved.

On 5/8/19 at 2:30 PM, four residents in the group interview said there had been an issue with cold food and the issue was resolved and the quality of the food had also improved.

On 5/9/19 at 4:23 PM, the CDM was interviewed. The CDM said there had been an issue with food not being hot enough and the facility had fixed the problem with the purchase of a plate warmer and insulated hall carts to keep the food hot.

The allegation was substantiated. However, no deficiencies were cited related to the allegation because it was determined the facility had identified and fixed the food concerns.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #10:

Staff were not in the dining room and did not assist residents with their meals when needed.

FINDINGS #10:

During the survey, meals were observed, resident records were reviewed, Resident Council minutes were reviewed, facility grievances were reviewed, staff were interviewed, and residents and family members were interviewed.

Shauna Kraus, Administrator
August 8, 2019
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On 5/6/19 from 5:30 PM to 6:37 PM and on 5/7/19 from 12:15 PM to 12:47 PM, 26 residents were observed in either the dining room or in their rooms. During both observations there were 4 staff members in the dining room who were assisting residents with their meals, including cutting up food when the residents needed or requested. Another staff member had dropped off trays to residents and assisted residents who needed it prior to them leaving the room.

Record review of 4 residents, including a resident admitted August 2018, did not document they had a concern regarding assistance with meals. The facility grievances and Resident Council minutes did not document residents experienced a concern with assistance with their meals.

Three individual residents, four residents in the group interview, and two family members said there were no concerns with residents being assisted with meals and/or staff being present during meal times.

Two CNAs and one nurse said staff were always in the dining room due to choking concerns and assist residents to cut up their meals and assisted them to eat. They said if residents ate in their rooms and needed assistance, then a staff member assisted them in their rooms.

Based on the investigative findings, the allegation could not be substantiated.

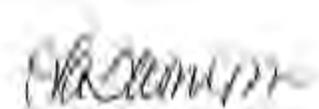
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



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TAMARA PRISOCK—ADMINISTRATOR
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October 25, 2019

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

Provider #: 135143

Dear Ms. Kraus:

On **May 6, 2019** through **May 10, 2019**, an unannounced on-site complaint survey was conducted at Serenity Healthcare. The complaint was investigated in conjunction with the annual recertification survey. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008059

ALLEGATION #1:

The facility did not accurately assess residents and provide adequate medical intervention when they had a change in condition.

FINDINGS #1:

During the investigation 11 residents were observed for quality of care issues and 15 residents' records, which included four closed records, were reviewed for quality of care. Residents and family members were interviewed. Staff members were interviewed and observed as they provided care for the residents. The facility's grievances, and Resident Council minutes were also reviewed.

During the investigation of residents for quality of care, no concerns were identified. Staff were observed providing care to the residents and no concerns were identified.

Resident Council Meeting minutes and grievances from November 2018 to April 2019, did not include documentation about concerns with quality of care.

One resident whose family had a concern about the resident suffering a stroke, record documented she was seen by a physician on 1/21/19, 1/29/19, 2/22/19 and on 2/27/19. The physician assessed the resident and reviewed her medications. There was no documentation the resident had signs and symptoms of stroke. The resident's nurse's notes were reviewed and there was no documentation the resident had manifested signs and symptoms of stroke.

On 5/9/19 at 2:14 PM, the Director of Nursing (DON) said the resident did not have a stroke in the facility. There was no signs and symptoms of stroke observed with the resident.

One resident's medical record documented she was admitted to the facility on 1/18/19. A nurse's note documented the resident had some confusion and the physician was notified who ordered a urine test. The urine test came back positive for infection and the resident was started on Keflex (an antibiotic) three times a day. A nurse's note the following morning, documented the resident was seen by the physician due to hallucinating. Staff were advised to continue to monitor resident's behavior. A nurse's note that evening documented the resident was observed throwing items on the floor and was yelling out in the hallway. The physician was notified of resident's behavior and the physician ordered staff to send the resident to the hospital for evaluation. The resident's family representative was notified of the physician's order.

One resident's medical record documented she complained of some coughing and difficulty swallowing to the physician. The physician ordered a speech evaluation and the resident was seen by the Speech Therapist, due to difficulty swallowing. The resident was assessed to have mild difficulty swallowing and was advised to have skilled therapy to strengthen swallow function and slow swallow initiation, but the resident refused the therapy. The resident was then given swallow exercises and safety strategies.

When interviewed, the Physical Therapy Director said the resident was seen by the Speech Therapist once and there was no other speech evaluation completed on the resident

Based on investigative findings, the allegation could not be substantiated and no deficient practice was identified.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility did not prevent residents from developing pressure ulcers.

FINDINGS #2:

Residents' records were reviewed and a family member was interviewed.

One resident's nurse's notes documented her refusals to get out of bed to go to the bathroom. The nurse's notes also documented the resident stated she would rather "mess" herself than get up to use the bathroom as it hurt to get up. The resident continued to be incontinent of her bowel and bladder and staff applied barrier cream after each episode. The resident's record documented she refused to be repositioned for fear of falling out of bed during cares.

An interdisciplinary team meeting, documented the resident refused to attend, and her representative attended in her behalf. Documentation included the Therapy Department discussed the resident's lack of progress and lack of motivation to participate in her therapy. The Therapy department placed a seven day notice of discontinuation of the resident's therapy, but the representative said he had a talk with the resident and she was willing to participate. The documentation stated the Therapy department agreed to provide the skilled therapy to the resident as appropriate, depending on the resident's participation.

Documentation in the resident's record 2 weeks after the interdisciplinary team meeting, noted the resident had open areas on her coccyx that measured 0.5 centimeter (cm) by 0.5 cm, and a peri-wound was red and blanching. Four days later, the resident was noted to have 0.5 cm x 0.5 cm x less than 0.1 cm open area on her left buttock, and 0.4 x 0.4 x less than 0.1 cm open area on her right buttock. The resident had a bariatric pressure reduction mattress since her admission to the facility. The resident was educated and asked to allow the staff to reposition her to which the resident responded "Just leave me on my back."

A physician's note, documented the physician was notified of the resident's open areas to the coccyx and sacrum. Upon assessment the physician documented the resident had a very shallow moisture associated ulcer in the sacral area just to the left of midline, and it was a very classic appearance of moisture associated skin breakdown. The physician's note documented that it was not related to pressure. The physician also documented the resident was very fearful during the assessment with two person assist when turned to sides for fear of falling out of bed. The physician noted the resident was not taking anti-anxiety medication. Medications were offered to the resident that morning but she refused.

A family member of a resident currently in the facility was interviewed over the phone, and said she had no concern with the cares and services her resident was receiving in the facility. The representative said, her resident had a wound on his feet which was present when he was admitted to the facility, and it was healing. The representative said she visited her resident almost everyday in the facility and did not see any concern.

Based on the results of the investigation, the allegation was substantiated, but not cited, as no deficient practice was identified.

CONCLUSION:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility failed to provide adequate nutritional support to a resident to prevent weight loss.

FINDINGS #3:

Residents were observed eating in their room, and resident records were reviewed.

Two residents were observed eating in their room and no concern was identified.

During review of residents' medical records, the following was documented for one resident admitted on 1/18/19:

- 1/22/19 - the resident was first seen by the Dietitian for initial evaluation. The Dietitian note documented the resident had poor dentition related to missing some teeth. The resident ate independently and denied swallowing issues. The Dietitian noted the resident had inadequate intake on admission related to decreased appetite due to difficulty of chewing some food as evidenced by poor dentition. The resident complained some meats were difficult to chew and requested for the meat to be chopped. The resident stated she enjoyed having meals in her room and had no desire to eat in the dining room. The Dietitian encouraged the resident to eat in the dining room and notified the kitchen to chop meat for the resident's liking, to offer snacks three times a day or as the resident desired. The Dietitian also informed the resident of the availability of alternate meals if she did not like the meal served.
- 1/28/19- the resident was on regular diet, thin liquids and chopped meat as requested. It was documented the resident had a weight loss of 11.8 pounds since admission. The resident was eating 26-50% of her meals. The Dietitian documented resident's weight loss was related to fluid shifts secondary to her recent surgery and decreased intakes.

The Dietitian recommended to provide the resident MedPass (A fortified nutritional shake) 2 ounces four times a day. The resident was also encouraged to eat in the dining room and staff offered snacks to the resident three times a day.

- 1/29/19- a physician's note documented the resident complained of some coughing, dry mouth and difficulty swallowing at times with eating. A swallowing evaluation by a Speech Therapist was requested by the physician. The physician also prescribed lozenges the resident could take as needed.
- 1/31/19- a Speech Therapist's evaluation documented the resident had mild signs and symptoms of clinical dysphagia (difficulty swallowing). The Speech Therapist recommended the resident have skilled therapy services to strengthen her swallow function, and for slow swallow initiation, which the resident refused. The resident was then given some swallow exercises and safety strategies for swallowing.
- 2/4/19- a form signed by the resident, documented she declined to get up out of bed for meals despite education. The form included documentation poor positioning in bed while eating may cause choking/aspiration which had the potential to cause death. The form also documented the information was reviewed with the resident and she understood the potential risks of noncompliance and the benefits of compliance with current's physician's orders.
- 2/12/19- the resident was on regular diet, thin liquids and chopped meat as requested, and had a weight loss of 9.6% over approximately one month. The documentation included the Dietitian discussed with the resident her weight loss. The documentation stated the resident responded she had a decreased appetite overall. The resident stated she declined the snacks offered to her because she did not feel hungry in between meals. The Dietitian's note also documented the resident's relative was present during her conversation with the resident. The Dietitian encouraged the resident to eat in the dining room with the availability of alternate meals.
- 2/19/19- the resident's weight was down by 11.5% over approximately one month. The documentation stated the resident was taking her MedPass every day, four times a day per her Medication Administration Record, her meal intake was 26-50% and, her fluid intake was below average. The Dietitian recommended adding extra gravies and sauces to the resident's meals to increase moisture and nutrition and to offer her ice cream. The resident continued to decline her snacks and offers of alternate meals.
- 2/22/19- a physician's note documented the resident had a 21 pound weight loss and he had been notified. The physician note documented the resident did not have much of an appetite. The note included the resident complained of dry mouth and difficulty swallowing. The physician prescribed lozenges and a speech evaluation was requested.

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The physician reviewed the resident's medications and ordered the following laboratory tests: complete blood count (CBC), complete metabolic panel (CMP), Prealbumin, c-reactive protein (CRP), erythrocyte sedimentation rate (ESR), with diagnoses that included: weight loss, xerostomia (dry mouth) and hypothyroidism. The resident was prescribed Cevimeline (medication to treat symptoms of dry mouth). Upon receipt of the laboratory result, the physician ordered some changes on the resident's medications.

Based on the investigative findings, the allegation was substantiated but not cited, as no deficient practice was identified.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

Two of the allegations were substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj