

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

PRINTED: 09/17/2019
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 C 07/03/2019
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	<p>INITIAL COMMENTS</p> <p>A complaint survey was conducted July 3, 2019 at Serenity Healthcare. The facility was found to be in substantial compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Leader Brad Perry, LSW Carmen Blake, RN</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

08/01/2019

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.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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September 16, 2019

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

Provider #: 135143

Dear Ms. Kraus:

On **July 3, 2019**, an unannounced on-site complaint survey was conducted at Serenity Healthcare. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008168

ALLEGATION #1:

Staff were not properly trained and residents were not transferred properly with sit-to-stand mechanical lifts, which caused them to fall and sustain injuries.

FINDINGS #1:

An unannounced onsite complaint investigation was conducted from 7/2/19 to 7/3/19.

During the investigation, three resident records were reviewed, three residents were observed, the facility's grievances were reviewed, the facility staff training records for mechanical lifts was reviewed, and interviews were conducted with staff, residents, and family members.

From 7/2/19 to 7/3/19, staff were observed to transfer three residents with sit-to-stand mechanical lifts. All three transfers were conducted appropriately and were safe for the residents.

Three residents' records and their Incident and Accident reports were reviewed, including a resident admitted May 2019. Two of the residents' records documented they had care plans in place to use mechanical lifts. Their Incidents and Accident reports did not document falls due to mechanical lifts. A third resident's record, admitted May 2019, documented a physical therapy note, dated 5/17/19, which stated the resident participated with transfers to the toilet and was able to transfer and sit safely on the toilet seat. An incident report, dated 6/27/19, documented the resident fell off the toilet to her left side while the resident attempted to wipe herself as one staff member assisted to change her pants. The incident investigation documented the resident sustained rib fractures due to her fall. The incident investigation documented staff had followed the care plan and a new intervention to the care plan was added to include a second staff member next to the resident when on the toilet and when unattached from the mechanical lift.

Two residents said staff transferred them correctly with sit-to-stand mechanical lifts.

Five Certified Nursing Assistants (CNAs) and two nurses were interviewed on 7/2/19 and 7/3/19. The CNAs and nurses all said they were trained on mechanical lifts, including sit-to-stand lifts, before they used them with residents.

One of the two CNAs, who transferred the resident to the toilet, was interviewed on 7/3/19. The CNA said the staff had never had a concern with the resident being transferred with the mechanical lift and had performed that function since the resident was cleared by the therapy department. The CNA said the resident was not attached to the mechanical lift at the time of the fall and said the resident had never attempted to wipe herself prior to the incident on 6/27/19 and that motion caused her to fall off the toilet.

The Nurse who assessed the resident after the fall, was interviewed on 7/3/19. The Nurse said the resident was on the floor and was not attached to the mechanical lift at the time of the fall.

The Administrator was interviewed on 7/3/19. The Administrator said they had completed the investigation and found the staff had followed the care plan and the resident was transferred correctly. The Administrator said that prior to the incident, the staff had no indications the resident had attempted to wipe herself. The Administrator said after the incident the resident's care plan was updated for two staff members to assist the resident while on the toilet and all the staff were re-educated on resident safety as a precaution.

It could not be established the facility failed to safely transfer a resident to the toilet. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents were overdosed on pain medication.

FINDINGS #2:

From 7/2/19 to 7/3/19, three residents were observed for signs of overdose. No concerns were observed.

Three residents' records were reviewed, including a resident admitted May 2019. Two of the residents' records documented they were provided appropriate pain medication for their medical symptoms. A third resident's record, admitted May 2019, documented she had pain medication ordered on an as-needed basis for pain control for June and July 2019. The Medication Administration Record for those months documented the resident received less than the maximum amount allowed. Nurse's notes, dated 7/1/19, documented the resident was not overdosed due to pain medication. An Emergency Room (ER) Visit note, dated 7/1/19, documented the hospital staff could not find anything wrong with the resident and they were able to answer the staff's questions. The ER note documented the resident's family member thought a seizure medication's side effects caused the resident to be drowsy.

Two residents were interviewed on 7/3/19 and said they had no concerns regarding their pain medication. Three nurses and two CNAs were interviewed on 7/2/19 and 7/3/19. The CNAs and nurses all said they monitored residents for overdoses. The CNAs said they immediately notified a nurse of any overdose concerns. The nurses said they contacted the physician for overdose concerns and followed the physician's orders.

A resident's family member was interviewed on 7/3/19 and said they had been working with the resident's outside physician regarding concerns about possible side effects to a seizure medication. The family member did not think pain medication was a cause for the resident's drowsiness.

The Director of Nursing (DON) was interviewed on 7/3/19. The DON said the resident was not overdosed.

It could not be established the facility failed to administer and monitor pain medication correctly. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Resident's visitors were being told to leave the facility.

FINDINGS #3:

From 7/2/19 to 7/3/19, staff were observed interacting with residents' visitors and none of the visitors were told by staff to leave the facility.

Three residents' records were reviewed, including a resident admitted May 2019. Two of the residents' records documented no concerns regarding visitors being told to leave the facility. A third resident's record, admitted May 2019, documented in a nurse's note, dated 7/2/19, the resident was closing her eyes while in the dining room. Two nurses asked the resident what was wrong, and the resident reported she was uncomfortable with the visitor sitting at the table with her. One of the nurses explained to the visitor the resident felt uncomfortable with them there and was asked to leave and come back another time.

Two residents were interviewed on 7/3/19, and they said visitors could visit them whenever they wanted and had no concerns regarding staff mistreating visitors. A resident's family member was interviewed on 7/3/19 and said they had never been asked to leave the facility.

Three CNAs and two nurses were interviewed on 7/2/19 and 7/3/19, and said residents could have visitors anytime of the day and night. One nurse was interviewed on 7/3/19, and said she and another nurse noticed a resident, admitted May 2019, was agitated on 7/2/19 while in the dining room. The nurse said she and another nurse approached the resident and asked the resident questions to determine what was wrong. The nurse said the resident responded that she was uncomfortable with the person visiting. The nurse said they were concerned for the resident's well-being and one of the nurses explained to the visitor the situation and the visitor agreed to leave. The nurse said the visitor was told they could come back another time when the resident wanted them there.

It could not be established the facility failed to ensure residents' visitors were allowed to visit residents in the facility. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Referral to the appropriate agency.

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

Shauna Kraus, Administrator
September 16, 2019
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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,

A handwritten signature in black ink, appearing to read "Laura Thompson". The signature is cursive and somewhat stylized.

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj