STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135143	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Healthcare	1134 Cheney Dr West Twin Falls, ID 83301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 40902 Based on record review, policy review, staff interview, it was determined the facility failed to ensure a resident's MDS assessment accurately reflected their status at the time of the assessment (Resident #30) and a resident's comprehensive MDS assessment was completed prior to the required completion date (Resident #211). This was true for 2 of 2 residents whose MDS assessments were reviewed. This failure created the potential for harm if care decisions were based upon inaccurate or lack of information. Findings include: The facility's policy titled, Conducting an Accurate Resident Assessment, revised 12/22/23, stated, The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas .each individual assessor is responsible for certifying the accuracy of responses relative to the resident's condition and discharge or entry status . 1. Resident #30 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including hepatic encephalopathy (brain dysfunction due to liver dysfunction). An admission MDS assessment, dated 4/24/24, documented Resident #30 was cognitively intact. Additionally, the assessment documented Resident #30 did not have a life expectancy of six months or less and did not include hospice status. Resident #30's care plan, initiated on 4/15/24, included hospice care for hepatic encephalopathy terminal condition (an illness or condition which cannot be cured and is likely to lead to death). An Order Summary Report, included an order for Resident #30 to be admitted to hospice on located in the EMR under the Orders tab, included admission to hospice on 04/15/24. During an interview on 7/11/24 at 9:49 AM, the MDS Coordinator and DON confirmed the admission MDS for Resident #30 was coded incorrectly and the admission MDS should have included Resident #30's prognosis of six months or less and hospice should have been coded as well. During an interview on 7/11/24 2:19 PM, the ADON stated her expectation was for all assessments to be accurate. The ADON confirmed that Resident #30 had been on hospice services since admission. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135143	A. Building B. Wing	07/11/2024

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #211 was admitted to the facility on [DATE], with multiple diagnoses including stroke, weight loss, and cancerous tumor of the pancreas. An admission MDS assessment, dated 7/5/24 was pending. Further review of the assessment revealed the date for completion of the admission assessment was 7/8/24. During an interview on 7/11/24 at 9:49 AM, the MDS Coordinator stated Resident #211's admission MDS was not submitted on time by the 7/8/24 because it got missed. The MDS Coordinator confirmed that it was past the 14-day period. She stated they were waiting for therapy to complete their section of the assessment, but Resident #211was not on therapy and a hospice resident would require MDS coordinators to complete that section and not therapy. MDS Coordinator reviewed the MDS assessment and acknowledged it was not completed correctly since it documented Resident #211 was not a hospice resident. During an interview on 7/11/24 at 2:19 PM, the ADON stated she knew nothing about MDS assessments, but she would expect staff to submit assessments timely within specified timeframes.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, record review. policy review, and staff interview, the facility failed to ensure residents received meal assistance or were provided meal recommendations. This was true for 2 of 5 residents (#29 and #39) reviewed for nutritional status. This failure created the potential for harm if residents became dehydrated and they experienced unplanned weight loss. Findings include: The facility's policy titled, Weight Monitoring, revised 1/2/24, documented interventions will be identified, implemented, monitored, and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. 1. Resident #29 was admitted on [DATE], with multiple diagnoses including dementia, fractures and other multiple trauma, hypothyroidism, and history of skin cancer. A significant change MDS assessment, dated 6/16/24, documented Resident #29 was severely cognitively impaired. Resident #29's care plan, revised 5/9/24, documented she was at risk for weight fluctuations related to post hospitalization and rehabilitation activities. The care plan documented the goal was for Resident #29 not to experience significant weight loss/gain in the next 180 unless clinically unavoidable. Interventions included speech therapy. Recommendations included to provide Resident #29 with close supervision, verbal cues, cut and prepare foods, and cues to eat. Resident #29's Comprehensive Nutrition Assessment, dated 6/13/24, documented Resident #29 had significant weight loss. The assessment documented Resident #29 had some confusion and did not answer nutrition assessment questions. The assessment stated Resident #29 was on a fortified regular diet, regular texture, and thin liquids. Resident #29 liked to have whole milk with meals. The assessment further documented Resident #29's meal intake decreased to 58 percent. Resident #29 needed assistance with feeding at mealtimes and was now sitting at the assist table in the dining room. The assessment documented Resident #29's weight trend was 140 pounds on 6/3/24, 147.1 pounds on 5/10/24, and 149.2 pounds on 5/7/24, and her weight decreased 6.1 percent in one month which was significant. A Nutrition/Dietary Note, dated 6/14/24, documented the RD's recommendation for Resident #29 was to trial finger foods for one week and change her seating to the assistance table in the dining room for feeding assistance as needed. The note documented Resident #29 had triggered for significant weight loss. The note further documented Resident #29's care plan was updated, kitchen implemented on 6/13/24, and Resident #29's responsible party was notified. A physician order, dated 6/21/24, documented Resident #29 was to receive a regular diet, regular texture, and thin liquids. She was to receive fortified meals and Ensure (nutritional supplement) two times a day for inadequate oral intake and the Kitchen was to send 4 ounces of Ensure with lunch and dinner. Resident #29's record documented she had a 7.6% weight loss in 62 days: (continued on next page)

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	135143	A. Building B. Wing	07/11/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 7/8/24 at 137.8 Lbs (pounds) - 7/1/24 at 137.4 Lbs - 6/24/24 at 138.0 Lbs - 6/13/24 at 140.0 Lbs - 6/3/24 at 140.0 Lbs - 5/27/24 at 143.1 Lbs - 5/20/24 at 145.4 Lbs - 5/13/24 at 147.2 Lbs - 5/10/24 at 147.1 Lbs - 5/9/24 at 146.8 Lbs - 5/8/24 at 148.1 Lbs - 5/7/24 at 149.2 Lbs A Nutrition At Risk Review Note, dated 7/1/24, documented Resident #29 was to continue to sit at the assistance table, needed cues and encouragement during meals and Resident #29 was dependent on staff for feeding. The note documented Resident #29's weight trend was 137.4 pounds on 7/1/24, 138 pounds on 6/24/24, 140 pounds on 6/3/24, and 149.2 pounds on 5/7/24. The note documented Resident #29 had non-significant weight changes at 1 week and 1 month. The note further documented Resident #29 had a 7.9 percent weight decrease in 2 months since her admission. Recommendations/New Interventions included staff were to assist Resident #29 with feedings as needed and have her continue to sit at the assistance table. During an observation on 7/9/24 at 1:22 PM, Resident #29's meal arrived at the regular table in the dining room where Resident #29 was seated. Resident #29 was served chicken and mushrooms, pasta, bread, fruit, green beans, milk, and a half cup of a nutritional supplement. Resident #29 was observed feeding herself the fruit and drinking her milk. No staff assisted or cued Resident #29 until 2:01 PM when RNA #1 at the adjacent table, inquired briefly about Resident #29's meal one time. At 2:03 PM, the Activity Director wheeled Resident #29 out of the dining room. Resident #29 was observed to have eaten poorly. Resident #29's record for meal consumption, dated 7/9/24, documented she consumed 26-50% of her meal for lunch. (continued on next page)

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	135143	A. Building B. Wing	07/11/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/24 at 6:02 PM, Resident #29's meal arrived at the regular table in the dining room where Resident #29 was seated. Resident #29 was served shepherd's pie, pears, a roll, milk, half cup of a nutritional supplement, water, and raw vegetables with dip. Resident #29 was observed only feeding herself the fruit. No staff assisted or cued Resident #29. At 6:20 PM, the ADON stopped at Resident #29's table to encourage another resident to eat but did not encourage Resident #29 to eat. No staff assisted or cued Resident #29 to eat throughout her meal. At 6:27 PM, CNA #6 walked over to Resident #29 and asked her if she was going to eat and Resident #29 said, No. CNA #6 then wheeled Resident #29 out of the dining room. CNA #6 was asked what happened now that Resident #29 did not eat well. CNA #6 stated, we will give her an Ensure and we have a hard time getting her to eat. Resident #29's record for meal consumption, dated 7/9/24 documented she consumed 0-25 percent of her dinner. Resident #29's meal ticket for breakfast, dated 7/10/24, documented to provide Resident #29 cues to eat, cut up and prepare her meals, provide fortified menu, and to provide close supervision and verbal cues. It further documented Resident #29 was to be assigned to the dining room assistance table 2, seat 4. During an interview on 7/10/24 at 11:10 AM, the ADON was asked if she was aware of Resident #29's weight loss. The ADON stated, No, she was not aware because she had only been the ADON for one week and her past role at the facility did not involve her knowing such details. The ADON was asked who would know about Resident #29's weight loss. The ADON stated the previous ADON, and CDM who were no longer employed at the facility and the DON who was on vacation, and the RD. The ADON was asked why staff did not intervene during lunch and dinner on 7/9/24 when Resident #29 did not eat well. The ADON stated she did not know. The ADON was asked about Resident 329's Nutrition At Risk assessment, dated 7/1/24, which documented Resident #29 needed to be fed by staff at times. The ADON stated she thought Resident #29 had graduated from that but she would need to ask speech therapy. The ADON was asked what her expectation would be if staff saw Resident #29, who was known to have a poor appetite. The ADON stated she would see about moving Resident #29 to another table if staff noticed Resident #29 not eating. During an interview on 7/10/24 at 1:42 PM, the ST was asked if she was aware of Resident #29's weight loss. The ST stated, No but Resident #29 was not currently her patient. The ST stated Resident #29 had been on speech therapy services and was seated at the assisted dining table but because of the other resident who was recently admitted and needed to be at that the assisted dining table, Resident #29 was placed at a regular table. The ST stated Resident #29 needed her food cut up and prepared and required tactile cues with the first bite. The ST stated Resident #29's dementia was getting worse and she was not easily willing to eat so getting Resident #29 started with the first bite was critical. The ST further stated when Resident #29 was seated at the assisted dining table, she did get the needed assistance. (continued on next page)

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	135143	A. Building B. Wing	07/11/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 10:35 AM, the RD was asked if she was aware of Resident #29's weight loss. The RD stated yes and Resident #29 was followed in the Nutrition at Risk program. The RD stated Resident #29 received fortified foods and a nutritional supplement twice daily. The RD stated Resident #29 was seated at the assisted dining table and sometimes staff needed to provide feeding assistance to Resident #29. The RD was asked if she was aware Resident #29 was not sitting at the assisted dining table for lunch and dinner on 7/9/24 and she had very poor intake. The RD was informed by the surveyor staff did not assist or cue Resident #29 or cut her food up such as the raw vegetables per the recommendations. The RD stated she was not aware of this, but yesterday the alert on the ticket to cut up her food was changed to read more clearly. The RD further stated Resident #29's food had always been required to be cut up. The RD stated her expectation was for staff to provide Resident #29 tactile cues and provide feeding assistance, seat Resident #29 at an assisted dining table, provide tray set up, and cut her food up. The RD stated she expected staff to try and get Resident #29 to eat the first bite of food and utilize Ensure as a last resort. During an interview on 7/11/24 at 10:54 AM, the CDM stated the tray cards were hard to read and CNAs did not understand the cards so he changed the alerts. The CDM stated before this change Resident #29's tray card did instruct staff Resident #29 was supposed to be at an assisted dining table, but he was not sure why Resident #29 was changed to a regular table. The CDM further stated the raw vegetables Resident #29 received at dinner on 7/9/24 was appropriate for Resident #29 according to ST but staff should have cut them up for easier consumption as Resident #29 had missing teeth. 40902 2. Resident #39 was admitted to the facility on [DATE] and with multiple diagnoses of moderate protein calorie malnutrition. An admission MDS assessment, dated 5/27/24, documented Resident #39 had no cognitive impairment. Resident #39's care plan, dated 5/21/24, documented Resident #39 was at nutritional risk. Interventions in were to follow Speech swallow strategies which included close supervision, slow rate, slow bites, alternate bite and drink, effortful swallows, and chin tuck with foods. A Speech Therapy Evaluation and Plan, dated 5/24/24, documented Resident #39 had a diagnosis of Dysphagia (difficulty swallowing). The treatment approach included treatment of swallowing dysfunction and/or function for feeding and evaluation of oral and pharyngeal swallow function. Nursing provided the following recommendations: close supervision, verbal cues, slow rate, small bites, alternate bite and drink and effortful swallows. Resident #39's meal tickets, dated 7/9/24, for breakfast, lunch, and dinner included soft bite size-mix-regular bread. The meal tickets included Alerts: Alternate bite and drink. [NAME] tuck with foods and liquids. Cut bread into bite sizes, effortful swallows, no rice, slow rate, small bites. Supervision-Close. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a lunch observation on 7/9/24 at 1:42 PM, Resident #39 was seated at one of the restorative tables along with one another resident. NA #1 was seated at the table in between both residents. NA #1 picked up Resident #39's meal ticket and looked at it. Resident #39 was served chopped chicken with gravy over noodles, green beans, toasted bread, and milk. Resident #39 fed himself without staff assistance and did not take drinks in between bites. Resident #39 took 11 bites before the first sip of milk. Staff did not cue him or ensure he was taking small bites or swallowing before taking another bite. Resident #39 took several large spoonsful of green beans and did not swallow before he took another bite. During a dinner observation on 7/9/24 at 6:12 PM, Resident #39 was seated at the restorative tables along with one another resident. CNA #7 was at the table seated between Resident #39 and another resident. Resident #39 received shepherd's pie without peas, carrots, and cut up toasted bread with milk. CNA #7 did not look at Resident #39's meal ticket and did not cue Resident #39 during the meal. Resident #39 took multiple big bites of the shepherd's pie and did not drink between bites. Resident #39 coughed at 6:14 PM, 6:15 PM, and 6:18 PM while eating, but there was no indication of choking. CNA #7 did not intervene or provide cueing. Resident #39 did not take more than three drinks of milk during the meal. During an interview on 7/10/24 at 12:14 PM, NA #1 said she knew that residents who sat at table 11 required assistance with meals. She stated there was one resident who sat there who always choked. She said she was referring to Resident #39. She said she reminded him to slow down, watch his bite size, and reminded him to swallow the first bite before taking another. But she stated she forgot that day to cue him and remind him to swallow between bites. During an interview on 7/10/24 at 12:15 PM, CNA #1 stated the residents' meal tickets will say what type of meal assistance they required. She stated she did not look at Resident #39's meal ticket because another staff told her to sit at that table to assist another resident. She said it was the first time she sat at that table with Resident #39. CNA #1 stated she was unaware Resident #39 had choking incidents in the past or of meal assistance Resident #39 needed. During an interview on 7/10/24 at 1:35 PM, the Speech Therapist said that staff were aware of what type of assistance residents required with meals. She stated she provided a sheet with all recommendations to the Dietary Manger and the ADON. She stated the recommendations were care planned, and provided on the bottom of the meal tickets and there was a seating chart to indicate which residents required assistance with dining. The Speech Therapist said all the CNA and NA staff knew there were three assist tables that residents who sat at required supervision and cueing. She said all CNA and NA staff were provided with education on the dining assistance. She said staff should provide Resident #39 with a cue at start of a meal for him to remember his chin tucks, and every couple of bites he should be take a drink. She stated Resident #39 should take only small bites and staff should be queuing for him. During an interview on 7/11/24 at 2:16 PM, the ADON said she was not familiar with Resident #39, but she expected staff to look at the tray card and follow the tray card alerts and speech recommendations. She said staff should cue residents who require it while eating to ensure residents' safety to prevent choking.

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	135143	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, policy review, review of Resident Council minutes, review of facility grievances, and resident and staff interview, it was determined the facility failed to ensure resident meals were served following the facility's designated meal schedule. This was true for 4 of 5 residents (#20, #29, #30, and #111) interviewed for concerns with food. This failure had the potential to impact residents in the facility who were at risk for nutritional compromise and had the potential to harm residents if they experienced hunger, low blood sugar levels, or did not receive adequate nutritional support for healing or weight loss. Findings include: The facility's policy titled, Frequency of Meals, dated 8/22/23, documented, The facility will ensure that each resident receives at least three meals daily without extensive time lapses between meals.I. The facility has scheduled three regular mealtimes, comparable to normal mealtimes in the community, per day and has scheduled three regular snack times. The facility meal schedule documented breakfast was scheduled at 7:30 AM to 8:30 AM, lunch was at 12:30 PM, and dinner was at 5:00 PM. 1. Resident #111 was admitted to the facility on [DATE], with multiple diagnoses including heart failure, peripheral vascular disease, and transient cerebral ischemic attack (a brief blockage of blood flow to the brain that usually lasts only a few minutes and does not cause long-term damage), Resident #R111's diet order, dated 7/4/24, documented he was to receive a regular diet. During an interview on 7/8/24 at 11:01 AM, Resident #111 was asked about the food at the facility. Resident #111 stated the food service is the worst. The meals are late. Yesterday lunch was served at 1:15 PM in the dining room and it should be 12:30 PM. On 7/9/24 at 6:02 PM, Resident #111 received her meal in the dining room, 62 minutes after the designated time. At 6:09 PM Resident #111 stated the food was warm, but late. 2. Resident #30 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including hepatic encephalopathy (brain dysfunction due to liver dysfunction). Resident #30's diet order included a regular diet with small bite-sized and thin liquids. During an interview on 7/08/24 at 11:08 AM, Resident #30 stated mealtimes needed to be improved due to dinner meals not served until 6:30 PM to 7:00 PM, and lunch meals not served until 2:00 PM. 3. Resident #20 was admitted to the facility on [DATE] with multiple diagnoses including a traumatic subdural hemorrhage, depression, heart failure, and chronic respiratory failure. Resident #20's diet order was for a regular diet and thin liquids. (continued on next page)

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	135143	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/8/24 at 2:01 PM, Resident #20's lunch tray arrived in her room delivered by CNA #2. At 2:51 PM, CNA #3 and CNA #4 walked into Resident #20's room and woke Resident #20 up, asking her if she wanted to eat. Resident #20 asked what time it was, and CNA #4 said it was almost 3:00 PM. Resident #20 then declined her meal saying it was too late to eat lunch. CNA #4 was asked why Resident #20 declined her lunch and CNA #4 confirmed she refused due the late hour. Resident #20's meal consumption record, documented Resident #20 refused her lunch on 7/8/24. 4. Resident #29 was admitted to the facility on [DATE], with multiple diagnoses dementia, fractures and other multiple trauma, hypothyroidism, and history of skin cancer. A physician order, dated 6/21/24, documented Resident #29 was to have a regular diet, thin liquids consistency, fortified meals, and Ensure (nutritional supplement) 2 times a day for inadequate oral intake. The kitchen was to send 4 ounces of Ensure with lunch and dinner. A Nutrition At Risk Review Note, dated 7/1/24, documented Resident #29 was to continue to sit at the assistance table, and needed cuing and encouragement during meals. The note documented Resident #29 was at times dependent on staff for feeding. On 7/9/24 at 1:22 PM, Resident #29 was served her lunch in the dining room, 52 minutes after the designated scheduled time. On 7/9/24 at 6:02 PM, Resident #29 was served her dinner in the dining room, 62 minutes after the designated scheduled time. 5. The following meals were observed served past the designated mealtime: - On 7/8/24 at 12:58 PM, lunch service started in the dining room, 28 minutes after the designated time. - On 7/8/24 at 1:56 PM, the lunch hall cart arrived on the East Hall, 86 minutes after the designated time. - On 7/8/24 at 2:00 PM, the lunch hall cart arrived on the [NAME] Hall, 90 minutes after the designated time. - On 7/9/24 at 12:49 PM, lunch service in progress on the East Hall, 19 minutes after the designated time. - On 7/9/24 at 1:20 PM, lunch service started in the dining room, 50 minutes after the designated time. - On 7/9/24 at 5:30 PM, the dinner hall cart arrived on the East Hall, 30 minutes after the designated time. - On 7/9/24 at 5:46 PM, the dinner hall cart arrived on the East Hall, 46 minutes after the designated time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135143	A. Building B. Wing	07/11/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 7/9/24 at 5:53 PM, lunch service started in the dining room, 53 minutes after the designated time. Resident Council Minutes, dated 5/28/24, provided by the facility, included, Discussion about shortages of ingredients to make the food, or food delivery did not arrive on time. No details were included about what the discussion concerning food delivery not arriving timely. A grievance report, dated 7/2/24, provided by the facility, documented, We have had a grievance from a family member that their loved lunch one had not received their tray and it was 1pm. They further disclosed that the staff member that was passing the hall tray had thought that this resident was in the dining room because the tray was not on the hall cart. The staff member ordered the hall tray and told the family member that they would bring it down when it was ready. The family stated that at 1:45pm they returned to the nurses station and care giver was at the desk and so was a meal tray and when they asked if it was their loved ones the care giver read the tray ticket, got up and took it to the room. The report documented the resolution was staff education. During an interview on 7/10/24 at 1:31 PM, the CDM was asked about the tardiness of lunch on 7/8/24 and lunch and dinner on 7/9/24. The CDM stated his first day at the facility was 7/8/24 and he noticed the late lunch. The CDM stated the fact that the previous dietary manager left her position and took half the dietary staff with her caused a problem because they had to hire new staff and train them. The CDM went on to say the late meals were also a result of time management issues that he was working with the staff on it. The CDM was asked if he was aware residents were complaining of meals being late. The CDM stated the Resident Council decided on 12:30 PM as lunch time in the dining room but he changed the meal carts and they now go out after the dining room. The CDM was asked if that would cause the hall trays to be late causing further complaints. The CDM stated they are considering other solutions. During an interview on 7/11/24 at 11:27 AM, the RD was asked if she was aware of resident complaints of late meals and she stated, Yes. The RD was asked when she become aware of resident complaints of late meals, the RD stated she became aware in the last two weeks by the previous dietary manager. The RD stated she and the previous dietary manager were trying to work out a solution.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135143	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Healthcare	1134 Cheney Dr West Twin Falls, ID 83301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on observation, policy review, record review, and staff interview, the facility failed to ensure enhanced barrier precautions were followed. This was true for 1 of 1 resident (Resident #8) reviewed. This failure increased the risk of spreading multidrug resistant organisms. Findings include: The facility's policy titled, Enhanced Barrier Precautions, dated 5/6/24 states, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms . 'Enhanced barrier precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities .High-contact resident care activities include .changing briefs or assisting with toileting . Resident #48 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including stroke and right lower leg open wound. Resident #48's Clinical Physician Orders, dated 7/5/24, documented Resident #48 was to be placed on EBP. A physician's order, dated 7/9/24, included orders for care of Resident #48's right lower extremity wound including a wound vacuum (a device that decreases air pressure on the wound which can help the wound heal more quickly). Review of Resident #48's care plan, initiated 6/20/24, documented Resident #48 was to have EBP with signage posted outside the room indicating EBP and the high-contact resident care activities that required the use of gown and gloves while providing cares in Resident #39's room. During observation and interview on 7/8/24 at 11:20 AM, EBP signage was observed outside Resident #48's door indicating staff should wear a gown and gloves for procedures. LPN #1 stated Resident #48 was on EBP due to a wound on her right lower leg. During an observation on 7/8/24 at 1:55 PM, Resident #48 had an EBP sign outside her door, and was stating she needed assistance. The surveyor went to get assistance from staff due to her call light not working. CNA #1 and NA #1 came to assist Resident #48 and provide peri care. CNA #1 and NA #1 wore gloves but did not put on gowns during Resident #48's peri care. During an interview on 7/8/24 at 1:55 PM, NA #1 confirmed Resident #48 was on EBP and she and her co-worker were busy and did not wear gowns but should have. NA #1 confirmed she was hired 2/28/24 and had received EBP training. During an interview on 7/11/24 at 10:15 AM, CNA #1 stated she recalled providing care for Resident #48 on 7/08/24 for changing and repositioning. CNA #1 stated she was a shower aide and she went in to assist with cares for Resident #48 on 7/8/24 and she did not notice the EBP sign on door and was not aware she needed to wear a gown. CNA #1 confirmed she was hired 11/15/23 and had received EBP training.