



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

November 6, 2014

Rene Stephens, Administrator  
Hillcrest Home  
1411 Falls Avenue East, Suite 703  
Twin Falls, ID 83301

RE: Hillcrest Home, Provider #13G048

Dear Ms. Stephens:

This is to advise you of the findings of the Medicaid/Licensure survey of Hillcrest Home, which was conducted on October 24, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Rene Stephens, Administrator  
November 5, 2014  
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6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **November 18, 2014**, and keep a copy for your records.

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 the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by November 18, 2014. If a request for informal dispute resolution is received after November 18, 2014, 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 our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



ASHLEY HENSCHIED  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

AH/pmt  
Enclosures

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

PRINTED: 11/05/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/24/2014
NAME OF PROVIDER OR SUPPLIER  HILLCREST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2216 HILLCREST DRIVE 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
W 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification survey conducted from 10/20/14 to 10/24/14.</p> <p>The survey was conducted by:</p> <p>Ashley Henscheid, QIDP, Team Lead Karen Marshall, MS, RD, LD</p> <p>Common abbreviations used in this report are:</p> <p>CFA - Comprehensive Functional Assessment IPP - Individual Program Plan LPN - Licensed Practical Nurse</p> <p>W 216 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must include physical development and health.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals' CFAs include comprehensive health information for 1 of 3 individuals (Individual #3) whose CFAs were reviewed. This resulted in a lack of information being available on which to base program intervention and health decisions. The findings include:</p> <p>1. Individual #3's IPP, dated 9/16/14, documented he was a 62 year old male whose diagnoses included severe mental retardation and Parkinson's Disease.</p> <p>Individual #3's record contained results, dated 6/12/14, from an overnight study he participated</p>	W 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kene Stephens TITLE: Administrator (X6) DATE: 11/19/14

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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W 216	<p>Continued From page 1</p> <p>in. The report documented Individual #3 was diagnosed with nocturnal hypoxemia. Further, the notes documented "It was decided today that might [sic] be best to treat his nocturnal hypoxia with oxygen..."</p> <p>However, Individual #3's CFA was reviewed and comprehensive information regarding his oxygen use, needed for his nocturnal hypoxemia, could be found.</p> <p>When asked, during an interview on 10/23/14 from 2:00 - 4:50 p.m., the Facility Manager stated Individual #3's need for oxygen was missed in the assessment.</p> <p>The facility failed to ensure Individual #3's record included comprehensive assessment information related to his physical health.</p>	W 216	<p><b>W216</b></p> <p>The CFA will be updated to incorporate items associated with physical health and corresponding recommendations for treatments. Facility Manager will review the other CFAs for the facility and update the document to include changes in physical health and recommendations for treatment. At the time the diagnosis or the physical health changes the nursing department will submit a change of status document via email to the Facility Manager, QIDP and Administrator. The CFA will be updated by the Facility Manager to accurately reflect the diagnosis change in a timely manner. QIDP and Facility Manager will review files at least annually to ensure that the physical health items that are currently being treated are correctly assessed in the CFA and that recommendations are implemented in programmatic formats.</p> <p>Date of Correction: 12-15-2014 Responsible: QIDP, LPN, Facility Manager</p>
W 325	<p>483.460(a)(3)(iii) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure routine screening laboratory examinations were provided to 1 of 3 individuals (Individual #2) whose laboratory records were reviewed. This resulted in the potential for medical concerns to go undetected. The findings include:</p> <p>1. Individual #2's IPP, dated 6/27/14,</p>	W 325	

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W 325	<p>Continued From page 2</p> <p>documented he was a 41 year old male whose diagnoses included moderate mental retardation. His physician's order sheets, dated 2/14/14 - 8/15/14, stated he received Depakote (a mood stabilizer drug) 750 mg daily.</p> <p>In addition, his physician's order sheets contained an order for a Depakote (valproic acid) level to be obtained every 6 months.</p> <p>Individual #2's laboratory analysis sheet, dated 8/21/14, did not contain a valproic acid test level.</p> <p>The Nursing 2015 Drug Handbook contained a Depakote black box warning which stated patients with mental retardation were at high risk for hepatotoxicity (chemically-caused liver damage).</p> <p>When asked during an interview on 10/22/14 at 1:50 p.m., the LPN reviewed Individual #2's physician orders and his laboratory results and said the valproic acid level was missed on the 8/21/14 laboratory analysis.</p> <p>The facility failed to ensure Individual #2's valproic acid level was monitored as ordered by the physician.</p>	W 325	<p><b>W325</b></p> <p>Laboratory orders have been followed to obtain the requested lab work for the individual in question. Nursing department will establish work flow sheet to ensure that doctor orders for laboratory requests are met according to established guidelines. QIDP, LPN and Facility Manager will do monthly review at face to face Q meetings to ensure previous orders have been followed through for all individuals in the facility and to assess upcoming laboratory needs requested by physicians.</p> <p>Date of Correction: 12-15-2014 Responsible: QIDP, LPN, Facility Manager</p>	
W 336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>This STANDARD is not met as evidenced by:</p>	W 336		

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W 336	<p>Continued From page 3</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure nursing reviews were completed on a quarterly basis for 3 of 3 individuals (Individuals #1 - #3) whose medical records were reviewed. This resulted in the potential for medical problems to not be identified in a timely fashion. The findings include:</p> <p>1. Individual #1 - #3's medical records were reviewed. Individual #1 - #3's records included nursing reviews that were completed on 9/26/13, 12/31/13, 3/21/14, and 7/28/14. The medical records did not include a completed review for the second quarter (April, May, June) of 2014.</p> <p>During an interview on 10/23/14 from 2:00 - 4:50 p.m., the LPN said the quarterly nursing reviews for the second quarter of 2014 were rescheduled and completed on 7/28/14.</p> <p>The facility failed to ensure nursing reviews were completed on a quarterly basis.</p>	W 336	<p><u>W336</u></p> <p>Quarterly nursing reviews have been updated to ensure that that they are met within the established time frames, specifically, within each quarter. A file review during survey noted that the quarterly review had been delayed by 30 days, missing one quarter even though the corresponding schedule of assessments established actually included 4 total reviews for the year. LPN and RN have scheduled corresponding assessments to align within the correct time frames for the regulatory guidelines. Any adjustments will be noted by LPN and RN and dates will be established from that point forward to keep the reviews within the quarter as required. Reminders have been set for the beginning of the last month in each quarter, March, June, September, and December. If a scheduled review must be changed there is still adequate time in that month to be sure it happens in a timely manner.</p> <p>Date of Correction: 11-30-2014 Responsible: LPN, RN</p>	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  
**HILLCREST HOME**

STREET ADDRESS, CITY, STATE, ZIP CODE  
2215 HILLCREST DRIVE  
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) COMPLETE DATE
M 000	16.03.11 Initial Comments  The following deficiencies were cited during the annual licensure survey conducted from 10/20/14 to 10/24/14.  The survey was conducted by:  Ashley Henscheid, QIDP, Team Lead Karen Marshall, MS, RD, LD	M 000	MM730 – see W216	
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data  Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W216.	MM730		
MM750	16.03.11.270.02(d)(ii) Routine Screening Laboratory Examinations  Routine screening laboratory examinations, as determined necessary by the physician, and special studies when the index of suspicion is high. This Rule is not met as evidenced by: Refer to W325.	MM750	MM750 – see W325	
MM766	16.03.11.270.03(c)(iii) Periodic Reevaluation  The periodic reevaluation of the type, extent, and quality of services and programming; and This Rule is not met as evidenced by: Refer to W336.	MM766	MM766 – see W336	

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Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Karen Marshall* TITLE *Administrata* (X6) DATE *11/19/14*

STATE FORM 6299 QBDY11 continuation sheet 1 of 1