



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- GOVERNOR
RICHARD M. ARMSTRONG -- DIRECTOR

TAMARA PRISOCK -- ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON -- PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

April 4, 2013

Cynthia Brewer, Administrator
Bronco Senior Services DBA Hillcrest
1093 S Hilton Street
Boise, ID 83705

License #: RC-998

Dear Ms. Brewer:

On January 16, 2013, a follow-up, licensure and complaint investigation survey was conducted at Bronco Senior Services. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Polly Watt-Geier, MSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Polly Watt-Geier, MSW
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Assisted Living Facility Program



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February 5, 2013

CERTIFIED MAIL #: 7012 1010 0002 0836 0089

Cynthia Brewer, Administrator
Bronco Senior Services dba Hillcrest
1093 S Hilton Street
Boise, ID 83705

CORRECTED LETTER

Dear Ms. Brewer:

This letter corrects the calculation of the Civil Monetary Penalties identified on page 5 of the February 4, 2013 letter. No other changes have been made.

Based on the state follow-up, licensure survey and complaints investigation survey conducted by Department staff at Bronco Senior Services on January 16, 2013, it has been determined the facility **failed to protect residents from neglect - this is a repeat deficiency**. The facility failed to monitor a diabetic resident's ulcerated feet or follow orders from the physician or the hospital to provide care for his wounds. The facility also failed to monitor another resident's care when the resident developed infected wounds from a leaking catheter bag.

The facility also failed to **protect residents from inadequate care - this is a repeat deficiency**. The facility failed to re-order medications in time for the resident to receive them, failed to ensure medications were given in accordance with physician's orders, and made serious medication errors that endangered the health and safety of the residents. Additionally, the facility retained a resident for whom they were not licensed and did not have the capacity to care for, as the resident had active Methicillin-resistant Staphylococcus (MRSA) and an Unstageable/Stage III pressure ulcer. The facility also failed to have nursing staff available to conduct assessments and ensure appropriate interventions when residents experienced changes of condition. The facility also violated a resident's rights by taking his medications from him without an assessment to determine if he was no longer safe to self-administer, and then, without his knowledge, continuing to give him a medication which he had chosen to stop taking and for which they did not have a physician's order to give. The facility also violated another resident's right to his personal property as they opened his mail without his permission. The facility failed to coordinate a resident's foley catheter care and wound care with an outside provider.

PROVISIONAL LICENSE and LIMIT ON ADMISSIONS

These core issue deficiencies seriously impair the capacity of Bronco Senior Services to furnish services of an adequate level or quality to ensure that residents' health and safety are not jeopardized. As a result of the survey findings, the Department is issuing the facility a **provisional license, effective February 4, 2013, through June 4, 2013**. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.

A provisional license may be issued when a facility is cited with one (1) or more core issue deficiencies, or when noncore issues have not been corrected or become repeat deficiencies. The provisional license will state the conditions the facility must follow to continue to operate. See Subsections 900.04, 900.05 and 910.02 of these rules.

The conditions of the provisional license are as follows:

1. **Ban on all new admissions.** Readmission from the hospital will be considered after consultation between the facility, the resident/family and the Department. The ban on new admissions will remain in effect until the Department has determined that the facility has achieved full compliance with the requirements.
2. **Consultant.** A registered nurse or licensed administrator consultant, with a minimum of five (5) years experience working for a residential care assisted living facility in Idaho, who is approved by the Department, and who will be obtained and paid for by the facility. This consultant must have an Idaho nursing license or an Idaho Residential Care Administrator (RCA) license, and may not also be employed by the facility or company that operates the facility. The consultant must be allowed unlimited access to the facility and its systems for the provision of care to residents. The name of the consultant with the person's qualifications will be submitted to the Department for approval no later than February 8, 2013.
3. **Facility Nurse.** A permanent, full-time, Licensed Professional Nurse (RN), who is licensed in the State of Idaho, and whose license is in good standing, shall be retained on a full-time basis (no less than 40 hours per week) and dedicated exclusively to the facility. The licensed nurse may not be the same individual as the consultant (described in #2 above). The nurse's duties shall encompass all nursing related requirements described in IDAPA 16.03.22, Rules for Residential Care or Assisted Living Facilities in Idaho.
4. **Weekly Reports.** The Department approved consultant will submit a weekly written report to the Department commencing on February 14, 2012 and every Friday thereafter. The reports will address progress on correcting the deficiencies on the Statement of Deficiencies and Non-Core Issues Punch Lists.
5. **Compliance.** The facility will maintain, on an ongoing basis, the deficient area in a state of compliance in accordance with the submitted Plan of Correction;
6. **Provisional License.** A provisional license is hereby issued which is to be prominently displayed in the facility. Upon receipt of this provisional license, return the full license currently held by the facility.
7. **Alleging Compliance.** When the consultant and the administrator agree the facility is in full compliance, they will notify the Department and a follow-up survey will be conducted.

If the facility fails to comply with any of the conditions of the provisional license, or it is determined at the follow-up survey that any of the core issue deficiencies still exist, or if new core issue deficiencies are identified, the Department will have no alternative but to proceed with additional enforcement actions which may include the imposition of temporary management and the revocation or summary suspension of the facility's license.

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300. no later than twenty-eight (28) days after this notice was mailed. Any such request should be addressed to:

Debby Ransom, R.N., R.H.I.T.
Bureau Chief, Licensing and Certification
Department of Health and Welfare
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

PLAN OF CORRECTION

You have an opportunity to make corrections and thus avoid further enforcement actions, which could include the imposition of temporary management or revocation of the facility license. To do so, you must immediately and closely study the enclosed Statement of Deficiencies and write a Plan of Correction by answering each of the following questions for each deficient practice. You are strongly encouraged to seek the assistance of an experienced, successful residential care administrator to assist you.

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- By what date will the corrective action(s) be completed?

Return the signed and dated Plan of Correction to us by February 17, 2013, and keep a copy for your records.

Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop. We urge you to begin correction immediately and thus avoid revocation of the facility's license. **Correction of these deficiencies must be achieved by March 2, 2013.**

You have the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care Program for a Level I IDR meeting. The request for the meeting must be made with ten (10) business days of receipt of the Statement of Deficiencies (February 17, 2013). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after February 17, 2013, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at www.assistedliving.dhw.idaho.gov under the heading of Forms and Information.

REPEAT NON-CORE DEFICIENCIES

Please bear in mind that thirty-six (36) non-core issue deficiencies were identified on the punch list, fifteen (15) of which were identified as repeat punches. Three (3) of the repeat deficiencies (licensed nurse to address changes in health status and implement new orders, having a negotiated service agreement that clearly identifies the resident and describes the services that will be provided, and the administrator responding to complaints in writing) have now been cited on three consecutive surveys, as follows:

- 10/07/11
- 08/28/12
- 01/16/13

These deficiencies, which have been cited on three consecutive surveys, are direct violation(s) of the following administrative rules for Residential Care or Assisted Living Facilities in Idaho:

IDAPA 16.03.22.305. LICENSED PROFESSIONAL NURSE RESPONSIBILITY REQUIREMENTS.

The licensed professional nurse must assess and document, including date and signature, for each resident as described in Subsections 305.01 through 305.08 of these rules.

02. Current Medication Orders. Assure the residents' medication orders are current by verifying that the medication listed on the medication distribution container, including over-the-counter-medications as appropriate, are consistent with physician or authorized provider orders. A copy of the actual written, signed and dated orders must be present in each resident's care record.

IDAPA 16.03.22.320. REQUIREMENTS FOR THE NEGOTIATED SERVICE AGREEMENT.

The Negotiated Service Agreement must be completed and signed no later than fourteen (14) calendar days from the date of admission. A written interim plan must be developed and used while the Negotiated Service Agreement is being completed.

01. Use of Negotiated Service Agreement. Each resident, regardless of the source of funding, must enter into a Negotiated Service Agreement. The Negotiated Service Agreement provides for coordination of services and instruction to the facility staff. Upon completion, the agreement must clearly identify the resident; describe services to be provided, the frequency of such services, and how such services are to be delivered. The Negotiated Service Agreement must be implemented.

IDAPA 16.03.22.350. REQUIREMENTS FOR HANDLING ACCIDENTS, INCIDENTS, OR COMPLAINTS.

The administrator must assure that the facilities policies and procedures are implemented.

04. Written Response to Complaint Within Thirty Days. The person making the complaint must receive a written response from the facility of the action taken to resolve the matter or reason why no action was taken within thirty (30) days of the complaint.

CIVIL MONETARY PENALTIES

The following administrative rules for Residential Care or Assisted Living Facilities in Idaho give the Department the authority to impose a monetary penalty for these violations:

IDAPA 925. ENFORCEMENT REMEDY OF CIVIL MONETARY PENALTIES.

01. Civil Monetary Penalties. Civil monetary penalties are based upon one (1) or more deficiencies of noncompliance. Nothing will prevent the Department from imposing this remedy for deficiencies which existed prior to survey or complaint investigation through which they are identified. Actual harm to a resident or residents does not need to be shown. A single act, omission or incident will not give rise to

imposition of multiple penalties, even though such act, omission or incident may violate more than one (1) rule.

02. Assessment Amount for Civil Monetary Penalty. When civil monetary penalties are imposed, such penalties are assessed for each day the facility is or was out of compliance. The amounts below are multiplied by the total number of occupied licensed beds according to the records of the Department at the time noncompliance is established.

b. Repeat deficiency is ten dollars (\$10).

Based on findings that you have repeatedly failed to correct these deficiencies the Department is imposing the following penalties:

For the dates of August 28, 2012 through January 16, 2013:

Penalty	Number of Deficiencies	Times number of Occupied Beds	Times Number of days of non-compliance	Amount of Penalty
\$10.00	3	76	141	\$ 321,480

Maximum penalties allowed in any ninety day period per IDAPA 16.03.22.925.02.c:

# of Occupied Beds in Facility	Initial Deficiency	Repeat Deficiency
3-4 Beds	\$1,440	\$2,880
5-50 Beds	\$3,200	\$6,400
51-100 Beds	\$5,400	\$10,800
101-150 Beds	\$8,800	\$17,600
151 or More Beds	\$14,600	\$29,200

Your facility had seventy-six (76) occupied beds at the time of the survey. Therefore, your maximum penalty is: \$10,800.

Send payment of \$10,800 by check or money order, made payable to:

Licensing and Certification

Mail your payment to:

Licensing and Certification - RALF
PO Box 83720
Boise, ID 83720-0009

Payment must be received in full within 30 calendar days from the date this notice is received. Interest accrues on all unpaid penalties at the legal rate of interest for judgments. Failure of a facility to pay the entire penalty, together with any interest, is cause for revocation of the license or the amount may be withheld from Medicaid payments to the facility.

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300, no later than twenty-eight (28) days after this notice was mailed. Any such request should be addressed to:

Debby Ransom, R.N., R.H.I.T.
Bureau Chief, Licensing and Certification
Department of Health and Welfare
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

The Residential Care Assisted Living Facility Licensing and Certification team is here to assist you and your consultant in developing an appropriate plan to bring the facility back into compliance, Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,



JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Assisted Living Facility Program

JS/tfp

cc: Steve Millward, Licensing & Certification
Idaho Department of Health and Welfare Division of Medicaid notification Group
Cathy Hart, Ombudsman, Idaho Commission on Aging

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R998	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2013
NAME OF PROVIDER OR SUPPLIER BRONCO SENIOR SERVICES DBA HILLCREST		STREET ADDRESS, CITY, STATE, ZIP CODE 1093 S HILTON STREET BOISE, ID 83705		
(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)	(X6) COMPLETE DATE
{R 000}	<p>Initial Comments</p> <p>The following deficiencies were cited during the follow-up, licensure survey and complaint investigation conducted between January 7, 2013 and January 16, 2013 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Polly Watt-Geier, MSW Team Leader Health Facility Surveyor</p> <p>Matt Hauser, QMRP Health Facility Surveyor</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Rachel Corey, RN, BSN Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Survey Abbreviations and Definitions: ~ @ = at ~ &/+ = and ~ Algidex Ag = A technologically advanced silver wound dressing used to provide immediate and sustained antimicrobial activity. ~ Caregivers A-K = represents current or former staff members of the facility. ~ Darco Wedge = a wedge used to off-load pressure from the heel by shifting weight to the mid and forefoot to promote faster healing of wounds. ~ Interdry AG = A knitted polyester textile dressing with silver complex designed to manage moisture, odor and inflammation in skin-to-skin</p>	{R 000}	<p>The following is Hillcrest's Plan of Correction as required by the Idaho Department of Health & Welfare Survey for the follow-up survey complaint survey and full survey dated January 16, 2013 and received at the facility via certified mail on February 5, 2013. The Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions outlined in the Statement of Deficiencies. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or findings. We have not presented any contrary/factual or legal arguments, nor have we identified all mitigating factors.</p>	

Bureau of Facility Standards

TITLE

(X6) DATE

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

STATE FORM

6689

JV7H12

If continuation sheet 1 of 52

Bureau of Facility Standards

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{R 000}	Continued From page 1 contact areas. ~ LPN = Licensed Practical Nurse ~ MAR = Medication Assistance Record ~ MD = physician ~ meds = medications ~ mg = milligrams ~ MRI = Magnetic resonance imaging ~ MRSA = Methicillin-resistant Staphylococcus Aureus ~ NSA = Negotiated Service Agreement ~ p.o. = by mouth ~ Pt = patient ~ Res = Resident ~ RN = Registered Nurse ~ TBD = To Be Determined ~ Telfa = dressing material for wounds ~ Tubigrip = an elastic tubular bandage used to reduce swelling and/or keep bandages in place. ~ UAP = unlicensed Assistive Person ~ Unna boot = a gauze bandage used on the foot to the knee to protect leg ulcers and reduce swelling. The bandage is usually covered by ace wraps or elastic bandages. ~ w/ = with	{R 000}		
{R 008}	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, record review and interview it was determined, the facility retained 1 of 1 sampled residents (Resident #18), who had a Stage III pressure ulcer and active MRSA. The facility failed to provide medical care and/or assessment for 7 of 8 residents whose health	{R 008}	1. Ref. 16.03.22.520 A. Corrective Actions: A State approved consultant and full-time facility RN were retained. A systemic review, analysis and implementation were commenced. 24/7 on-site and telephonic RN oversight available to staff and residents.	

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{R 008}	Continued From page 2 care records were reviewed (Resident #5, #6, #9, #11, #17, #19 and #20) and they had experienced a change of condition. Additionally, the facility failed to provide assistance and monitoring of medications for 6 of 17 residents (Resident #4, #5, #8, #9, #10 and #13), whose medications were reviewed. The facility also failed to protect 1 of 1 resident's (Resident #7) right to refuse medical treatment and personal property. The facility failed to protect 1 of 1 resident's (Resident #9) right to privacy. The facility further failed to coordinate care for 1 of 4 sampled residents (Resident #17), who had outside service providers. The findings include: I. Retention of a Resident Resident #18, a 65 year-old male, was admitted to the facility on 6/17/11 with diagnoses that included diabetes and multiple sclerosis. Resident #18 was discharged from the facility on 12/28/12 and was not available for interview. A. Pressure Ulcer Stage III The "National Pressure Ulcer Advisory Panel [NPUAP]" described the following pressure ulcers: * Stage II pressure ulcer - a shallow open ulcer without slough. * Stage III pressure ulcer - Full thickness tissue loss and slough may be present * Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.	{R 008}	Resident # 18 has been discharged from the facility. Resident #20 has experienced subsequent episode diagnosed at the hospital as a TIA. Current RN performed assessment at alert of onset of symptoms; resident was transported 911 to the ER and treated accordingly. A return from the hospital triggered an assessment by facility RN. Incident and Accident Report followed all current facility policies and procedures. Resident #11-all changes of condition are reported to all care staff, facility RN and administrator via shift reports. The electronic communication is responded to with instructions from facility RN, daily. All reported events/changes of condition are reviewed by Administrator and RN daily. Resident #5-a full investigation was completed and reported to family regarding medication error. Daily monitoring of all medication exceptions and variations are monitored and reviewed by facility RN and Administrator. As necessary, investigations are conducted following facility policies and procedures.	

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{R 008}	Continued From page 3 IDAPA 16.03.22.152.05.b states that "No resident will be admitted or retained who requires ongoing skilled nursing care not within the legally licensed authority of the facility. Such residents include: ix. A resident with a Stage III or IV pressure ulcer;" A facility "Skin and Body Assessment" form, dated and signed by the facility nurse on 12/8/12, documented the resident was seen by home health three times per week for wound care. Resident #18's "Resident Assessment Form," dated 12/8/12, documented that the resident had skin problems. On the side of the assessment, was a handwritten note, documenting the resident was to be seen by a wound clinic and home health agency. A physician's order, dated 9/8/12, documented "...start home health wound care for an eschar covered pressure ulcer to his right Achilles heel area." According to the NPUAP, the eschar in the heel ulcer, indicated the ulcer was unstageable on 9/8/12. A physician's order, dated 10/2/12, documented Resident #18 was referred to a wound clinic for wound care. Home health "Skilled Nursing Notes" documented the following: *On 9/11/12, "Pressure ulcer on heel of right foot...unable to stage, slough present. I asked patient to see MD at the wound clinic for evaluation due to wound proximity to tendon."	{R 008}	Resident #9 has discharged from the facility. Resident #19 has been assessed and monitored by the facility RN on an ongoing basis. The caregivers shift reports properly all episodes of symptoms. Medical services have been sought for any symptoms beyond baseline. RN and Administrator track ongoing condition and have recommended emergent services and contract services to this Resident's guardian. Resident #6 is seen by hospice on an almost daily basis. Hospice has been instructed to debrief caregiving staff immediately following client visit. Care staff sign off on visit notes. RN reviews all visit notes daily for and provides instructions and follow up as necessary. Resident #17 has been re-admitted to facility with Department of Health and Welfare approval based on facility RN and facility consultant RN assessment and coordination of care. Home health services and a comprehensive care plan to direct care staff are in place. Facility RN monitors and reviews all cares and treatments daily.	

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{R 008}	Continued From page 4 *On 9/15/12, "Pressure ulcer on heel of right foot unable to stage; slough present, necrotic [dead] tissue partially covering wound bed..." *On 9/19/12, "Pressure ulcer on right heel of right foot, unable to stage; slough present. Wound bloody/sanguineous with foul odor. Wound bed color red, purple, tan/brown, wet moist. Necrotic tissue partially covering wound bed...status of the wound is deteriorated." Home health "Skilled Nursing Notes," from 10/8/12 through 12/21/12, documented Resident #18's pressure ulcer on the back of his right foot was a Stage III. The notes documented the ulcer had further breakdown, which was exhibited by: foul smelling drainage, necrotic tissue, eschar and slough. "Wound Clinic Care Notes," from 10/2/12 through 12/11/12, documented Resident #18 had a Stage III pressure ulcer on his right Achilles. The notes documented the pressure ulcer had a significant amount of drainage, which had a foul odor. The notes also documented the pressure ulcer had an exposed tendon and necrotic tissue present. Between 9/8/12 and 12/21/12, Resident #18 had a pressure ulcer on his right Achilles heel, which was first documented as unstageable and then was documented as a Stage III pressure ulcer. On 1/9/13 at 1:42 PM, the former nurse stated Resident #18 had a Stage III and/or unstageable pressure ulcer, but he refused to go to the physician to have the ulcer evaluated because he did not want to move out. The former nurse further stated, the administrator was aware of the Stage III and/or unstageable pressure ulcer and	{R 008}	Resident #4 has discharged from the facility. Resident #10 receives medication as signed doctor's orders reflect and provided by the pharmacy in a timely fashion. Facility RN has set a schedule with doctor's office regarding generation of narcotics prescription sent to pharmacy, giving pharmacy adequate time to fill and deliver medications on a monthly basis. Resident #13-All doctor's orders, current medication lists and electronic MAR have been reviewed, audited and reconciled. The facility RN completed audit. Resident #5 Facility has reviewed facility policy with family regarding timely notification and delivery of medications, when provided by family instead of facility pharmacy. The family and facility RN have agreed on a schedule of alert. If medication is not delivered to facility in a timely manner, the facility will order medication per doctor's order and maintain medication delivery/administration as prescribed by resident's physician.	

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{R 008}	<p>Continued From page 5</p> <p>did not give the resident a 30 day notice.</p> <p>On 1/10/13 at 12:10 PM, the administrator confirmed Resident #18 had a Stage III and/or an unstageable pressure ulcer. She further stated she did not know the facility could not retain a resident who had an unstageable pressure ulcer.</p> <p>On 1/14/12, at 11:40 AM, Caregiver F stated Resident #18's foot was not healing well.</p> <p>The facility retained Resident #18 for three months after he developed a pressure ulcer that exceeded the level the facility was licensed to care for.</p> <p>B. MRSA</p> <p>IDAPA rule 16.03.22.152.05.b states that "No resident will be admitted or retained who requires ongoing skilled nursing care not within the legally licensed authority of the facility. Such residents include:</p> <p>xi. A resident who has MRSA in an active stage."</p> <p>A home health "Skilled Home Care Visit Report," dated 10/2/12, documented the resident's "wound" was cultured and tested positive for active MRSA. This report was signed by the administrator.</p> <p>A "Provider's Orders and Progress Note," dated 10/5/12, documented Resident #18 tested positive for active MRSA. The order also documented to reculture the pressure ulcer on 10/29/12.</p> <p>A facility "24 Hour Shift Report," dated 10/12/12, documented, "Isolated in room. Use standard</p>	{R 008}	<p>Daily review by facility RN of all medication exceptions assures immediate identification and correction in medication administration to residents.</p> <p>#5 medications-orders have been reviewed by facility RN. RN has verified dosage and amounts necessary and available to properly administer medications by care staff. Family is transitioning receipt of medications to facility pharmacy to correct past lag-times from mail order pharmacy and repackaging needs to ensure availability of medications to facility for proper dispensing.</p> <p>In addition to daily shift reports of any change of condition observed or reported by resident and/or family by/to care giving staff, RN and Administrator review and document follow up assessments and investigations. RN provides instructions to staff via EMAR email for continued monitoring and education.</p> <p>Resident #8-treatments or missed treatments are reviewed daily by facility RN.</p> <p>Resident #9 has discharged from facility.</p>	



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NAME OF PROVIDER OR SUPPLIER BRONCO SENIOR SERVICES DBA HILLCREST		STREET ADDRESS, CITY, STATE, ZIP CODE 1093 S HILTON STREET BOISE, ID 83705		
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{R 008}	Continued From page 6 universal precautions..." A home health "Skilled Nursing Note," dated 10/17/12, documented Resident #18's wound clinic visit had been canceled as the resident could not be transported in the facility van, due to having active MRSA. The note also documented the resident had not been transferred to skilled care, but was "confined to room due to MRSA." A home health "Skilled Nursing Note," dated 10/22/12, documented, "Isolation precautions contact MRSA." A home health "Skilled Nursing Note," dated 10/29/12, "Await results of culture last week. Pt is anxious to have infection cleared so he can leave his room." A "Provider's Orders and Progress Note," dated 10/29/12, documented the resident could be released from isolation as the MRSA in the wound was clear. On 1/9/13 at 1:42 PM, the former nurse stated Resident #18 had active MRSA and was in isolation for a week in the facility. She stated the administrator refused to give the resident a discharge notice when his wound culture came back positive for active MRSA. On 1/11/13 at 1:58 PM, Caregiver C confirmed Resident #18 had a MRSA infection. The caregiver further stated staff had to gown up when they went into the resident's room, because of the MRSA. On 1/11/13 at 3:25 PM, Caregiver H stated staff had to "gown up" to go in Resident #18's room due to the MRSA.	{R 008}	Resident #7 All staff have been in-serviced on facility policy and procedure on receiving medications via mail for residents. Resident #7 has expressed satisfaction that his rights are being upheld. Administrator reviews medication receipt log and follows up with Resident to ensure that the medications were delivered according to facility policy and ensuring his rights. B. Measures: Daily review of clinical processes (see Attachment A) by Administrator, Consultant and RN. A daily list of priorities and actions is agreed upon for execution. Daily review of previous day's list is executed for follow up and completion. All systems (paper and electronic are reviewed). Current Assessments, NSAs and Care Plans have been completed and implemented to the agreement of Resident/Responsible Parties and facility. Facility has retained a full-time RN. The RN reviews all contract services agencies visit documentation,	

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{R 008}	<p>Continued From page 7</p> <p>On 1/14/13 at 11:40 AM, Caregiver F stated they were not told why Resident #18 was isolation to his room.</p> <p>On 1/14/13 at 4:00 PM, the administrator confirmed Resident #18 was in the building at least two weeks with active MRSA.</p> <p>The facility retained Resident #18 for 23 days, after he was diagnosed as having active MRSA</p> <p>The facility retained Resident #18, who they were not licensed to care for, as the resident had an unstageable/Stage III pressure ulcer with an active MRSA infection.</p> <p>II. Emergency Intervention/Nursing Assessments when residents had changes in condition</p> <p>A nurse's note, dated 12/9/12, documented staff should direct all nurse's questions to the shift lead (who was an unlicensed assisted person) or to the on-call lead, also a UAP.</p> <p>On 1/9/13 at 12:28 PM, Caregiver A and a random caregiver stated they reported changes of condition to the day/evening shift lead caregiver (who was not a licensed medical professional) and he then determined "who needs to be told."</p> <p>On 1/9/13 at 1:42 PM, the former facility nurse stated she had been on-call 24 hours a day for months because the facility refused to give on-call hours to the LPN. The nurse stated to resolve the issue, the administrator designated herself as the on-call person, even though she was not a licensed medical professional. The nurse further stated, the administrator only</p>	{R 008}	<p>specifically addressing wound care, staging and discharge to appropriate level of care for all Stage III and above as well as looking for any MRSA. Upon retention of RN the facility has appropriately coordinated wound care staging and successful discharge of two residents requiring higher level of care.</p> <p>Change-of-condition is communicated, responded to and followed up as follows: Immediate notification via EMAR email to all care staff and administration, telephonic notification to RN and Administrator, written shift report and an Incident/Accident Report if applicable.</p> <p>RN reviews gathered information (vitals, range of motion, observed behaviors, conditions of resident), assesses scope of condition and delivers verbal and written instructions to care staff. RN completes follow-up assessment, investigates and documents and reviews with Administrator.</p>	

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{R 008}	<p>Continued From page 8</p> <p>notified her when residents had "extreme changes." The nurse stated, the procedure was later changed and the caregivers were to notify the shift leads of residents' changes in conditions. She stated the shift leads would then notify the administrator, who would determine a course of action.</p> <p>On 1/9/13 at 9:19 AM, Caregiver B stated when residents had a change in condition, staff were to first notify the shift leads, then if the shift leads felt that a resident required further care, staff were then allowed to notify the nurse.</p> <p>On 1/9/13 at 11:03 AM, the facility's contract nurse stated she had been told by the day/evening shift lead caregiver (who was not a licensed medical professional) that she would be notified of issues "only if it's important." The contract nurse confirmed she had not been notified of residents' changes of conditions.</p> <p>On 1/11/13 at 1:53 PM, Caregiver C stated it was the facility's policy to notify the shift lead of changes of condition and the shift lead would determine if it warranted calling a nurse.</p> <p>On 1/11/13 at 3:00 PM, the former LPN stated she was not notified of changes of condition. She stated, initially the calls for changes of condition were supposed to go to the facility RN. However, the administrator changed the practice. The nurse stated, "[Administrator's name] decided to have the calls go to her and she would make the decision" about whether the RN was called or not. The LPN further stated she quit working for the facility, because she felt her license was in jeopardy due to not being allowed to do her job.</p> <p>On 1/14/13 at 11:40 AM, Caregiver F stated if a</p>	{R 008}		

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{R 008}	<p>Continued From page 9</p> <p>resident had a change of condition, they would notify the shift lead. The caregiver stated, the shift lead would then document the concern and determine if the facility contract nurse needed to be notified.</p> <p>On 1/14/13 at 4:00 PM, the administrator stated when the facility was utilizing a contract nurse, residents' changes of condition went through the shift lead. She further stated the shift lead would determine if the facility's contract nurse needed to be called. The administrator stated the facility contract nurse should have reviewed the shift notes and followed up on any issues. However, she confirmed that "issues" had not been addressed.</p> <p>On 1/15/13 at 11:01 AM, Caregiver D stated when the former nurse left, the facility hired a contract nurse and staff were told they could not call the contract nurse without permission from the administrator. The caregiver stated the facility recently hired a new nurse, but staff have had limited contact with him. The caregiver further stated, "So pretty much all of nursing questions go through the [Day/evening shift lead caregiver's name]," (who was not a licensed medical professional).</p> <p>On 1/16/13 at 4:05 PM, Caregiver E stated that when a resident had a change of condition, the staff notified the shift lead and also passed the information onto the next shift at shift change. The caregiver stated the staff had not "had anyone to call and haven't really had a nurse."</p> <p>The facility had multiple nursing changes between November 2012 and January 2013. During this time, caregivers were told to report changes of condition to the shift lead and</p>	{R 008}	<p>C. Monitoring</p> <p>The facility RN and Administrator has 24/7 real-time access to electronic EMAR to address alerts (Incident and Accidents, Medication Incident reports, MARs, TARs and shift reports). Alerts can only be cleared by RN or Administrator after follow up directives, investigations and reporting or logs are updated. Monthly review by Administrator and RN to align services and reviews with Administrator.</p> <p>The facility has a medication delivery log and policy that all staff have been in-serviced on. Medication receipt is noted via electronic email, and shift report to all administration. RN reviews for current doctor's order then executes proper administration of medication via EMAR. Any additional quantities not on medication carts is logged in and maintained by RN in the controlled med room. Staff were specifically in-serviced on Residents opening their own mail, then staff logging medication in log.</p> <p>A letter dated January 16, 2013 was sent to families and residents explaining regulations and the periodic audits by staff of medications in apartments.</p>	

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{R 008}	<p>Continued From page 10</p> <p>administrator, who were not licensed medical professionals. The shift lead and administrator would determine if the facility nurse needed to be notified.</p> <p>For the following examples, the facility did not ensure an RN was notified to assess residents' changes of conditions. Without an RN's assessment, it could not be determined if emergency/medical interventions were warranted:</p> <p>1. Resident #20, a 93 year-old female, was admitted on 10/22/07 with diagnoses that included high blood pressure and a prior stroke.</p> <p>According to womenshealth.gov website, a transient ischemic attack or TIA can last for a few minutes or as long as a day. One sign that a person is experiencing a TIA is, "sudden confusion or trouble talking or understanding speech...." The website further documented if a person experiences the above sign, 911 should be immediately summoned as a TIA can be a sign that a full stroke may occur.</p> <p>An incident report, dated 11/6/12 at 9:45 AM, documented the hair dresser informed a caregiver that Resident #20 was having a difficult time talking while she was getting her hair done. The incident report further documented, the caregiver went to the resident's apartment and the resident "was not able to speak [sic] at all" and "wasn't sure what was happening." The incident report further documented the caregiver checked the resident's vital signs and the resident was placed on 2 hour checks. The incident report did not document the facility nurse was notified of the incident or that the resident was medically evaluated at the time of the incident.</p> <p>There were no care notes, nursing notes or other</p>	{R 008}	<p>provided to billing statements for cares.</p> <p>Monitoring systems include: head-to-toe skin assessments by RN upon admission or change-of-condition; daily review of contract services visit reports, in-servicing of staff regarding observation and documentation of skin integrity. Staff successfully trigger RN involvement and timely coordination of care via email, EMAR documentation and shift reports.</p> <p>D. Facility will be in substantial compliance with this deficiency by March 20, 2013.</p> <p>E. Facility Consultant provides daily support and review of all processes and completes a weekly review of completion and compliance.</p> <p>Compliance of this core deficiency satisfies non-core deficiency items: 1-23</p>	

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{R 008}	<p>Continued From page 11</p> <p>incident reports which documented the resident's condition prior to or after the incident on 11/6/12.</p> <p>A hospital history and physical, dated 11/20/12 between 2:15 PM and 3:25 PM, documented, the resident had been in "in her usual state of health until earlier this morning at approximately 8:30 when she developed inability to speak and inability to find the right words." The history and physical also documented the resident had been experiencing these symptoms "off and on in increasing fashion over the last 2 months, approximately 1 per week, that increased to about 1 to 2 per week, and then she has had one of these episodes every day for the last 3 days." The history and physical documented the episode on 11/20/12 at 8:30 AM had been the longest episode the resident had experienced, as it lasted between 1.5 and 2 hours. Additionally, the history and physical documented the resident had experienced "similar symptoms in January 2011" when she had been diagnosed as having a stroke. The history and physical diagnosed the resident as having a TIA.</p> <p>Resident #20, who had experienced a stroke in January 2011, had an episode on 11/6/12, where she was not able to converse with staff, a sign of a stroke. There was no documentation the nurse had been notified of the resident's changes in speech. Additionally, there was no indication the resident was medically evaluated, until 11/20/12.</p> <p>According to the history and physical, the resident had been experiencing frequent and increased episodes of not having the ability to talk for 2 months. There was no documentation that Resident #20 was medically assessed at any time during that 2 month time-frame, to address the changes in her physical condition. This placed</p>	{R 008}		

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{R 008}	<p>Continued From page 12</p> <p>Resident #20 at risk for suffering a permanent disability from an untreated stroke.</p> <p>2. Resident #11, an 83 year-old female, was admitted to the facility on 11/9/09 with diagnoses that included diabetes and neuropathy.</p> <p>During the facility tour, on 1/7/13 at 11:45 AM, Resident #11 was observed in her room, laying on the couch. She was coughing and stated she had been sick for over a week. She stated she had not felt well for a "long time." She said she could not remember if the facility nurse had assessed her. She stated the caregivers knew she was not feeling well.</p> <p>A progress note, dated 11/21/12 at 8:00 PM, documented the resident "threw up" while laying in bed and had taken a fever reducer for a temperature of 100 degrees. When the caregiver took the resident's temperature at 9:30 PM, her temperature was still 100 degrees. It further documented, the day/evening shift lead caregiver, who was not a licensed medical professional, directed caregivers to give the resident a fever reducer. There was no documentation the facility nurse was notified.</p> <p>A "Shift Communication Log," dated 11/21/12 for the 2:00 PM to 10:00 PM shift, documented the "resident was in her room shaking, saying she wasn't feeling good. I brought her hot tea that seemed to help. Fever of 100 F [Fahrenheit]."</p> <p>A "Shift Communication Log," dated 12/24/12 for the 2:00 PM to 10:00 PM shift, documented, "resident says that lately every morning she feels weak and cold until noon/1 PM. She says when she stands up she feels light-headed and tired and all she wants to do all day is sleep."</p>	{R 008}		

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{R 008}	Continued From page 13 A progress note, dated 12/27/12, documented the resident was not feeling well. A "Shift Communication Log," dated 12/27/12, documented the resident was "not feeling good today." A "Shift Communication Log," dated 1/1/13, documented the "resident was not feeling well and did not come down to lunch." On 1/9/13 at 11:35 AM, the facility contract nurse stated that she had not been notified Resident #11 had been ill since November. She further stated, caregivers reported changes in condition to the day/evening shift lead caregiver, who was not a licensed medical professional. She stated she was not notified unless it was deemed "important" by the shift lead. On 1/9/13 at 3:10 PM, Resident # 11 was observed lying in her bed and stated she had recently seen a physician and was diagnosed with pneumonia. On 1/9/13 at 3:20 PM, the facility's contract nurse stated she was not aware that Resident #11 had recently been to the physician or that she was diagnosed as having pneumonia. From 11/21/12 through 1/9/13, Resident #11 had a temperature of 100 degrees and had thrown-up. During this time, it was also documented the resident had felt light-headed, weak and tired. There was no documentation the facility nurse had been notified of Resident #11's changes in health nor was it documented the resident had been medically evaluated or treated until 1/9/13.	{R 008}		

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{R 008}	<p>Continued From page 14</p> <p>3. Resident #5, a 79 year old-male, was admitted on 8/16/12 with diagnoses which included artrial fibrillation, hypertension, peripheral vascular disease and coronary artery disease.</p> <p>An e-mail from the day/evening shift lead caregiver, dated 11/11/12 at 7:37 PM, documented there had been a medication error. The e-mail documented that between 11/7 and 11/11/12, Resident #5 had three Exelon Patches on his body at one time.</p> <p>On 1/8/13 at 8:58 AM, the resident's family member stated Resident #5's spouse had noticed the resident playing with his food and thought the resident had a stroke. The family member stated the spouse reported the concerns to the staff and staff called the family. The family member came into the facility and took the resident to the emergency room where he was found to be wearing several medication patches.</p> <p>On 1/8/13 at 2:32 PM, the administrator stated facility staff had not witnessed Resident #5's change of condition. She stated the resident's spouse had observed the changes in his mental status and had contacted the family, who took Resident #5 into the emergency room to be evaluated.</p> <p>On 1/9/13 at 1:42 PM, the former nurse stated, Resident #5's spouse informed caregivers the resident was not really eating, as he had been playing with his food. The nurse stated the spouse suspected the resident had a stroke. The nurse further stated, she was told the caregivers called the administrator three or four times over the weekend to inform her of the resident's mental status changes. She stated she had not been informed that Resident #5's was acting</p>	{R 008}		

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{R 008}	<p>Continued From page 15 differently until 11/12/11.</p> <p>On 1/11/13 at 3:00 PM, the former LPN stated she was never notified Resident #5 had experienced a change in his mental status. She further stated, the family was very upset because the day/evening shift lead caregiver, "tried to be a nurse" and take care of situation.</p> <p>On 1/15/13 at 11:01 AM, Caregiver D stated Resident #5 was not feeling well for "a good two to three days" before the resident was evaluated at the hospital.</p> <p>On 1/16/13 at 12:46 PM, Caregiver G stated Resident #5's spouse had reported the resident was "acting weird" and "having a stroke for about a week." The caregiver confirmed the former nurse was not notified of the resident's change in mental status.</p> <p>The emergency room report from 11/11/12, was not found in the resident's record. The facility could not locate a copy of the emergency report when it was requested during survey.</p> <p>There was no incident report or other care notes documenting what change of condition the resident experienced. Additionally, there was no documentation as to how long the resident was not "his usual self" prior to being seen by a medical professional.</p> <p>Between 11/7 and 11/11/12, Resident #5 had 3 Exelon Patches applied to his skin. At some point, the resident's spouse reported that he had a change in his mental status. The facility staff did not notify the nurse of the resident's change of mental status at that time, nor did the facility immediately seek to have Resident #5 medically</p>	{R 008}		

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{R 008}	Continued From page 16 assessed or treated. The resident was not treated until the family took the resident to the ER. 4, Resident #9, a 90 year-old male, was admitted to the facility on 1/7/12 with diagnoses that included mild cognitive impairment and depression. Progress notes, written by caregivers documented the following: *On 9/22/12 at 5:00 PM, Resident #9 "got very dizzy" in the dining room. The progress note documented the resident asked the caregiver to assist him back to his room. The progress note further documented that as the caregiver was taking the resident to his room, the resident started to fall and needed to be assisted into a wheelchair and escorted back to his apartment. *On 9/24/12, untimed, Resident #9 "was not feeling well" and his daughter requested the caregiver to check his blood pressure. The note also documented the daughter requested to have the resident's blood pressure checked again in the morning. *On 10/4/12, untimed, Resident #9 had requested to be medically evaluated as he had "woke up & thought he might be getting sick." The note documented the resident was out of the facility at a medical facility. There was no documentation the nurse had been notified or assessed Resident #9's dizzy spells, weakness, or blood pressure concerns. Additionally, the resident was not evaluated by a medical professional until 10/4/12, which was 12 days after he experienced dizziness.	{R 008}		

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{R 008}	<p>Continued From page 17</p> <p>On 1/7/13 at 12:00 PM, Resident #9 was observed standing with his walker in front of his walk-in closet. The resident stated he felt "weak and dizzy" and fell against the wall and started to slide to the floor. A surveyor assisted him to sit on his seated walker while she pushed the call light for help. The resident made his way to the sofa and stated he felt like he may "pass out." Two caregivers arrived to check on him at 12:27 PM, 27 minutes later. One caregiver checked the resident's vital signs and told the resident she would notify the day/evening shift lead, who was not a licensed medical professional, of how the resident was feeling. The caregiver also stated the shift lead would determine if a nurse needed to be called. Additionally, the caregiver reported to the surveyor that the resident had not been himself "all weekend."</p> <p>On 1/8/13 at 9:40 AM, Resident #9 stated "[Day/evening shift lead caregiver's name] came to my room yesterday and said you look okay to me and left." Resident #9 stated he had not been seen by a nurse, only the "[Day/evening shift lead caregiver's name]."</p> <p>On 1/9/13 at 11:45 AM, the facility's contract nurse stated, "Caregivers should have reported that episode to me." She further stated, "I never get called because it is up to the [Day/evening shift lead caregiver's name] or the [Administrator's name] to decide if or when I should be called."</p> <p>On 1/14/13 at 11:25 AM, the day/evening shift lead caregiver (who was not a licensed medical professional) stated the nurse was not called for Resident #9 because he thought Resident #9 "looked better."</p>	{R 008}		

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{R 008}	<p>Continued From page 18</p> <p>Resident #9 experienced dizziness and weakness, which were not reported to the facility nurse. Without a licensed professional's evaluation, the seriousness of his symptoms could not be examined or treated.</p> <p>5. Resident #19, a 94 year-old female, was admitted to the facility in 6/09 with diagnoses that included hypertension, depression and anxiety.</p> <p>On 11/21/12, A fax sent from a facility caregiver to the physician, documented the resident fell and complained of feeling dizzy. There was no documentation indicating the RN was notified or assessed Resident #19's after she felt dizzy and fell.</p> <p>On 11/28/12 at 2:00 PM, A physician's visit report documented Resident #19 was seen at her physician's office for "Hip pain - post fall; left hip pain goes into back and down her leg as well."</p> <p>The resident was not medically evaluated until 7 days after her fall.</p> <p>On 1/9/13 at 10:30 AM, Resident #19 was observed sitting on her seated walker in a hallway. She was observed telling medications aides and the administrator that she was having "chest pain" and wanted to be seen by her physician. A medication aide stated she had given the resident some Advil for pain. The resident was observed to continue complaining of chest pain, so a medication aide called the resident's son to have him talk to the resident. The administrator stated, Resident #19 "has good days and bad ones." She stated, when the resident complains of chest pain or not feeling well, it was usually a behavior, so "we call her son and he comes in and gets her settled down." The</p>	{R 008}		

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{R 008}	Continued From page 19 facility nurse was not observed to be notified of Resident #19's complaints of chest pain. An unsigned NSA, dated 11/14/11, did not document Resident #19 had a behavior of frequently complaining of chest pains. On 1/10/13 at 9:30 AM, the facility's contract nurse stated she was not aware of Resident #19's complaints of chest pain. She stated, she should have been called and informed of the situation, but was not. There was no documentation in Resident #19's record that she had been assessed by the facility RN when she experienced dizziness, hip pain and chest pains. Additionally, the resident was not medically evaluated when these physical changes of condition were reported to staff. 6. Resident #6, an 89 year-old female, was admitted to the facility on 4/16/10 with diagnoses that included hypertension and chronic obstructive pulmonary disease. A "Hospice Report Form," dated 10/19/12, documented the resident's "...eye was bugging her last night...." A "Hospice Note," dated 11/5/12, documented the resident had redness under her right eye and that the facility was notified. A "Hospice Report Form," dated 11/5/12, documented the resident had redness under her right eye and it was "bugging her." A "Hospice Note," dated 11/6/12, documented the redness under the resident's eye was getting worse.	{R 008}		

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{R 008}	Continued From page 20 A "Hospice Report Form," dated 11/6/12, documented the "redness under right eye getting worse-spreading to left eye and cheek." A "Hospice Aide Visit Note," dated 11/8/12, documented Resident #6 was "...extremely weak today. She was unable to stand and it took two people to get her in the wheelchair. CM [hospice case manager] notified. Right eye getting more red/swollen." A "Hospice Report Form," dated 11/14/12, documented the "... resident weak and a two person transfer." A "Hospice Report Form," dated 11/21/12, documented "When I came in the room, room reeked of urine. She was soaked in urine. She said she slept in her chair all night because she was unable to call for help and no one came in to help her...." A "Hospice Aide Visit Note," dated 11/21/12, documented Resident #6 was "found to be incontinent of urine. Pt reported slept in chair, phone not working-found unplugged. Reported no staff in to check on her." A "Hospice Health Report," dated 11/28/12, documented "...has red dots on her back. They don't look swollen & they don't bug her. CM & facility notified." There was no documentation the facility nurse was notified or assessed Resident #6's changes of condition which included: swelling and redness of her right eye, increased weakness, skin changes and incontinent issues.	{R 008}		

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{R 008}	<p>Continued From page 21</p> <p>7. Resident #17, an 89-year old male, was admitted to the facility on 12/9/07 with diagnoses that included hypertension, alcohol dependence and diabetes.</p> <p>An emergency department hospital report, dated 11/14/12, documented Resident #17 was diagnosed with "dehydration." Additionally, the report documented that Resident #17 needed to stay hydrated and return to the emergency room if he experienced "confusion," "fever," or "worsening weakness."</p> <p>A "Shift Assignment report," dated 11/15/12, documented Resident #17 was "very weak" and needed extra help. There was no further documentation that Resident #17 had returned to the emergency department as instructed by the hospital, after he experienced weakness on 11/15/12. Further, there was no documentation the facility RN had been notified or assessed him after he became "very weak" on 11/15/12.</p> <p>A "Shift Communication Log," dated 11/17/12, documented the resident was "still acting out of character, please watch and document."</p> <p>On 1/14/13 at 11:25 AM, the day/evening shift lead caregiver stated when Resident #17 became weak on 11/15/12, the RN should have been notified and assessed the resident, but had not. The caregiver further stated Resident #17's change of condition "fell through the cracks."</p> <p>On 1/14/13 at 4:19 PM, the administrator stated she was not aware of Resident #17's change of condition or the hospital instructions to return to the emergency department if signs of weakness were observed. She confirmed the resident should have been assessed by the facility RN or</p>	{R 008}		

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{R 008}	<p>Continued From page 22</p> <p>evaluated by a physician.</p> <p>There was no documentation that Resident #17 had returned to the emergency department as instructed by the hospital, after he experienced weakness on 11/15/12. Further, there was no documentation the facility RN had been notified or assessed Resident #17 after he became "very weak" on 11/15/12.</p> <p>The facility failed to provide medical care and/or assessment for Resident #5, #6, #9, #11, #17, #19 and #20 when they experienced changes in their mental or physical condition.</p> <p>III. Assistance and Monitoring of Medications</p> <p>1. Resident #4, a 59 year-old male, was admitted to the facility on 6/26/12 with diagnoses of hypertension and diabetes. The admission and discharge record documented the resident was discharged on 12/21/12.</p> <p>A. Insulin</p> <p>A physician's order, dated 7/18/12, documented: the resident was to receive the following Novolog at mealtimes for blood sugar of:</p> <p>*0 - 100 Units, no Novolog *100 - 200 = 60 units. *Greater than 200 = 65 units.</p> <p>Resident #4's October 2012 MAR documented that on 10/11/12, the above order was discontinued and the following change was implemented:</p> <p>"Novolog Flex, Inject by subcutaneous route per protocol, presently 60 units with each meal,</p>	{R 008}		



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{R 008}	<p>Continued From page 23</p> <p>adjusted for blood glucose."</p> <p>Resident #4's record did not contain a physician order that was congruent with the change in Novolog dosages noted on the October 2012 MAR. Additionally, there was no documentation indicating what "adjusted for blood glucose" meant.</p> <p>Resident #4's November 2012 and December 2012 MARs, did not document the amount of insulin given. It was unclear from the MARs if the resident received 60 units of Novolog or if additional units were given to "adjust for blood glucose."</p> <p>On 1/8/13 at 11:00 AM, Caregiver K stated Resident #4 was assisted with his insulin and he received "60 units no matter what." The caregiver stated it was unclear what "adjusted for blood glucose" meant.</p> <p>On 1/8/13 at 2:20 PM, the administrator stated she was unaware there were no clear orders in Resident 4's record indicating the amount of insulin he should have received.</p> <p>On 1/9/13 at 11:00 AM, the facility contract nurse stated she was unaware of how much insulin Resident #4 should be taking. She confirmed "adjusted for blood glucose" needed clarification.</p> <p>On 1/9/12 at 2:15 PM, a former nurse stated she worked at the facility until the middle of November, and "there was a sliding scale for his insulin."</p> <p>On 1/11/13 at 3:15 PM, the former LPN stated, she recalled Resident #4 was on 60 units with each meal and also had a sliding insulin scale.</p>	{R 008}		

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{R 008}	<p>Continued From page 24</p> <p>On 1/11/13 at 3:30 PM, Caregiver H stated Resident #4 received 60 units with each meal and a sliding scale.</p> <p>The facility did not provide appropriate assistance and monitoring of Resident #4's insulin. It was unclear what amount of Novolog insulin he was required to take, as a clear insulin order was not present in his record.</p> <p>B. Levaquin</p> <p>Resident #4's record contained a physician's order, dated 12/18/12, which documented he was on Levaquin 500 mg daily.</p> <p>Resident #4's December 2012 MAR did not document the resident received the Levaquin.</p> <p>On 1/8/13 at 10:10 AM, the day/evening shift lead caregiver confirmed the order was not implemented and stated the order was "somehow missed."</p> <p>On 1/8/13 at 2:20 PM, when asked about the Levaquin order, the administrator stated, "I thought [Day/evening shift lead caregiver's name] already told you the order was missed."</p> <p>A history and physical, dated 12/21/12, documented "Patient had been previously started on Levaquin 500 mg p.o. daily for suspected osteomyelitis [an infection of the bone or bone marrow] in his left small toe."</p> <p>Levaquin was not implemented as ordered to treat Resident #4's suspected osteomyelitis.</p> <p>C. Medication discrepancies</p>	{R 008}		

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{R 008}	<p>Continued From page 25</p> <p>Resident #4's record contained emergency department discharge orders, dated 11/4/12. The orders documented that Lasix, lisinopril and spironolactone were to be held until the resident's next follow-up appointment. It was not documented when the resident's follow-up was scheduled or if he attended the follow-up appointment.</p> <p>Resident #4's November and December 2012 MARs documented the following:</p> <p>*lisinopril 10 mg was given the entire two months and not put on hold on 11/4/12 as ordered.</p> <p>*Lasix 40 mg twice daily was not given from 11/4/12 through 11/10/12. Lasix was documented as given, the rest of the month of November and December 2012:</p> <p>*spironolactone was not given on the 5th through the 10th of November. It was given on the 11th and 12th of November, but not for the remainder of the month or anytime in December.</p> <p>There were no orders in Resident #4's record, documenting that Lasix and spironolactone were to be resumed.</p> <p>On 1/8/13 at 2:25 PM, the administrator was asked about the discrepancies. She stated she would fax the resident's physician for clarification.</p> <p>On 1/9/13 at 9:45 AM, the facility contract nurse acknowledged that medication errors had occurred. She stated she had been so busy doing assessments to determine how much the facility could bill for each resident, that she had not been able to ensure medications were given as</p>	{R 008}		

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{R 008}	<p>Continued From page 26</p> <p>ordered.</p> <p>On 1/9/13 at 12:54 PM, a list of medications from the resident's physician's office were received at the facility. The list was not signed by the physician. During this time, the day/evening shift lead caregiver stated this was the most "up to date orders" and would be the orders he would follow. The list included Lasix 20 mg (not 40 mg) daily, not twice daily. All other medications were congruent with the November and December MARs except the list included clonidine, 0.2 mg daily. Clonidine was not documented on the Resident's November or December 2012 MAR. The October 2012 MAR listed clonidine as discontinued on 10/24/12. It was unclear if the resident's clonidine needed to be resumed.</p> <p>During the survey, the facility was not able to rectify the discrepancies with signed physician's orders. Therefore, it could not be determined if the resident had received the correct amount of Lasix, or whether the resident was to be on lisinopril, spironolactone or clonidine.</p> <p>2. Resident #10, a 59 year-old female, was admitted to the facility on 4/20/11 with a diagnosis of a traumatic brain injury.</p> <p>A physician's order, dated 11/20/13, documented the resident was to receive morphine sulfate 15 mg three times daily for pain.</p> <p>Resident #10's record contained a January 2013 MAR, which documented the resident was to receive: morphine sulfate 15 mg at 8:00 AM, 2:00 PM and 5:00 PM. On the following days, the medication was documented as "Not available:"</p> <p>*1/5: 5:00 PM dose</p>	{R 008}		



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{R 008}	<p>Continued From page 27</p> <p>*1/6: 8:00 AM, 2:00 PM, 5:00 PM dose *1/7: 8:00 AM, 2:00 PM, 5:00 PM dose</p> <p>On 1/7/12 at 11:30 AM, Resident #10 stated she had been in an accident and suffered "a lot of pain," as a result of injuries related to the accident. She stated she was very upset and currently in a lot of pain, because she had not received pain medication "since Friday." She further stated, "They don't get my meds renewed, then I am out."</p> <p>On 1/10/13 at 10:55 AM, the day/evening shift lead caregiver stated that morphine had to be renewed every 30 days by the physician, so sometimes there was a delay on waiting for the physician to reorder the medication. He further stated, staff were instructed to reorder the medication several days in advance to avoid a delay.</p> <p>On 1/10/13 at 11:55 AM, a pharmacy technician stated that while there was a 3 to 4 day delay in waiting for the physician to reorder the medication. The technician stated, the facility could have avoided the delay by reordering the medication a week before it ran out.</p> <p>On 1/15/13 at 11:40 AM, Caregiver D stated Resident #10 was "always running out of meds. [Day/evening shift lead caregiver's name] thinks she is drug seeking, so it is not his priority to get her meds."</p> <p>On 1/16/13 at 4:05 PM, Caregiver E stated that "A few days ago" Resident #10 was given her last pain medications and this had been reported to the next shift. However, they stated they had no knowledge if the ordering of medication had been followed up on.</p>	{R 008}		

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{R 008}	Continued From page 28 Resident #10, missed 7 doses of pain medication, when the facility failed to reorder her medications in a timely manner. This failure caused Resident #10 to suffer with unnecessary pain. 3. Resident #13, a 81 year-old male, was admitted to the facility on 11/11/2005 with diagnoses of diabetes and hypertension. A. lisinopril Resident #13's record contained a history and physical, dated 10/9/12, which documented, "D/C [discontinue] lisinopril. I believe that his blood pressure is so low that he will not need anything else." In another section of the history and physical, it was documented, "Stop lisinopril 10 mg, 1 tab(s) orally, once a day." Resident #13's October, November and December 2012 MARs documented lisinopril 10 mg was given each day. Resident #13's record contained an incident report, dated 10/10/12, which documented, "Got report of Res in hall on floor. Res had a low BP. Stated he felt weak. Leaned up against the wall and slide [sic] to the floor..." Resident #13's physician discontinued lisinopril on 10/9/12, due to low blood pressure, which the facility did not implement. On 10/10/12, Resident #13 fell due to weakness and had a "low BP." On 1/10/13 at 10:00 AM, the facility contract nurse stated she was unaware that lisinopril had been discontinued and would fax the physician for clarification.	{R 008}		



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{R 008}	<p>Continued From page 29</p> <p>4. Resident #5, a 79 year-old male, was admitted to the facility on 8/16/12 with diagnoses which included artrial fibrillation, hypertension, peripheral vascular disease and coronary artery disease. Resident #5 was taken to the hospital on 1/4/13, and was out of the facility during the survey.</p> <p>A. Plavix</p> <p>A physician's order, dated 11/12/12, documented the resident was to receive Plavix 75 mg once a day.</p> <p>The November 2012 MAR, documented the resident did not receive Plavix due to the "medication not available" on the following dates: *11/13/12, 11/14/12, 11/15/12, 11/17/12, 11/18/12, 11/20/12, 11/26/12 and 11/30/12.</p> <p>On 1/9/13 at 8:58 AM, Resident #5's family member stated the facility did not give timely notice to them when medications needed to be re-filled and often waited until the pills were gone to notify the family. The family member further stated that on occasion, it took a couple of weeks to get the medications re-filled.</p> <p>On 1/10/13 at 3:26 PM, the day/evening shift lead careglver stated if the resident's medications came from a non-facility pharmacy, it was the family's responsibility to order medications and to make sure the medications were available for the residents.</p> <p>Resident #5 missed 8 doses of Plavix during the month of November because medications were not available in the facility.</p>	{R 008}		

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{R 008}	Continued From page 30 B. Coumadin/warfarin A physician's order, dated 11/5/12, documented Resident #5 should receive the following amounts of warfarin on the following days: warfarin 10 mg Monday, Wednesday and Friday warfarin 7.5 mg Tuesday, Thursday, Saturday and Sunday The physician's order, dated 11/5/12, also documented to hold the warfarin dose on 11/6/12. The November 2012 MAR, documented Resident #5 was assisted with both 10 mg and 7.5 mg on 11/5/12 (Monday). The resident received 17.5 mg of warfarin instead of the 10 mg, as ordered. The November 2012 MAR, documented Resident #5 was assisted with both 10 mg and 7.5 mg of warfarin on 11/6/12 (Tuesday). The resident received 17.5 mg of warfarin, instead of the medication being held. A physician's order, dated 11/12/12, documented Resident #5 should receive warfarin 10 mg every day. The November 2012 MAR, documented Resident #5 was assisted with 7.5 mg of warfarin rather than the ordered 10 mg on the following dates: * 11/13/12 (Tuesday) * 11/15/12 (Thursday) * 11/17/12 (Saturday) * 11/18/12 (Sunday) Resident #5 was assisted with 2.5 mg less of warfarin on 4 occasions, between 11/13 and 11/18/12, than what was ordered.	{R 008}		



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{R 008}	<p>Continued From page 31</p> <p>A physician's order, dated 11/19/12, documented Resident #5 should receive warfarin 7.5 mg every day.</p> <p>The November 2012 MAR, documented Resident #5 was assisted with 10 mg of warfarin on 11/19/12.</p> <p>The physician's order, dated 11/19/12, also documented the warfarin dose should be held on 11/20/12.</p> <p>The November 2012 MAR, documented Resident #5 received 7.5 mg of warfarin on 11/20/12, when the medication should have been held.</p> <p>The November and December 2012 MARs, documented Resident #5 received 10 mg of warfarin, rather than the 7.5 mg ordered on 11/19/12 on the following days:</p> <ul style="list-style-type: none"> * 11/26/12 (Monday) * 11/28/12 (Wednesday) * 11/30/12 (Friday) * 12/03/12 (Monday) * 12/05/12 (Wednesday) <p>Resident #5 received 2.5 mg above the ordered 7.5 mg dose on 6 occasions between 11/19 and 12/5/12. Additionally, Resident #5 received 7.5 mg of warfarin on 11/20/12, when it was ordered to be held.</p> <p>In November 2012, Resident #5 received the incorrect amount of warfarin on 13 occasions. On two of those occasions, the warfarin should have been held.</p> <p>5. Resident #8, a 92 year old male, was admitted</p>	{R 008}			

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{R 008}	<p>Continued From page 32</p> <p>to the facility on 11/30/09 with diagnoses which included diabetes and congestive heart failure.</p> <p>A "Skin and Body Assessment," dated 12/2/12, documented Resident #8's skin was dry and he had "cellulitis" on his left lower leg.</p> <p>A physician's order, dated 11/2/12, documented the resident was to be assisted with triamcinilone cream twice a day.</p> <p>The December 2012 MAR, documented Resident #8 was to be assisted with triamcinilone cream on his legs every night by 6:30 PM. However, the MAR documented the resident was not assisted with triamcinilone cream on the following days, as the medication was not available:</p> <p>*12/6/12, 12/7/12, 12/8/12, 12/9/12, 12/11/12, 12/12/12, 12/13/12 and 12/15/12.</p> <p>On 1/7/13 at 11:15 AM, Resident #8 stated he needed to have a cream put on his legs at night and the facility always ran out of the cream. He stated the facility did not reorder the cream until they ran out. He stated recently he went 11 days without the cream and his legs were very dry, flaky and painful.</p> <p>On 1/10/13 at 11:26 AM, the home health nurse stated the resident should be assisted with putting cream on his leg at least once a day. She stated she was not aware that the facility did not have the cream available.</p> <p>Resident #8 was not assisted with his cream for eight days because the medication was not available at the facility.</p> <p>6. Resident #9, a 90 year-old male, was admitted</p>	{R 008}		

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{R 008}	<p>Continued From page 33</p> <p>to the facility on 1/7/12 with diagnoses that included depression.</p> <p>A. Plavix</p> <p>On 1/7/13 at 9:30 AM, Resident #9 stated he asked his physician to discontinue his Plavix, because he had concerns about the side-effects of the medication. The physician agreed to discontinue the medication and as far as the resident knew, he had not been receiving it.</p> <p>On 1/8/13 at 9:27 AM, Resident #9's medications were observed in the medication cart. One of the resident's bubble packs read, "Plavix 75 mg daily."</p> <p>Resident #9's December 2012 and January 2013 MARs documented Resident #9 received Plavix 75 mg daily.</p> <p>Resident's #9's record did not contain a physician's order for the medication. Between 1/7/13 and 1/16/13, the facility was not able to find the original order or obtain a physician's order for Resident #9's Plavix.</p> <p>On 1/7/13 at 11:45 AM, the day/evening shift lead caregiver stated he was not able to find the order for Resident #9's Plavix and would request an order from the physician.</p> <p>Resident #9 was assisted with 39 doses of Plavix in December and January, without his knowledge. Additionally, the facility assisted Resident #9 with a medication, in which they did not have a current physician's order.</p> <p>The facility failed to provide assistance and monitoring of medications to Resident #4, #5, #8,</p>	{R 008}		

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{R 008}	Continued From page 34 #9, #10 and #13. IV. Resident Rights A. The right to refuse medical treatment According to IDAPA 16.03.22.550.12. Control and Receipt of Health-Related Services, "d. the right to refuse medical services based on informed decision making.... i. the facility must document the resident has been informed of the consequences of the refusal; ii. the facility must document that the resident's physician...has been notified of the resident's refusal." 1. Resident #9, a 90 year-old male, was admitted to the facility on 1/7/12 with diagnoses that included depression. On 1/7/13 at 9:30 AM, Resident #9 stated the facility had taken over managing his prescription medications. "[Day/evening shift lead caregiver's name] got involved and told me he had called my doctor and told the doctor I was refusing to take some of my medications and that I was no longer able to handle my own medications." The resident stated, "I did refuse to take Plavix. I researched the medication and didn't like the side-effects and warnings I read about the drug." Resident #9 further stated, "I called my doctor and told him that I was not going to take Plavix. The doctor told me that he would discontinue the order for it." Resident #9 stated he was not assessed by a nurse, or informed by a nurse, that he was no longer capable to manage his medications.	{R 008}		

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{R 008}	<p>Continued From page 35</p> <p>Resident #9 stated, "[Day/evening shift lead caregiver's name] and the administrator, (who were not licensed medical professionals), made the decision that I was no longer capable to handle my own medications."</p> <p>Resident #9's record contained a "Resident Assessment Form," dated 10/24/12, which documented the resident "required routine oral medication management..."</p> <p>Resident #9's record was reviewed and did not include a nursing assessment to reflect the reason why the facility began managing his prescription medications. There was nothing documented by the nurse or caregivers that he had refused to take his Plavix or other medications. The facility also did not document the resident had been informed of the consequences of refusing any medications. Additionally, the facility did not document that Resident #9's physician had been notified of the resident refusing to take his medications, including Plavix.</p> <p>Caregivers' notes and nursing notes were reviewed from 9/23/12 through 1/16/12. There was no documentation found that Resident #9 had refused to take his prescribed medications.</p> <p>On 1/7/13 at 9:42 AM, the day/evening shift lead caregiver stated, "[Resident #9's name] refused to take his Plavix that was ordered." The caregiver further stated that Resident #9's refusal to take the Plavix was not "a safe decision."</p> <p>On 1/7/13 at 2:13 PM, the administrator stated she could not locate a nursing assessment that documented Resident #9 was not capable to independently manage his medications.</p>	{R 008}			

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{R 008}	<p>Continued From page 36</p> <p>The facility did not allow Resident #9 to refuse his Plavix and took his ability to manage his prescription medications away from him. Additionally, the facility did not ensure a registered nurse evaluated the resident's ability to safely self-medicate, prior to taking away his right to do so.</p> <p>B. Right to retain personal property</p> <p>According to IDAPA 16.03.22.550.04.c Requirements for Residents' Rights, "The administrator must assure thatEach resident has the right to retain and use his own personal property in his own living area so as to maintain individuality and personal dignity."</p> <p>The facility's Policy and Procedure Manual, documented the following: "the RN, must evaluate each Resident with self-medication orders. This should be completed at move in and quarterly or upon change of condition to determine if they can administer their own medications...Residents who need assistance with the administration of their medications must have written authorization from their physician...Residents who are receiving assistance with the administration of their medications by community staff may keep their medications in their own apartment."</p> <p>1. Resident #9, a 90 year-old male, was admitted to the facility on 1/7/12 with diagnoses that included depression.</p> <p>On 1/7/13 at 9:30 AM, Resident #9's room was observed to have two medi-sets on the kitchen counter with a variety of medications in them. It was unclear what medications were inside of the</p>	{R 008}		

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{R 008}	Continued From page 37 medi-sets as they were not labeled. Additionally, there were over 50 medications observed in the walk-in closet and on the kitchen counter. On 1/7/13 at 2:13 PM, the administrator stated she could not locate a nursing assessment that documented Resident #9 was not capable to independently manage his medications. On 1/8/13 at 10:55 AM, the day/evening shift lead caregiver was questioned as to why medications were still present in Resident #9's room, if the facility was managing them. He stated he was not aware that Resident #9 had other medications in his room. The caregiver further stated, "I took all those medications out of his room. He must have bought more medications and brought them in. He still drives his car, so he probably went to the store for the over-the-counter medications." He stated, "I am going to go get those meds out of his room right now, because it is against the facility's policy for those medications to be in his room." On 1/9/13 at 9:10 AM, Resident #9 stated, "[Day/evening shift lead caregiver's name, a Medication Tech's name and a new caregiver] came in to my room and cleaned me out of all my meds without saying a word to me." On 1/9/13 at 11:00 AM, Caregiver K stated Resident #9 was very upset when the day/evening shift lead caregiver went into his room and took his medications without his permission. The caregiver further stated, "[Day/evening shift lead caregiver's name] has taken over the medication department since the former RN left a few months ago." On 1/9/13 at 11:40 AM, the facility contract nurse	{R 008}		

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(R 008)	<p>Continued From page 38</p> <p>stated she had assessed Resident #9 in December. She stated the assessment did not include the resident's ability to manage his own medications. The nurse further stated the day/evening shift lead caregiver should not have been allowed to take Resident #9's medication out of his room. She stated the resident should have been assessed by a nurse to determine if he was able to safely self-administer his medications.</p> <p>On 1/14/13 at 11:40 AM, Caregiver F stated the resident was upset his medications being taken from him and told staff, "You are violating my rights by taking my medications away from me."</p> <p>On 1/14/13, a typed note was sent to Licensing & Certification which documented the following regarding Resident #9: "...Since [Day/evening shift lead caregiver's name] removed [Resident #9's name] medication from his room through intimidation, the resident is very upset and left the facility...He is very angry at [Day/evening shift lead caregiver's name]."</p> <p>The facility did not ensure a registered nurse evaluated whether Resident #9 could safely self-administer medications, prior to removing the resident's medications from his room.</p> <p>The facility failed to protect Resident #9's right to refuse medical treatment and his right to his personal property.</p> <p>C. Privacy</p> <p>According to IDAPA 16.03.22.550. Requirements for Residents' Rights, "The administrator must assure that policies and procedures are implemented to assure that residents' rights are</p>	(R 008)		

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{R 008}	<p>Continued From page 39</p> <p>observed and protected....."</p> <p>.02 "Privacy. Each resident must be assured the right to privacy with regard to accommodations, medical and other treatment, written and telephone communication...."</p> <p>The facility's Policy and Procedure Manual, dated 09/2012, documented under "General Guidelines", item #3 "...Always tell the Resident what you are going to do, why you are going to do it and ask his or her permission before you do it..."</p> <p>1. Resident #7, a 93 year-old male, was admitted to the facility on 3/31/12 with diagnoses that included diabetes and hypertension.</p> <p>A "Resident Assessment Form," dated 4/23/12, documented Resident #7 ordered and managed his own medications.</p> <p>Resident #7 was interviewed on 1/8/13 at 7:15 AM, and stated, "I'm tired of them opening my mail, because I have some high powered drugs that are in the envelope."</p> <p>From 1/07/13 through 1/16/13, three caregivers stated they were instructed to open the Resident #7's mail before giving it to the resident because narcotics were often sent, which required tracking.</p> <p>On 1/10/13 at 2:40 PM, Resident #7's spouse stated caregivers brought her husband's mail already opened. She stated her husband had not agreed to the caregivers opening his mail and that he did not like the practice.</p> <p>On 1/14/13 at 4:38 PM, the administrator stated</p>	{R 008}		

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{R 008}	Continued From page 40 she was not aware of Resident #7's mail being opened before staff delivered it to his room. There was no documentation found in Resident #7's record that he had agreed to having his mail opened prior to receiving it. The facility did not protect a resident's rights to privacy when they opened his mail, without his permission. The facility did not protect Resident #9's right to refuse medical treatment nor his right to his personal property. Additionally, the facility did not protect Resident #7's right to privacy, when they opened his mail without his permission. V. Coordination of Care Resident #17, an 89 year-old male, was admitted to the facility on 12/9/07, with diagnoses that included hypertension, alcohol dependence and diabetes. A. Foley Catheter A "24 Hour Shift Report," dated 10/16/12, documented Resident #17 returned to the facility with a Foley catheter and leg bag. Resident #17's record did not contain instructions on what assistance the resident needed with his Foley catheter or how to care for the Foley catheter. A "Home Health Certification and Plan of Care," dated 1/3/13, documented home health began providing care for Resident #17's Foley catheter. The care plan documented his Foley catheter was changed on 1/3/13. The care plan	{R 008}		

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NAME OF PROVIDER OR SUPPLIER BRONCO SENIOR SERVICES DBA HILLCREST		STREET ADDRESS, CITY, STATE, ZIP CODE 1093 S HILTON STREET BOISE, ID 83705		
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{R 008}	<p>Continued From page 41</p> <p>documented the resident reported the Foley catheter was "not changed for 5-6 weeks." The care plan also documented his foley was to be changed "every 4 weeks starting 1/3/13." Additionally, the care plan documented home health would visit every other day to assist the resident.</p> <p>A "Resident Assessment Form," dated 12/11/12, documented Resident #17 was independent with toileting. The "Notes" section documented the resident had a Foley catheter that was being taken care of by home health. However, home health was not started until 1/3/13.</p> <p>Resident #17 had a Foley catheter in place from 10/16/12 to 1/3/13, with no documentation identifying who was to care for the catheter or what type of assistance or care was to be provided. On 1/3/13, home health was initiated to care for the catheter; however, it was unclear who managed the resident's catheter care needs when home health was not present at the facility.</p> <p>B. Wound & Skin Care</p> <p>Resident #17's "Home Health Certification and Plan of Care," was faxed to the facility on 1/9/13. The care plan documented that Resident #17 had a "diabetic/neuropathic ulcer on the first metatarsal head of the bottom of the left foot." The care plan documented the ulcer may need to be debrided by an RN, "Silver PolyMem" needed to be applied to the wound bed and "optifoam" needed to be shaped in a circle to relieve direct pressure on his wound site. Additionally, the care plan documented the wound dressing needed to be changed twice a week and as needed for drainage.</p>	{R 008}		

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{R 008}	<p>Continued From page 42</p> <p>The "Home Health Certification and Plan of Care," also documented Resident #17 had right lower extremity "cellulitis with mild redness to knee" and one to two pitting edema to the right knee.</p> <p>A "Skilled Home Care Visit Report Form," dated 1/3/13, documented Resident #17 needed to stay seated as much as possible and limit his walking due to his diabetic foot ulcer.</p> <p>A second "Skilled Home Care Visit Report Form," dated 1/3/13, documented staff were to use lotion on the resident's bilateral lower extremities. The report also documented the caregivers needed to place a "tubigrip" on the resident's right leg and compression hose on the left leg.</p> <p>There was no documentation Resident #17's wound was debrided. Nor was there documentation the wound had been treated or the dressing changes had been changed. Additionally, there was no documentation that lotion, tubigrip or compression hose were applied to Resident #17's legs.</p> <p>Resident #17 was interviewed, on 1/10/13 at 10:05 AM, and stated home health services were started on 1/1/13. He stated home health assisted him with his catheter care, wound care and physical therapy to strengthen his legs.</p> <p>On 1/10/13 at 10:39 AM, the day/evening shift lead caregiver and the administrator (who were not licensed medical professional) stated they were unaware Resident #17 was receiving home health services.</p> <p>On 1/14/13 at 4:21 PM, the administrator stated she was not aware Resident #17 had a diabetic</p>	{R 008}		

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{R 008}	Continued From page 43 foot ulcer. The facility was not aware Resident #17 had home health services. The facility failed to provide oversight of Resident #17's care needs, as they did not ensure the resident's Foley catheter was changed as ordered. The facility was also not aware that Resident #17 had a diabetic ulcer on his foot nor did they ensure the resident received wound care as ordered by a physician. The facility also did not ensure Resident #17's cellulitis was treated or that the orders to treat the cellulitis were implemented. The facility did not provide oversight or coordinate Resident #17's care needs to ensure his foley catheter was changed, wound care was provided as ordered and cellulitis treatments were initiated. The facility retained Resident #18, who had a Stage III pressure ulcer and active MRSA. The facility failed to provide medical care and/or assessment for Residents #5, #6, #9, #11, #17, #19 and #20, when they experienced a change of condition. Additionally, the facility failed to provide assistance and monitoring of medications for Residents #4, #5, #8, #9, #10 and #13. The facility also failed to protect Resident #7 right to refuse medical treatment and personal property. The facility further failed to protect Resident #9's right to privacy. Additionally, the facility failed to coordinate care for Resident #17, who had an outside service provider. These failures resulted in inadequate care. REPEAT CORE DEFICIENCY	{R 008}		
{R 009}	16.03.22.525 Protect Residents from Neglect. The administrator must assure that policies and	{R 009}		

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{R 009}	<p>Continued From page 44</p> <p>procedures are implemented to assure that all residents are free from neglect.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review it was determined the facility did not protect 2 of 8 sampled residents (Residents #4 and #17), who experienced changes of condition, from neglect. The findings include:</p> <p>IDAPA 16.03.22.011.24 defines neglect as "Failure to provide...medical care necessary to sustain the life and health of a resident."</p> <p>1. Resident #4, a 59 year-old male, was admitted to the facility on 6/26/12 with diagnoses of hypertension and diabetes. The admission and discharge record documented the resident was discharged on 12/21/12.</p> <p>Resident #4's record contained a fax from the former facility RN to the physician, dated 11/7/12, which documented, "Resident has a sore on Rt [right] leg that is increasing in size and depth. Would you like Home Health ordered or do you want to see him?"</p> <p>A "Physician's Review & Visit Form," dated 11/12/12, documented, "Dress right lower leg daily. Remove exudate [drainage], place Silvadene, Telfa pad and wrap. Wound Clinic Consult placed."</p> <p>There was no documentation in the record indicating the wound treatment ordered on 11/12/12 was implemented.</p> <p>A "Physician's Review & Visit Form," dated 11/16/12, documented Resident #4 was to visit</p>	{R 009}	<p>3. Ref. 16.03.22.525</p> <p>A. Corrective Actions A State approved consultant and full-time facility RN were retained. A systemic review, analysis and implementation were commenced. This review included proper delegation, training and observation of staff in the execution of care and compliance to proper scope of practice, 24/7 on-site and telephonic RN oversight available to staff and residents.</p> <p>Resident #4 has been discharged from facility.</p> <p>Resident #17 has been re-admitted to facility with Department of Health and Welfare approval based on facility RN and facility consultant RN assessment and coordination of care. Home health services and a comprehensive care plan to direct care staff are in place. Facility RN monitors and reviews all cares and treatments daily.</p>	

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{R 009}	<p>Continued From page 45</p> <p>the wound clinic on 11/20/12, and "needs shoe stretched @ L [left] 5th toe..." There was no documentation in the resident's record indicating the order to have his shoe stretched was implemented.</p> <p>A "Physician's Review & Visit Form," dated 11/20/12, documented the resident was to wear Tubigrip stockings on his left lower leg during all waking hours. The physician also ordered an Unna boot to his right leg, which was to be changed by the facility on 11/23/12. Additionally, the physician documented that the open area on the resident's right leg was to be protected with an "absorbant pad" and was ordered to be changed by the facility on 11/23/12. The physician ordered a follow-up at the wound clinic in one week.</p> <p>There was no documentation in the record the resident's Unna boot or right leg dressing was changed on 11/23/12.</p> <p>A "Physician's Review & Visit Form," dated 12/4/12, documented the resident was to have Nystatin powder and "Interdry AG fabric" daily between his toes. The resident was now to wear Unna boots bilaterally; the dressing was to be changed on his right lower extremity twice a week, with one of those dressing changes occurring at the wound clinic. The physician also ordered dressing changes to Resident #4's left fifth toe, which was also to be changed twice weekly, with one dressing change occurring at the wound clinic.</p> <p>There was no documentation in the resident's record the ordered treatments between the toes, to the left 5th toe, or to the right lower extremity were implemented. Further, there was no</p>	{R 009}	<p>B. Measure</p> <p>Daily review of clinical processes (see Attachment A) by Administrator, Consultant and RN. A daily list of priorities and actions is agreed upon for execution. Daily review of previous day's list is executed for follow up and completion. All systems (paper and electronic are reviewed). Current Assessments, NSAs and Care Plans have been completed and implemented to the agreement of Resident/Responsible Parties and facility.</p> <p>Communication with doctor's offices regarding clarification, new orders, and/or refills are documented in Nurses Notes and Physician Communication forms in the resident medical record. Notes are entered into EMAR per RN instruction.</p> <p>RN and Administrator reviews med exception and variance reports daily to track incidences trends and unusual occurrences. Investigation follows as necessary.</p>	

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{R 009}	<p>Continued From page 46</p> <p>documentation the Unna boots were implemented.</p> <p>The facility contract nurse documented on a "Skin and Body Assessment," dated 12/7/12, "Unable to see skin. Done at wound clinic."</p> <p>A "Physician's Review & Visit Form," dated 12/11/12, documented the physician ordered the facility to change a dressing to Resident #4's left 5th toe on Friday and Saturday with "Algidex Ag 1/4" and "continue placement of Lotrimin cream" between left toes. He also ordered "Interdry Ag" between left toes.</p> <p>There was no documentation in the record the 12/11/12 orders were implemented.</p> <p>A physician's report, dated 12/18/12, documented, "Left 5th toe wound, related to poor shoe fit and complicated by diabetes...An MRI has been ordered for this patient's left foot, as this wound is worsening, as evidenced by increased depth...[Facility's name] was called."</p> <p>A "Wound Care Order," dated 12/18/12, documented "Bactobran" was to be applied three times daily to Resident #4's fifth toe and an "absorb pad to cover." "Web spaces" were to be applied bilaterally to Resident #4's feet. Unna boots were to be applied twice weekly and a "Darco Wedge" was to be used to elevate his left foot.</p> <p>There was no documentation in Resident #4's record the 12/18/12 orders were implemented.</p> <p>A fax to the physician, dated 12/19/12, documented the facility was unable to do wound care and the resident did not qualify for home</p>	{R 009}	<p>C. Monitoring The facility RN and Administrator has 24/7 real-time access to electronic EMAR to address alerts (Incident and Accidents, Medication Incident reports, MARs, TARs and shift reports). Alerts can only be cleared by RN or Administrator after follow up directives, investigations and reporting or logs are updated. Monthly review by Administrator and RN to align services provided to billing statements for cares.</p> <p>Monitoring systems include: head-to-toe skin assessments by RN upon admission or change-of-condition; daily review of contract services visit reports, in-servicing of staff regarding observation and documentation of skin integrity. Staff successfully trigger RN involvement and timely coordination of care via email, EMAR documentation and shift reports.</p> <p>D. Facility will be in substantial compliance with this deficiency by March 2, 2013.</p> <p>E. Facility Consultant provides daily support and review of all processes and completes a weekly review of completion and compliance.</p>	

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{R 009}	Continued From page 47 health. "He will have to go to he wound clinic for dressing changes." There was no documentation informing the physician that dressing changes had not been implemented by the facility as ordered. On 12/19/12, "Physician's Orders" from the wound clinic, documented, "Spoke with [day/evening shift lead caregiver's name] from [Facility's name] regarding wound care." The clinic note further documented the caregiver reported that the facility was not able to provide wound care and had not been providing wound care. Additionally, the clinic note documented the facility received the orders. A hospital report, dated 12/24/12, documented Resident #4 was diagnosed with osteomyelitis and possible septic arthritis in his left 5th toe. The report further documented, "I learned from my nurse today that his assisted living is not doing any wound care or compression, as we had been sending them orders to do so. We have talked to the manager regarding this and he is going to see that the orders are taking care of." On 1/8/13 at 10:40 AM, the day/evening shift lead caregiver confirmed facility staff did not provided Resident #4's wound care. On 1/8/13 at 11:00 AM, Caregiver K stated the resident had received all of his wound care at the wound clinic and did not recall facility staff performing any wound care. On 1/8/13 at 2:20 PM the administrator stated she recalled that Resident #4 had a fall resulting in an abrasion, which was not healing and had been treated at the wound clinic. She stated the facility did not do his wound care.	{R 009}	Facility has retained a full-time RN. The RN reviews all contract services agencies visit documentation, specifically addressing wound care, staging and discharge to appropriate level of care for all Stage III and above as well as looking for any MRSA. Upon retention of RN the facility has appropriately coordinated wound care staging and successful discharge of two residents requiring higher level of care. Change-of-condition is communicated, responded to and followed up as follows: Immediate notification via EMAR email to all care staff and administration, telephonic notification to RN and Administrator, written shift report and an Incident/Accident Report if applicable. RN reviews gathered information (vitals, range of motion, observed behaviors, conditions of resident), assesses scope of condition and delivers verbal and written instructions to care staff. RN completes follow-up assessment, investigates and documents and reviews with Administrator.	

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{R 009}	Continued From page 48 On 1/9/13 at 11:00 AM, the facility contract nurse stated, "I don't know who was doing the wound care. We couldn't get nursing to come in to do the care." On 1/9/13 at 2:20 PM, a former facility nurse stated during her employment, she recalled the resident required daily dressing changes. She confirmed daily dressing changes were not done for Resident #4. On 1/9/13 at 2:38 PM, Resident #4 was interviewed at his current facility. He stated, "They [the facility] would not take care of serious wounds, which is why I am here now. I have a hole in my foot." On 1/11/13 at 3:00 PM, the former LPN stated she was not aware of the ordered dressing changes for Resident #4. She stated that the facility RN had attempted to get home health services to provide the wound care for Resident #4, as the facility was unable to provide the wound care. On 1/14/13 at 10:30 AM, Caregiver F stated they did not recall any wound care being done for Resident #4. From 11/12/12 until 12/18/12 (36 days), multiple physician's orders for wound care were ordered. However, the RNs, LPN, administrator, lead caregiver, resident and physician stated the wound care had not been done at the facility. Nor was there documentation the facility nurse had monitored and evaluated Resident #4's wound, to ensure appropriate healing. The failure to implement physician orders for wound care lead to Resident #4 developing a serious infection	{R 009}	All staff have reviewed and signed off on Resident's Rights as part of the facility Policies and Procedures. These rights, specifically the right of a resident to refuse medications, treatments, and/or cares, a resident's right to privacy and property was discussed at an all-staff meeting. Proper mail delivery was also reviewed. C. Monitor: The facility RN and Administrator has 24/7 real-time access to electronic EMAR to address alerts (Incident and Accidents, Medication Incident reports, MARs, TARs and shift reports). Alerts can only be cleared by RN or Administrator after follow up directives, investigations and reporting or logs are updated. Monthly review by Administrator and RN to align services provided to billing statements for cares. The Life Enrichment Coordinator fields any questions or concerns at the monthly resident's meeting regarding the Resident's Rights. Information is captured in the meeting minutes. A copy of minutes is given to Administrator for record and follow-up/investigation, as necessary.	

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{R 009}	Continued From page 49 (osteomyelitis) in the bone of his toe. 2. Resident #17, an 89 year-old male, was admitted to the facility on 12/9/07 with diagnoses that included hypertension, alcohol dependence and diabetes. A "24 Hour Shift Report," dated 10/16/12, documented Resident #17 returned to the facility with a Foley catheter and leg bag. Resident #17's record did not contain instructions on what assistance the resident needed with his Foley catheter or how to care for the Foley catheter. Further, the facility RN had not assessed his ability to self-manage his new leg bag and Foley catheter. A "24 Hour Shift Report," dated 10/22/12, documented Resident #17's "leg bag is leaking, resident stated that he will call in AM to get it fixed." The was no further documentation that the leg bag had been fixed or that staff had followed up on the issue. Additionally, there was no documentation the facility RN had been notified the leg bag was leaking or had assessed Resident #17 health status regarding his leaking leg bag. A "Skin and Body Assessment," completed by the facility RN, dated 12/11/12, documented Resident #17 had a Foley catheter and his bilateral legs were "noted to be red and scaley." There was no further documentation the facility RN had followed up, made recommendations, or sought or provided treatment for Resident #17's skin condition. A "Skin Integrity Monitoring form," dated 12/24/12, completed by an unlicensed caregiver,	{R 009}	D. Facility will be in substantial compliance with this deficiency by March 20, 2013. E. Facility Consultant provides daily support and review of all processes and completes a weekly review of completion and compliance. Compliance of this core deficiency satisfies non-core deficiency items: 24-36	

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{R 009}	Continued From page 50 documented Resident #17's "R [right] foot, leg bag allegedly 'leaked'- top of foot is very red, skin has peeled off, #9 toe very large, purple discoloration - I used a basin w/warm soapy water to clean area - rinsed and patted dry -advised to not put sock back on to allow area to breath." The Skin Integrity Monitoring form also documented Resident #17's "leg bag needs to be fixed to avoid this issue." The following is from "MOISTURE LESIONS: THE EFFECT OF URINE AND FECES ON THE SKIN," Wound Essentials, Volume 3, 2008; "In severe cases, the skin can be so badly damaged that a moisture lesion develops - these are painful and require prompt treatment to prevent them growing in size.... There is a clear link between incontinence and the formation of pressure ulceration, hence the inclusion of continence status in many pressure ulcer risk assessment tools (Norton et al, 1975; Towney and Erland, 1988; Waterlow, 1988)... Healthcare professionals must be very clear that if moisture lesions are not treated correctly, they can worsen and the patient may develop secondary pressure damage or ulceration. Therefore, it is imperative that advice is sought immediately from a specialist practitioner, such as an infection control nurse, tissue viability nurse or continence advisor to ensure the patient receives the best possible care (http://www.wounds-uk.com/pdf/content_9427.pdf)." An "Incident/Accident Report," dated 12/27/12, documented Resident #17 had a red and swollen right foot with skin sloughing and "diabetic neuropathies." The report documented the nurse suspected sepsis related to his leaking catheter leg bag and Resident #17 was transported to the	{R 009}		

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NAME OF PROVIDER OR SUPPLIER BRONCO SENIOR SERVICES DBA HILLCREST		STREET ADDRESS, CITY, STATE, ZIP CODE 1093 S HILTON STREET BOISE, ID 83705		
(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
{R 000}	<p>Continued From page 51</p> <p>Hospital. The report also documented the resident was still in the hospital and had not been re-evaluated as of 12/31/12.</p> <p>Resident #17's record did not contain a report from his 12/27/12 - 12/31/12 hospital visit. Additionally, there were no discharge instructions from his 12/27/12 - 12/31/12 hospital visit.</p> <p>On 1/9/13 at 11:03 AM, the facility's contract nurse stated Resident #17's catheter bag had been leaking. She stated as a result urine soaked into his skin, which became inflamed and septic. She further stated, the resident had peripheral neuropathy and did not feel pain in his lower legs and feet when the skin started breaking down. She stated she was angry because no one saw anything or reported anything to me. The contract nurse stated, she cleaned the resident's leg and put on a Vaseline based gauze covering over his leg and sent him out non-emergency to the hospital.</p> <p>From 10/16/12 until 12/27/12, Resident #17's leg bag on his catheter was leaking on his diabetic neuropathic leg and foot. The facility did not ensure the leaking leg bag was replaced prior to the resident going to the hospital on 12/27/12 for sepsis in his leg.</p> <p>The facility failed to protect Resident #4 from neglect when they failed to treat his wounds and prevent serious infection in the bone of his toe and Resident #17 when they did not implement interventions to repair his leg bag which would have prevented sepsis developing in his leg. These failures led to neglect.</p> <p>REPEAT CORE DEFICIENCY</p>	{R 000}		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

MEDICAID LICENSING & CERTIFICATION - RALF
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name Bronco Senior Services DBA Hillcrest	Physical Address 1093 S Hilton St	Phone Number 345-4460
Administrator Cynthia Brewer	City Boise	Zip Code 83705
Team Leader Polly Watt-Geier	Survey Type Licensure, Follow-up and Complaint	Survey Date 01/16/13

NON-CORE ISSUES

Item #	RULE # 13.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	220.02	The facility admission agreements did not include if the residents could transition to Medicaid nor that there was an extra cost by using the non-facility pharmacy. Additionally, Resident #3, #9 & #10 did not have admission agreements signed by all responsible parties. Also, Resident #1, #10 & #11 did not have current admission agreements (Previously cited 10/7/11).	3/7/13	
2	225.01	The facility did not identify or evaluate Resident #2, #6, #7, #8 & #9's behaviors (Previously cited 8/28/12).	3/26/13	
3	225.02	The facility did not develop interventions for Residents #2, #6, #7, #8 & #9's behaviors. (Previously cited 8/28/12)	3/26/13	
4	300.01	The current nurse had not delegated nursing functions to staff (Previously cited 10/7/11). A facility RN did not document 90 day nursing assessments.	3/7/13	
5	300.02	Resident #6's oxygen order was not implemented as ordered.	4/3/13	
6	305	Nursing assessments did not include all required items in 305.01 through 305.08.	4/3/13	
7	305.02	There were no current medications orders for Resident #8 & #15 (Previously cited 10/7/11 & 8/28/12). Additionally, not all PRN medications were available as ordered.	4/4/13	
8	305.03	Residents were not assessed upon admission by the facility RN or for changes of condition, such as reflected in the shift change reports or observations made during the survey (Previously cited 8/28/12).	4/3/13	
9	305.04	The facility RN did not make recommendations to the administrator when residents had medical needs which required follow-up. For example: Sepsis, MRSA, Stage of pressure ulcers and issues related to Foley catheter.	3/26/13	

Response Required Date
02/15/13

Signature of Facility Representative

Date Signed

4/16/13

2 of 45

Reset Form

Print Form



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ASSISTED LIVING
Non-Core Issues
Punch List

Table with 3 columns: Facility Name, Physical Address, Phone Number, Administrator, City, Zip Code, Team Leader, Survey Type, Survey Date.

NON-CORE ISSUES

Table with 5 columns: Item #, RULE #, DESCRIPTION, DATE RESOLVED, L&C USE. Contains 20 rows of non-core issues.

Table with 3 columns: Response Required Date, Signature of Facility Representative, Date Signed.

3 d #5

Reset Form

Print Form



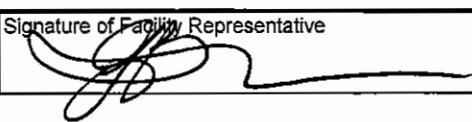
IDAHO DEPARTMENT OF
HEALTH & WELFARE

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P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name Bronco Senior Services DBA Hillcrest	Physical Address 1093 S Hilton St	Phone Number 345-4460
Administrator Cynthia Brewer	City Boise	Zip Code 83705
Team Leader Polly Watt-Geier	Survey Type Licensure, Follow-up and Complaint	Survey Date 01/16/13

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
21	350.01	The administrator was not notified of all incident and accidents, for example: elopement, medication errors, or unusual events (Previously cited 8/28/12).	3/26/13	
22	350.02	The administrator did not complete an investigation of all incidents, accidents and complaints (Previously cited 8/28/12).	3/26/13	
23	350.04	The administrator did not complete a written response of findings to complaintants within 30 days (Previously cited 10/7/11 & 8/28/12).	3/26/13	
24	625.03	There was no evidence the 16 hours of orientation included all the required content (325.03.a-l).	3/26/13	
25	630.01	9 of 9 staff did not have documented specialized training in dementia.	3/26/13	
26	630.02	9 of 9 staff did not have documented specialized training in mental illness.	3/26/13	
27	630.04	9 of 9 staff did not have documented specialized training in traumatic brain injury (Previously cited 10/7/11).	3/26/13	
28	700.01	The care notes did not include caregivers first and last names, signatures, nor time and date.	3/11/13	
29	711.01	The facility did not document when Residents #2, #6, #7, #8 & #9 exhibited behaviors to include specific time and date, interventions and effectiveness (Previously cited 8/28/12).	3/7/13	
30	711.04	The facility did not document when Resident #4 refused cares or treatments, nor that the resident was informed of the consequences. Additionally, there was no documentation the physician was notified of these refusals (Previously cited 8/28/12).	4/3/13	
31	711.08.b	Caregivers did not document the catheter care they provided to Resident #17.	3/26/13	
32	711.08.c	Caregivers did not document all unusual events nor the facility's response to those events.	3/26/13	
Response Required Date 02/15/13	Signature of Facility Representative 		Date Signed 1/16/13	



IDAHO DEPARTMENT OF

HEALTH & WELFARE Food Establishment Inspection Report

Residential Assisted Living Facility Program, Medicaid L & C
3232 W. Elder Street, Boise, Idaho 83705
208-334-6626

Critical Violations

Noncritical Violations

DBA Hillcrest

Establishment Name Bronco SR		Operator Cynthia Brewer	
Address 1093 S. Hutton St Boise ID 83705			
County ADA	Estab # 20828	EHS/SUR #	Inspection time: _____ Travel time: _____
Inspection Type: High		Risk Category: High	
Follow-Up Report: OR		On-Site Follow-Up:	
Date: _____		Date: _____	

Items marked are violations of Idaho's Food Code, IDAPA 16 02.19, and require correction as noted.

# of Risk Factor Violations	<u>0</u>	# of Retail Practice Violations	<u>0</u>
# of Repeat Violations	_____	# of Repeat Violations	_____
Score	<u>100</u>	Score	<u>100</u>
A score greater than 3 Med or 5 High-risk = mandatory on-site reinspection		A score greater than 6 Med or 8 High-risk = mandatory on-site reinspection	

RISK FACTORS AND INTERVENTIONS (Apply Food Code applicable sections in parentheses)
The letter to the left of each item indicates that item's status at the inspection.

	Item/Location	COS	R
<input checked="" type="radio"/> Y	1. Certification by Accredited Program, or Approved Course; or correct responses; or compliance with Code	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	4. Discharge from eyes, nose and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	7. Handwashing facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	13. Returned / reservice of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>

	Item/Location	COS	R
<input checked="" type="radio"/> Y	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	24. Additives / approved, unapproved (3-207)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Y	26. Compliance with variance and HACCP plan (8-201)	<input type="checkbox"/>	<input type="checkbox"/>

Y = yes, in compliance
N/O = not observed
COS = Corrected on-site
N = no, not in compliance
N/A = not applicable
R = Repeat violation
 = COS or R

Item/Location	Temp	Item/Location	Temp
Scrambled eggs	165°	Salad dressing	39.2°
Polish Sausage	180°	Spaghetti sauce	170°

GOOD PRACTICES (X = in compliance)

	COS	R		COS	R		COS	R
<input type="checkbox"/>			27. Use of ice and pasteurized eggs	<input type="checkbox"/>		34. Food contamination	<input type="checkbox"/>	
<input type="checkbox"/>			28. Water source and quantity	<input type="checkbox"/>		35. Equipment for temp. control	<input type="checkbox"/>	
<input type="checkbox"/>			29. Insects/rodents/animals	<input type="checkbox"/>		36. Personal cleanliness	<input type="checkbox"/>	
<input type="checkbox"/>			30. Food and non-food contact surfaces: constructed, cleanable, use	<input type="checkbox"/>		37. Food labeled condition	<input type="checkbox"/>	
<input type="checkbox"/>			31. Plumbing installed; cross-connection; back flow prevention	<input type="checkbox"/>		38. Plant food cooking	<input type="checkbox"/>	
<input type="checkbox"/>			32. Sewage and waste water disposal	<input type="checkbox"/>		39. Thawing	<input type="checkbox"/>	
<input type="checkbox"/>			33. Sinks contaminated from cleaning maintenance tools	<input type="checkbox"/>		40. Toilet facilities	<input type="checkbox"/>	
				<input type="checkbox"/>		41. Garbage and refuse disposal	<input type="checkbox"/>	
						42. Food utensils/in-use	<input type="checkbox"/>	
						43. Thermometers/Test strips	<input type="checkbox"/>	
						44. Warewashing facility	<input type="checkbox"/>	
						45. Wiping cloths	<input type="checkbox"/>	
						46. Utensil & single-service storage	<input type="checkbox"/>	
						47. Physical facilities	<input type="checkbox"/>	
						48. Specialized processing methods	<input type="checkbox"/>	
						49. Other	<input type="checkbox"/>	

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) <i>[Signature]</i>	(Print) Karen Anderson	Title Director	Date 1/16/13
Inspector (Signature) <i>[Signature]</i>	(Print) Karen Anderson	Date 1-16-13	Follow-up: (Circle One) Yes No



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

February 4, 2013

Cynthia Brewer, Administrator
Bronco Senior Services Dba Hillcrest
1093 S Hilton Street
Boise, ID 83705

Dear Ms. Brewer:

An unannounced, on-site Follow-up, Licensure and complaint investigation survey was conducted at Bronco Senior Services between January 7, 2013 and January 16, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005744

Allegation #1: An identified caregiver was physically rough and verbally aggressive with several residents.

Findings #1: Between 1/7/13 and 1/16/13, 42 residents were interviewed. All residents denied being mistreated by caregivers. Three family members were interviewed and stated staff members were caring and treated residents with dignity and respect. Eleven caregivers stated they had not heard any complaints from residents regarding being mistreated by any staff members, or witnessed any staff members being physically rough or verbally aggressive with residents.

Between 1/7/13 and 1/16/13, thirty-seven hours were spent directly at the facility. Staff members were observed treating residents in a kind manner.

The complaint log did not document complaints regarding staff being physically rough or verbally aggressive.

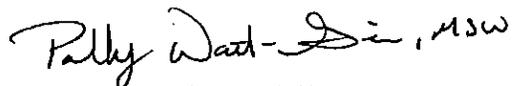
Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

- Allegation #2:** An identified caregiver did not assist residents with their needs.
- Findings #2:** Between 1/7/13 and 1/16/13, forty-two residents were interviewed. All residents stated caregivers were responsive to their requests and they received the assistance they needed. Three family members were interviewed and stated caregivers provided the care their loved ones required. Eleven caregivers stated they had not heard any complaints from residents not getting the cares they required.
- Between 1/7/13 and 1/16/13, thirty-seven hours were spent directly at the facility. Staff members were assisting residents with various tasks. Residents were observed well-groomed and dressed appropriately.
- The complaint log contained a complaint documenting that a resident expressed concerns when a caregiver encouraged him to be more independent with ADLs (activities of daily living). The caregiver was counseled and an apology was sent to the resident.
- Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.
- Allegation #3:** The administrator did not investigate all residents' complaints and respond to them in writing.
- Findings #3:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 and 350.04 for not investigating all complaints and providing a written response to all complainants. The facility was required to submit evidence of resolution within 30 days.
- Allegation #4:** The facility RN did not complete assessments on self-medicators to ensure they could safely self-medicate.
- Findings #4:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.06 for not ensuring the facility RN conducted assessments on residents who self-medicated, to ensure they were safe to do so. The facility was required to submit evidence of resolution within 30 days.

Cynthia Brewer, Administrator
February 4, 2013
Page 3 of 3

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG/

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



IDAHO DEPARTMENT OF
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P.O. Box 83720
Boise, Idaho 83720-0009
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FAX: 208-364-1888

February 4, 2013

Cynthia Brewer, Administrator
Bronco Senior Services DBA Hillcrest
1093 S Hilton Street
Boise, ID 83705

Dear Ms. Brewer:

An unannounced, on-site Follow-up, Licensure and complaint investigation survey was conducted at Bronco Senior Services between January 7, 2013 and January 16, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005801

- Allegation #1: The facility did not provide appropriate assistance and monitoring of medications.
- Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not providing appropriate monitoring and assistance of medications. The facility was required to submit a plan of correction.
- Allegation #2: The facility retained a resident with a stage III pressure ulcer.
- Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for retaining a resident with a Stage III or greater pressure ulcer. The facility was required to submit a plan of correction.
- Allegation #3: Medications were being pre-poured.
- Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.e for not ensuring staff did not pre-pour medications. The facility was required to submit evidence of resolution within 30 days.
- Allegation #4: The facility did not provide a secure environment to a resident who wandered.

Cynthia Brewer, Administrator
February 4, 2013
Page 2 of 2

Findings #4: Substantiated. However, the facility was not cited as they acted appropriately by implementing a wanderguard system and increased supervision to keep the identified resident safe.

Allegation #5: The administrator forced residents to sign "Terms of Endearment" agreements against their will.

Findings #5: Between 1/7/13 and 1/16/13, 42 residents, and eleven staff were interviewed. All residents denied being forced to sign "Terms of Endearment" agreements. Three residents confirmed they declined to sign them. Staff members stated they were not aware of the administrator forcing residents to sign "Terms of Endearment" agreements, but stated a few residents preferred not to be called terms of endearment and all staff were made aware of those residents.

On 1/14/13 at 11:05 AM, the shift lead caregiver stated "Terms of Endearment" forms were created, to obtain permission from residents to use terms of endearment, like "honey." He stated, residents were asked to sign them if they did not mind being called terms of endearment, and a few residents declined signing them. He further stated, terms of endearment were "second nature" for some caregivers, so the form was an effort to ensure residents' rights were not violated.

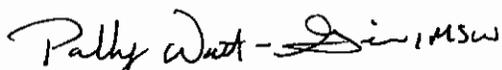
On 1/14/13 at 4:28 PM, the administrator denied forcing residents to sign "Terms of Endearment" agreements.

Twenty records were reviewed and did not contain "Terms of Endearment" forms.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



IDAHO DEPARTMENT OF
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February 4, 2013

Cynthia Brewer, Administrator
Bronco Senior Services DBA Hillcrest
1093 S Hilton Street
Boise, ID 83705

Dear Ms. Brewer:

An unannounced, on-site Follow-up, Licensure and complaint investigation survey was conducted at Bronco Senior Services between January 7, 2013 and January 16, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005821

Allegation #1: An unlicensed caregiver was bubble packing residents' medications.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01 for allowing an unlicensed caregiver to bubble pack medications. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Polly Watt-Geier, MSW

Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



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February 4, 2013

Cynthia Brewer, Administrator
Bronco Senior Services DBA Hillcrest
1093 S Hilton Street
Boise, ID 83705

Dear Ms. Brewer:

An unannounced, on-site Follow-up, Licensure survey and complaint investigation was conducted at Bronco Senior Services between January 7, 2013 and January 16, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005833

Allegation #1: Residents were not assisted with their medications as prescribed by their physicians.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not providing appropriate assistance and monitoring of medications. The facility was required to submit a plan of correction.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program