



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

May 9, 2013

CERTIFIED MAIL #: 7007 3020 0001 4050 8043

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

Dear Ms. Brewer:

I. BACKGROUND

Bronco Senior Services dba Hillcrest was initially licensed by the Department on July 1, 2011.

During an August 20 through 28, 2012, complaint investigation and follow-up survey, core issue deficiencies for inadequate care, exploitation and neglect were identified. The facility also received thirty-four (34) non-core deficiencies.

A follow-up, licensure and complaint investigation survey was conducted from January 7, 2013 through January 16, 2013. Repeat core issue deficiencies were identified for both neglect and inadequate care. Additionally, the facility received thirty-six (36) non-core deficiencies, fourteen (14) of which were repeat deficiencies from the August 2012 survey. The facility was placed on a provisional license, effective February 4, 2013 through June 4, 2013, required to hire a consultant, and admissions to the facility were limited. The facility consultant and administrator alleged they were back in compliance on March 20, 2013.

A follow-up survey to verify compliance was conducted April 22 through 29, 2013. Two additional complaints were also investigated during the survey. Sixteen (16) non-core deficiencies were identified, nine (9) of which had also been cited on each of the two previous surveys. The nine deficiencies cited on three consecutive surveys include: failing to evaluate behaviors that were distressing to the resident or to others; failing to develop interventions to address behaviors that were distressing to the resident or to others; failing to ensure medication orders were current and matched the medication assistance records; failing to ensure skin break down was assessed by the facility nurse; failing to have the facility nurse conduct an assessment to determine if residents who were administering their own medications were safe to do so; failing to ensure the residents' records (negotiated service agreements) correctly described both the status of the resident and the cares they required assistance with; failing to conduct investigations of resident incidents and injuries; failing to document what interventions were used and whether they were effective when residents exhibited behaviors; and failing to ensure residents were informed of the consequences of refused medications, and failing to notify the resident's physician of the refusals.

II. PROVISIONAL LICENSE and LIMIT ON ADMISSIONS

Bronco Senior Services' repeated failure to correct non-core deficiencies and to comply with the requirements for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) seriously impairs the ability of the facility to provide safe and adequate services to residents. As a result of the survey findings, the provisional license issued effective **February 4, 2013, through June 4, 2013 shall remain in place.** 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 for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22).
- 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, and who is approved by the Department, 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 must not be employed by the facility or company that operates the facility. **The consultant must verify that corrections for each identified deficiency are implemented not only for the residents identified in the survey, but for all residents in the facility.** The name and qualifications of the consultant will be submitted to the Department for approval no later than May 17, 2013.
- 3. Facility Nurses.** 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 facility is strongly encouraged to retain two, full time nurses, at least one of which has a minimum of five (5) years of experience in assisted living in Idaho.** 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 May 24, 2013, and every Friday thereafter. **The reports will address each non-core deficiency, including specific actions taken during that week by the consultant to verify that the facility is working to correct the deficiency, and including a list identifying each resident for whom the consultant conducted a quality assurance check and personally verified correction of the deficiency as it related to that resident. Should the consultant's reports fail to demonstrate thorough quality assurance measures and specific actions taken by the consultant to assure that the facility is correcting the deficiencies, the facility shall be required to obtain an alternate consultant.**
- 5. Compliance.** The facility will achieve substantial compliance with the rules for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) as demonstrated by having no core issue deficiencies identified

during the follow-up survey, and will ensure correction of all non-core deficiencies as demonstrated by no deficiencies repeated from either the January 16, 2013 or the April 29, 2013 Non-Core Issues Punch Lists.

6. Provisional License. The provisional license will continue to be prominently displayed in the facility.

III. 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 repeat deficiencies:

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 March 20, 2013 through April 29, 2013:

Penalty	Number of Deficiencies	Times number of Occupied Beds	Times Number of days of non-compliance	Amount of Penalty
\$10.00	9	58	41	\$ 214,020

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 fifty-eight (58) 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

Cynthia Brewer
May 9, 2013
Page 4 of 4

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 the continuation of the provisional license or the imposition of civil monetary penalties 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:

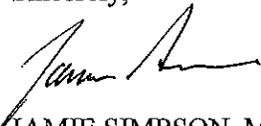
Tamara Prisock, Administrator
Licensing and Certification
Department of Health and Welfare
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

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

A follow-up survey will be conducted prior to the June 4, 2013 expiration of the provisional license. 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 core issue deficiencies exist, or any of the non-core issue deficiencies cited on the January 16, 2013 or April 29, 2013 are cited again, the Department will have no alternative but to proceed with revocation of the facility's license.

The Residential 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



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 Matt Hauser	Survey Type Complaint and Follow-up	Survey Date 04/29/13

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	221.01	Resident #1 was given a 15-day discharge notice.		7/11/13 RSLG
2	225.01	The facility did not evaluate Resident #1's behaviors (Previously cited on 8/28/12 and 1/16/13).		7/21/13 RSLG
3	225.02	The facility did not develop interventions for Resident #1 and #10's behaviors (Previously cited on 8/28/12 and 1/16/13).		7/21/13 RSLG
4	300.01	The facility RN did not document 90 day nursing assessments for all residents (Previously cited on 1/16/13).		7/21/13 RSLG
5	300.02	The facility did not ensure physician's orders were implemented appropriately, examples include but are not limited to: Resident #1's eye drops and Haldol, Resident #8's morphine, Resident #11's Fosomax and Miralax, Resident #13's Lyrica, and Resident #14's insulin (Previously cited on 1/16/13).		7/21/13 RSLG
6	305.02	The facility did not ensure physician's orders were current and matched medication assistance records, for example; Resident #7 did not have orders for Regaloid, B12, MOM and Norco, Resident #9 did not have current orders for all medications, Resident #4 orders did not match the medication assistance record or what he currently was taking, additionally not all PRN and narcotics were available for residents (Previously cited on 10/7/11, 8/28/12 and 1/16/13).		7/21/13 RSLG
7	305.03	The facility RN did not assess Resident #16's skin breakdown and Resident #6's skin lesion (Previously cited on 8/28/12 and 1/16/13).		
8	305.06.b	The facility RN did not assess Resident's #2, #3, #4, #9, #14, #15 and #16's ability to self-administer their medications. (Previously cited on 8/28/12 and 1/16/13).		7/21/13 RSLG
9	310.01	A family member filled Resident #4's medi-set (Previously cited on 1/16/13).		7/21/13 RSLG

Response Required Date
05/29/13

Signature of Facility Representative

Date Signed

4/29/13



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

May 9, 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 and complaint investigation survey was conducted at Bronco Senior Services, DBA Hillcrest between April 22, 2013 and April 29, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005902

Allegation #1: The facility charged an identified resident for assistance with medications, when he managed his own.

Findings #1: Substantiated. The facility was previously cited for their billing practices on January 16, 2013. Additionally, the facility reviewed the resident's billing and sent the resident a refund, for charging him for assistance with medication between the end of January 2013 and February 9, 2013.

Allegation #2: The facility did not dispose of an identified resident's expired over-the-counter medications.

Findings #2: Substantiated. However, the facility was previously cited on January 16, 2013 for not appropriately providing assisting and monitoring with medications and for not documenting medication destructions as required by IDAPA 16.03.22.310.02.a-f.

Allegation #3: An identified resident was not assessed by the facility nurse, when he was not feeling well.

Findings #3: Substantiated. However, the facility was previously cited for not assessing or medically evaluating the identified resident's changes of condition on the January 16, 2013 survey. The identified resident moved out of the facility on 2/9/13. The

Cynthia Brewer, Administrator
May 9, 2013
Page 2 of 2

identified resident's closed record, was reviewed on 4/24/13. There was no documentation of any further changes of condition between 1/16 and 2/9/13. Additionally, the administrator, shift lead and a caregiver were interviewed. They did not recall the identified resident having any changes of condition after 1/16/13, until he moved out of the facility on 2/9/13.

Allegation #4: The identified resident paid the facility for the month of February, however, he moved out of the facility at the beginning of February and did not receive a partial reimbursement.

Findings #4: The facility's admission and discharge log was reviewed on 4/25/13. The log documented, the resident physically moved out of the facility on 2/9/13, however, he was not discharged from the facility until 2/22/13.

On 4/25/13 at 8:42 AM, the administrator stated the resident had given a 30 day verbal notice of discharge on 1/24/13. She stated the thirty day period went until 2/22/13, but he had been charged the entire month. She confirmed the resident had been charged for the additional 6 days at the end of February past his 30 day notice period. She stated she had accounting working on it and the facility would be refunding the resident for the additional 6 days he had been charged.

Substantiated. However, the facility was not cited as they acted appropriately by issuing a reimbursement to the identified resident, for the 6 additional days past the 30 day notice period.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on **04/29/2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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,

Rally Datt - Signed for

Matt Hauser, QMRP
Health Facility Surveyor
Residential Assisted Living Facility Program

MH/pwg

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



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

May 9, 2013

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

Dear Ms. Brewer:

An unannounced, on-site complaint investigation survey was conducted at Bronco Senior Services from April 22, 2013, to April 29, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006000

- Allegation #1:** The administrator did not provide a written response to a complainant.
- Findings #1:** Substantiated. However, the facility was not cited, as according to IDAPA 16.03.22.350.04, the facility has 30 days to respond to the complainant in writing. On 4/22/13, the complaint log was reviewed; the facility had documentation that the complaint was received on 3/27/13 and an investigation had been initiated.
- Allegation #2:** An identified resident's medications were not given according to physician's orders.
- Findings #2:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.300.02 for not implementing the residents' medications as ordered. The facility was required to submit evidence of resolution within 30 days.
- Allegation #3:** The facility allowed a family member to administer a resident's medication.
- Findings #3:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.d for allowing a family member to administer Haldol to an identified resident. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The facility did not remove an identified resident's Lidoderm patches as ordered.

Findings #4. Substantiated. However, the facility was not cited as on 4/22/13, it was determined the facility had corrected the deficient practice prior to the survey. The facility identified the problem and implemented interventions to prevent it from happening again, by adding a reminder on the April 2013 Medication Assistance Record to remind staff to remove the patch. Facility staff documented they were removing the patch at 8:00 PM. During the survey, two medication aides stated they had been instructed on the importance of removing the patch. One random resident, who also received a Lidoderm patch, stated staff had been good about removing her patch each evening.

Allegation #5: A urinary analysis was not implemented as ordered.

Findings #5. On 4/22/13, the identified resident's record was reviewed. It was determined that a urinary analysis (UA) order on 2/4/13 was not implemented as ordered until 2/27/13. However, the facility had been cited on 1/16/13 for not implementing physician orders and did not allege compliance until 3/20/13. The identified resident's care notes documented that UAs were obtained on 3/29/13 and 4/11/13 as ordered.

Substantiated, but not cited, as the deficient practice occurred prior to the facility's date of compliance and current UA orders had been implemented.

Allegation #6: The facility did not manage an identified resident's frequent urinary tract infections (UTIs).

Findings # 6: Between 4/22/13 and 4/25/13, five caregivers were interviewed separately. All stated they had been trained to encourage the identified resident to drink adequate fluids; they were instructed to assist the resident with frequent toileting and provide assistance with peri-care.

On 4/22/13 at 1:10 PM, the facility RN stated she instructed staff to assist the resident frequently with peri-care and encourage her to drink plenty of fluids. She further stated, she had spoken with the resident's doctor about possible medical interventions to manage the resident's frequent UTIs, but the resident was not a candidate for any prophylactic treatments.

A history and physical, dated 3/14/13, documented, "recurrent UTIs been a problem for years now." It further documented, the resident had been treated for two bladder infections within the "last 5 weeks."

On 4/22/13, care notes documented the facility RN educated staff on observing

Cynthia Brewer, Administrator
May 9, 2013
Page 3 of 3

the identified resident for side-effects of antibiotic therapy for the treatment of the UTIs.

Unsubstantiated, however the facility was issued a deficiency at 16.03.22.320.01 for not updating the resident's Negotiated Service Agreement to reflect her current care needs.

Allegation #7: The facility did not develop behavioral interventions to manage an identified resident's behaviors.

Findings #7: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.225.01 and 225.02 for not evaluating behaviors and developing interventions to manage behaviors. The facility was required to submit evidence of resolution within 30 days.

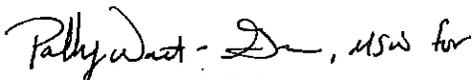
Allegation #8: The facility gave an identified resident an inappropriate discharge notice.

Findings #8: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.221.01 for giving an identified resident a 15-day discharge notice. The facility was required to submit evidence of resolution within 30 days.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on **04/29/2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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,



Matt Hauser, QMRP
Health Facility Surveyor
Residential Assisted Living Facility Program

MH/pwg

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