



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

August 22, 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 between August 14 and August 15, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006145

Allegation #1: Residents were given the wrong medication.

Findings #1: Insufficient evidence was available at the time of the investigation in the records reviewed to substantiate this allegation.

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

Allegation #2: Medication aides pre-poured residents medications.

Findings#2: On 8/15/13 10:42 AM, a facility nurse confirmed that medication aides had pre-poured residents' medications, which did result in medication errors. She stated it was the facility's policy for aides to dispense and assist, one resident with their medications at a time. She stated when it was reported to her that an aide pre-poured medication she would verbally reprimand them, place a disciplinary note in their record and retrain them on how to properly dispense and assist with medications. She stated she had disciplined a medication aide who had pre-poured medications on 8/12/13. Additionally, she stated if an aide continued to make errors, or not follow the facility's medication policy, they were terminated.

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On 8/15/13 a written disciplinary note, regarding the incident on 8/12/13, was reviewed. The note documented the aide had been verbally counseled about not pre-pouring medications and was retrained on the facility's policy regarding assisting residents with medications.

Substantiated. However, the facility was not cited as when medication aides did not follow the facility's medication policy they acted appropriately by retraining, or terminating the medication aide.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

A handwritten signature in black ink, appearing to read "Gloria Keathley", with a long, sweeping flourish extending to the right.

Gloria Keathley, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

GK/TFP

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



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1093 S Hilton Street
Boise, ID 83705

Dear Ms. Brewer:

An unannounced, on-site complaint investigation survey was conducted at Bronco Senior Services between August 14 and August 15, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006113

Allegation #1: Prescriptions were not filled in a timely manner, which resulted in a delay in treatment.

Findings #1: Substantiated. However, the facility was not cited as prior to the complaint investigation the facility conducted an investigation, determined where the breakdown in communication occurred, and then implemented a systematic change to prevent this type of occurrence in the future.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Gloria Keathley, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

GK/tp

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



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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 between August 14 and August 15, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006059

Allegation #1: Caregivers assessed residents and determined when to give medications without the involvement and direction of the licensed nurse.

Findings #1: Insufficient evidence was available at the time of the investigation to validate this allegation.

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

Allegation #2: Residents did not receive medications as ordered by their physicians.

Findings #2: Substantiated. However, the facility was not cited as the problem was corrected prior to the complaint investigation and no other medication errors were identified.

Allegation #3: The facility nurse did not assess residents when they had a change of condition.

Findings #3: Insufficient evidence was available at the time of the investigation to validate this allegation.

Unsubstantiated.

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Allegation #4: The facility management told staff not to talk with surveyors.

Findings #4: On 8/14/13 and 8/15/13, six staff were interviewed. All six staff stated they had not been told to not talk with surveyors. They further stated they were told to answer questions if interviewed and if they did not know the answer, they were to direct the surveyor to the administrator.

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

Allegation #5: Medications were removed from residents' rooms without their permission.

Findings #5: On 1/16/13, the facility was previously cited for residents having medications in their rooms without being assessed to safely self-administer medications.

A letter from the facility to all residents and family members, dated 1/18/13, documented the facility would make periodic audits of medications in the residents' apartments to ensure that all medications had physicians' orders. Further, it documented if the medication did not have a physician's order, the medication would be removed until an order could be obtained.

On 8/15/13, the administrator confirmed the facility did audit residents rooms and removed medications as indicated.

On 8/15/13, the admission agreement was reviewed, but did not contain information regarding the rooms audits for medications.

Substantiated, however the facility was not cited because they took actions to correct a previous deficiency regarding the same concern. Technical assistance was provided regarding updating the admission agreement to clearly describe the facility's policy for self-administration of medications and room audits.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,



Gloria Keathley, LSW
Health Facility Surveyor

Residential Assisted Living Facility Program

GK/ftp

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