C.L. "BUTCH" OTTER -- Governor RICHARD M. ARMSTRONG -- Director LESLIE M. CLEMENT - Administrator DIVISION OF MEDICAID Post Office Box 83720 Boise, Idaho 83720-0036 PHONE: (208) 334-6626 FAX: (208) 364-1888

October 7, 2010

Laura Elaine Todd, Administrator Alpine Manor II Po Box 281 Kimberly, ID 83341

Dear Ms. Todd:

An unannounced, on-site complaint investigation survey was conducted at Alpine Manor II on July 29, 2010. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00004419

Allegation #1: The facility was chemically restraining an identified resident with medications.

Findings #1: On July 29, 2010, the identified resident's record was reviewed and contained

documentation of all the medications she took while at the facility. The identified resident's record documented she did not receive any as needed (PRN) medications.

Additionally, the identified resident's record documented she did not receive

medications for anxiety or behaviors and only received an herbal supplement for sleep on a routine basis. There was no documentation the identified resident had been

over-medicated or recieved any medications that could be used as a chemical restraint.

Unsubstantiated. Although the allegation may have occurred, it could not be verified

during the complaint investigation.

Allegation #2: Residents' medications were not given as ordered by physician.

Findings #2: On July 29, 2010, four residents' medical records and physician orders were reviewed.

All four resident records documented that all medications had been been given as ordered by the physician. Two residents' medications were observed and consistent

with what was ordered by the physician.

On July 29, 2010, four residents were asked about their medications. All four stated their medications were given correctly, on time, and as ordered. Two family members

were interviewed on July 29, 2010, and neither had any concerns regarding

medications.

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

Allegation #3:

Staff were sleeping on the night shift.

Findings #3:

On July 29, 2010, four residents records were reviewed. All four records documented residents had night needs that required up-and-awake staff.

Throughout the afternoon on July 29, 2010, four residents were asked if night shift staff were awake and available during the night when they required assistance. All four residents stated staff were always awake and promptly available during the night shift. On July 29, 2010, three staff were asked if night shift staff were sleeping. All three stated night shift staff stayed awake during the night shift due to resident needs. On July 29, 2010 at 10:50 a.m., the administrator stated night shift staff were required to stay up and awake because the residents required assistance throughout the night.

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

Allegation #4:

The administrator did not investigate or report bruises from an unknown origin on an identified resident.

Findings #4:

On July 29, 2010, the identified resident's closed record was reviewed and documented the resident did have bruises on the face and arms. The resident's record contained care notes that documented the bruises were noted when the resident was admitted to the facility and were the result of a fall prior to being admitted.

Incident and accident reports from May 20, 2009, through June 29, 2010, were also reviewed. All incidents and accidents were found to have been appropriately investigated and reported.

Two staff were interviewed on July 29, 2010. Both staff stated they recalled the identified resident having bruises upon admission. The administrator also stated during an interview on July 29, 2010, that the resident had been admitted with the bruises and they were the result of a fall the resident had sustained prior to being admitted to the facility.

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

Allegation #5:

The owner of the facility pulled on a resident roughly.

Findings #5:

On July 29, 2010, the facilities incident and accident reports from May 20, 2009, through June 29, 2010, were reviewed. All incidents and accidents were found to have been properly investigated and reported. The facility had not received any complaints during the year.

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On July 29, 2010, four residents were asked if they had ever seen the owner of the facility roughly pulling on or being physically rough with any residents. All four stated the owner had never been rough with them and they had never seen the owner be rough with any other residents. They all stated the owner was very nice and gentle. Two staff member were asked on July 29, 2010, if they had ever seen the owner be physically rough with any residents. Both staff stated they had not. Additionally, two family members were interviewed on July 29, 2010, and neither had any concerns regarding the owner being physically rough.

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

Allegation #6:

The caregivers refused to assist residents with cares.

Findings #6:

On July 29, 2010, four residents' records were reviewed and contained documentation that caregivers provided resident cares at least daily. An identified resident's record documented she also received cares as specified in her plan of care. There was no evidence any resident had not received cares.

Throughout the afternoon on July 29, 2010, four residents were asked if they received assistance from caregivers and if caregivers had ever refused to assist them. All four stated caregivers readily provided assistance with cares and had never refused to assist them. Two family members were interviewed on July 29, 2010, and both stated their family members were very well cared for and the staff were attentive to their needs.

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

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,

MATT HAUSER, QMRP Health Facility Surveyor

Residential Assisted Living Facility Program

MH/sm