



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

JUDY A. CORDENIZ – ADMINISTRATOR
LICENSING AND CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

August 14, 2012

Janette Bower, Administrator
Alpine Meadows Assisted Living, LLC
1695 S Locust Grove Rd
Meridian, ID 83642

License #: RC-988

Dear Ms. Bower:

On July 10, 2012, a Follow-Up survey was conducted at Alpine Meadows Assisted Living, LLC. 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 Gloria Keathley, LSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

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



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July 16, 2012

CERTIFIED MAIL #: 7007 3020 0001 4050 7787

Janette Bower, Administrator
Alpine Meadows Assisted Living, LLC
1695 S Locust Grove Rd
Meridian, ID 83642

Dear Ms. Bower:

On **July 10, 2012**, a complaint investigation and follow-up survey was conducted by our staff at Alpine Meadows Assisted Living, Llc. As a result of the survey, core issue deficiencies were cited. Enclosed is a Statement of Deficiencies.

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ◆ 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)?
- ◆ What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **July 29, 2012**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

You have available 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 1 IDR meeting. The request for the meeting must be made within

Janette Bower, Administrator
July 16, 2012
Page 2 of 2

ten (10) business days of receipt of the statement of deficiencies (**July 29, 2012**). 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 & Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **July 29, 2012**, 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.

Please bear in mind that three non-core issue deficiencies were identified on the punch list and two were identified as repeat punches. As explained during the exit conference, the completed punch list form and accompanying evidence of resolution (e.g., receipts, photographs, policy updates, etc.) needs to be submitted to our office no later than August 9, 2012.

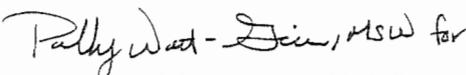
If the facility fails to submit acceptable evidence of resolution within sixty (60) days from when the facility was found out of compliance, or on a subsequent survey visit, it is determined that any of these deficiencies still exist, the Department will have no alternative but to initiate the enforcement of civil monetary penalties, as described in IDAPA 16.03.22.910.02 and IDAPA 16.03.22.925.

Please ensure the facility is continually monitoring its compliance with state rules, as further repeat punches identified during future surveys could result in enforcement actions including:

- a. Issuance of a provisional license
- b. Limitations of admissions to the facility
- c. Hiring a consultant who submits periodic reports to the Licensing and Certification
- d. Civil monetary penalties

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

GK/ftp

Enclosure

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R988	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/10/2012
NAME OF PROVIDER OR SUPPLIER ALPINE MEADOWS ASSISTED LIVING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1695 S LOCUST GROVE RD MERIDIAN, ID 83642		
(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}	Initial Comments The following deficiency was cited during the follow-up survey conducted on 07/09/2012 at your residential care/assisted living facility. The surveyors conducting the survey were: Gloria Keathley, LSW Team Leader Health Facility Surveyor Matt Hauser, QMRP Health Facility Surveyor	{R 000}	July 25, 2012 Plan of Action and Corrective Action for Deficiency R 008 Alpine Meadows Assisted Living	
{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, interview and record review, it was determined the facility did not provide an interior environment which was secure for 1 of 1 sampled residents (Resident #1) who was cognitively impaired and at risk for elopement. This had the potential to affect other residents who were cognitively impaired. The findings include: IDAPA 16.03.22.250.14 documents, "Secure Environment. If the facility accepts and retains residents who have cognitive impairment, the facility must provide an interior environment and exterior yard which is secure and safe." During a previous survey, conducted on 5/18/12, the facility received a core deficiency for not providing a secure environment for Resident #1.	{R 008}	1. What corrective action(s) will be accomplished for those specific residents found to have been affected by the deficient practice? The main entry door and the door to the patio were outfitted with coded keypad to exit, and this was operational by 5/22/12. A code must be entered to exit these two identified doors. The gates in the fenced area will be monitored on a regular basis. Weather proof signs have been placed on each gate to remind those using the gate to relock them and to not leave those unattended when unlocked. On 7/23/12 a keypad was installed on the third door noted in the follow up survey 7/9/12. The operation of this third key pad is the same as the two previously installed. 2. How will you identify other residents that may be affected by the same deficient practice and what corrective action will be taken? Current or future residents that are cognitively impaired will not be shown how to activate the keypad to release the door.	

Bureau of Facility Standards

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

STATE FORM

TITLE

(X6) DATE

Administrative 7/26/12

6899

OZUJ12

If continuation sheet 1 of 3

accept Kelly 7-20-12

RECEIVED

JUL 27 2012

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Bureau of Facility Standards

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{R 008}	<p>Continued From page 1</p> <p>On the follow-up survey, conducted on 7/9/12, the facility was observed to have a coded key pad installed on the main entrance door and the patio door. A door at the end of the southeast hallway led to a secured yard. A door on the northwest hallway was observed to have a door alarm and would sound if the door was opened. The northwest door led out to the side of the building and was close to Overland Road, which is a five lane road.</p> <p>Resident #1 was admitted to the facility on 10/5/11, with diagnoses which included Alzheimer's disease.</p> <p>Resident #1's "Daily Behavior Monitoring Plan," dated 11/1/11, documented the resident had exit seeking behaviors and was to be placed on 15 minute checks.</p> <p>A "Fax Cover," dated 7/5/12, to Resident #1's physician, documented, "...He goes to the door and tries to leave. On 7/4/12 he came down the hall without any clothes on except a jacket. He had a binder and was going to coach football...."</p> <p>On 7/9/12 at 10:30 AM, the northwest hallway door was tested. The alarm sounded, however, staff were not observed checking to see if a resident had left the building.</p> <p>On 7/9/12 between 10:35 AM and 10:45 AM, a caregiver that was in the medication room on the first floor stated she did not hear the door alarm. Another caregiver who was in the laundry room on the first floor stated she did not hear the door alarm. A Health Facility Surveyor who was in a room at the end of the southeast hallway on the second floor stated he did not hear the door alarm.</p>	{R 008}	<p>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? The door keypad will be maintained in a working order. Reviews will be made by supervisor to ensure caregivers are routinely checking exterior gates to ensure they are locked and signs are in place.</p> <p>4. How will corrective actions be monitored and how often will monitoring occur to ensure that the deficient practice will not recur? Doors are monitored daily as they will not open if key pad is not used. Night shift will check-off the duty list that both gates are locked. Supervisor will review duty list periodically to ensure duty is being performed. Night shift will also visually inspect that signs are on gates.</p> <p>5. What date will the corrective action be completed? Keypads were installed and operational 5/22/12 on the front and patio doors. Night Caregiver duty of checking gate was added to duty list 6/11/12 and signs were installed on gates 6/11/12. The door in the Northwest hallway had a keypad installed and operational on 7/23/12.</p>		

Bureau of Facility Standards

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{R 008}	Continued From page 2 On 7/9/12 at 10:50 AM, the administrator was told by the Health Facility Surveyors that caregivers did not hear the door alarm that was tested at 10:30 AM. The administrator stated she was not aware that staff could not hear the door alarm if they were in a resident's room or behind other closed doors in the facility. The facility failed to provide Resident #1 with a secure interior environment. This failure resulted in inadequate care. THIS IS A REPEAT CORE DEFICIENCY.	{R 008}			

