



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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DIVISION OF LICENSING & CERTIFICATION
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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
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July 8, 2013

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

Dear Ms. Todd:

An unannounced, on-site complaint investigation survey was conducted at Alpine Manor between June 27 and June 27, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006040

Allegation #1: The facility did not conduct an investigation into stolen narcotics.

Findings #1: On 6/27/13, an investigation report regarding missing narcotics was reviewed. The report, dated 3/26/13, documented the administrator reported the theft to law enforcement on 3/26/13 at 5:00 PM. Law enforcement instructed the administrator to do an "internal investigation," because the police would "not get involved." The report further documented, seven staff members were tested for drugs. One of the seven tested positive, but had a prescription for the medication identified.

On 6/27/13 at 4:30 PM, the administrator confirmed the facility had missing narcotics. She stated she felt she had done everything possible to conduct an internal investigation. She stated she had a staff meeting about the entire situation and staff were provided additional training regarding the facility policy for controlled substance tracking. She stated, staff had been "lax" about completing a double-count of controlled substances. She stated that, either the house manager or administrator were now present at each shift change to ensure the double-count was taking place.

On 6/27/13 at 4:45 PM, the controlled substance tracking was observed. The number of medications was congruent with the numbers of medications documented on the controlled substance tracking sheets.

Unsubstantiated.

Allegation #2: Narcotics were left unlocked on several occasions and the facility had not corrected the problem.

Findings #2: On 6/27/13 between 3:30 PM and 6:00 PM, the facility medication cabinet was observed to be locked. At no time during the survey, did a caregiver leave the medications unsecured.

On 6/27/13 between 3:30 PM and 6:00 PM, three caregivers were interviewed. All denied having any current problems with keeping medications secured.

On 6/12/13 at 4:30 PM, the administrator confirmed the facility did have problems with ensuring the medications were secured. She stated when the facility had problems with missing medications, they found there were many areas that also needed attention. She stated a meeting was held and training was provided to staff regarding the handling of medications.

Unsubstantiated. The facility identified the problem and corrected it prior to the complaint investigation.

Allegation #3: The medication aides were not tracking controlled substances.

Findings #3: On 6/27/13 at 4:30 PM, the administrator confirmed the facility had problems with controlled substances. She stated she had a staff meeting about missing narcotics and staff were provided additional training regarding the facility policy for controlled substance tracking. She stated, staff had been "lax" about completing a double-count of controlled substances. She stated that, either the house manager or administrator were now present at each shift change to ensure the double-count was taking place.

On 6/27/13 at 4:45 PM, the controlled substance tracking was observed. The number of medications was congruent with the numbers of medications documented on the controlled substance tracking sheets.

Substantiated. However, not cited as the facility identified and corrected the problem prior to 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,



Donna Henscheid
Health Facility Surveyor
Residential Assisted Living Facility Program

DH/TFP

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



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Dear Ms. Todd:

An unannounced, on-site complaint investigation survey was conducted at Alpine Manor between June 27 and June 27, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005974

Allegation #1: Residents were left in soiled briefs and bedding throughout the night.

Findings #1: Insufficient evidence was available at the time of the investigation 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.

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,

Donna Henscheid
Health Facility Surveyor
Residential Assisted Living Facility Program

DH/ftp

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