



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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February 7, 2013

Leslie Erfurth, Administrator  
Ivy Place Residence - Ivy Place Inc  
1307 North 25th Street  
Boise, ID 83702

Dear Ms. Erfurth:

An unannounced, on-site complaint investigation survey was conducted at Ivy Place Residence - Ivy Place Inc on February 5, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00005578**

**Allegation # 1:** Residents were served hot dogs and chili for an entire week.

**Findings #1:** On 2/5/13 at 9:00 AM, observations were made of the facility's kitchen cabinets, freezer, refrigerator and pantry, where a variety of food items were stored.

On 2/5/13 at 9:15 AM, the house manager stated her job included grocery shopping for the facility and she bought food items to follow the menu. She further stated, when the menu was not followed staff were instructed to document substitutions that were made to the menu. The house manager stated, when there were left overs, they would be served a few days later to ensure the same food was not served at the next meal.

Menus from April 2012 through February 2013, documented food items such as, corn dogs, hot dogs, and saucy franks were served once or twice during a month, but there was no documentation hot dogs and chili were served for an entire week.

On 2/5/13 at 9:20 AM, two outside agency care providers stated they had not observed the facility serving the same food items day after day and confirmed the facility served a variety of foods.

On 2/5/13 at 9:40 AM, the administrator stated she had not received complaints regarding food being served repeatedly. She stated if there had been a verbal or written complaint she would have documented the concern and provided a written response to the complainant.

Unsubstantiated.

**Allegation #2:** Two employees did not pass the criminal history and background checks and were allowed to work.

**Findings #2:** Thirteen closed and current employee records were reviewed on 2/5/13. All records contained cleared background checks that were completed by the Idaho State Criminal History Unit.

The administrator stated that all employees had past a criminal history background check. Additionally, she stated that all employees had to have a cleared background checks or they would not be allowed to work at the facility.

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

**Allegation #3:** A secured environment was not provided to residents who wander.

**Findings #3:** On 1/5/13 at 8:55 AM, observations were made of 4 residents sitting in the living room, another resident resting in bed and another resident sleeping in bed.

On 1/5/13 at 9:05 AM, the house manager stated five of six residents residing at the facility required the assistance of at least one caregiver to transfer and to assist them with mobility. She stated one resident was a new admission and was independent with ambulation, but had not shown any signs of wandering or trying to leave the facility. The house manager stated the facility had working locks and alarms and if they had a resident that was wandering or attempting to elope they would implement the alarms and locks. The house manager activated the alarm system to verify the alarms worked. She stated the exterior yard was secured by a key pad lock that required a number code to open the gate.

Incident reports and care notes were reviewed from May 2012 through

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February 2013. There was no documentation related to resident's who wandered or attempted to elope.

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

**Allegation #4:** The medication cabinet did not lock leaving medications unsecured.

**Findings #4:** On 2/5/13 at 9:00 AM, observations were made of the medication storage areas. All three medication cabinets were observed locked by a chain and combination lock. The house manager stated the facility used the combination locks because they had a problem with keys breaking in the past.

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



Karen Anderson, RN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

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