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November 25, 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 November 20, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006114

Allegation #1: Facility caregivers transferred residents in a rough and abusive manner.

Findings #1: On 11/20//13 from 10:15 AM to 2:15 PM, two transfers were observed. Two caregivers were observed working together in a slow and gentle manner to transfer the residents. They were observed to explain to the residents what they would be doing, prior to doing it and conducted the transfers in a patient manner. Additionally, the two caregivers and the house manager were observed to be responsive to residents' needs and interacted with them in a kind manner. During this time, two interviewable residents stated caregivers were friendly and caring.

On 11/20/13 between 10:15 AM and 2:15 PM, two outside agency staff were interviewed. Both staff members stated they visited the facility frequently and had observed caregivers transferring and interacting with residents in a kind manner. One outside agency staff member was a social worker with an adult protection background, who stated she had not observed any indication that any of the residents had been mistreated.

On 11/20/13 between 10:15 AM and 2:15 PM, two family members were interviewed. They stated they had witnessed staff members transfer residents in

Allegation #2: The facility had a higher than average rate of falls and bruises of unknown origin due to interventions not being developed to prevent a reoccurrence.

Findings #2: On 11/20/13, the facility's incidents and accidents were reviewed from June 2013 until the current date. There were nine documented incidents, which included 2 skin tears, 5 falls, two bruises of unknown origin and one bruise of known origin. The incident reports documented various preventative interventions, such as: padding wheel chair legs to prevent skin tears, using an arm sling when transferring to prevent skin tears, transfer training in-services, bed alarms/chair alarms, utilizing low beds, alert charting, frequent checks, and altering the environment.

On 11/20/13 at 10:40 AM, a caregiver stated the facility staff would talk about incidents and accidents during staff meetings to determine preventative strategies.

On 11/20/13 at 11:29 AM, the administrator stated staff were compliant with reporting incidents and accidents to her, so that an investigation could be conducted.

On 11/20/13 at 1:16 PM, a caregiver stated she had worked at the facility three months and could not recall any falls occurring. She further stated, she was taught during orientation to document any accident or incident and report each occurrence to the administrator so that it could be investigated.

On 11/20/13 at 1:20 PM, a caregiver stated the administrator investigated all incidents and accidents and took them seriously. She further stated, "we try to be proactive to prevent falls and accidents from even occurring."

On 11/20/13 at 1:55 PM, the facility RN stated staff were good about calling her for all incidents and accidents. She further stated, "One fall is too many. We always try to prevent them." She further stated, she had not observed an unusual amount of bruising of unknown origin, and that the cause of most bruises were identified through an investigation.

On 11/20/13 between 10:15 AM and 2:15 PM, two outside agency staff stated they felt the incident accident rate was very low for the facility and that staff called them for each incident and accident. They further stated, they had not observed bruising of unknown origin with their residents.

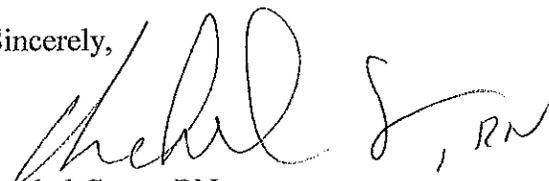
Two residents' records were reviewed. Care notes, nursing notes and outside agency notes were reviewed. One record contained documentation that a bruise located on the residents arm was thought to be caused by a transfer upon interview with staff. The RN assessed the bruise and an in-service was provided

Leslie Erfurth, Administrator

November 25, 2013

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Sincerely,

A handwritten signature in black ink, appearing to read "Rachel J., RN". The signature is fluid and cursive, with a large initial "R" and a distinct "J." followed by "RN".

Rachel Corey, RN

Health Facility Surveyor

Residential Assisted Living Facility Program

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