IDAHO DEPARTMENT OF
HEALTH & WELFARE

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) 334-5747
FAX: (208) 364-1811

December 12, 2007 **HAND DELIVERED**

Marilyn and Kendall Sheppard, Owners
Ivy Gardens Assisted Living
1107 15th Avenue South
Nampa, ID 83651

RE: Summary Suspension and Revocation of Residential Care and Assisted Living Facility License

Dear Marilyn and Kendall Sheppard,

Please accept this letter as notice that we have found conditions at Ivy Gardens Assisted Living that pose an immediate danger and jeopardy to residents such that it is necessary to summarily suspend your license, transfer residents, and initiate license revocation action.

This action is being taken pursuant to Idaho Code §39-3345, §67-5254, IDAPA 16.03.22.900.01.b and IDAPA 16.03.22.930.01.a. and stems from a survey and complaint investigation of the facility conducted December 12, 2007. During this survey, the surveyors identified the facility is currently operating without a licensed administrator or a licensed nurse. The facility did not employ staff who had been trained to assist residents with their medications. There was no evidence the staff who were employed were trained in CPR or First Aid.

Our surveyors found that the facility is substantially out of compliance with our rules requiring the protection of the health, safety, and welfare of residents. The facility's owners have not employed staff trained and qualified to care for the residents and have not initiated policies and procedures that ensure residents' medical and safety needs are met. As a result, the facility does not have systems in place to ensure residents' emergency needs are met.

Taken together, these deficiencies present conditions that place every resident of the facility at immediate risk for their health, safety, and welfare. For these reasons, the facility's license is suspended immediately, and the residents must be moved out as soon as feasible pursuant to IDAPA 16.03.22.930.01.b. The facility must contract with a licensed nurse or medication certified staff to come in and assist residents with their medications at each med pass until the last resident has moved out. The facility must also ensure at least one staff who is certified in both CPR and FA is present in the facility at all times until the last resident has moved out. If all residents have not moved out by noon on Monday, December 17, 2007, or, if the facility fails to maintain CPR/FA certified staff or persons certified to assist with medications, the Department will impose temporary management pursuant to

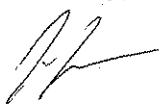
IDAPA 16.03.22.930.01.a. All compensation and per diem costs of the temporary manager must be paid by the licensee.

You have the right to contest the action pursuant to IDAPA 16.05.03.300, by filing a request for administrative review **within 28 days of the date of this letter**. Your request should be directed to:

Randy May, Deputy Administrator
Division of Medicaid-DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

However, because this is an emergency, the license suspension will not be stayed by an appeal.

Sincerely,



JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Community Care Program

JS/sc

Cc: Marie Penav, RN, Region III-DHW
Cathy Hart, State Ombudsman, Idaho Commission on Aging
Sarah Scott, Adult Protection Services, Area III Agency on Aging
Richard Armstrong, Director, Division of Medicaid
Randy May, Deputy Administrator, Division of Medicaid
Paul Leary, Acting Deputy Administrator, Division of Medicaid
Willard Abbott, Deputy Attorney General, Human Service Division

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FAX: (208) 364-1888

December 31, 2007

Marilyn Sheppard
Ivy Gardens Assisted Living
1107 15th Avenue South
Nampa, ID 83651

Dear Ms. Sheppard:

On December 14, 2007, a state licensure survey, complaint investigation was conducted at Ivy Gardens Assisted Living. Enclosed are the findings of the Medicaid State Licensing and Certification survey team.

If you have questions regarding this information or need further assistance, please contact our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Community Care Program

JS/sc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13R754		12/14/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY GARDENS ASSISTED LIVING	1107 15TH AVE SOUTH NAMPA, ID 83651

(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 standard survey and complaint investigation conducted on 12/12/07 at your residential care/assisted living facility included core issue deficiencies. The following deficiencies sited included: licensed administrator requirement and inadequate care.The surveyors conducting your standard health care and complaint investigation survey's were: Maureen McCann, RN Team Coordinator Health Facility Surveyor Rachel Corey, RN, BSN Health Facility Surveyor Debbie Sholley, LSW Health Facility Surveyor Survey Definitions: NSA = Negotiated Service Agreement UAI = Uniform Assessment Instrument UAP = Unlicensed Assistive Personnel	R 000		
R 004	16.03.22.215.03 Licensed Administrator Requirement - 30 Days The facility may not operate for more than thirty (30) days without a licensed administrator. This Rule is not met as evidenced by: Based on interview, observation and record review, it was determined the facility failed to retain a licensed administrator responsible for the	R 004		

Bureau of Facility Standards

TITLE (X6) DATE

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

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NAME OF PROVIDER OR SUPPLIER IVY GARDENS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 15TH AVE SOUTH NAMPA, ID 83651		

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R 004	Continued From page 1 day-to-day operations for a period of more than 30 days. On 12/12/07 at 7:30 a.m., upon arrival to the facility, a "For Sale" sign was observed in the front yard. On 12/12/07 at 7:35 a.m., a caregiver stated the facility owner was trying to sell the facility. The owner had tried to sell it to her son (co-owner) and his wife, but they were unable to buy it. The caregiver also stated the facility administrator was the co-owner's wife. On 12/12/07 at 7:50 a.m., an administrator license was observed posted on the wall in the living room. The expiration date on the license was 1/30/08. A pre-survey search revealed the facility was co-owned by a mother (whose administrator license was observed posted on the wall) and her son. On 12/12/07 at 7:40 a.m., the caregiver placed a phone call to who she considered "the administrator", (co-owner's wife), who, for the report will be referred to as the "facility manager", but was unable to reach her. However, the caregiver left a message for the "facility manager", to call the facility as soon as possible. On 12/12/07 at 10:00 a.m., after several attempts to reach the co-owner and his wife, were unsuccessful, the caregiver called the mother/owner. She stated she was no longer the administrator...that she had sent a letter to the Bureau on September 9, 2007, as well as to her son and his wife, notifying everyone that she had resigned her position as the facility administrator and had nothing to do with the facility since. She stated she was last in the facility on September 7,	R 004		

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R 004	Continued From page 2 2007. She also confirmed she was actively trying to sell the facility. She stated her son and his wife were now running the facility and were looking for an administrator because they could not pass the administrator exam. She also stated that she was not willing to come to the facility to assist with the current survey, but she would try and reach her son on his cell phone. She stated did not have a home phone number for him. On 12/12/07 at 10:05 a.m., the caregiver left a message for the co-owner (son) to call the facility as soon as possible. On 12/12/07 at 10:20 a.m., via phone conversation to staff at "Licensing and Certification" at the Bureau, no documentation was found in the facility folder regarding the owner/licensed administrator's letter resigning from the administrator position at the facility. On 12/12/07 at noon, the caregiver stated she had finally reached the co-owner and his wife, but they were unable to come to the facility immediately, however they would come as soon as they were available. On 12/12/07 at 12:30 p.m., the "facility manager" arrived at the facility. She stated she did not have an administrator's license and there was no current licensed administrator for the facility. She stated the licensed administrator was last at the facility, "about 4 months ago". The licensed administrator did tell her that she had resigned and they had been looking for an administrator since. She also stated she had been "running" the facility since they first opened. When asked who was responsible for monitoring the resident's records, she stated, "Oh, I never took care of the records, [the owner/licensed administrator] did. I	R 004		

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R 004	Continued From page 3 just take care of the residents. I make sure they get their meals, medications, like that". When asked about her husband's involvement, she stated, "he just does the financials and sometimes "fixes things" (handyman) when he can". She further stated her husband was at work and would not be coming to the facility today during the survey. On 12/12/07 at 1:15 p.m., the owner confirmed the facility had operated without a licensed administrator from early September until 12/12/07. The facility had operated without a licensed administrator responsible for the day-to-day operations for at least, more than 90 days.	R 004		
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 failed to develop, implement and update NSA's to identify and describe resident's needs for 5 of 5 sampled residents, which at the time of the survey, represented 100 % of the facility census. The facility also failed to assure a licensed professional nurse was available to provide nursing services to the residents for approximately 1 full year. Additionally, 100 % of the staff did not have current CPR nor 1st Aid certification.	R 008		

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R 008	Continued From page 4 A. NSA: Developing, Implementing and Updating NSA's 1. Review of Resident #1's record revealed the resident was admitted to the facility on 1/5/04, with diagnoses which included schizophrenia, depression, non-insulin dependent diabetes mellitus, hypertension and incontinent bladder. The record did not contain an NSA. 2. Review of Resident #2's record revealed the resident was admitted to the facility on 10/13/07 with diagnosis including anti-social personality disorder, mild mental retardation and a history of sexual misconduct with minors. The resident's record did not contain a NSA nor a UAI. On 12/12/07 at 4:45 p.m., the "facility manager" stated Resident #2 came to her from another facility. She stated she was aware she had received some information on the resident, but had not had the time to review the information. When the "facility manager" was asked how she determined the care needs of each resident she stated, "I take the word of the case manager to determine if I can take them or not. They all know what kind of residents I take." She further stated, to date, she had not spoken to Resident #2's case manager and was not aware of his specific care needs. 3. Review of Resident #3's record revealed the resident was admitted to the facility on 11/22/04 with diagnoses including diabetes, bipolar, psychosis, and decreased range of motion in left arm and leg. The most current NSA was dated 3/10/05. 4. Resident #4 did not have a record to review. Additionally, there was no admission/discharge	R 008		

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R 008	Continued From page 5 log to determine the admission date. When asked about the resident's record, the "facility manager" stated she was waiting for the resident's day treatment program to complete the admission agreement and other admission paperwork. 5. Resident #5 did not have a record to review. When asked about the resident's record, staff handed the survey team 2 pieces of paper. One was titled, "Pharmacy Services Provider Agreement" signed by the resident on 12/11/07. The other was titled, "Instructions for Your Discharge" from a psychiatric hospital dated 11/21/07. This form listed medications the resident was to take after discharge from the hospital, allergies and a diet order. There was no documentation of a diagnosis, except for a note documenting the instruction, "contact your local physician concerning your COPD". On 12/12/07 at 1:45 p.m., the resident confirmed she had been admitted to the facility on 11/21/07 when discharged from the state hospital. On 12/12/07 at 1:30 p.m., during an interview, the "facility manager" confirmed none of the residents had an NSA. When asked, who and how it was determined what their care needs were, she stated, "They all are independent. They all have state workers. I keep in close contact with them (state workers). When the resident needs something or there is a problem we all sit at the table and talk it out." The facility failed to develop, implement and update NSA's on 5 of 5 sampled residents (100 percent of the facility census). B. NURSING: Requirement for Nursing Services	R 008		

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R 008	Continued From page 6 1. Review of Resident #1's record revealed the last nursing assessment completed by the facility nurse was dated 6/9/06. There was no other documentation in the resident's record signed by the facility nurse. 2. Review of Resident #2's record revealed no nursing assessment had ever been completed. 3. Review of Resident #3's record revealed the last nursing assessment was dated 6/9/06. The record contained unsigned physician's orders for two different types of insulin. The record did not contain a nursing assessment concerning the resident's ability to safely self-administer insulin. On 12/12/07 at 7:45 a.m., during the facility tour, a caregiver confirmed Resident #3 self-administered insulin, as she showed surveyors where the resident kept his insulin in an unlocked drawer. Additionally, an opened sharps container exposing used needles was observed. On 12/12/07 at 4:05 p.m., Resident #3 stated that staff were not involved with his insulin administration, nor had a nurse assessed his ability to self-administer insulin. Further, the resident stated, "Staff only help me with personal problems, things like that." 4. Resident #4 (no admission date available), did not have a record to review. 5. Resident #5 admitted on 11/21/07, did not have a record to review. On 12/12/07 at noon, during a review of a binder titled, "Nurse Delegation Binder", the last entry was dated 7/6/06. This was the last documented	R 008		

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R 008	Continued From page 7 evidence of a facility nurse having contact with the facility - 17 months prior to the survey. On 12/12/07 at 11:10 a.m., a caregiver stated during an interview, that "there has not been a (facility) nurse here in at least one year" On 12/12/07 at 1:15 p.m., during an interview, the "facility manager" stated, "The last time a (facility) nurse was here was about 9 or 10 months ago." On 12/12/07 at 4:15 p.m., during an interview, Resident #1 stated, "I have not seen an nurse in months and months...I can't even remember the last time I saw a (facility) nurse here (at the facility)." The last documented evidence that a facility nurse visited the facility was 7/6/06. The facility failed to assure a licensed professional nurse was available to provide nursing services including: nursing assessments, assuring medications were current, addressing changes in the resident's health or mental status, conducting self-administered medication assessments, reviewing all prescribed and over-the-counter medications for side effects, interactions, abuse or a combination of adverse effects, as well as instructing and delegating unlicensed caregivers in appropriate interventions to sustain the life and health of 5 of 5 facility residents (100 % of the facility census). Furthermore, the facility unlicensed assistive personnel were assisting with medication for 3 of 5 residents without nurse delegation. Additionally, 2 of 5 residents were self-administering medications without a nursing assessment to assure resident's competency.	R 008		

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R 008	Continued From page 8 In summary, the absence of an administrator, facility nurse, and resident records including NSA's, contributed to unlicensed personnel having no guidance or direction to meet the health needs of 100 % percent of the residents. Furthermore, resident safety was compromised due to staff working without CPR or 1st Aid training and nurse delegation to perform nursing care or assistance with medications. On 12/13/07 at 11:30 a.m., the facility was issued a summary suspension.	R 008		

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December 31, 2007

Marilyn Sheppard, Owner
Ivy Gardens Assisted Living
1107 15th Ave South
Nampa, ID 83651

Dear Ms. Sheppard:

On December 14, 2007, a complaint investigation survey was conducted at Ivy Gardens Assisted Living. The survey was conducted by Rachel Corey, RN, Maureen McCann, RN, Debra Sholley, LSW and Jamie Simpson, MBA, QMRP. This report outlines the findings of our investigation.

Complaint # ID00003265

Allegation #1: Residents were not observed taking their medication.

Findings: Based on observation and interview, it was determined residents were not observed taking their medications.

On December 12, 2007 at 8:05 a.m., the caregiver stated, "I don't watch all the residents take their medications because I know certain residents will take their medications without me watching."

On December 12, 2007 at 5:10 p.m., the caregiver was observed assisting one of the residents with his/her medication. The caregiver gave the resident the medication, and then instead of watching the resident take the medication, she turned and walked down the hallway.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not providing assistance and monitoring of medication. The facility was issued a Summary Suspension on December 13, 2007 which resulted in the loss of a license to operate a Residential Care or Assisted Living Facility in the State of Idaho.

Allegation #2: The facility did not provide a secure interior environment and residents could come and go as they wanted.

Findings: Based on observation and interview, it was determined the facility did not provide a secure interior environment.

On December 12, 2007 at 7:35 a.m., the front door of the facility was observed to be unlocked.

On December 12, 2007 at 7:55 a.m., the caregiver stated, "I stay up until midnight however, all the residents are home by 10:00 p.m. The residents can come and go, but they are good about telling me when they leave and when they will be back."

On December 12, 2007 at 4:05 p.m., a resident stated, "If I want to go somewhere I tell staff where I'm going, but I pretty much leave as I please."

Conclusion: Substantiated. However, the facility was not cited as the current residents did not require a secure environment due to their cognition, level of care, and per Idaho rules governing Idaho Assisted Living or Residential Care facilities.

Allegation #3: An identified resident left the facility at 11:00 p.m., and the caregiver did not know when the resident returned.

Findings: Based on interview and record review, it could not be determined the facility did not provide adequate supervision to the identified resident.

On December 12, 2007 at 7:55 a.m., the caregiver stated, "I stay up until midnight however, all the residents are home by 10:00 p.m. The residents can come and go, but they are good about telling me when they leave and when they will be back."

On December 12, 2007 at 4:05 p.m., a random resident stated he was not aware of any residents leaving the facility and not returning on time.

On December 12, 2007 the identified resident was not living at the facility and therefore could not be interviewed.

Review of the facility records revealed no documentation regarding a resident leaving the facility and not returning in a timely manner. Additionally, there was no documentation the identified resident required supervision when leaving the facility.

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

Allegation #4: The facility did not give the identified resident a 30-day written notice of discharge, nor assist the resident in finding a new facility to live in.

Findings: Based on record review, it was determined the facility did not provide the identified resident a 30-day written notice of discharge.

The identified resident's record contained a 2-week notice of discharge dated October 26, 2007. Further, there was no documentation the facility provided the identified resident with alternative living options.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.221.01 for not providing the identified resident with all the required termination of admission agreement information. The facility was issued a Summary Suspension on December 13, 2007 which resulted in the loss of a license to operate a Residential Care or Assisted Living Facility in the State of Idaho.

Allegation #5: The facility failed to provided coordination with outside service providers.

Findings: Based on interview and record review, it was determined the facility did not coordinate cares with outside service providers.

On December 12, 2007 at 8:12 a.m., the caregiver stated all current residents required outside service providers as part of their cares. However, she was not aware of who the outside service provider was for each resident, nor how to locate the information.

Review of all the current resident records revealed no contracts, care plans or care notes from outside service providers.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.711.07, 16.03.22.711.08 and 16.03.22.730.03 for not ensuring the records for all residents requiring outside services contained care plans, care notes and contracts from those outside service providers. The facility was issued a Summary Suspension on December 13, 2007 which resulted in the loss of a license to operate a Residential Care or Assisted Living Facility in the State of Idaho.

Allegation #6: Residents were not treated with dignity and respect.

Findings: Based on interview and observation, it could not be determined staff did not treat residents with dignity and respect.

On December 12, 2007 between 7:35 a.m., and 5:30 p.m., there were no observed incidents in which staff did not treat residents with dignity and respect.

On December 12, 2007 between 7:35 a.m., and 5:30 p.m., 4 of 5 residents interviewed denied staff did not treat them with dignity and respect.

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

Allegation #7: The facility did not have a two-day supply of perishable foods.

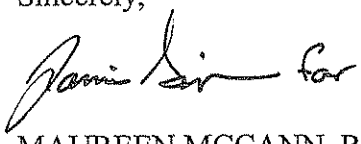
Findings: Based on observation, it could not be determined the facility did not have a two-day supply of perishable foods.

On December 12, 2007 between 4:30 p.m. and 5:30 p.m., dinner preparation was observed and a kitchen inspection was conducted. It was observed a two-day supply of perishable foods were present along with a seven-day supply of non-perishable foods.

Conclusion: Unsubstantiated. Although the allegation may have occurred, it could not be validated during the complaint investigation. However, the facility was cited at 16.03.22.451.01 for not following a menu that was signed and approved by a registered dietician or nutritionist. Additionally, the facility was cited at 16.03.22.451.03 for not providing therapeutic diets.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



MAUREEN MCCANN, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

MM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Maureen McCann, RN, Health Facility Surveyor

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

December 31, 2007

Marilyn Sheppard, Administrator
Ivy Gardens Assisted Living
1107 15th Ave South
Nampa, ID 83651

Dear Ms. Sheppard:

On December 14, 2007, a complaint investigation survey was conducted at Ivy Gardens Assisted Living. The survey was conducted by Rachel Corey, RN, Maureen McCann, RN, Debra Sholley, LSW and Jamie Simpson, MBA, QMRP. This report outlines the findings of our investigation.

Complaint # ID00003263

Allegation #1: Residents were not observed taking their medication.

Findings: Based on observation and interview it was determined facility staff did not observe residents taking their medications.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for failure to provide assistance and monitoring of medication. The facility was issued a Summary Suspension on which resulted in the loss of a license to operate a Residential Care or Assisted Living Facility in the State of Idaho.

Allegation #2: Residents were not assisted with medications as scheduled.

Findings: Based on observation and record review, it could not be determined the facility did not assist with medications as scheduled.

On December 12, 2007 3 of 3 medication adminstration records reviewed documented the residents' medication were given as scheduled

On December 12, 2007 at 5:00 p.m., the caregiver on duty was observed assisting residents with their medications as scheduled.

Conclusion: Unsubstantiated. Although the allegation may have occurred, it could not be validated during the complaint investigation. However, the facility was issued a deficiency at IDAPA 16.03.22.520 for failure to provide adequate care to the residents. The facility was issued a Summary Suspension on December 13, 2007 which resulted in the loss of a license to operate a Residential Care or Assisted Living Facility in the State of Idaho.

Allegation #3: The caregiver sleeps in until 9:30 a.m., and the residents do not get served breakfast.

Findings: Based on observation and interview, it could not be determined the residents did not get served breakfast.

On December 12, 2007 at 7:35 a.m., the caregiver was observed up and awake. Additionally, 4 plastic containers of cold cereal were observed sitting on the breakfast bar.

On December 12, 2007 at 7:45 a.m., the caregiver stated residents usually have cold cereal and coffee for breakfast. However, "if they prefer eggs and toast I prepare that for them."

On December 12, 2007 at 10:45 a.m., a resident stated, "The (caregivers name) is a sweetheart, she caters to my needs and fixes me breakfast in the morning."

Conclusion: Unsubstantiated. Although the allegation may have occurred, it could not be validated during the complaint investigation. However, the facility was cited at 16.03.22.451.01 for not following a menu that was signed and approved by a registered dietician or nutritionist.

Allegation #4: The facility did not provide a secure interior environment and residents could come and go as they wanted.

Findings: Based on observation and interview, it was determined the facility did not provide a secure interior environment.

On December 12, 2007 at 7:35 a.m., the front door of the facility was observed to be unlocked.

On December 12, 2007 at 7:55 a.m., the caregiver stated, "I stay up until midnight however, all the residents are home by 10:00 p.m. The residents can come and go, but they are good about telling me when they leave and when they will be back."

On December 12, 2007 at 4:05 p.m., a resident stated, "If I want to go somewhere I tell staff where I'm going, but I pretty much leave as I please."

Conclusion: Substantiated. However, the facility was not cited as the current residents did not require a secure environment due to their cognition, level of care, and per Idaho rules governing Idaho Assisted Living or Residential Care facilities.

Allegation #5: The facility did not coordinate cares with outside service providers (ACT team).

Findings: Based on interview and record review, it was determined the facility did not coordinate cares with outside service providers.

On December 12, 2007 at 8:12 a.m., the caregiver stated all current residents required outside service providers as part of their cares. However, she was not aware of who the outside service provider was for each resident, nor how to locate the information.

Review of all the current resident records revealed no contracts, care plans or care notes from outside service providers.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.711.07, 16.03.22.711.08 and 16.03.22.730.03 for not ensuring the records for all residents requiring outside services contained care plans, care notes and contracts from those outside service providers. The facility was issued a Summary Suspension on December 13, 2007 which resulted in the loss of a license to operate a Residential Care or Assisted Living Facility in the State of Idaho.

Allegation #6: Unlicensed assistive personnel were filling resident medi-sets in the absense of a licensed nurse.

Findings: Based on interview, it was determined unlicensed assistive personnel were filling medi-sets in the absence of a licensed nurse.

On December 12, 2007 at 8:05 a.m., the caregiver stated one of the residents takes his required afternoon and evening medications in a medi-set to his day treatment program.

On December 12, 2007 at 12:31 p.m., the facility owner's wife confirmed the facility did not have a licensed nurse. Additionally, she confirmed the facility had been without a licensed nurse for approximately one year.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for failure to provide assistance and monitoring of medications. The facility was issued a Summary Suspension on December 13, 2007 which resulted in the loss of a license to operate a Residential Care or Assisted Living Facility in the State of Idaho.

Allegation #7: Residents were not treated with dignity and respect.

Findings: Based on interview and observation, it could not be determined staff did not treat residents with dignity and respect.

On December 12, 2007 between 7:35 a.m., and 5:30 p.m., there were no observed incidents in which staff did not treat residents with dignity and respect.

On December 12, 2007 between 7:35 a.m., and 5:30 p.m., 4 of 5 residents interviewed denied staff did not treat them with dignity and respect.

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

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

MAUREEN MCCANN, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

MM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Maureen McCann, RN, Health Facility Surveyor

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Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

December 12, 2007 **HAND DELIVERED**

Marilyn and Kendall Sheppard, Owners
Ivy Gardens Assisted Living
1107 15th Avenue South
Nampa, ID 83651

RE: Summary Suspension and Revocation of Residential Care and Assisted Living Facility License

Dear Marilyn and Kendall Sheppard,

Please accept this letter as notice that we have found conditions at Ivy Gardens Assisted Living that pose an immediate danger and jeopardy to residents such that it is necessary to summarily suspend your license, transfer residents, and initiate license revocation action.

This action is being taken pursuant to Idaho Code §39-3345, §67-5254, IDAPA 16.03.22.900.01.b and IDAPA 16.03.22.930.01.a. and stems from a survey and complaint investigation of the facility conducted December 12, 2007. During this survey, the surveyors identified the facility is currently operating without a licensed administrator or a licensed nurse. The facility did not employ staff who had been trained to assist residents with their medications. There was no evidence the staff who were employed were trained in CPR or First Aid.

Our surveyors found that the facility is substantially out of compliance with our rules requiring the protection of the health, safety, and welfare of residents. The facility's owners have not employed staff trained and qualified to care for the residents and have not initiated policies and procedures that ensure residents' medical and safety needs are met. As a result, the facility does not have systems in place to ensure residents' emergency needs are met.

Taken together, these deficiencies present conditions that place every resident of the facility at immediate risk for their health, safety, and welfare. For these reasons, the facility's license is suspended immediately, and the residents must be moved out as soon as feasible pursuant to IDAPA 16.03.22.930.01.b. The facility must contract with a licensed nurse or medication certified staff to come in and assist residents with their medications at each med pass until the last resident has moved out. The facility must also ensure at least one staff who is certified in both CPR and FA is present in the facility at all times until the last resident has moved out. If all residents have not moved out by noon on Monday, December 17, 2007, or, if the facility fails to maintain CPR/FA certified staff or persons certified to assist with medications, the Department will impose temporary management pursuant to

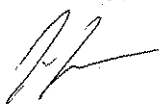
IDAPA 16.03.22.930.01.a. All compensation and per diem costs of the temporary manager must be paid by the licensee.

You have the right to contest the action pursuant to IDAPA 16.05.03.300, by filing a request for administrative review **within 28 days of the date of this letter**. Your request should be directed to:

Randy May, Deputy Administrator
Division of Medicaid-DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

However, because this is an emergency, the license suspension will not be stayed by an appeal.

Sincerely,



JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Community Care Program

JS/sc

Cc: Marie Penav, RN, Region III-DHW
Cathy Hart, State Ombudsman, Idaho Commission on Aging
Sarah Scott, Adult Protection Services, Area III Agency on Aging
Richard Armstrong, Director, Division of Medicaid
Randy May, Deputy Administrator, Division of Medicaid
Paul Leary, Acting Deputy Administrator, Division of Medicaid
Willard Abbott, Deputy Attorney General, Human Service Division