



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-364-1962
FAX: 208-364-1888

May 6, 2014

Malynda Seiler, Administrator
Turtle & Crane
1950 1st Street
Idaho Falls, Idaho 83401

License #: RC-857

Ms. Seiler:

On March 21, 2014, a state licensure/follow-up survey and complaint investigation were conducted at Turtle & Crane. 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.

Your submitted plan of correction and evidence of resolution are being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations, and implement a monitoring system to make certain the deficient practices do not recur.

Thank you for your work to correct these deficiencies. Should you have questions, please contact Karen Anderson, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Karen Anderson, RN

KAREN ANDERSON, RN
Team Leader
Health Facility Surveyor

KA/sc

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



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April 1, 2014

CERTIFIED MAIL #: 7007 3020 0001 4050 8340

Malynda Seiler
Turtle & Crane
1950 1st Street
Idaho Falls, ID 83401

Dear Ms. Seiler:

Based on the state licensure survey and complaint investigation conducted by Department staff at Turtle & Crane between March 20, 2014 and March 21, 2014, it has been determined that the facility failed to protect residents from abuse by failing to implement their abuse policies and procedures. As a result, 1 of 2 female residents was not protected from abuse. Further, the facility failed to protect residents from inadequate care by failing to coordinate care for 2 of 3 sampled residents who were receiving outside services.

These core issue deficiencies substantially limit the capacity of Turtle & Crane to furnish services of an adequate level or quality to ensure that residents' health and safety are protected. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **May 5, 2014**. **We urge you to begin correction immediately.**

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)?
- ◆ By what date will the corrective action(s) be completed?

Malynda Seiler
April 1, 2014
Page 2 of 2

Return the **signed and dated** Plan of Correction to us by **April 14, 2014**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with IDAPA 16.03.22.003.02, 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 ten (10) business days of receipt of the Statement of Deficiencies. See the IDR policy and directions on our website at www.assistedliving.dhw.idaho.gov. If your request for informal dispute resolution is not received within the appropriate time-frame, your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. Your evidence of resolution (e.g., receipts, pictures, policy updates, etc.) for each of the non-core issue deficiencies is to be submitted to this office by **April 20, 2014**.

If, at the follow-up survey, the core deficiency still exists or a new core deficiency is identified, or if any of the six repeat non-core punches are identified as still out of compliance, the Department will have no alternative but to initiate an enforcement action against the license held by Turtle & Crane.

Enforcement actions may include:

- imposition of civil monetary penalties;
- issuance of a provisional license;
- limitation on admission to the facility;
- requirement that the facility hire a consultant who submits periodic reports to Licensing and Certification.

Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions. Should you have any questions, or if we may be of assistance, please contact us at (208) 364-1962 and ask for the Residential Assisted Living Facility program. Thank you for your continued participation in the Idaho Residential Care Assisted Living Facility program.

Sincerely,



JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Assisted Living Facility Program

KA/sc

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R857	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/21/2014
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NAME OF PROVIDER OR SUPPLIER
TURTLE & CRANE

STREET ADDRESS, CITY, STATE, ZIP CODE
1950 1ST STREET
IDAHO FALLS, ID 83401

(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	<p>Initial Comments</p> <p>The following deficiencies were cited during the licensure, follow-up and complaint survey conducted between March 20, 2014 and March 21, 2014, at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Karen Anderson, RN Team Leader Health Facility Surveyor</p> <p>Maureen McCann, RN Health Facility Surveyor</p> <p>Rachel Corey, RN, BSN Health Facility Surveyor</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Survey Definitions:</p> <p>ALF = Assisted Living Facility arterial ulcers = a condition caused by a lack of blood flow to the lower extremities Aspect = part of something bid = twice daily caps = capsules cont = continue cm = centimeters c/o = complained of dc'd = discontinued decubs - decubitus ulcers hr = hour MAR = medication assistance record medial = extending toward the middle meds = medications</p>	R 000		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Malynda Seiler

TITLE

Administrator

(X6) DATE

5-5-14

Bureau of Facility Standards

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R 000	Continued From page 1 mg = milligrams mm = millimeters NSA = Negotiated Service Agreement po = by mouth prn = as needed pt = patient q = every qid = 4 times daily R = right Regs = regulations Res = resident tid = 3 times daily UAI = Uniform Assessment Instrument	R 000		
R 006	16.03.22.510 Protect Residents from Abuse. The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse. This Rule is not met as evidenced by: Based on record review, observations and interviews, it was determined the facility did not implement their abuse policy and procedures. As a result 1 of 2 female residents (Resident #2), who resided in building #1, were not protected from abuse. The findings include: According to the facility's abuse policy, "Any employee who witnesses an act or has any knowledge of resident abuse shall immediately...Call it to the attention of his/her immediate supervisor...Complete the Facility incident report..." The policy further documented, the facility administrator would determine whether or not "the employee or resident should be suspended pending completion of the investigation" and the Incident would be reported	R 006	<i>in compliance as of 5-5-14.</i> 16.03.22.510 Protect Residents from Abuse All-staff meeting was conducted on April 4, 2014 (see Attachment A) which consists of all staff that were present at this meeting. All staff was re-educated to understand company Policy and Procedures concerning abuse. Specific posters on reportable incidents have been posted in all three buildings (see Attachment B). A non-fall incident form has been created and will be implemented at an all-staff meeting to be held on April 18, 2014 for any reportable incident that is not a fall (see Attachment C). Upon orientation, all new hires will have to review the abuse policy and procedures with administrator and will sign showing compliance and understanding of newly implemented abuse polices and Procedures.	

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R 006	<p>Continued From page 2</p> <p>to "the proper authorities within 4 hours of the incident."</p> <p>On 3/20/14, Resident #2 and Resident #5 were observed residing in building one.</p> <p>Resident #5's record documented he was a 94 year-old male, admitted to the facility on 5/21/12, with a diagnosis of hypertension.</p> <p>Resident #5's UAI/NSA, dated 6/11/13, documented he was independent with mobility within the facility, "Oriented to person, place, time...does not require directions or reminding from others...judgement is good, makes appropriate decisions."</p> <p>Resident #2's record documented she was an 84 year-old female admitted to the facility on 9/29/12, with a diagnosis of dementia and osteoporosis.</p> <p>Resident #2's UAI/NSA, dated 10/11/13, documented the resident "is frequently unable to discern and avoid situations in which he/she may be abused, neglected or exploited...occasionally judgment is poor, may make inappropriate decisions,...occasionally disoriented to person, place or time."</p> <p>On 3/20/14 at 7:40 AM, Resident #5 was observed sitting on the edge of his bed in his room. He stated, he was friends with a resident (Resident #2) and was not allowed into her room. He stated, one day he was sitting beside her in her room and the next thing he knew, "She had her shirt off." He stated a caregiver came in and reported it to management and the family of Resident #2; "it became an ordeal." He stated, "I did not touch her bare breast. They should have gotten my side of the story."</p>	R 006	<p>Continued from page 1</p> <p>Resident #5 has moved from the facility.</p> <p>On March 22, 2014</p>	
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R 006	<p>Continued From page 3</p> <p>On 3/20/14 at 8:37 AM, a caregiver stated they heard about an incident where Resident #5 and Resident #2 were found together and Resident #2 did not have her shirt on. The caregiver further stated, he/she was told "it was taken care of and not to worry about it." The caregiver stated, the administrator did not address concerns brought to her and had instructed staff that certain incidents did not need to be documented.</p> <p>On 3/20/14 at 10:15 AM, the house manager stated an incident with Resident #2 and Resident #5 was reported to her by a former caregiver. She stated the caregiver reported that she went into Resident #2's room and her shirt was off and Resident #5 was touching her breasts. She further stated, "I had gotten his side of the story and staffs" and the information was reported to the administrator. She stated, she did not know if it was documented, investigated, or reported to Adult Protection, but "we try to not let him down there (Resident #2's room)". She stated, "he asks to get her up in the morning, but we try to beat him to it." She stated, the family of Resident #2 had instructed them to "keep them apart."</p> <p>On 3/20/14 at 10:25 AM, a caregiver working in the building where Resident #2 and #5 resided, stated she had not heard of an incident occurring with the two residents, but stated staff were "not allowed to leave them in a room together."</p> <p>On 3/20/14 at 10:30 AM, Resident #2's son was interviewed. He stated, it was reported to him, a few months ago, that his mom was found in her room beside Resident #5 with her shirt off. He further stated, Resident #5 was "of sound mind, overbearing and likes to rule the roost." He stated, his mother could be talked "into anything"</p>	R-006		

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R:006	<p>Continued From page 4</p> <p>due to her dementia and "she was always very modest." He stated, she would never have taken her shirt off and "we put a stop to it." He stated, the facility got Resident #5's daughter involved and Resident #5 was no longer allowed into his mother's room. He further stated, "as far as I know there has not been another incident."</p> <p>On 3/20/14 at 11:15 AM, the administrator stated it was reported to her that a staff member walked into Resident #2's room and Resident #5 was "helping her get her blouse on." She stated, Resident #5 was reminded that he was not to be in her room. She further stated, she did not investigate the incident further and did not have the staff member document her observations of the incident. She confirmed the incident was not reported to Adult Protection.</p> <p>On 3/20/14 at 11:28 AM, the former caregiver, who witnessed the incident, stated, a few months ago, she was doing hourly night checks and walked into Resident #2's room. She stated, she could hear two people in the bathroom. She opened the door and Resident #5 was "fondling" Resident #2's breasts. She stated, she reported it to the administrator and nothing was done. She further stated, Resident #5 had been "caught fondling her at least 4 other times." She further stated, she was instructed by the administrator to tell Resident #5 "it was not appropriate" if he was caught "fondling" Resident #2. She further stated, she documented her observations "all over Bluestep (computer program)," but she thought the administrator made the documentation "disappear."</p> <p>On 3/20/14 at 2:37 PM, the ombudsman stated Resident #5 was "cognizant," but had a "confused girlfriend." She further stated, the "facility</p>	R 006		

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R 006	<p>Continued From page 5</p> <p>requests [Resident #5's name] to be supervised with his girlfriend" because he was found with her and her blouse was open. She further stated, she had talked with the administrator and told her it would be inappropriate for the two residents to be alone together. She further stated, she also spoke with Resident #5 and reinforced what she talked with the administrator about.</p> <p>A note dated 3/25/14 was sent to licensing and certification on 3/26/14. The note, which was signed by the facility Operations Director, stated he had been informed of the incident around November 27, 2013.</p> <p>Resident #2 and Resident #5's records were reviewed and did not contain documentation of any incident in which Resident #2 was found with Resident #5 in her room with her shirt off or in which Resident #5 was found fondling Resident #3</p> <p>Care notes printed from an electronic charting system documented the following regarding Resident #5:</p> <p>*11/27/13, "was a good boy and done as he asked and staid [sic] out of [Resident #2's name] room."</p> <p>*12/28/13, Resident #5 "has been worried about [Resident #2's name] today. He hasn't really left her side. He walked her to bed twice..."</p> <p>*12/31/13, Resident #5 "...was coming out of [Resident #2's name] room explsined [sic] to him that he wasn't allowed to be in there..."</p> <p>*1/2/14, "...He showed [Resident #2's name] her room when she forgot..."</p>	R 006		

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R 006	<p>Continued From page 6</p> <p>*1/3/14, "...He helped show [Resident #2's name] where her room was..."</p> <p>*1/13/14, "...noticed he had went and woke up" Resident #2.</p> <p>*1/14/14, "...He asked if he could go wake up [Resident #2's name] i [sic] told him no that she is sleeping, he said she didn't mind waking her up said that it was too early for her to wake up but he had went and done it anyway..."</p> <p>*1/24/14, "He keeps sneaking back to [Resident #2's name]'s room several times after she goes to bed..."</p> <p>*1/29/14, "...woke up once to see if [Resident #2's name] had been out here..."</p> <p>*2/19/14, asked if Resident #2 was up and if he could go and wake her up.</p> <p>*3/17/14, "...woke up once to see if [Resident #2's name] had came out..."</p> <p>On 3/20/14 at 9:04 AM, Resident #5 and Resident #2 were observed sitting together at breakfast. Resident #5 was observed to touch Resident #2's hand. When they were both finished eating, Resident #5 was observed escorting Resident #2 back to her room. Resident #5 stated to Resident #2, "it is the last door on the left." At this time, the surveyor followed Resident #2 into her room (and the end of a hallway) and interviewed her. She stated she was not sure how long she resided at the facility, or all the things staff helped her with, but stated Resident #5 "helps me and checks on me."</p>	R 006		

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R 006	<p>Continued From page 7</p> <p>On 3/20/14 at 10:02 AM, Resident #5 was observed sitting in the dining room asking staff if Resident #2 was asleep in her room.</p> <p>On 3/20/14 at 11:00 AM, Resident #5 was observed sitting in the dining room asking another resident to go check on Resident #2 in her room and see what she was doing.</p> <p>On 3/20/14 at 12:05 PM, Resident #5 was observed escorting Resident #2 to the table for lunch.</p> <p>An incident occurred in which Resident #5 (who was fully cognizant) was found alone, with Resident #2, (who had dementia); her shirt was off and he was fondling her breasts. The administrator did not report the information to Adult Protection, document an investigation or implement interventions to protect Resident #2. Resident #5 continued to have unsupervised access to Resident #2's room. The facility failed to protect Resident #2 from abuse.</p>	R 006		
R 008	<p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to coordinate care for 2 of 3-sampled residents (Resident #3 and #4), who were receiving outside services. The findings include:</p>	R 008	<p>16.03.22.520 Protect Residents from Inadequate care.</p> <ul style="list-style-type: none"> • Company wide training was held April 4, 2014 educating staff on wounds and preventative measures for wounds. Pressure ulcer prevention handout retrieved from Health and Welfare website and distributed to all staff member and med carts for future reference. <ul style="list-style-type: none"> o Verbal teachings on repositioning techniques and the importance of frequent skin assessments and open communication to facility RN and 	

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R 008	<p>Continued From page 8</p> <p>I. Coordination of Care</p> <p>A. Wounds</p> <p>IDAPA 16.03.22.011.08, states inadequate care is "When a facility fails to provide...coordination of outside services."</p> <p>1. Resident #4's record documented she was an 86 year-old female, admitted to the facility on 7/1/13, with a diagnosis of Parkinson's disease.</p> <p>On 3/20/14 at 9:30 AM, Resident #4 was observed sitting on a sofa sleeping. The resident was dressed for the day and was wearing a pair of casual shoes. An interview with the resident was not conducted due to her being asleep.</p> <p>On 3/20/14 at 10:20 AM, a caregiver stated Resident #4 required assistance from caregivers to meet all of her daily needs. She stated the resident was wheelchair bound and relied on caregivers for mobility and transferring.</p> <p>On 3/20/14 at 10:30 AM, a home health RN stated, Resident #4 had a wound on her big and little toes. He stated, he managed her wound care, and the facility nurse managed nursing care for the facility. The home health nurse stated, "I do my own thing and she does her thing."</p> <p>On 3/20/14 at 4:20 PM, another caregiver stated, the resident's big toe had a "black cap" on the end of the toe, and the small toe wound was open and had been open for awhile,</p> <p>On 3/20/14 at 4:35 PM, Resident #4 was sleeping in bed, laying on her right side. Upon observation, the resident's right great toe had a circular wound that was approximately 2 centimeters by 2</p>	R 008	<p>Meetings held with all Outside Service companies servicing this facility specifying our expectations including but not limited to: weekly skin measurements on wounds, direct communication with facility RN, weekly meetings set up with all Outside Service companies to discuss their current patients in our facility, direct communication from staff to RN and RN to staff (RN Communication Form – see Attachment D), and the facility RN will now co-assess Outside Service nurses findings weekly.</p> <ul style="list-style-type: none"> Resident #4 discharged to the hospital for change of condition regarding her iron deficiency March 23, 2014, did not return to facility after this discharge. <p>Facility Nurse will be reviewing all new admissions and all new medication orders. To ensure that all new orders are current and that all medications are in the facility.</p> <p>Facility nurse will be in the facility to implement all new medication orders, staff training of all signs or symptoms on adverse reactions.</p>	

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R 008	<p>Continued From page 9</p> <p>centimeters in diameter with a black colored wound bed. Because the resident was sleeping on her right side, and the side of her foot was laying against the bed, the wound on her right small toe could not be observed. There was no pressure relieving device in place to keep pressure off of the resident's great toe or small toe.</p> <p>Resident #4's NSA, dated 7/22/13, documented she received services from an outside agency. The NSA was not updated to include the status of Resident #4's wounds, nor what interventions were put in place to prevent further skin breakdown.</p> <p>On 9/5/13, a note from the Foot and Ankle Center, documented Resident #4 went to the clinic for an evaluation of her right big toe. The Podiatrist documented, the resident's "Chief Complaint" was "Right big toe pain." The clinical note documented that "Surgical and mechanical debridement" of the toe nail was performed "bilaterally to reduce thickness and length of the toenails."</p> <p>On 10/3/13, a note from the Foot and Ankle Center, documented Resident #4 had a follow-up of an "ingrown toenail right great toe." The Podiatrist documented in the clinical note, the resident had "noticed increased redness and tenderness to the area." The note documented the "medial border of the right great toe was debrided...to alleviate the ingrown area of the toenail."</p> <p>A facility nursing assessment, dated 11/14/13, (over 2 months after the wound developed) documented Resident #4 had a wound on her right great toe caused by an in-grown toenail.</p>	R 008		

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R 008	<p>Continued From page 10</p> <p>There was no further documentation indicating the nurse made recommendations regarding the wound or had followed up to determine if the wound was improving and that Resident #4 continued to be appropriate for assisted living.</p> <p>On 12/18/13, a note from the Foot and Ankle Center, documented Resident #4 complained of pain from an ingrown toenail on her right big toe. The podiatrist documented the "distal aspect" (end of her toe) was "tender to the touch, as well as red in color. However, there is no evidence that this is being caused by an ingrown toenail...She has a small ulcer on the distal aspect, measuring about 3 mm in diameter. The ulcer does not appear to be infected nor is it draining." The Podiatrist's documented, he had dispensed one pair of postoperative shoes to take "pressure off the distal aspect of her toes which is where the pain is greatest."</p> <p>There were eight home health nursing notes contained in Resident #4's record. The home health notes were dated 2/17/14 through 3/10/14. The notes documented the resident received skilled nursing care for dressing changes for a wound on her small right toe. The note did not describe the condition of the wound. There was nothing documented regarding the status of Resident #4's right great toe wound from 2/17/14 through 3/10/14.</p> <p>One of the home health nurse note, dated 2/21/14, documented instructions to have the facility observe the resident's foot and ensure there was no pressure on the resident's right small toe when she laid down. The home health nurse, further documented to "use pressure relieving device to keep pressure off area."</p>	R 008		
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STREET ADDRESS, CITY, STATE, ZIP CODE

TURTLE & CRANE

**1950 1ST STREET
IDAHO FALLS, ID 83401**

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R 008	<p>Continued From page 11</p> <p>Another one of the home health nurse note, dated 2/26/14, documented instructions to "place pillow under R ankle to keep pressure off R small toe."</p> <p>There was no documented evidence, the facility nurse coordinated care to ensure the home health nurse interventions and podiatry orders were implemented.</p> <p>A facility nursing assessment, dated 2/15/14, documented Resident #4 had a wound on her right great toe and a wound on her right little toe. The nurse did not describe either wound. There was no documentation the facility nurse evaluated the resident's wounds to ensure they were improving and that Resident #4 continued to be appropriate for assisted living.</p> <p>On 3/12/14, six months after the first assessment documented on 9/5/13, the facility nurse documented in a progress note, Resident #4 had "Redness to top of R Great toe" and she would continue to monitor the progress of the wound. The facility nurse documented, Resident #4 had a Stage I pressure ulcer on her right small toe that measured "0.9 cm x 0.1 cm." She also documented, the home health nurse would continue to do dressing changes on the small toe until it healed. The facility nurse did not include any recommendations or interventions to prevent further skin breakdown.</p> <p>On 3/20/14 at 4:40 PM, Resident #4's daughter stated that family visited the resident daily. She stated the family had concerns related to the wound on her mother's big toe as it had not improved, and was present prior to November. She stated home health was currently managing the wound care for her toes. The family member stated she had never observed interventions to</p>	R 008		

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R.008	<p>Continued From page 12</p> <p>keep the pressure off of her mother's big and little toes. The daughter stated she thought about placing an object under the covers, to keep them off her toes and put something under her feet to keep them up and off the bed. The daughter said her mother had a pair of special shoes in the closet to keep pressure off her toes while she was out of bed; however, she had not observed her mother wearing the shoes.</p> <p>A facility nursing assessment, dated 3/20/14, documented Resident #4 had wounds on her right great toe and right little toe. She documented the wound on the right great toe was a Stage II, had a cap over the wound and was "slowly healing." Yet the nurse documented the wound was a Stage I on 3/12/14, and had progressed to a "Stage II" on 3/20/14. The facility nurse documented the following recommendations "When Resident is in bed staff will help with proper positioning and turning as needed to aide [sic] in pressure ulcer healing. When edema is present aide [sic] in elevating legs while sitting..." The nurse did not document specifically how staff were to properly position the resident to aid in pressure ulcer healing.</p> <p>On 3/25/14, a home health agency, sent additional information to the survey team. An un-dated hand written note, by the Director of Nurses' documented, "Both wounds on her R foot are arterial ulcers. As such, they are not staged - only pressure wounds are staged. Thus they are not unstageable wounds." The Director of Nurses, further documented "the wound near the small toe had decreased in size from previous, and as arterial wound is not staged. The area on the R great toe HAS improved as ALF regs require improvement..."</p>	R 008		

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R 008	<p>Continued From page 13</p> <p>Resident #4 had a wound on her right great toe that was identified on 9/5/13. There was no documentation by the facility or the outside agency that the wound on her big toe improved or had healed. A Podiatrist's evaluation, dated 12/18/13, documented the resident had a small ulcer on the end of her right great toe that measured about 3 mm in diameter. On 3/20/14, a home health nurse took a photo of the resident's right great toe. The measurement of the wound was approximately 2 centimeters in diameter, as opposed to the 3 mm measurement on 12/18/13.</p> <p>From 11/14/13 though 3/20/14, Resident #4 had two identified wounds on her toes. The facility nurse did not ensure she coordinated care with the home health nurses, to determine if the resident's wounds were improving and appropriate for assisted living. Additionally, the facility nurse did not evaluate if the interventions recommended by the home health nurses were implemented to further reduce skin breakdown. As a result, the wound on the resident's right great toe that was identified on 9/5/13, persisted and had increased over six times in size. Further, another wound on the same foot developed.</p> <p>The home health nurse, facility nurse and podiatry documentation were incongruent regarding the status of Resident #4's wounds. This indicated the facility did not appropriately coordinate care by reviewing outside agency notes and seeking clarification when needed. Additionally, interventions recommended by home health and podiatry were not implemented. As a result, Resident #4 had one wound that persisted for six months. Additionally, the resident developed another wound on the same foot. The facility nurse documented this wound had progressed from a Stage I to a Stage II over a</p>	R 008		

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R 008	<p>Continued From page 14</p> <p>one month time frame.</p> <p>2. Resident #3's record documented he was a 73 year-old male, admitted to the facility on 1/4/14, with diagnoses of dementia, a history of a compression fracture of his spine, severe kyphosis and chronic back pain.</p> <p>The following home health nurse notes, were documented in Resident #3's record:</p> <p>* 2/14/14: Resident #3 had three, Stage II pressure ulcers to coccyx.</p> <p>* 3/10/14: Resident #3 had two, Stage II pressure ulcers to coccyx. The description of the wounds documented they were:</p> <p>* "#1 wound 1x1"</p> <p>* "#2 wound 1x1"</p> <p>There were no other wound measurements documented by licensed nurses in Resident #3's record.</p> <p>The following progress notes, documented by caregivers, were contained in Resident #3's record:</p> <p>* 2/8/14 at 9:58 PM: A caregiver "discovered two pea size decubs on his bottom."</p> <p>* 2/14/14 at 12:48 PM: Home health to "dress his bottom."</p> <p>* 3/8/14 at 10:00 AM: The house manager documented, the resident's "buttocks remain the same as in they are not healing that I can see since he went on to home health [2/14/14]."</p>	R 008		

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R 008	<p>Continued From page 15</p> <p>* 3/18/14 1:56 PM: The house manager documented, "I am concerned today as the two open areas on both butt cheeks look the very same as they did when he first started home health."</p> <p>An RN assessment, dated 2/15/14, documented Resident #3's skin was "pink, warm" and had "2 bedsores on buttock & rash on neck." The note did not include the size of the wounds or document if the nurse had evaluated if the wounds were improving.</p> <p>An RN progress note, dated 3/10/14, documented "Resident has two Stage I wounds to coccyx. Home Health into do dressing changes." There were no other facility nurse notes regarding skin issues in the resident's record since his admission on 1/4/14.</p> <p>There was no wound assessment documentation in Resident #3's record from either the facility nurse or a home health nurse which described the resident's wounds to determine if they were improving bi-weekly.</p> <p>On 3/20/14 at 11:00 AM, the home health skilled nurse who had been attending to Resident #3's wounds, stated she had never met the facility nurse. She stated she felt the resident needed to be seen more than twice weekly to manage his wounds, but the agency had only been authorized 2 visits a week. She stated there had not been coordination of care with the facility nurse to discuss the resident needing an increase in skilled nursing visits which could have included the facility nurse also attending to the resident's wounds.</p>	R 008		

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R 008	<p>Continued From page 16</p> <p>On 3/20/14 at 12:40 PM, the house manager stated when a resident had a change in condition and the resident was receiving outside agency services, she had been instructed to contact the nurse from the outside agency. She stated the facility nurse, "usually lets the home health or hospice agency take over."</p> <p>On 3/20/14 at 2:30 PM, the house manager stated she felt the home health nurse "needed to come in more often" than twice weekly to care for Resident #3's buttock wounds.</p> <p>The facility nurse did not coordinate wound care with Resident #3 and #4's home health agencies to assure the residents' wounds were in accordance with the assisted living facility's licensing rules. This failure resulted in inadequate care.</p> <p>II. Assistance and Monitoring of Medications:</p> <p>A. Valproic acid:</p> <p>1. Resident #3's record documented he was a 73 year-old male, admitted to the facility on 1/4/14, with diagnoses of dementia, a history of a compression fracture of his spine, severe kyphosis and chronic back pain.</p> <p>Medication orders, dated 1/31/14, documented Resident #3 was to take valproic acid 250 mg by mouth tid for mood stabilization.</p> <p>Resident #3's January through March 2014 MARs were reviewed. Valproic acid was not documented on any of the MARs.</p> <p>On 3/20/14 at 2:40 PM, the administrator confirmed valproic acid was not on Resident #3's</p>	R 008		

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R 008	<p>Continued From page 17</p> <p>MAR and that she could not find a physician's order discontinuing the medication.</p> <p>On 3/20/14, Resident #3's medications were observed. Valproic acid for Resident #3 was not found in the medication cart.</p> <p>Resident #3 did not receive valproic acid for at least 48 days.</p> <p>B. Pain medications:</p> <p>Resident #3's MARs were reviewed. The resident received the following pain medications between 1/4/14 and 3/19/14:</p> <ul style="list-style-type: none"> * 1/4/14 - 1/14/14: Oxycodone 5 mg tid * 1/15/14 - 2/10/14: Hydrocodone 5/325 mg tid * 2/11/14 - 2/21/14: Oxycodone 5 mg qid * 2/22/14 - 3/12/14: Acetaminophen-Oxycodone 325/5 mg qid * 3/12/14 - 3/19/14: Morphine 30 mg bid <p>The following physician's orders were found in the Resident's record:</p> <ul style="list-style-type: none"> * 10/23/13: "Acetaminophen/hydrocodone 325/5 TID prn - usually 2 caps daily." * 1/31/14: "Oxycodone 1-2 tabs po q6 h prn pain...advised ALF staff to ramp up slowly to prevent oversedation causing falls, respiratory depression and constipation." The medication was documented to be given as a routine medication on Resident #3's MAR. 	R 008		

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R 008	<p>Continued From page 18</p> <p>The dates of the physician's orders found in the resident's record, did not correspond with the dates which pain medications were changed. There was no physician's order found for morphine. There was no documentation explaining these discrepancies.</p> <p>On 3/20/14, morphine tabs were observed in the medication cart for Resident #3. There was no hydrocodone or oxycodone observed in the medication cart.</p> <p>The following progress notes were documented in Resident #3's record by caregivers:</p> <ul style="list-style-type: none"> * 1/5/14: The resident's family member told the staff the resident would get agitated when he was in pain. * 1/14/14: The resident "was extremely aggitated [sic] this am. He spat his pills out at me...he was swearing a lot using the F [sic] word on anybody...he claimed that he is always in pain with his back. i [sic] will cont to monitor him. i [sic] believe his aggitation [sic] is from a lot of breakthrough pain." * 1/16/14: The resident complained of "pain to his back x4 today." * 1/17/14: The resident had "a good day for the most part" other than needing "stronger pain meds" for his back. * 1/22/14: The resident had "a lot of agitation." The caregiver spoke with the home health nurse about getting a pain patch for the resident and "gave a prn clonaxepam [sic] for anxiety." * 1/23/14: The resident complained of "a lot" of 	R 008		

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R 008	<p>Continued From page 19</p> <p>breakthrough pain and complained of "his head hurting."</p> <p>* 1/24/14: The resident complained of "pain to his back and head."</p> <p>* 1/28/14. The resident still complained of pain to lower back.</p> <p>* 2/1/14: The resident "has been in a lot of pain tonight."</p> <p>* 2/4/14: The resident "continues to c/o back pain all the time."</p> <p>* 2/7/14: The resident was "in a lot of pain today. had tears in his eyes he was in so much pain."</p> <p>* 2/10/14: "A lot of break through pain."</p> <p>* 2/17/14: The resident was very agitated even after receiving clonazepam. He continued to complain of back pain. The caregiver documented she would notify the physician's office that the resident continued to complain of pain, "thus causing him agitation [sic] and increased anxiety."</p> <p>* 2/27/14: The resident complained of "a broken back today."</p> <p>* 2/28/14: The resident came back from a physician's visit in severe pain. "Stated that he is in a lot of pain."</p> <p>* 3/3/14: The resident still complains of "a broken back."</p> <p>* 3/6/14: The resident is still complaining "everyday about pain."</p>	R 008		

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R 008	<p>Continued From page 20</p> <p>* 3/12/14: "Oxycodone was dc'd this am." The resident is now taking "morphine 30 mg. q12 h."</p> <p>* 3/19/14: The resident "js not complaining of a lot of back pain but is walking with some struggle today."</p> <p>On 3/20/14 between 3:15 PM and 3:40 PM, the house manager and a caregiver stated Resident #3 had a lot of pain, but it appeared to be better controlled since he began taking morphine.</p> <p>An RN assessment, dated 1/4/14, documented Resident #3 had back pain which was controlled by hydrocodone.</p> <p>An RN assessment, dated 2/15/14, documented in Resident #3 had back pain which was controlled by oxycodone.</p> <p>The facility nurse did not appropriately evaluate Resident #3's response to the prescribed pain medications and report her concerns back to the physician. Caregivers documented the resident continued to complain of pain yet the nurse documented the resident's pain was controlled. As a result, Resident #3 continued to experience unrelieved pain.</p> <p>C. Behavior Medications:</p> <p>A behavior management plan was not found in Resident #3's record.</p> <p>Resident #3's NSA (care plan) dated, 1/18/14, documented the following entries under the following headings:</p> <p>* "Behavioral Management...Resident has</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R857	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/21/2014
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NAME OF PROVIDER OR SUPPLIER TURTLE & CRANE	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 1ST STREET IDAHO FALLS, ID 83401
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(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 008	<p>Continued From page 21</p> <p>aggressive behavior."</p> <p>* "Disruptive/Socially Inappropriate Behavior...Is not disruptive, aggressive, or socially inappropriate, is not dangerous to self or others."</p> <p>* "Medications...Facility RN will monitor medications...every 90 days, more if needed."</p> <p>An RN assessment, dated 1/4/14, documented Resident #3 was alert, confused and oriented to person. The nurse did not complete the section regarding behaviors.</p> <p>An RN assessment, dated 2/15/14, documented Resident #3 was lethargic, confused and forgetful and had "Physically/verbally aggressive, exit seeking behaviors." The assessment did not include an evaluation of the potential causes of resident's behaviors.</p> <p>The following were physician's orders for Resident #3's behavior modifying medications:</p> <p>* 1/31/14: Valproic acid 250 mg by mouth tid a day for mood stabilization.</p> <p>* 1/13/14: Clonazepam 1 mg by mouth bid as needed for agitation.</p> <p>* 2/26/14: Risperidone 5 mg po bid for mood stabilization.</p> <p>Physician clinic notes documented the following:</p> <p>* "2/20/14 12:36 ADDENDUM", documented by a nurse at the physician's office to the physician. The house manager at Resident #3's assisted living facility "is wondering if she can discuss the pt mood stabilizer medications with you by</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R857	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2014
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NAME OF PROVIDER OR SUPPLIER TURTLE & CRANE	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 1ST STREET IDAHO FALLS, ID 83401
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(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-008	<p>Continued From page 22</p> <p>telephone, she is requesting an additional medication if possible."</p> <p>* 2/28/14: The physician documented, the "manager of the ALF...wanted to try him on risperidone so I decided to order 0.5 mg bid. Risk of stroke discussed." The note further documented, the nurse practitioner had prescribed valproic acid. "Continue current medications" which included, clonazepam 1 mg bid and valproic acid 250 mg tid.</p> <p>Resident #3's January through March 2014 MARs were reviewed. Valproic acid was not documented on any of the MARs.</p> <p>The following progress notes were documented in Resident #3's record by caregivers:</p> <p>* 1/5/14: The resident's family member told the staff when the resident was in pain, he got agitated.</p> <p>* 1/11/14: The resident was very agitated.</p> <p>* 1/14/14: The resident "was extremely aggitated [sic] this am. He spat his pills out at me...he was swearing a lot using the F [sic] word on anybody...he claimed that he is always in pain with his back. i [sic] will cont to monitor him. i [sic] believe his aggitation [sic] is from a lot of breakthrough pain."</p> <p>* 1/15/14: The resident "was given a prn clonzapam [sic] this am for increased anxiety."</p> <p>* 1/22/14. The resident had "a lot of agitation." Spoke with the home health nurse about a pain patch and "gave a prn clonaxepam [sic] for anxiety."</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R857	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2014
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NAME OF PROVIDER OR SUPPLIER TURTLE & CRANE	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 1ST STREET IDAHO FALLS, ID 83401
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R 008	<p>Continued From page 23</p> <p>* 2/9/14: The resident was agitated "most of the day."</p> <p>* 2/11/14: The resident received "prn clonazepam given at 1300...this res has been extremely irritated all shift."</p> <p>* 2/13/14: The resident "has been very aggitated [sic] today...a prn clonazepam had little effect.</p> <p>* 2/17/14: The resident was very agitated even after receiving clonazepam. He continued to complain of back pain. The caregiver documented she would notify the physician's office that the resident continued to complain of pain, "thus causing him aggitation [sic] and increased anxiety."</p> <p>* 2/20/14: A physician's order was received for a new pain medication as well as a new behavior modifying medication.</p> <p>* 2/23/14: The resident was very agitated today.</p> <p>* 2/25/14: The resident was agitated in the morning.</p> <p>* 2/27/14: The resident was very agitated tonight.</p> <p>* 3/2/14: The resident was "agetated [sic] for most of my shift using a lot of profanity and banging on doors, stripped his bed several [sic] times..."</p> <p>* 3/5/14: The resident "started to get a little agitated in the afternoon, wondered [sic] halls."</p> <p>* 3/6/14: The resident was "wandering, slamming doors, swearing at traffic...somewhat defiant. prn</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R857	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2014
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NAME OF PROVIDER OR SUPPLIER TURTLE & CRANE	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 1ST STREET IDAHO FALLS, ID 83401
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R 008	<p>Continued From page 24</p> <p>clonazepam today."</p> <p>* 3/12/14: The resident "has been much calmer with the resperadone [sic] on board."</p> <p>* 3/12/14: The resident "had a very good night much more plesent [sic] sence [sic] they changed his meds."</p> <p>A home health visit note, dated 2/14/14, documented the nurse had sent a message to the physician "concerning meds for behaviors. Give a Clonazepam for agitation today if needed."</p> <p>No facility nurse progress notes or assessments were found in Resident #3's record regarding the resident's behaviors or the need for behavior modifying medications. There was no documentation of facility nurse involvement when a caregiver requested an additional behavior modifying medication from the physician. Finally, there was no nursing assessment to determine if the agitation was related to unmanaged pain.</p> <p>The facility did not appropriately assist with Resident #3's valproic acid when he did not receive the medication for 48 days. The facility nurse did not appropriately monitor Resident #3's medications to determine if Resident #3's pain medication was effective and if his agitation was related to unmanaged pain.</p> <p>The facility failed to provide coordination of medical care for Resident #3 and #4's wounds. Additionally, the facility failed to appropriately assist with, and monitor Resident #3's medications. This resulted in inadequate care.</p>	R 008		

Facility TURTLE & CRANE	License # RC-857	Physical Address 1950 1ST STREET	Phone Number (208) 557-0186
Administrator Malynda Seiler	City IDAHO FALLS	ZIP Code 83401	Survey Date March 21, 2014
Survey Team Leader Karen Anderson	Survey Type Licensure, Follow-up and Complaint Investigation	RESPONSE DUE: April 20, 2014	
Administrator Signature	Date Signed		
<i>Malynda Seiler</i>	<i>3-21-14</i>		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	009.01	One of 7 staff worked on the night shift alone without having a Criminal History Check completed. ***Previously cited on 1/29/09	4/21/14	KA
2	225.01	The facility did not evaluate behaviors for Resident #3, #6 and #7.	4/21/14	KA
3	225.02	The facility did not develop interventions for Resident #3, #6 and #7's specific behaviors.		
4	250.10	The cold water faucet in the kitchen handwashing sink bld 2 was not working.	4/21/14	KA
5	300.01	The facility nurse did not assess changes in conditions to include Residents #3 and #4's pressure ulcers, and when Residents' #3, #4 and a random resident experienced acute declines in cognition and functioning. ****Previously cited on 11/4/10.	4/21/14	KA
6	305.04	The facility RN did not make recommendations for treating and preventing further breakdown of wounds for Residents #1, #3 and #4.	4/21/14	KA
7	305.07	The facility RN did not conduct a review of Residents' #3 and #4, and a random resident's medications for side effects and interactions. ***Previously cited 1/29/09	4/21/14	KA
8	310.01.d	Unlicensed caregivers administered PRN psychotropics medications, without consulting the nurse.	4/21/14	KA
9	310.04.a	Non-medication interventions, including behavior management were not attempted prior to utilizing psychotropic medications to address behaviors.	4/21/14	KA
10	310.04.e	Behavior updates were not provided to the physician for conducting psychotropic medication reviews for Residents' #2 & 6.	4/21/14	KA
11	320.01	NSAs did not clearly described residents' needs such as preventative measures for skin breakdown and Resident #2's dietary needs.	4/21/14	KA
12	350.02	Administrator did not investigate all complaints, incidents and accidents, such as Resident #7's violent outbursts toward both residents and staff. ***Previously cited 1/29/09	4/21/14	KA
13	350.04	Administrator did not provide a written response to complainants.	4/21/14	KA



Facility TURTLE & CRANE	License # RC-857	Physical Address 1950 1ST STREET	Phone Number (208) 557-0186
Administrator Malynda Seiler	City IDAHO FALLS	ZIP Code 83401	Survey Date March 21, 2014
Survey Team Leader Karen Anderson	Survey Type Licensure, Follow-up and Complaint Investigation		RESPONSE DUE: April 20, 2014
Administrator Signature <i>Malynda Seiler</i>	Date Signed <i>3-21-14</i>		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
14	350.07	The facility did not notify L&C of reportable incidents such as, when a resident grabbed another by the wrist, and would not let go, causing red marks, and when Resident #4 required hospitalization due to a medication error. ***Previously cited 1/29/09 & 11/4/10	4/21/14	KA
15	430.03	A random resident did not have a bed.	4/21/14	KA
16	600.05	A night shift staff worked alone without first completing orientation training. Staff interviewed had not been trained on policies, procedures, documentation or behavior management.	4/21/14	KA
17	630.01	Three staff interviewed had not had specialized training in dementia.	4/21/14	KA
18	711.08.a	There was no documentation for when Resident #2 refused her diet.	4/21/14	KA
19	711.08.c	Not all unusual events were documented, nor did all staff have the capability to document in resident files, or the computer system.	4/21/14	KA
20	711.08.e	There was no documentation in the records of when the facility RN had been contacted for changes of condition. ***Previously cited 11/4/10***	4/21/14	KA
21				
22				
23				
24				
25				
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27				
28				
29				
30				



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-364-1962
FAX: 208-364-1888

April 1, 2014

Malynda Seiler, Administrator
Turtle & Crane
1950 1st Street
Idaho Falls, Idaho 83401

Ms. Seiler:

An unannounced, on-site complaint investigation survey was conducted at Turtle & Crane between March 20, 2014 and March 21, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006422

Allegation #1: The administrator did not provide a written response to family members and residents when there were complaints related to visiting hours and not being able to bring their loved one home made food.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.04 for the administrator not providing a written response to complainants. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

KAREN ANDERSON, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

KA/sc

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



IDAHO DEPARTMENT OF

HEALTH & WELFARE Food Establishment Inspection Report

Residential Assisted Living Facility Program, Medicaid L & C
3232 W. Elder Street, Boise, Idaho 83705
208-334-6626

Critical Violations

Noncritical Violations

Establishment Name <u>Twille and Course</u>		Operator <u>Mahyada Seider</u>	
Address <u>1950 1st Idaho Falls</u>			
County	Estab #	EHS/SUR.#	Inspection time: <u>11:00 AM</u> Travel time:
Inspection Type: <u>Standard</u>		Risk Category: <u>High</u>	
Follow-Up Report: OR		On-Site Follow-Up:	
Date: _____		Date: _____	
Items marked are violations of Idaho's Food Code, IDAPA 16.02.19; and require correction as noted.			

# of Risk Factor Violations <u>4</u>	# of Retail Practice Violations <u>0</u>
# of Repeat Violations	# of Repeat Violations
Score <u>4</u>	Score <u>0</u>
A score greater than 3 Med or 5 High-risk = mandatory on-site reinspection	A score greater than 6 Med or 8 High-risk = mandatory on-site reinspection.

RISK FACTORS AND INTERVENTIONS (Idaho Food Code applicable sections in parentheses)

The letter to the left of each item indicates that item's status at the inspection.

	Demonstration of Knowledge (2-102)	COS	R
<input checked="" type="checkbox"/> N	1. Certification by Accredited Program; or Approved Course; or correct responses; or compliance with Code	<input type="checkbox"/>	<input type="checkbox"/>
Employee Health (2-201)			
<input checked="" type="checkbox"/> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
Good Hygienic Practices			
<input checked="" type="checkbox"/> N	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	4. Discharge from eyes, nose and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
Control of Hands as a Vehicle of Contamination			
<input checked="" type="checkbox"/> N	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	7. Handwashing facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>
Approved Source			
<input checked="" type="checkbox"/> N	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
Protection from Contamination			
<input checked="" type="checkbox"/> N	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	13. Returned / reservice of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>

	Potentially Hazardous Food Time/Temperature	COS	R
<input checked="" type="checkbox"/> N	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
Consumer Advisory			
<input checked="" type="checkbox"/> N	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
Highly Susceptible Populations			
<input checked="" type="checkbox"/> N	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
Chemical			
<input checked="" type="checkbox"/> N	24. Additives / approved, unapproved (3-207)	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> N	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	<input type="checkbox"/>	<input type="checkbox"/>
Conformance with Approved Procedures			
<input checked="" type="checkbox"/> N	26. Compliance with variance and HACCP plan (8-201)	<input type="checkbox"/>	<input type="checkbox"/>

Y = yes, in compliance N = no, not in compliance
N/O = not observed N/A = not applicable
COS = Corrected on-site R = Repeat violation
 = COS or R

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<u>Yogurt</u>	<u>41.0</u>	<u>minted potatoes</u>	<u>47.5</u>	<u>bronte tea</u>	<u>210</u>		
<u>Sausage gravy</u>	<u>53.7</u>	<u>potatoes</u>	<u>56</u>	<u>reheated potatoes</u>	<u>170</u>		

GOOD RETAIL PRACTICES (input checked box = not in compliance)

	COS	R		COS	R		COS	R
<input type="checkbox"/> 27. Use of ice and pasteurized eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 34. Food contamination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 42. Food utensils/in-use	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 28. Water source and quantity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 35. Equipment for temp. control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 43. Thermometers/Test strips	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 29. Insects/rodents/animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 36. Personal cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 44. Warewashing facility	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 30. Food and non-food contact surfaces: constructed, cleanable, use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 37. Food labeled/condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 45. Wiping cloths	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 31. Plumbing installed; cross-connection; back flow prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 38. Plant food cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 46. Utensil & single-service storage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 32. Sewage and waste water disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 39. Thawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 47. Physical facilities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 33. Sinks contaminated from cleaning maintenance tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 40. Toilet facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 48. Specialized processing methods	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> 41. Garbage and refuse disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 49. Other	<input type="checkbox"/>	<input type="checkbox"/>

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) <u>Mahyada Seider</u> (Print)	Title <u>Operator</u>	Date <u>3-21-14</u>
Inspector (Signature) <u>[Signature]</u> (Print)	Date <u>3-20-14</u>	Follow-up: (Circle One) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>



Residential Assisted Living Facility Program, Medicaid L & C
3232 W. Elder Street, Boise, Idaho 83705
208-334-6626

Page 2 of 2
Date 3-20-14

Establishment Name <i>Turtle and Crane</i>	Operator <i>Malynda Sider</i>	
Address <i>1950 1st Idaho Falls</i>		
County Estab #	EHS/SUR.#	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

- 5. Kitchen staff did not change gloves between tasks or wash hands when changing gloves.
 - 12. Bleach sanitizing solution measured too strong.
 - 17. A casserole, mashed potatoes and sausage gravy was prepared on the night shift and not cooled properly. At 11:30 AM each measured above 41°.
 - 20. Not all left overs were date marked.
- Evidence of resolution due 3/31/14

Person in Charge <i>Malynda Sider</i>	Date <i>3-21-14</i>	Inspector <i>[Signature]</i>	Date <i>3-20-14</i>
--	------------------------	---------------------------------	------------------------