



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

October 9, 2014

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

Provider ID: RC-857

Ms. Seiler:

On August 6, 2014, a state licensure/follow-up survey was 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 Gloria Keathley, LSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

GLORIA KEATHLEY, LSW
Team Leader
Health Facility Surveyor

GK/sc

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



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P.O. Box 83720
Boise, Idaho 83720-0009
EMAIL: rafc@dhw.idaho.gov
PHONE: 208-364-1962
FAX: 208-364-1888

August 20, 2014

CERTIFIED MAIL #: 7007 3020 0001 4050 8524

Malynda Seiler, Administrator
Turtle & Crane
PO Box 2122
Idaho Falls, Idaho 83403

Ms. Seiler:

On August 6, 2014, a state licensure/follow-up survey was conducted by Department staff at Turtle & Crane. The facility was cited with a core issue deficiency for failing to protect residents from inadequate care.

This core issue deficiency substantially limits the capacity of Turtle & Crane to provide for residents' basic health and safety needs. The deficiency is described on the enclosed Statement of Deficiencies.

PROVISIONAL LICENSE:

As a result of the survey findings, a provisional license is being issued to the facility effective August 20, 2014. The license will remain in effect through February 16, 2015. **Please return the license currently held by the facility.** The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.

A provisional license may be issued when a facility is cited with one (1) or more core issue deficiencies, or when non-core issues have not been corrected or become repeat deficiencies. The provisional license will state the conditions the facility must follow to continue to operate. See Subsections 900.04, 900.05 and 910.02 of these rules.

The conditions 1- 5 of the provisional license are as follows:

CONSULTANT:

1. A licensed residential care administrator or residential care RN consultant, with at least three years' experience working as an administrator or RN for a residential care or assisted living facility in Idaho, shall be obtained and paid for by the facility, and approved by the Department. This consultant must have an Idaho Residential Care Administrator's license or be properly licensed through the Idaho Board of Nursing and may not also be employed by the facility or the company that operates the facility. The purpose of the consultant is to assist the facility in identifying and implementing appropriate corrections for the deficiencies. Please provide a copy of the enclosed consultant report content requirements to the

consultant. The consultant shall be allowed unlimited access to the facility's administrative, business and resident records and to the facility staff, residents, their families and representatives. The name of the consultant with the person's qualifications shall be submitted to the Department for **approval no later than August 29, 2014.**

CONSULTANT REPORTS:

2. A weekly written report must be submitted by the Department-approved consultant to the Department commencing on **September 5, 2014.** The reports will address progress on correcting the core deficiency identified on the Statement of Deficiencies as well as the non-core deficiencies identified on the punch list. When the consultant and the administrator agree the facility is in full compliance, they will notify the Department and request a follow-up survey be scheduled.

PLAN OF CORRECTION:

3. 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?

An acceptable, **signed** and **dated** Plan of Correction must be submitted to the Division of Licensing and Certification within **ten (10) calendar days of your receipt of the Statement of Deficiencies.** You are encouraged to immediately develop and submit this plan so any adjustments or corrections to the plan can be completed prior to the deadline.

EVIDENCE OF RESOLUTION:

4. Non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) describes the requirements for submitting evidence that the non-core issue deficiencies have been resolved:

910. Non-core Issues Deficiency.

01. Evidence of Resolution. *Acceptable evidence of resolution as described in Subsection 130.09 of these rules, must be submitted by the facility to the Licensing and Survey Agency. If acceptable evidence of resolution is not submitted within sixty (60) days from when the facility was found to be out of compliance, the Department may impose enforcement actions as described in Subsection 910.02.a through 910.02.c of these rules.*

The eight (8) non-core issue deficiencies must be corrected and evidence (including but not limited to receipts, pictures, completed forms, records of training) must be submitted to this office by **September 5, 2014.**

CIVIL MONETARY PENALTIES

5. Of the eight (8) non-core issue deficiencies identified on the punch list, five (5) were repeat punches. One (1) of the repeat deficiencies was cited on both of the two (2) previous surveys, 11/4/2010 and 3/21/2014. This repeat deficiency is listed below.

300.01 - Licensed Professional Nurse. A licensed professional nurse (RN) must visit the facility at least once every ninety (90) days or when there is a change in the resident's condition. The licensed professional nurse is responsible for delegation of all nursing functions, according to IDAPA 23.01.01, "Idaho Board of Nursing Rules," Section 400.

The following administrative rules for Residential Care or Assisted Living Facilities in Idaho give the Department the authority to impose a monetary penalty for this violation:

IDAPA 925. ENFORCEMENT REMEDY OF CIVIL MONETARY PENALTIES.

01. Civil Monetary Penalties. Civil monetary penalties are based upon one (1) or more deficiencies of noncompliance. Nothing will prevent the Department from imposing this remedy for deficiencies which existed prior to survey or complaint investigation through which they are identified. Actual harm to a resident or residents does not need to be shown. A single act, omission or incident will not give rise to imposition of multiple penalties, even though such act, omission or incident may violate more than one (1) rule.

02. Assessment Amount for Civil Monetary Penalty. When civil monetary penalties are imposed, such penalties are assessed for each day the facility is or was out of compliance. The amounts below are multiplied by the total number of occupied licensed beds according to the records of the Department at the time noncompliance is established.

b. Repeat deficiency is ten dollars (\$10). (Initial deficiency is eight dollars (\$8)).

For the dates of 5/8/2014 through 8/6/2014:

Penalty	Number of Deficiencies	Times number of Occupied Beds	Times Number of days of non-compliance	Amount of Penalty
\$10.00	1	44	90	\$ 39,600

Maximum penalties allowed in any ninety-day period per IDAPA 16.03.22.925.02.c:

# of Occupied Beds in Facility	Initial Deficiency	Repeat Deficiency
3-4 Beds	\$1,440	\$2,880
5-50 Beds	\$3,200	\$6,400
51-100 Beds	\$5,400	\$10,800
101-150 Beds	\$8,800	\$17,600
151 or More Beds	\$14,600	\$29,200

Your facility had 44 occupied beds at the time of the survey. Therefore, your maximum penalty is: \$6400.

Send payment of \$6,400 by check or money order, made payable to:

Licensing and Certification

Mail your payment to:

**Licensing and Certification - RALF
PO Box 83720
Boise, ID 83720-0009**

Payment must be received in full within 30 calendar days from the date this notice is received. Interest accrues on all unpaid penalties at the legal rate of interest for judgments. Failure of a facility to pay the entire penalty, together with any interest, is cause for revocation of the license.

ADMINISTRATIVE REVIEW

You may contest the provisional license, requirement for a consultant or civil monetary penalty by filing a written request for administrative review pursuant to IDAPA 16.05.03.300, which states: **the request must be signed by the licensed administrator of the facility, identify the challenged decision, and state specifically the grounds for your contention that this decision is erroneous.** The request must be received **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

**Tamara Prisock, Administrator
Division of Licensing and Certification - DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036**

Upon receipt of a written request that meets the requirements specified in IDAPA 16.05.03.300, an administrative review conference will be scheduled and conducted. The purpose of the conference is to clarify and attempt to resolve the issues. A written review decision will be sent to you within thirty (30) days of the date of the conclusion of the administrative review conference.

If the facility fails to file a request for administrative review within the time period, this decision shall become final.

INFORMAL DISPUTE RESOLUTION

Pursuant to IDAPA 16.03.22.003.02, you have available the opportunity to question the core issue deficiency 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 Assisted Living Facility Program for an IDR meeting. The request for the meeting must be in writing and must be made within ten (10) business days of receipt of the Statement of Deficiencies. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal, including reference to the specific deficiency to be reconsidered and the basis for the reconsideration request. If your request for informal dispute resolution is received more than ten (10) days after you receive the Statement of Deficiencies, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at www.assistedliving.dhw.idaho.gov under the heading of Forms and Information.

FOLLOW-UP SURVEY

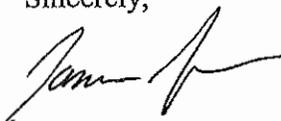
An on-site, follow-up survey will be scheduled after the administrator and consultant submit a letter stating that all deficiencies have been corrected and systems are in place to assure the deficient practices remain corrected. If at the follow-up survey, the core issue deficiency still exists, a new core issue deficiency is identified, non-core deficiencies have not been corrected, or the facility has failed to abide by the conditions

of the provisional license, the Department will take further enforcement action against the license held by Turtle & Crane. Those enforcement actions will include one or more of the following:

- Revocation of the Facility License
- Summary Suspension of the Facility License
- Imposition of Temporary Management
- Limit or Ban on Admissions
- Additional Civil Monetary Penalties

Division of Licensing and Certification staff is available to assist you in determining appropriate corrections and avoiding further enforcement actions. Please contact our office at (208) 364-1962 if we may be of assistance, or if you have any questions.

Sincerely,



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

JS/sc

Enclosure

cc: Medicaid Notification Group

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 R 08/06/2014
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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 000}	<p>Initial Comments</p> <p>The following deficiency was cited during the Follow-up survey conducted between 8/4/14 and 8/6/14 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Gloria Keathley, LSW Team Coordinator Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Rae Jean McPhillips, RN, BSN Health Facility Surveyor</p> <p>Donna Henscheid, LSW Health Facility Surveyor</p> <p>Survey Definitions:</p> <p>Black Box Warning = a specific warning issued by the Food and Drug Administration.</p> <p>BG = Blood Glucose BP = Blood Pressure EMT = Emergency Medical Technician ER = Emergency Room IV = Intravenous LPN = Licensed Practical Nurse MAR = Medication Assistance Record mg = milligrams NSA = Negotiated Service Agreement PA = Physician's Assistant PRN = As Needed RN = Registered Nurse UAI = Uniform Assessment Instrument</p>	{R 000}		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Melinda Soloro* TITLE: *Administrator* (X6) DATE: *9-9-14*

STATE FORM 6899 CZVR12 If continuation sheet 1 of 13

Bureau of Facility Standards

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

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{R 008}	Continued From page 1	{R 008}		
{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, record review and interview, it was determined the facility failed to coordinate care for 2 of 6 sampled residents (#1 and #5) who were receiving outside services. Further, the facility failed to assist and monitor medications for 2 of 8 sampled residents (#3 and #5). The findings include:</p> <p>IDAPA 16.03.22.011.08 defines inadequate care as: "When a facility fails to provide...assistance and monitoring of medications and coordination of outside services."</p> <p>I. COORDINATION OF CARE</p> <p>At the time of survey, the facility had a census of 44 residents, 26 of whom received services from outside agencies.</p> <p>A. Dialysis Access Site</p> <p>1. Resident #5's record documented she was admitted to the facility on 5/7/14 with diagnoses that included end stage kidney disease and diabetes.</p> <p>A physician's order, dated 5/12/14, documented the resident required hemodialysis three times a week. Additionally, physician's orders documented Resident #5 was on Coumadin, an anticoagulation medication.</p>	{R 008}	<p>16.03.22.520 Protect Residents from Inadequate care.</p> <p>I. Coordination of Care</p> <p>A. Dialysis Access Site</p> <p>Corrective Action:</p> <p>. Facility will request Plan of Care (dialysis center) as well; from all Outside Services prior to resident admission or as needed upon change of conditions. All Outside Service contracts will be updated by October 1, 2014. Facility will have all Outside Services fill out new forms (which will be color green) for every visit. Facility Nurse will do training regarding all special Outside Services such as dialysis, chemotherapy, wound therapy, etc. prior to admission and on an as needed basis.</p> <p>The following measures will be put into place to ensure that deficiencies do not reoccur: All Facility Staff will be trained to a new updated on-line assisted living software program, specifically designed to connect and communicate with Facility Staff, Facility Nurses, and Facility Administration, along with a new education alert, which will be pink, to the staff from the nurse.</p> <p>. These corrective actions will be monitored by the Administrator; meeting weekly with staff and other facility personnel to discuss all changes and concerns about the residents ensuring that the follow up and changes are being handled.</p> <p>. These will be completed by October 1,</p>	

Bureau of Facility Standards

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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}	Continued From page 2 A combined NSA and UAI form, dated 5/20/14, documented Resident #5 had "end stage kidney disease." The NSA/UAI, was signed by the administrator and facility LPN. Resident #5's record contained an admission history and physical, dated 5/29/14, from a hospital. The history and physical documented, "Complicated dialysis access history with multiple access procedures in bilateral upper extremities..." The report also documented Resident #5 had a recent placement of an arteriovenous graft in her right upper arm. *According to the "National Kidney and Urologic Diseases Information Clearinghouse" (http://kidney.niddk.nih.gov) an arteriovenous graft is a surgical connection of an artery to vein, by the way of a plastic tube placed under the skin. Resident #5's graft was accessed three times a week by two large bore needles at the dialysis center. There was no documentation in Resident #5's record from the dialysis unit she attended 3 times a week for treatment. A nursing assessment, dated 5/13/14, documented the resident went to dialysis three times a week. There was no evidence the nurse assessed Resident #5's vascular access site. Two other nursing assessments, dated 6/9/14 and 6/19/14, also did not contain evidence of an assessment of the access site. A caregiver progress note, dated 6/26/14 at 6:26 AM, documented Resident #5 said her arm was still bleeding from dialysis. The caregiver documented she called the facility LPN, who	{R 008}	B. Renal Diet . Facility has added "diet" on the new Initial Assessment forms and nursing assessment forms. The facility will provide training to the staff when a specialized diet is ordered by the physician. . Facility nurse will assess every ninety days regarding changes or special diets. . Facility administrator will monitor weekly any diet changes and communicate with the facility nurse for follow-up. . Completed on September 8, 2014. C. Wounds . The facility has implemented new staff communication forms. The facility staff will be trained in a staff meeting on these forms, September 19, 2014. It will be used by administrator, facility nurse, and staff to communicate all changes in a residents care. . The facility staff will receive specific in-service/training regarding communication forms so that issues/concerns can be handled quickly and -with follow through. The training will also include the importance of having physician orders for treatments and medications that staff must follow. . The facility will implement a new out side service form (which will be green) which will ensure better follow-up and communication.	

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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 3</p> <p>advised her to call an ambulance. The caregiver documented the EMTs bandaged the resident's arm.</p> <p>On 6/26/14 at 11:19 AM, the LPN documented in progress notes, the dressing on the Resident #5's vascular access site was "saturated in blood and continued to bleed." The LPN documented she applied a new dressing and "wrapped with coban for pressure" to stop the bleeding. There was no documentation the LPN contacted the dialysis center to determine the correct method to control the bleeding.</p> <p>A caregiver progress note, dated 7/2/14 at 10:29 PM, documented Resident #5's "arm bled [sic] again but this one was controllanle [sic]." There was no documentation a nurse was contacted to assess the resident's arm or provide instructions on what to monitor for.</p> <p>On 8/5/14 at 8:30 AM, Resident #5 stated she had to go to the hospital twice when she had uncontrolled bleeding from her access site.</p> <p>On 8/5/14 at 8:52 AM, when a caregiver was asked what he was suppose to do when Resident #5's access site was bleeding, he responded, "her arm can bleed?!" He stated he had not been trained on what to do if Resident #5's access site started to bleed.</p> <p>On 8/5/14 at 11:00 AM, the LPN stated she was unaware Resident #5 had a surgical vascular access site. She stated the dialysis center just start an IV each time.</p> <p>On 8/6/14 at 9:57 AM, the facility RN stated she knew Resident #5 went to the hospital once for uncontrolled bleeding from the access site, but</p>	{R 008}	<p>Corrective action will be monitored by facility administrator. Administrator will meet with the facility nurse and staff to assure communication weekly.</p> <p>Completed/started September 5, 2014, this is ongoing</p> <p>II. Medications Corrective actions</p> <p>The facility will be updating their on-line assisted living software charting system- specifically designed to connect facility staff, nurse and administrator communication. It will chart/record all vitals including (BG).</p> <p>The facility nurse will use the new forms for communicating with staff on all new medication orders specifically pertaining to vitals.</p> <p>All NSA'S medication section and health concerns along with all EMARS will be completed by the facility nurse and will be reviewed by the administrator. A double check.</p> <p>The facility nurse will monitor all medication orders upon admission and any medication changes or concerns. The Administrator will review any medication changes for a double check.</p> <p>As of September 9, 2014 All current medication orders have been reviewed by facility nurse and followed-up by administrator in the current system being used. The new system will be in place by October 30, 2014.</p>	

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{R 008}	<p>Continued From page 4</p> <p>was unaware of a second visit. She stated she had not provided education to caregivers regarding potential complications that could arise from Resident #5 receiving dialysis, such as bleeding from the access site. She stated, "I hope it would be on the plan of care. I don't review the plan of care."</p> <p>Resident #5's record did not contain correspondence or care instructions from the dialysis unit regarding possible complications from dialysis or her vascular access site. Additionally, there was no evidence at the facility, or in Resident #5's record, that either the facility's RN or LPN had contacted the dialysis unit for information or guidance.</p> <p>B. Renal Diet</p> <p>2. Resident #5's record documented she was admitted to the facility on 5/7/14 with diagnoses that included end stage kidney disease and diabetes.</p> <p>A physician's order, dated 5/12/14, documented Resident #5 was to receive a "renal/diabetic" diet.</p> <p>A combined NSA and UAI form, dated 5/20/14, documented Resident #5 had "end stage kidney disease." The NSA/UAI, which was signed by the administrator and facility LPN documented the resident was on a "Renal/Diabetic" diet</p> <p>On 8/5/14 at 8:30 AM, Resident #5 stated the facility did not offer her a renal diet. Additionally, she stated facility staff questioned her about the renal diet on 8/4/14. She stated, she demonstrated to them how to find a renal diet from the web-based dietary program used by the facility.</p>	{R 008}		

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NAME OF PROVIDER OR SUPPLIER
TURTLE & CRANE

STREET ADDRESS, CITY, STATE, ZIP CODE
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IDAHO FALLS, ID 83401

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{R 008}	<p>Continued From page 5</p> <p>On 8/5/14 at 4:20 PM, a three-ringed binder contained a list of specialized diets for residents. The list documented Resident #5 was to receive a renal/diabetic diet.</p> <p>On 8/5/14 at 4:25 PM, a staff member stated Resident #5 was on a diabetic diet, but did not know if she was on a renal diet.</p> <p>On 8/6/14 at 10:01 AM, the RN stated the resident was offered a diabetic diet. She stated she was not aware if a renal diet was offered to Resident #5.</p> <p>The facility failed to provide a renal diet to Resident #5. Additionally, the facility failed to communicate on how to provide a renal diet.</p> <p>C. Wound</p> <p>3. According to her record, Resident #1 was admitted to the facility on 4/29/11, with diagnoses including hypertension and dementia.</p> <p>A progress note, dated 5/6/14, documented the resident would not swallow and was not bearing weight when transferring. It further documented, the resident had a very "dazed" look. This was reported to the administrator and written up as a change of condition. A change of condition assessment was conducted on 5/7/14, by the facility LPN and the resident was admitted to hospice.</p> <p>A caregiver progress note, dated 5/17/14, documented the left side of the resident's face was "swollen, red, hot and hard." It was reported to the hospice nurse who said to "keep an eye on it."</p>	{R 008}		

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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 R 08/06/2014	
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 008}	<p>Continued From page 6</p> <p>On 5/19/14, the facility LPN documented she and Resident #1's granddaughter, who was a PA, assessed the resident together and "noted" the resident had redness and swelling on the left side of her face, down her neck and into her ear lobe. The area was warm to the touch. An order was received for IV antibiotics to be administered by hospice. This was two days after the swelling was first noted by the caregivers.</p> <p>On 5/19/14, the facility RN documented the facility LPN reported Resident #1 "had some swelling" on the left side of her face. The RN documented the swelling started 1 to 2 days ago, but had increased. There was no further documentation after 5/19/14 by either of the facility nurses regarding the status of the resident's swelling.</p> <p>A physician's order, dated 5/19/14, documented an order for IV antibiotics for 7 days to treat facial cellulitis.</p> <p>*According to the "Mayo Clinic" website (www.mayoclinic.org/diseases), cellulitis is a potentially serious bacterial skin infection that can spread rapidly, and if not treated may quickly become life-threatening.</p> <p>On 5/21/14, the RN documented the resident's granddaughter took the resident to the ER and had a facial abscess lanced and drained. She further documented the facility LPN reported the dressing was dry and intact upon the resident's return to the facility.</p> <p>On 5/22/14, a caregiver documented the abscess on Resident #1's face was "draining" and a home health agency was performing and monitoring her</p>	{R 008}		

Bureau of Facility Standards

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{R 008}	<p>Continued From page 7</p> <p>IV's.</p> <p>There was no documentation the facility nurses coordinated the care of Resident #1's facial cellulitis and abscess with hospice.</p> <p>On 5/25/14, a caregiver documented she called the hospice agency to let them know Resident #1's right hand was swollen. The caregiver was told to take off the bandage from her right wrist and elevate it. There was no documentation why Resident #1 had a bandage on her right wrist.</p> <p>On 5/26/14, a caregiver documented in the progress notes Resident #1's son removed the packing out of the wound on her face and covered it with a bandage.</p> <p>There was no documentation in the record regarding why the wound required packing or that the wound had been assessed by either of the facility nurses.</p> <p>On 5/26/14, the facility RN documented the administrator reported to her the packing on Resident #1's wound was "hanging out." It documented that hospice had not arrived and the son came in, pulled out the packing and dressed the wound himself. There was no documentation the facility nurse had assessed the wound after the son pulled out the packing.</p> <p>On 5/29/14, a caregiver documented Resident #1 had increased signs of "decline and vomiting reported." There was no documentation by the facility nurse the resident's "decline" had been assessed or that the vomiting had been addressed.</p> <p>On 6/3/14, a progress note by the facility LPN</p>	{R 008}		

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{R-008}	Continued From page 8 documented hospice was being revoked by the family and Resident #1 was starting home health services. A home health progress note, dated 6/18/14, documented the resident had "behavioral changes" and was "lethargic, not eating and had abdominal pain." The nurse documented she requested the staff to take the resident's blood pressure one hour after each night's dose of ibuprofen was administered and to notify her if the reading was high. There was no documentation in Resident #1's MAR that blood pressures had been taken. There was no further documentation the facility nurse was aware of the resident's lethargy, abdominal pain or need for blood pressure monitoring and had coordinated the care with the home health agency. An RN note, dated 6/23/14, documented the home health nurse reported the left side of the resident's face was swollen again and is a "little firm and slightly warm." Orders were obtained for oral antibiotics for 10 days. On 8/6/14 at 9:35 AM, the facility LPN stated she "looked at" Resident #1's face a couple of times and reported to the facility RN. On 8/6/14 at 9:40 AM, the facility RN stated she had not assessed the resident's facial cellulitis or facial abscess. She stated that hospice or home health was taking care of the wound and was responsible for the IV antibiotics. Further, she stated Resident #3's "IV kept blowing." The RN also stated she was uncertain why home health had requested nightly blood pressure checks one hour after giving the resident ibuprofen.	{R-008}		

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{R 008}	<p>Continued From page 9.</p> <p>There was no documentation in the record the facility coordinated the care of the IV site and the need for blood pressures checks with the home health agency.</p> <p>On 8/11/14, a fax of Resident #1's blood pressures was received from the facility. The fax indicated the resident's blood pressure was recorded four times after 6/18/14, even though the June through August 2014 MARs indicated the resident received ibuprofen each night.</p> <p>There was no documentation the facility nurses coordinated with the hospice or home health agencies regarding Resident #1's cellulitis, the packing, dressing and monitoring of the abscess. Also, home health requested Resident #1's blood pressure be checked each night, but the facility did not coordinate to ensure this was done.</p> <p>The facility failed to coordinate services for Residents #1 and #5. This was a repeat core deficiency.</p> <p>II. MEDICATIONS</p> <p>1. According to her record, Resident #3 was admitted to the facility on 8/5/10 with a diagnosis of dementia.</p> <p>An NSA, dated 11/11/13, documented Resident #3 required staff assistance with medications:</p> <p>A "Physicians Quarterly Medication Review Report," signed and dated by the facility nurse on 7/7/14, documented the resident was to receive 0.5 mg of haloperidol, 1/2 tablet by mouth at bedtime. This would equal 0.25 mg per dose.</p>	{R 008}		

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{R 008}	<p>Continued From page 10</p> <p>*According to the "Nursing 2014 Drug Handbook" haloperidol is used to treat chronic psychosis. A "Black Box Warning" for elderly patients documented it was not an approved treatment of dementia related psychosis. The Handbook also documented there were multiple severe side effects including death, associated with the medication.</p> <p>A psychotropic medication review, dated 7/2/14, documented the resident received haloperidol 0.5 mg, 1/2 tablet daily or 0.25 mg.</p> <p>July through August 2014 MARs documented Resident #3 received 0.5 mg of Haloperidol from 7/7/14 through 8/6/14.</p> <p>On 8/5/14 at 11:00 AM, Resident #3's medications were observed in the medication cart. The Haloperidol bubble pack was labeled 0.5 mg, take one tablet daily. The pills observed in the Haloperidol bubble pack were whole and had not been cut into 1/2 tablets as ordered.</p> <p>On 8/6/14 at 11:25 AM, the facility nurse confirmed the current order should be for 1/2 tablet or 0.25 mg each day.</p> <p>Resident #3 received double the prescribe dose of Haloperidol for 29 days.</p> <p>2. Resident #5's record documented she was admitted to the facility on 5/7/14, with diagnoses that included diabetes and end stage kidney disease.</p> <p>A physician's order, dated 5/12/14, documented that Resident #5 was to receive Humalog sliding scale insulin based on the results of her BG levels.</p>	{R 008}		

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NAME OF PROVIDER OR SUPPLIER

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>A physician's quarterly medication review report documented facility staff were to check and record Resident #5's blood glucose level four times daily. The report also documented staff were to record the units of sliding scale insulin the resident injected.</p> <p>The June 2014 MARs documented the following:</p> <ul style="list-style-type: none"> * On 6/7, 6/16 and 6/26, the resident received incorrect doses of insulin. * 26 times staff did not document the BG levels and/or the amount of insulin given. <p>The July 2014 MARs documented the following:</p> <ul style="list-style-type: none"> * On 7/2 and 7/9, the resident received incorrect doses of insulin. * 42 times staff did not document the BG levels and/or the amount of insulin given. <p>The August 2014 MARs, from 8/1 until 8/4/14, documented the following:</p> <ul style="list-style-type: none"> * 10 times staff did not document the BG levels and/or the amount of insulin given. <p>On 8/5/14 at 8:30 AM, Resident #5 stated staff monitored her when she checked her BG levels prior to her injecting herself with insulin. She stated staff were suppose to document the BG levels and amount of insulin she self-injected.</p> <p>On 8/5/14 at 10:30 AM, the facility LPN stated staff were to monitor the resident when she checked her BG levels. She stated staff were to review the sliding scale insulin with the resident to ensure she injected the correct insulin dosage.</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 August 6, 2014
Survey Team Leader Gloria Keathley	Survey Type Follow-up	RESPONSE DUE: September 5, 2014	
Administrator Signature <i>Malynda Seiler</i>	Date Signed 8-6-14		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
1	153.01	The facility's abuse policy did not direct staff to notify Adult Protection immediately, nor did it describe how the residents were going to be protected during the investigation.	COS 8/6/14 gk	
2	225.01	The facility did not evaluate behaviors for Resident #2 and #3. (Previously cited 3/22/14)	9-18-14 gk	
3	225.02	The facility did not develop interventions for Resident #2 and #3. (Previously cited 3/21/14)	9-18-14 gk	
4	300.01	The facility nurse did not assess residents' changes in conditions to include: Resident #2's left hip fracture, Resident #8's wound status and Resident #5's nausea and vomiting. (Previously cited 11/4/10 and 3/21/14)	10-8-14 gk	
5	305.08	The facility did not provide education to facility staff regarding residents health care needs: such as Resident #1's IV site and facial cellulitis and abscess, Resident #5's dialysis and potential problems with the access site.	10-8-14 gk	
6	305.04	The facility nurse did not make recommendations to prevent further break down for Resident #8's wounds. (Previously cited 3/21/14)	10-8-14 gk	
7	320.01	NSAs did not clearly describe residents' needs. Such as Resident #5 receiving dialysis treatment, Resident #2's transfer needs and Resident #8's mobility needs. (Previously cited 3/21/14)	10-8-14 gk	
8	335.03	The facility did not have soap and paper towels in rooms where residents required personal care.	COS 8/10/14 gk	
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