PLAN OF CORRECTION

Turtle and Crane Assisted Living
1950 1st Street
Idaho Falls ID 83401

Provider ID: RC-1304

On 02/12/2025, a Health Care Complaint Investigation survey was conducted by Department staff at Turtle and Crane Assisted Living. As a result of the survey, core issue deficiencies were cited with the following plan of correction.

Rule Violation .510. REQUIREMENTS TO PROTECT RESIDENTS FROM ABUSE.

Describe what corrective actions will be accomplished for those residents/personnel/area found to have been affected by the deficient practice.

A staff meeting was conducted on 2/27/2025 detailing and explaining the Abuse, Neglect, and Exploitation policy, proper reporting, ways to protect residents who are suspected to be the victim of such, and what steps to take. Including immediate notification of the administrator; if the administrator is not available whether in person or immediately by the phone, who next to contact, etc. What steps to take to protect the resident in a variety of circumstances: i.e. if the perpetrator is a visitor, outside agency, employee, administrator, etc... Details explaining if the resident is in immediate danger, to contact 911 immediately.
All facility staff were also made aware of disciplinary action that may be taken against them due to improper reporting, for example: write up, suspension or potential termination.
The staff member that was involved in the incident is no longer employed at the facility.
The affected resident is currently safe from abuse, neglect or exploitation.

Describe how the provider will identify other residents/personnel/areas having the potential by the same deficient practice and what corrective action(s) will be taken.

Staff members were educated on the signs and symptoms abuse, neglect and exploitation, as well as signs of potential abuse that may not be as obvious, including behavior changes, unknown injuries, abnormal behavior with certain people, etc.
Facility completed a training during a staff meeting on 2/27/2025. The facility will conduct a 90-day review to ensure that complete understanding of this policy is maintained and followed by all facility staff.
The current Administrator and training Assistant Administrator have reviewed the policy, and both are in complete understanding of the policy and what steps to take in the event of another incident.
All facility staff understand that a staff member that has an allegation against them, will be placed on immediate unpaid suspension pending results of an investigation. They also understand that APS will be notified immediately and local law enforcement within 4 hours. They also understand that any report made, either verbal or written, will be addressed immediately. Staff are also aware that any incident regarding abuse, neglect, or exploitation should be reported immediately.

Describe how the corrective action will be monitored to ensure the deficient practice does not recur (QA program).

The facility Administrator will complete a 90-day review to ensure understanding of the policy, checking in with staff and residents about how they feel about the care that they witness/provide/receive. And reviewing incident reports and behaviors for patterns to avoid incidents and track trending and non-

trending behaviors and incidents.

Date when corrective action will be completed.

February 28, 2025

Program Comments

NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Turtle and Crane Assisted Living	RC-1304	1950 1st Street	208-715-5500
Administrator	City	Zip Code	Survey Date
Kindra Sagario	Idaho Falls	83401	02/12/2025
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Complaint Investigation		03/14/2025

Item #	Rule (16.03.22)	Description
1	.215.01. Administrator Responsibility.	The former administrator did not ensure all facility policies were implemented. The facility's undated "Abuse, Neglect and Exploitation" policy documented, "If a staff has a pending allegation of abuse in any form, they will be placed on unpaid suspended leave pending the results of the investigation." The former administrator did not follow the policy when they allowed a staff member to work with residents for eight days, from 6/15/24 to 6/26/24, after they were accused of abuse and before the investigation was completed.
3	.305.02.b. Quarterly Nursing Assessments.	The facility nurse did not ensure residents received their medications and treatments as ordered. For example, Resident #1 did not receive the correct dosage of trazodone, after it had been from 100 milligrams (mg) to 150 mg from 1/6/25 to 1/15/25. An observation progress note, dated on 1/6/25 at 8:00 PM, by the facility nurse, documented, Resident #1's trazodone was increased after a consultation with their physician. The facility nurse stated the administration team was responsible for ensuring the new medications orders were sent to the pharmacy when received from the physician. ***Previously cited on 4/11/24***
4	.335.02. Standard Precautions.	The facility did not follow standard infection control

		procedures. For example, house #3's kitchen microwave and refrigerators had debris and dried substances in them. House #2's kitchen had crumbs and a dried sticky substance on the floor, the cupboards had dried substances on the outside of the doors, and the inside of the cupboards had crumbs and debris in them. House #1's kitchen refrigerator had thawed meat drippings at the bottom of the refrigerator, the floor had crumbs on it, the outside cupboard doors had dried substances on them, and the crockpot and oven had grime and dried substances on them. The administrator confirmed the kitchens needed deep cleanings.

CORE ISSUES

Facility	License #	Physical Address	Phone Number
Turtle and Crane Assisted Living	RC-1304	1950 1st Street	208-715-5500
Administrator	City	Zip Code	Survey Date
Kindra Sagario	Idaho Falls	83401	02/12/2025
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Complaint Investigation		02/22/2025

Item #	Rule (16.03.22)	Description
2	.510. REQUIREMENTS TO PROTECT RESIDENTS FROM ABUSE.	Based on record review and interview, it was determined the facility did not protect 1 of 6 sampled residents (#3) from abuse when the administrator failed to immediately notify Adult Protective Services, complete thorough investigations according to the facility's policy, and protect residents after a caregiver allegedly abused a resident. This had the potential to affect 100% of the residents residing at the facility. The findings include: IDAPA 16.03.22.010.01 defines abuse as, "A non-accidental act of sexual, physical, or mental mistreatment or injury of a resident through the action or inaction of another individual." IDAPA 16.03.22.010.20.a defines abuse as a "core issue." IDAPA 16.03.22.215.01 documents, "The administrator is responsible for ensuring that policies and procedures are developed and implemented to fulfill the requirements in Title 39, Chapter 33, Idaho Code, and IDAPA 16.03.22, 'Residential Assisted Living Facilities'."

		IDAPA 16.03.22.215.07 documents, “The administrator must ensure that adult protection...are notified in accordance with Sections 39-5303 and 39-5310, Idaho Code,” which documents any employee of a health facility “...who has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected or exploited shall immediately report such information to the commission.” IDAPA 16.03.22 215.08.a documents, “The administrator or person designated by the administrator, must be notified of all...allegations of abuse, neglect or exploitation immediately...” IDAPA 16.03.22.215.08.b documents, “The facility administrator or designee must complete an investigation...for each...allegation of abuse, neglect or exploitation.” IDAPA 16.03.22.215.08.c documents, “Any resident involved must be protected during the course of the investigation.” IDAPA 16.03.22.215.08.e documents, “When abuse, neglect, exploitation, incidents, and accidents occur, corrective action must be immediately taken and monitored to ensure the problem does not recur.” IDAPA 16.03.22.510 documents, “The administrator must ensure policies and procedures are implemented to ensure all residents are free from abuse.” The facility's layout consists of three unattached buildings. House #3 was an assisted living unit and houses #1 and #2 were both memory care units which housed cognitively impaired residents.

		The facility's undated "Abuse, Neglect and Exploitation" policy documented, "any employee who witnesses an act or has any knowledge of resident abuse shall immediately: "call to the attention of his/her immediate supervisor. The immediate supervisor (if not the administrator) will contact the administrator or their designee immediately." Date and sign the incident report form and immediately submit to the facility administrator or designee, "in the event the administrator or their designee are not present in the facility, you are required to notify them "immediately by phone." The facility administrator shall report the abuse incident to "law enforcement within 4 hours and immediately to Adult Protection. "If a staff has a pending allegation of abuse in any form, they will be placed on unpaid suspended leave pending the results of the investigation." A complaint form, dated 6/15/24, documented Staff member A witnessed Staff member B in Resident #3's room and witnessed Staff member B "ripped alarm cord off of [his/her] body and neck. Resident #3 was frightened and flinched." [Staff member B] was yelling at Resident #3 to "stop getting up [he/she] was tired of playing [their] games and pushed [them] down hard in [their] chair." Resident #3 was trying to get up again and Staff member B "roughly shoved unknown meds" in their mouth and told Resident #3 he/she was not playing their game. The complaint form documented APS and law enforcement were contacted on 6/26/24, 11 days after the allegation was made. According to their record, Resident #3 was an 84 year old, who was admitted to the facility on 9/23/22, with diagnoses of dementia and anxiety. Resident #3 resided at the facility during the time of the survey in house #2.

		As-worked records documented Staff member B worked in house #2 during eight day shifts on 6/15/24, 6/18/24, 6/19/24, 6/20/24, 6/21/24, 6/22/24, 6/25/24, and 6/26/24, where Resident #3 resided, and the alleged abuse occurred. On 2/11/25, staff members stated the following regarding Staff member B's treatment of Resident #3 and reporting abuse to the former administrator: *A staff member stated they reported alleged physical and verbal abuse towards Resident #3 to the former administrator on three separate occasions, including the 6/15/24 incident. Two of these allegations were made prior to 6/15/24. On one of the alleged incidents, this staff member was asked to write down their statement by the former administrator. This staff member stated Staff member B continued to work after the statement was written and provided to the former administrator regarding the alleged abuse towards Resident #3. *A staff member stated Staff member B was verbally abusive towards Resident #3 multiple times prior to the incident that was reported on 6/15/24. This staff member had to intervene to promote appropriate interactions with Staff member B towards Resident #3. *A staff member stated Staff member B physically abused Resident #3 on 6/15/24 and they had reported the incident to the former administrator. On 2/11/25 at 2:23 PM, the former administrator stated she was aware of an alleged abuse allegation involving Staff member B towards Resident #3 "sometime in June 2024." The former administrator stated she did not know the facility's

		policy regarding how to protect residents after receiving an abuse allegation. The former administrator stated she called APS for direction and they instructed her to suspend Staff member B pending an investigation. The former administrator stated she notified the owner and the owner instructed her to not suspend Staff member B due to being "short staffed." The former administrator stated Staff member B continued to work on the floor in house #2 "a few days to a week" after she had been made aware of the alleged abuse. The former administrator stated "she did not follow policy" and did what the owner told her to do, which was to allow Staff member B to continue to work in house #2 with Resident #3. On 2/11/25 at 3:13 PM, the owner/current administrator stated she was not involved with the investigation of the alleged abuse regarding Staff member B and Resident #3, until 6/26/24. The owner/current administrator stated Staff member B had worked the entire day shift on 6/26/24. The owner/current administrator stated Staff member B should have been taken off the floor earlier than 6/26/24. She stated if she would have conducted the investigation herself, Staff member B would have already been taken off the floor pending the results of the investigation. The facility failed to appropriately respond when Resident #3 was allegedly abused by Staff member B on 6/15/24, or when two other allegations were made prior to 6/15/24. This allegation was not immediately reported to the administrator nor APS. After a complaint form had been completed on 6/15/24 regarding an allegation of abuse, the administrator did not protect Resident #3 and all other residents when Staff member B was allowed to work for eight days from 6/15/24 to 6/26/24. The former administrator and owner/current administrator failed to ensure the facility's policies for abuse

		were followed, including reporting, protecting residents during the course of an investigation, and implementing appropriate corrective action to prevent recurrence, in response to allegations of abuse towards Resident #3, which had the potential to affect 100% of the residents at the facility. These failures resulted in abuse.