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	06/05/2025
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	Health Care Licensure and Follow-Up		07/05/2025

Item #	Rule (16.03.22)	Description
1	.260.07. Toxic Chemicals.	The facility did not secure various cleaning chemicals in the laundry room and in the kitchen of building #2 and were was accessible to cognitively impaired residents on several occasions on 6/3/25. The facility administrator stated chemicals needed to be secured.
2	.305.06. Self-Administered Medication.	Resident #8 was not assessed prior to nor every 90 days to ensure they were safe to self-administer their anti-fungal cream, diclofenac, and their Nystatin powder. The facility nurse stated she was not aware Resident #8 self-administered their medications, and she had not completed the assessment for Resident #8 to ensure they were safe to self-administer medications.
3	.310.01.g. Medication Distribution System.	The facility did not ensure all residents' as-needed (PRN) medications were available. Resident #6 did not have their PRN inhaler, Systane solution eye drops, and their midodrine blood pressure medication available in the facility. Resident #8 did not have their Dulcolax and omeprazole available in the facility. The administrator stated the PRNs were not available in the medication carts.
4	.330.04.c.iv. Resident Care Records.	The administrator did not ensure staff documented the reason why three of seven residents did not receive their medications

		as ordered. For example, Resident #3's record documented they did not receive their celecoxib, metoprolol, and trazodone as prescribed on several occasions in May and June 2025. Resident #4's record documented they did not receive their lurasidone as prescribed on several occasions in May 2025. Resident #1's record documented they did not receive their Nuedexta as prescribed on several occasions in May 2025. The administrator stated Resident #3's family had refused to pay for or bring in these medications. She stated she had been working with Resident #1 and #4s' insurance companies to receive authorizations for their medications. The administrator stated she had not documented the reason for the medication issues.
5	.330.04.c.vii. Resident Care Records.	The facility nurse stated she had assessed residents for changes in their physical and mental conditions, but these assessments had not been consistently documented. For example, Resident #5 had been diagnosed with Clostridium difficile on 4/5/25 and Resident #6 had 22 falls between 2/24/25 to 5/28/25. The facility nurse stated she had assessed the residents for these issues but had not documented her assessments.
6	.330.04.c.xi. Resident Care Records.	The administrator stated she had completed investigations into Resident #6's incidents and accidents, but she had not consistently documented the interventions she had put in place to prevent recurrence of these incidents. For example, Resident #6 had 22 falls between 2/24/25 to 5/28/25 and the record did not contain documentation of what corrective actions were put in place to prevent future falls. Several staff stated the facility had implemented corrective actions after Resident #6's falls. The administrator stated she put measures in place in an effort to prevent fall recurrence but had not documented all of the fall prevention interventions.
7	.335.02. Standard Precautions.	The facility did not follow standard infection control procedures. For example: two medication technicians were

		observed to administer two unsampled residents' eye drops without wearing gloves. One of the staff did not perform hand hygiene prior to administering the eye drops. The facility nurse stated staff should have performed hand hygiene and worn gloves when administering eye drops. ***Previously cited on 2/12/25.***