

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	04/24/2026
Survey Team Leader	Survey Type		Response Due
Ramirez, Mina	Health Care Licensure and Follow-Up		05/24/2026

Item #	Rule (16.03.22)	Description
1	.161.04. Designated Smoking Areas.	During the survey between 4/21/26 and 4/23/26 multiple residents were observed smoking by the back sliding door in building #1 and by the front door of building #3 that were not designated smoking areas. The administrator confirmed residents were smoking in non-designated areas.
2	.250.09. Resident Sleeping Rooms.	The water temperatures in the facility were not maintained between 105 to 120 degrees F. For example, the water temperatures in building #1 ranged from 135.1 F and 138.7 F in resident bathrooms and shower rooms. The water temperatures in building #2 were found to be 124.1 F in the shower room. The administrator acknowledged the water temperatures were outside the range 105 to 120 degrees F.
3	.305.03. Change in Resident Health Status.	The facility nurse did not conduct nursing assessments when residents experienced changes in physical or mental health status. For example, Resident #4 experienced heavy stuttering, slurring of speech and left side body shaking on 8/25/25. Resident #4 fell on 8/30/25 and 10/23/25. Resident #5 had difficulty swallowing on 11/11/25, and experienced hallucinations on 11/30/25, and complained of difficulty with urination and were later diagnosed with a urinary tract infection (UTI) on 12/1/25. Resident #3 developed a lump on

		their neck on 1/6/26 which required assessment by their provider. The administrator confirmed the prior facility nurse did not complete assessments for these changes of condition.
4	.310.01.c. Medication Distribution.	The facility did not maintain the medication refrigerator temperatures between 38 and 45 degrees F where insulin was stored. The temperatures in building #1 were documented between 32 and 37 degrees 12 days in March and April 2026. The temperatures in building #2 were documented between 30 and 50 degrees for 36 days in March and April 2026 and building #3 documented temperatures between 20 and 37 degrees 21 days in March and April 2026 without corrective action taken. The facility nurse stated he was not aware temperatures were out of range.
5	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #8 was taking hydroxyzine, lithium, and lorazepam and Resident #9 was taking citalopram and did not have six-month psychotropic medication reviews completed. The facility administrator confirmed they did not complete a current psychotropic medication review.
6	.320.03. Signature, Date, and Approval of Agreement.	Negotiated Service Agreements (NSAs) were not signed and dated by Residents #1, #3, #4, #5, #6, #7, and #9, nor their legal guardians. The residents' last signed NSAs were over a year old and signatures were not obtained on any subsequent updates. The administrator stated their current process did not include obtaining signatures when updating NSAs.
7	.405.02.c. Prohibited Applications.	Relocatable Power Taps (RPTs) are prohibited with the use of appliances. Room #6 in building #3 was using a RPT to supply power to a microwave.
8	39-3321.2.d. Qualifications and Requirements of Administrator.	The facility did not develop interventions to prevent recurrences after residents' incidents. For example, Resident #1 had nine falls from January 2026 to April 2026 and did not have interventions developed to prevent recurrences. Resident #2 had falls on 3/4/26 and 4/3/26 and did not have interventions developed to prevent recurrences. The facility administrator confirmed interventions were not implemented

		following all incidents.
9	39-3321.2.e. Qualifications and Requirements of Administrator.	The administrator did not complete an investigation and written report within 30 days of each accident and incident. For example, Resident #1 had eight falls from January 2026 and March 2026, and Resident #6 had falls on 11/21/25 and 2/25/26. The administrator confirmed investigations were not completed for all incidents.