NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Rosetta of Twin Falls	RC-1171	1177 Eastridge Court	208-734-9422
Administrator	City	Zip Code	Survey Date
	Twin Falls	83301	09/15/2023
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Licensure and Follow-Up + complaint investigation		10/15/2023

Item #	Rule (16.03.22)	Description
1	.001.03. General Provider Responsibilities.	The Licensee did not provide necessary resources to ensure the facility operated consistent with the rules and statutes at IDAPA 16.03.22. The regional administrator was the oversight administrator for the facility due to not having a licensed administrator assigned as the person responsible for the day-to-day operation of the facility. The facility nurse did not have sufficient knowledge and experience with the rules, and was not aware of her role as the facility nurse due to the lack of not having an administrator. The facility continued to accept new admissions without having an administrator to train the staff of their daily duties. The facility also failed to maintain compliance and was cited with repeat deficiencies for 260.06, 305.02.b, and 305.03.
2	.009.06.c. Use of Previous Criminal History and Background Check.	Four of four employees, whose personnel records were reviewed and required State Police Background Checks, did not have these checks completed. The regional administrator stated the State Police Background Checks were not completed.
3	.215. REQUIREMENTS FOR A FACILITY ADMINISTRATOR.	The facility did not have a licensed administrator from 8/26/23 to 9/15/23. The regional administrator stated she was in the process of hiring an administrator for the facility.

4	.215.08.b. Investigation within Thirty Days.	The previous administrator did not conduct an investigation within 30 days when Resident #2 fell on 8/12/23, and when Resident #3 fell on 5/3/23 and was sent to the hospital. The regional administrator stated the incidents should have been investigated.
5	.215.08.d. Written Response to Complaint within Thirty Days.	The previous administrator did not provide a written response to complainants within 30 days. For example, the complaint log documented multiple undated complaints had been made either to the previous administrator and/or owner but none of the complainants received a written response. One of the undated complaints from Resident #5's family member documented a complaint was filed on 8/10/23 with the facility owner and there was not a written response. The regional administrator stated the complaints had not been completed with written responses within 30 days.
6	.215.08.e. Corrective Action.	The previous administrator did not implement corrective action to ensure the incidents did not recur when Resident #1 fell on 5/1/23, and when Resident #2 fell on 8/12/23. The regional administrator stated the previous administrator should have implemented interventions.
7	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe, and orderly manner. For example: The driveway had an old refrigerator, several broken chairs, multiple boxes of incontinent briefs, two hospital beds, and multiple boxes of miscellaneous items. The backyard patio had a broken recliner and multiple mattresses. Room #7's bathroom sink was chipped and a communal bathrooms sink had rust on it. Room #5's windows were coated with grime. The regional administrator stated some of the driveway trash had been cleaned up and the rest was going to be cleaned up soon.***Previously cited 12/3/21, 7/1/22, and 9/27/22***
8	.260.07. Toxic Chemicals.	Toxic chemicals were observed to be stored in unlocked areas, which were accessible to cognitively impaired residents on five separate occasions from 9/11/23 to 9/13/23. For example,

		Lysol disinfectant was observed in an unlocked cabinet in an unlocked bathroom. The door to the garage was left unlocked which contained multiple toxic chemicals, including paint thinner. The regional administrator acknowledged chemicals were to be locked up.
9	.305.02.b. Quarterly Nursing Assessments.	The facility did not ensure residents received their medications as ordered. For example: On 6/27/23 at 12:00 PM, Resident #3 was complaining of chest pain and unable to catch their breath and was sent to the emergency room, which was a result of Resident #3 having an anxiety attack due to not receiving their as needed pain medications. ***Previously cited 7/1/22 and 9/27/22***
10	.305.02.c. Current Medication Orders and Treatment Orders.	The facility did not ensure the actual written, signed, and dated orders were present in each residents' care record. For example, Resident #4's record did not have orders for 12 of 15 medications the resident received. Resident #2's record did not have orders for Tylenol and vitamin D. The regional administrator stated the orders were not in the records.
11	.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, when Resident #1 fell on 5/1/23 and was sent to the hospital on 6/17/23. When Resident #2 fell on 8/12/23. When Resident #4's catheter was leaking on 8/9/23. When Resident #3 was sent to the hospital on 5/3/23, 5/14/23, 6/27/23, and 7/18/23. The facility nurse stated she was hired at the end of July 2023 and was not aware she was to complete the change of condition assessments for the incidents after she was hired. The regional administrator stated the previous facility nurse did not complete change of condition assessments. ***Previously cited 7/1/22 and 9/27/22***
12	.310.01.c. Medication Distribution.	The facility's medication refrigerator temperatures, which contained insulin, were not monitored and documented daily. The most recent temperature logs were from July 2023. The

		regional administrator stated there were no current temperature logs.
13	.310.04. Behavior Modifying Medication.	The facility did not complete six month psychotropic medication reviews for Resident #3 who was taking psychotropic medications for longer than six months. The regional administrator confirmed the psychotropic medication reviews had not been completed.
14	.319. COMPREHENSIVE ASSESSMENT REQUIREMENTS.	Residents #1, #2, and #4 did not have demographics, nursing, and maladaptive behaviors assessed prior to being admitted. The regional administrator stated they were not completed prior to admission.
15	.320.01. Use of NSA.	Residents' NSAs did not clearly reflect the residents' needs nor describe the services to be provided. For example: Resident #2's NSA did not include specific wound care instructions or orders on how the wound care was provided by the home health agency nor what signs or symptoms of infection to monitor and who to notify, nor when the dressing became soiled or fell off or delineate between home health and facility services. Resident #4's NSA did not include specific instructions for catheter care or delineate between hospice and facility services. The regional administrator stated Resident #2 and Resident #4's NSAs did not include specific instructions to their NSAs.
16	.330.10. Personnel Records.	On 9/13/23, Resident #7 was sitting on the couch in the common area. Two staff members stated Resident #7 was there for adult day care two to three times a week. The two staff members were unaware of Resident #7's last name, emergency contact information, nor did not have any instructions for care and services Resident #7 required. The regional administrator stated they did not have any information on Resident #7.
17	.450. REQUIREMENTS FOR FOOD AND NUTRITIONAL CARE SERVICES.	The facility did not meet the standards for the Idaho Food Code when the kitchen inspection failed. Mandatory re-inspection required within 10 days.

18	.645.02. Delegation.	One of four staff, who passed medications, was not delegated by the current facility nurse prior to assisting residents with medications. All staff were not delegated individually with nursing tasks for Resident #2's wound care for dressing changes or Resident #4's catheter care. The facility nurse stated she had not completed the delegation for medications with all the medication technicians. The facility's nurse stated she was unaware she was to delegate these nursing tasks.
19	.335. REQUIREMENTS FOR INFECTION CONTROL.	Between 9/11/23 and 9/14/23, multiple resident restrooms and two communal restrooms did not have paper towels for staff, residents, or visitors. Two residents stated the facility did not provide them with paper towels.