# NON-CORE ISSUES

| Facility | License # | Physical Address | Phone Number |
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| Bluebonnet Haus | RC-1253 | 641 Rimview | 208-734-4445 |
| Administrator | City | Zip Code | Survey Date |
| Betty Bennett | Twin Falls | 83301 | 05/22/2026 |
| Survey Team Leader | Survey Type | | Response Due |
| McClenathan, Teresa | Health Care Licensure and Follow-Up | | 06/21/2026 |

| Item # | Rule (16.03.22) | Description |
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| 15 | .305.02.a. Quarterly Nursing Assessments. | The residents' Medication Administration Records (MARs) did not consistently match the medication labels and the medication orders. For example, Resident #1's MAR documented simethicone was to be given one to two tablets at breakfast, lunch, and dinner and the label documented the directions as four times daily, the MAR also documented their buspirone was to be given twice daily and the label documented the directions as four times daily. ***Previously cited on 12/11/23.*** |
| 15 | .305.02.b. Quarterly Nursing Assessments. | Residents did not consistently receive their medications as ordered. For example, Resident #2's sevelamer order was to take one tablet two times daily with food and one time with snacks. In all of January, February, and March 2026, the resident received the medication two times daily only, and in May 2026 they received the medication four times daily. The facility administrator/nurse stated the order changed frequently.***Previously cited on 12/11/23.*** |
| 15 | .305.02.c. Current Medication Orders and Treatment Orders. | The facility did not have current, signed orders for three of three identified residents and two of two unsampled residents in their records for any of their medications. The facility administrator/nurse confirmed there were no signed orders |

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| | | for the residents. ***Previously cited on 12/11/23.*** |
| 15 | .310.04.e. Psychotropic or Behavior Modifying Medication. | Resident #3 was taking trazodone for more than six months and did not have six-month psychotropic medication reviews completed. The facility administrator/nurse stated she was unaware psychotropic medications used for sleep needed to be reviewed every six months.<br>***Previously cited on 12/11/23*** |
| 16 | .330.15.c. Fire and Life Safety Records. | Facility installed portable fire extinguishers and were missing the monthly inspection for the months of March and April 2026 for all extinguishers in the facility. The administrator/nurse confirmed the visual inspections were not conducted. |
| 17 | .335.02. Standard Precautions. | The facility did not ensure infection control standards were followed. For example, during medication pass a medication technician was observed to not perform hand hygiene between medication passes. Staff were observed to help residents with their cares and then went into the kitchen to prepare food, without wearing an apron. The administrator/nurse confirmed staff were supposed to perform hand hygiene between medication passes. |
| 18 | .319.03. Nursing Assessment. | The facility nurse did not complete nursing assessments prior to admission for Resident #1, who was admitted on 3/1/24 and Resident #2 who was admitted on 2/2/24. The administrator/nurse confirmed the assessments had not been conducted. |
| 19 | .009.06.c. Use of Previous Criminal History and Background Check. | Four of four employees, whose files were reviewed and required an Idaho State Police background check, did not have the check completed prior to working alone with residents. The administrator/nurse confirmed Idaho State Police background checks were not completed. |
| 20 | .630.02. Mental Illness. | The facility housed residents who had a diagnosis of mental illness. Two of five staff, whose files were reviewed and required mental illness training, had not completed the training. The administrator/nurse confirmed the staff had not |

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| | | completed the training. |
| 21 | .630.03. Developmental Disability. | The facility housed residents who had a diagnosis of developmental disability. Two of five staff, whose files were reviewed and required developmental disability training, had not completed the training. The administrator/nurse confirmed the staff had not completed the training. |