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
Crystal Martinez	Twin Falls	83301	08/06/2025
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Licensure and Follow-Up		09/05/2025

Item #	Rule (16.03.22)	Description
1	.001.03. General Provider Responsibilities.	The Licensee failed to provide necessary resources to ensure the facility operated consistent with the rules and statutes at IDAPA 16.03.22 and title 39 and chapter 33. The facility did not receive sufficient support from the Licensee which resulted in multiple non-core deficiencies during the survey and the facility received repeat non-core deficiencies at: 001.03 for not having sufficient support from the corporate, 155.01 for not having a relocation plan, 260.06 for not keeping the facility in a clean, safe, and orderly manner, 305.02.b for not receiving medications as ordered, 310.01.c for not monitoring and documenting medication refrigerator temperatures daily, 320.03 for not having NSAs signed and dated by the resident or legal representatives, 330.14.b for not maintaining accurate as-worked schedules, 330.15.c for not monitoring fire extinguishers monthly, and 405.04 for not inspecting fuel-fire heating devices. On 8/5/25, the kitchen inspection failed and cited at 450. The facility staff did not receive training nor guidance to effectively implement Idaho Food Code. The facility continued to admit new residents without the necessary services available to meet their needs. The administrator stated she did not receive support from the

		corporation (licensee) to complete the administrative duties. ***Previously cited on 2/28/25, 9/27/24, and 9/15/23***
2	.009.03.b. Availability to Work.	One of five staff members, whose personnel record was reviewed, provided supervision and cares for residents on shifts in July and August 2025 without having a completed Criminal History and Background Check. The administrator confirmed the background check was still pending at the time of survey, and the employee worked alone with residents without line-of-sight supervision.
3	.151. ACTIVITY REQUIREMENTS.	During observations from 8/4/25 to 8/6/25, no activities were offered to the residents. Multiple residents stated the facility did not offer activities and stated they were "bored". The staff stated they did not have enough time to engage residents in activities. The administrator stated they were working on providing activities at the facility.
4	.155.01. Relocation Agreements.	The facility did not have a current written/signed agreement for transfer or relocation of residents in the event of an emergency where evacuation would be required. The administrator stated the facility did not have a current relocation agreement. ***Previously cited on 8/9/23 and 4/28/22***
5	.161.04. Designated Smoking Areas.	The facility did not have designated smoking areas clearly marked. During observations from 8/4/25 to 8/6/25, multiple unsampled residents were observed smoking outside uncovered patio and also under the covered patio. The residents stated they smoked wherever they felt like sitting and they were unaware they were suppose to smoke in a designated area. One of the unsampled residents was observed using a combustible disposal plastic garbage can with a plastic liner for an ashtray. The garbage bag liner contained ashes and cigarettes butts. The facility staff stated they did not have a designated smoking area and used the combustible garbage can as an ashtray.
6	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe and orderly

		manner. For example: during survey between 8/4/25 and 8/6/25, multiple flies were observed throughout the building in residents rooms, the common area, in the kitchen, and dining room. Multiple scuffs and scrapes were on the walls and moulding throughout the hallways and dining room, multiple blinds in residents rooms were broken, a missing window screen in the administrator's office that allowed flies and other insects into the facility. In the kitchen, the countertop next to the sink had a crack, which made for an uncleanable surface, and the kitchen flooring was bubbled causing an uneven surface. Both dishwashers had signs documenting they were broken. The administrator stated the flies had been a problem and both dishwashers had not been operable for at least the past six months. ***Previously cited on 2/28/25***
7	.305.02.b. Quarterly Nursing Assessments.	The facility did not ensure residents received medications and treatments as ordered by their provider. For example, Resident #3 had an order for fluticasone propionate nasal spray daily for allergies. Resident #3's June 2025 MAR, documented they did not receive the nasal spray two times, the July 2025 MAR, documented they did not receive the nasal spray eighteen times, and the August 2025 MAR, documented they did not receive the nasal spray four times. The facility nurse stated she was unaware Resident #3 was not receiving their nasal spray. The facility nurse stated the administrator was responsible to order medications from the pharmacy. ***Previously cited on 2/28/25, 9/27/24, 9/15/23, 9/27/22 and 7/1/22***
8	.305.03. Change in Resident Health Status.	The facility nurse did not assess residents after they experienced changes in their mental and health status. For example: Resident #3 fell on 6/28/25 and 7/8/25, and experienced "explosive" diarrhea on 6/28/25. Resident #2 fell on 8/2/25 and was sent to the hospital for an evaluation. The facility nurse stated she did not complete the assessments for Resident #3.

9	.310.01. Medication Distribution.	The facility utilized the facility administrator to package medications. The administrator confirmed she had been packaging medications. The facility nurse confirmed the administrator had been packaging medications and stated they were unaware only a licensed nurse or pharmacist could package medications.
10	.310.01.c. Medication Distribution.	The facility's medication refrigerator contained Onecia (rheumatoid medication), did not have temperatures monitored and documented daily, nor maintain the medication temperature between 38 and 45 degrees. For example: no temperatures were documented in April 2025, the May 2025 log was blank five times, and the June 2025 log was blank 10 times and were above 45 degrees on two occasions. On 8/6/25, the medication refrigerator was observed at 32 degrees. The regional administrator adjusted the temperature in the medication refrigerator and state they will continue to monitor. ***Previously cited on 2/28/25***
11	.310.04.a. Behavior Modifying Medication.	The facility did not attempt non-drug interventions prior to requesting medications for Residents #2 and #4. Resident #2 was taking Aripiprazole, Buspirone, and Haldol and Resident #4 was taking Citalopram; neither resident had current or previous behavior management plans. The administrator confirmed neither resident had behavior plans.
12	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #2 was taking Aripiprazole, Buspirone, and Haldol for longer than six months. Resident #2's six month psychotropic medication review did not include behavioral updates. The facility nurse stated it was the administrator's responsibility to process the six month psychotropic medication reviews.
13	.319. COMPREHENSIVE ASSESSMENT REQUIREMENTS.	Resident #1 did not have demographics, level of personal assistance requirements, and maladaptive behaviors assessed prior to being admitted on 8/4/25. Resident #3 did not have demographics, level of personal assistance requirements, and maladaptive behaviors assessed prior to being admitted on 5/2/25. The facility nurse stated she only completed the

		nursing section of the comprehensive assessment.
14	.320.01. Use of NSA.	Residents' Negotiated Service Agreements (NSAs) did not clearly reflect the residents' needs nor describe the services to be provided. For example: Resident #2, #3, and #4 all had multiple areas within their NSAs under the "Instructions:" section that documented "please indicate what assistance the resident needs to complete the task." This did not reflect residents' current status. The administrator stated the NSAs needed to be updated.
15	.320.03. Signature, Date, and Approval of Agreement.	NSAs were not signed and dated by Residents #2, #3, and #4. The administrator stated they were working on getting the NSAs signed and dated. ***Previously cited on 2/28/25 and 9/27/24***
16	.330.06. Additional Resident Records.	The facility did not evaluate nor develop interventions for ongoing behaviors when Resident #4 was sexully inappropriate towards residents and staff on 5/15/25, 6/22/25, and 7/1/25. The administrator stated they had not evaluated nor developed interventions for Resident #4.
17	.330.09. Water Supply.	The facility did not maintain an up-to-date admission and discharge register. At the time of the survey the facility had 14 residents and the admission and discharge register documented the facility housed 23 residents. The administrator stated the admission and discharge register needed updated.
18	.330.14.b. As Worked Schedules.	The facility's as-worked schedule did not document all the hours worked by facility staff nor the first and last names of each employee and their positions. The administrator stated the staff should have documented this information. ***Previously cited on 2/28/25***
19	.330.15.c. Fire and Life Safety Records.	Fire extinguishers were not consistently visually inspected monthly. The fire extinguisher located under the kitchen sink was missing the monthly inspection from January 2025 to August 2025. The regional administrator stated she was unaware there was a fire extinguisher under the kitchen sink.

		Previously cited on 8/9/23
20	.335.02. Standard Precautions.	During medication pass observations, medication technicians were observed administering medications to multiple residents without conducting hand hygiene between medication pass with each resident. Multiple staff members were observed not wearing aprons in the kitchen during meal prep after providing care needs to residents. Several times from 8/4/25 to 8/6/25, residents were observed entering the kitchen and helping themselves to drinks without washing their hands. During observations from 8/4/25 to 8/6/25, flies were observed to be in and around the kitchen and on the food served to the residents.
21	.405.04. Prohibited Applications.	The facility did not have the fuel-fired heating devices inspected annually, including the gas fireplace located in the common area. The regional administrator stated they did not have the fuel-fired heating inspections completed. ***Previously cited on 8/9/23***
22	.450. REQUIREMENTS FOR FOOD AND NUTRITIONAL CARE SERVICES.	The facility did not meet the standards for the Idaho Food Code. Kitchen inspection failed on 8/5/25. Mandatory re-inspection required within 10 days.
23	.460.02.d. Frequency of Meals.	The facility did not offer snacks and fluids between meals and at bedtime. During observations from 8/4/25 to 8/6/25, no snacks or fluids were offered to the residents. Multiple residents stated snacks and fluids were rarely offered.
24	39-3308 Assessment (4)b Assessments	The facility nurse did not review and implement new orders, which resulted in some residents not receiving their medications as ordered by their physician. For example: Resident #1's orders for Adempas, bupropion, duloxetine, Eliquis, Farxiga, gabapentin, metoprolol succinate, montelukast, olanzapine, pantoprazole, quetiapine, spironolactone, torsemide, and tramadol were all implemented by the administrator and not the facility nurse. Resident #3's scheduled vitamin D3 and as needed Senna Plus and Tylenol were not implemented at all. Additionally,

		Resident #3's oxycodone was implemented at the wrong time. The facility nurse stated she and the administrator both reviewed and implemented orders.
25	39-3321.2.d. Qualifications and Requirements of Administrator.	The facility did not identify and monitor patterns of accidents and incidents nor develop interventions to prevent recurrences. The administrator stated they previously had a system to track incidents, but did not currently track patterns of incidents and did not identify any patterns.
26	39-3321.4. Qualifications and Requirements of Administrator.	The administrator did not immediately implement corrective action to ensure incidents did not recur. For example: Resident #3 fell 6/28/25 and 7/8/25 and Resident #2 fell on 8/2/25. The administrator stated she did not immediately implement corrective action.
27	39-3321.5. Qualifications and Requirements of Administrator.	The administrator did not notify licensing and certification when Resident #2 fell and hit their head on 8/2/25 and required assessment at the emergency room. The administrator stated she did not report the incident to licensing and certification.