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	01/08/2026
Survey Team Leader	Survey Type		Response Due
Lu, Melvin	Health Care Non-Core Deficiency Follow-Up		02/07/2026

Item #	Rule (16.03.22)	Description
28	.151. ACTIVITY REQUIREMENTS.	During observations from 1/6/26-1/7/26, no activities were offered to residents. Multiple residents stated the facility did not offer activities and they wanted to participate in activities. Staff stated activities were not offered on a regular basis and assumed most residents were not interested. ***Previously cited 8/6/25***
28	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe and orderly manner. For example: Three outside window screens were missing, paint was falling off of several trim pieces on the outside of the building, siding was either cracked or missing along several exterior areas of the building, two exterior ventilation covers were missing, two exterior dryer vent covers were missing, an exterior light in the patio area did not have a cover, the driveway was observed to have a large missing piece leaving exposed raised areas causing a trip hazard, a tile was observed glued to the kitchen counter with caulking leaving the edges uncleanable, and the yard was observed to have several piles of dog feces. ***Previously cited on 8/6/25 and 2/28/25***
28	.305.03. Change in Resident Health Status.	The facility nurse did not assess residents after they experienced changes in their health status. For example:

		Resident #1 had experienced episodes of diarrhea on over the previous two days and also during the month of December on one occasion and Resident #2 had experienced swelling around the cite of their pain pump on 1/6/26. The administrator stated the previous facility nurse had not been assessing Resident #1 when they experienced diarrhea symptoms and Resident #2 had not been assessed by a facility nurse. ***Previously cited 8/6/25***
28	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #1 was taking Seroquel for isolation, buspirone for anxiety and Lamictal for depression and their six-month reviews did not include behavioral updates. In addition, Resident #3 was taking trazodone for longer than six months and the facility did not complete a 6-month psychotropic medication review. The facility administrator confirmed Resident #1's reviews were missing behavioral data and the facility did not complete a review for Resident #1. ***Previously cited 8/6/25***
28	.320.01. Use of NSA.	Residents' Negotiated Service Agreements (NSAs) did not clearly reflect the residents' needs nor describe the services to be provided (this should be outcome based). For example: Resident #1's NSA did not include instructions for caregivers on how to assist them with their isolation, anxiety nor depression, Resident #2's NSA did include the use of their pain pump and Resident #3's NSA did not provide instructions for caregivers on how to assist them with toileting, transferring, grooming, dressing nor bathing. The administrator verified the NSAs needed updated. ***Previously cited on 8/6/25***
28	.320.03. Signature, Date, and Approval of Agreement.	NSAs were not signed and dated by Resident #4 or their representative, who was admitted 10/3/25. The administrator stated they made an attempt to obtain a signature but did not subsequently follow up to get the NSA signed. ***Previously cited 8/6/25, 2/28/25, and 9/27/24***
28	39-3321.5. Qualifications and Requirements of Administrator.	The administrator did not notify licensing and certification

		when an unsampled resident fell and hit their head on 9/30/25 and went to the hospital for further assessment. They administrator stated they were not aware all incidents requiring assessment outside the facility are required to be reported to licensing and certification. ***Previously cited 8/6/25***