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
Katie Brahosky	Twin Falls	83301	05/20/2026
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	Healthcare Licensure/Followup and Complaint Investigation		06/19/2026

Item #	Rule (16.03.22)	Description
29	.305.03. Change in Resident Health Status.	The facility nurse did not conduct assessments when residents had changes in physical or mental status. For example, Resident #2 had falls on 2/9/26, 4/2/26, and 4/14/26, went to the hospital for a urinary tract infection and sepsis and was started on an antibiotic medication, they required a cushion in their chair to prevent pressure injuries, had a wound to their buttocks, started home health services, had bleeding and clots in their urinary catheter, and had a wound to their toe. These changes of conditions were confirmed by the resident and staff. The facility nurse stated she did not always assess residents for changes of condition, including for Resident #2's changes, partially because staff did not always alert her to the changes. See 330.04.c.vi. ***Previously cited on 1/8/26 and 8/6/25.***
30	.335.02. Standard Precautions.	The facility did not follow infection control standards. For example, during tour, several residents' bathrooms were observed to not have liquid soap. During medication pass, a medication technician was observed to not perform hand hygiene between residents' passes. Prior to meal service three staff members were observed to assist residents with cares and then went into the kitchen to assist with lunch and did not

		wear aprons. The facility nurse stated she expected staff to perform hand hygiene after each medication pass.
31	.405.03. Telephone.	The facility failed to maintain medical gas storage and handling in accordance with NFPA 99 Chapter 11. For example, an oxygen tank was observed to be unsecured and laid down on the floor in resident room #11 between 5/18/26 and 5/20/26.
32	39-3316 Resident Rights (2) Privacy	The facility did not protect residents' rights for privacy. For example, on 5/18/26 several residents' medication records, which included the residents' names and type of medication, were observed to be in an open file storage area on the outside the of administrator's office door, clearly visible to other residents and visitors. Between 5/19/26 and 5/20/26, the computer on the medication cart was left unlocked and residents' profiles and information was visible to other residents and visitors on several occasions. The administrator confirmed staff should protect residents' medical information.
33	.455. FOOD SUPPLY.	The facility did not maintain a seven day supply of non-perishable foods. The facility only had 25 cans of various vegetables, soup, chili, and tuna fish for 12 residents. The facility manager stated she missed the last shopping day prior to the surveyors' observations and stated she only shopped enough for a weeks supply of food.
34	.460.03.a. Food Preparation Area.	During the lunch preparation and service, one dog was observed inside the kitchen which later went into the dining room during meal service where another dog was already interacting with residents eating their meals. The administrator stated the dogs should not be in either the kitchen nor dining room during meals.
35	.305.02.b. Quarterly Nursing Assessments.	Residents were not administered their medications as ordered. For example, Resident #6 was observed asking staff why their Tramadol had not been available in the facility for several days. Resident #6's May 2025 medication administration record documented they had not received the schedule medication nine times from 5/17/26 to 5/19/26. The facility administrator

		stated Resident #6 had not received their Tramadol due to pharmacy issues and the same issue had happened in the past.
36	.330.04.c.vi. Resident Care Records.	The facility nurse was not consistently notified when residents had changes in physical or mental status. For example, when Resident #6's Tramadol was not available for several days, as well as several incidents with Resident #2 including falls or new wounds. The facility nurse stated she was not always notified of incidents and would at times find them inadvertently on reports.